STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225264	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42742 Based on interview and record review, the facility failed to treat one Resident (#63) with dignity and respect, out of a total sample of 19 residents, by not allowing the Resident to exercise his/her right to smoke. Findings include: Review of the facility's policy titled Smoking Policy, revised July 2017, indicated but was not limited to the following: -Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. -A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive), and as determined by staff. -Any smoking related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Resident #63 was admitted to the facility in July 2024. Review of Resident #63's quarterly Smoking Assessment, dated 10/29/24, indicated but was not limited to the following: -Resident desires to smoke - yes -Resident has been observed smoking and is able to do so safely and independently - yes -Resident has received facility smoking policy and agrees to follow it - yes -Resident agrees to have smoking items held at the nurses' station and not in their room or on their person - yes (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comments: Resident ruled safe by therapy to smoke independently. Smoking materials kept at nursing station. During an interview on 1/14/25 at 4:21 P.M., Resident #63 said since his/her room was changed from the 1st Floor Unit to the 2nd Floor Unit upon returning from the hospital after being sectioned (involuntary commitment of people experiencing a mental health crisis) due to an incident that had occurred on the 1st floor the end of December, he/she has not been allowed to go outside to smoke. The Resident said he/she was independent with smoking prior to this when residing on the 1st floor but now needs staff to go out with him/her because a key is needed for the elevator. Resident #63 said staff haven't taken him out and he/she feels stuck here. The Resident said he/she did nothing wrong when residing on the 1st floor and there's been no plan for him/her to smoke since arriving on the 2nd Floor Unit. Resident #63 said the Administrator said he'd review it in 30 days to see how he/she does. The Resident said he/she is independent and feels he/she should be allowed to go outside, and his/her rights are being violated. The Resident said he/she is not agreeable to wait 30 days as the Administrator had suggested and should be allowed to smoke saying, It's my right, and I feel like I'm on probation up here. The Resident also said he/she feels like a prisoner and has no freedom like he/she did on the first floor. During an interview on 1/14/25 at 4:30 P.M., Unit Manager (UM) #1 said there's an agreement with the Administrator that there wouldn't be the privilege of smoking unless staff assisted the Resident off the unit and down to smoke but the Resident hasn't gone out to smoke since arriving to the unit that she knew of. She said there were no cigarettes stored at the nurses' station for the Resident. During an interview on 1/15/25 at 8:19 A.M., Nurse #11 and Nurse #5 said since the Resident has been on the second floor, he/she has expressed the desire to smoke to everyone but he/she has an agreement with the Administrator that as long as he/she was on the second floor, he/she could not smoke. They said the Resident agreed to this, but it wasn't documented anywhere that they knew of. They said they themselves had not brought the Resident out to smoke and did not report the Resident's desire to smoke to anyone. Nurse #5 said the agreement is to not smoke even if with a staff member. Review of Resident #63's comprehensive care plans indicated a care plan for Smoking, initiated 8/23/24, which indicated the following: -Goals: Resident will practice safe smoking habits -Interventions: Resident will keep smoking materials at the nursing station, Resident will utilize a sign out book, and Resident offered Nicotine patch (declined), 8/23/24 Further review of the Smoking care plan did not indicate any current smoking related restrictions or concerns. Review of the Social Worker's progress note, dated 1/10/25, indicated but was not limited to the following: -Met with the Resident to discuss concerns regarding being moved to the second floor and not being allowed to go outside to smoke. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Social Worker's progress note, dated 1/14/25 at 12:13 P.M., indicated but was not limited to the following: -Ombudsman advised Social Worker that resident has the right to go out and smoke, even in a non-smoking facility. During an interview on 1/15/25 at 8:27 A.M., the Social Worker said she started in her role on 12/12/24 but became full-time on 12/30/24. She said she was unsure if there was any written agreement with the Administrator that the Resident would not smoke while on the 2nd floor but would ask. She said the Resident should be allowed to smoke, it was his/her right and that the Ombudsman was just in yesterday and said the Resident needs to be allowed to smoke so they're working on that now. She said the Resident said it isn't a big deal but mentions it a lot so obviously it is a big deal. She said the smoking care plan had not been updated to reflect the Resident's current need to be escorted out to smoke. The Social Worker said it's a non-smoking facility so had to confirm with the Ombudsman that it was okay for the Resident to smoke. During an interview on 1/15/25 at 10:22 A.M., the Administrator said the 30-day agreement had nothing to do with smoking, it was to monitor the Resident's behaviors so there was a disconnect with staff on this. He said he was not aware the Resident had expressed a concern related to smoking and no staff have come forward to him. He said the Resident leaves the facility to go to church on Sundays and left his/her cigarettes with the church driver and, since then, has never heard the Resident wanted to smoke. The Administrator said when the Resident was on the 1st floor, he/she was allowed to smoke independently. During an interview on 1/15/25 at 12:44 P.M., Resident #63 said until yesterday (two weeks after returning from the hospital) no one, including the Administrator and Director of Nursing (DON), had discussed a plan for him/her to smoke. The Resident said he/she was told by facility staff on 1/5/25 to leave his/her cigarettes with the church driver and not bring them back but could not identify who the staff person was that said it. He said the facility knows he/she doesn't have any cigarettes, and no one has helped him to obtain more or assist him/her to smoke.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 48695 Based on record review and interview, the facility failed to ensure one Resident's (#363) representative, as designated by the Resident, was able to make medical decisions for the Resident, in a sample of 23 records reviewed. Specifically, the facility failed to ensure that Resident #363's representative was able to change the Resident's Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form to meet their wishes. Findings include: Review of the facility's policy titled Advanced Directives, last revised December 2016, indicated but was not limited to: -Policy Statement- Advanced directives will be respected in accordance with state law and facility policy. -Policy Interpretation and Implementation: -Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. -If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. -Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. -The Director of Nursing Services or designee will notify the Attending Physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care. Review of the MOLST Form, dated August 2013, indicated but was not limited to: - Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. If no new form is completed, no limitations on treatment are documented and full treatment may be provided. Review of the website www.MOLST-MA.org indicated but was not limited to: - A person can ask for and receive needed medical treatment at any time, no matter what the MOLST form says. A person can also void the MOLST form and ask a clinician to fill out a new form with different instructions at any time. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #363 was admitted to the facility in October 2024 with diagnoses of encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition) and cerebral infarction (stroke). Review of the medical record for Resident #363 indicated a Physician completed a Health Care Activation Form on 10/11/24. The form indicated the physician determined Resident #363 lacked the capacity to make and/or communicate health care decisions. Review of Resident #363's MOLST signed by the Health Care Proxy (HCP), dated 10/16/24, indicated but was not limited to the following: - Do Not Resuscitate - Do Not Intubate and Ventilate - Transfer to Hospital - Use dialysis - Use artificial nutrition - Use artificial hydration Review of Resident #363's November Physician's Orders indicated but was not limited to: - Full Code, dated 10/16/24 - Invoked HCP, dated 10/20/24 - Follow MOLST, dated 10/16/24 Review of Resident #363's Interdisciplinary (IDT) Progress Notes indicated but not limited to: - 11/5/24: The resident's Family Representative (#3) called this writer and informed me that the invoked HCP would like to change the molst (sic) from DNR (Do Not Resuscitate) to Full Code. This writer advised her that he should immediately go to the hospital with the HCP to amend MOLST. Hospital RN (Registered Nurse) informed med (sic) that HCP amended the MOLST. Resident is a full code. Plan will be to update MOLST upon Resident #363 returning to the facility. - 11/12/24: Resident is listed as a DNR, but the HCP's daughter informed me that wishes are to be a full code. The HCP plans on being at the facility on Saturday to amend MOLST. - 11/18/24: Call placed to HCP. She stated she understands the importance of coming in to sign new MOLST reflecting Full Code status. and (sic) that as of now he/she is DNR. It was explained to her that patient will be DNR until she comes in to fill out a new one. She stated she will come when she can to fill out a new one. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephonic interview on 11/19/24 at 9:06 A.M., Family Representative (FR) #1 asked the surveyor to please call her daughter (FR #3) regarding Resident #363's advanced directives. During a telephonic interview on 11/20/24 at 12:04 P.M., FR #3 said FR #1 filled out the MOLST form for Resident #363 on the day he/she was admitted to the facility. FR #3 said FR #1 had signed a lot of forms that day and she did not realize what she was signing. FR #3 said FR #1 and Resident #363's wish are for Resident #363 to have been a Full Code. FR #3 said it was difficult for FR #1 to get to the facility because she does not drive. FR #3 said the facility had not offered another way for FR #1 to amend Resident #363's MOLST other than coming into the facility. During an interview on 11/18/24 at 2:39 P.M., Nurse Practitioner (NP) #2 said according to the facility records Resident #363 was a DNR. NP #2 and the surveyor reviewed Resident #363's MOLST and IDT progress notes. NP #2 said FR #1 would need to come the facility to fill out a new a MOLST, that would be the only way to amend the MOLST. During an interview on 11/18/24 at 3:37 P.M., Nurse #6 said she called Resident #363's HCP and FR #1 said her wishes for Resident #363 would be for him/her to be a full code. Nurse #6 said FR #1 would have to come to the facility to fill out a new MOLST. Nurse #6 said until FR #1 can come in and fill out a new MOLST Resident #363 would be considered a DNR. During an interview on 11/19/24 at 10:31 A.M., Nurse #5 said Resident #363 order for Full Code was a mistake. Nurse #5 and the surveyor reviewed Resident #363's MOLST. Nurse #363 said FR #1 could only change Resident #363's Advanced Directives if she would come in and sign a new MOLST. During a telephonic interview on 11/19/24 at 2:46 P.M., Physician #2 said the only way for FR #1 to change Resident #363's Advanced Directives would be for her to come in and sign a new MOLST. During an interview on 11/20/24 at 11:22 A.M., the Director of Nursing (DON) said Resident #363's MOLST could have been voided by two nurses to make him/her a Full Code. The DON said the facility could have also mailed Resident #363's HCP a new MOLST or someone could have driven one to his/her HCP's house. The DON said Resident #363 should have been made a Full Code per his/her HCP's wishes.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34145 Based on interview and record review, the facility failed to notify the Physician of recommendations or changes in condition for one Resident (#102), out of a total sample of 23 residents. Specifically, the facility failed to notify the physician of the lack of availability and delay in administering intramuscular (IM- injection deep into muscle tissue) antibiotic medication as ordered for Resident #102. Findings include: Review of the facility's policy titled Resident Change in Condition Policy, last reviewed February 2024, indicated but was not limited to: -Purpose: To facilitate nursing response for residents exhibiting change in condition, and to define requirements for notification of change in condition. - Procedure: -The resident's Physician, legal representative and/or responsible party is to be notified. -A change in condition will be documented in the nurse's notes, shift report book, and other area of the medical record as required. Resident #102 was admitted to the facility in September 2023 and had diagnoses including a history of urinary tract infections (UTI). Review of a Physician's note, dated 5/20/24, indicated Resident #102 presented with nausea and vomiting which the physician indicated was unusual for the Resident. The note indicated he would order a urinalysis with culture and sensitivity and screening chemistry and blood count. Review of a Nurse's note, dated 5/27/24 at 5:36 A.M., indicated Resident #102's urine results came back positive for a UTI. The physician was notified and gave an order for IM injection of Rocephin 1 gram (gm) once a day for three days. Review of a Physician's note, dated 5/27/24, indicated Resident #102 was seen by the physician and almost a week after the labs were ordered, the results were in and were consistent with a urinary tract infection caused by Escherichia coli (E. coli - a group of bacteria that can cause infections in your urinary tract). The physician indicated he initiated an empirical treatment with Rocephin 1 gm IM daily for three days. Review of the medical record indicated a telephone order (T.O.), dated 5/27/24, for Rocephin IM 1 gm every night at 6:00 P.M. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurse's note, dated 5/27/24 at 2:30 P.M., indicated the pharmacy informed the nurse that there was only one medication run secondary to the holiday and it would arrive on the evening run. The nurse indicated there was no access to the electronic medication dispensing system, and she changed the medication administration time in the computer. The note failed to indicate the nursing supervisor or Director of Nursing (DON) was notified of the need to access the electronic medication dispensing system to obtain the Rocephin that was unavailable from the pharmacy, and failed to indicate the physician was notified it was unavailable and was not administered as ordered. Review of a Nurse's note, dated 5/27/24 at 8:33 P.M., indicated the Rocephin had not arrived from the pharmacy, and the Resident was unable to start the medication. The Nurse's note failed to indicate the physician/physician extender was notified that the antibiotic was not administered as ordered. Review of a Nurse's note, dated 5/28/24 at 7:53 P.M., indicated Resident received Rocephin IM on 5/28/24. The note failed to indicate the physician was notified that the antibiotic was administered on 5/28/24 and not 5/27/24 as ordered. During an interview on 11/15/24 at 9:26 A.M., Nurse #6 said she wrote the note dated 5/27/24. She said the pharmacy could not deliver the Rocephin due to the holiday, and no one was in the building that has access to the electronic medication dispensing system. Nurse #6 said she did not notify the physician that the medication was not available, could not access the electronic medication dispensing system, and was not administered as ordered. During an interview on 11/15/24 at 9:56 A.M., Unit Manager #1 reviewed Resident #102's medical record and said the process is that if a medication is not available from pharmacy, the physician is to be notified, then nursing will access the medication from the electronic dispensing system or obtain an order to hold the medication and start it when it is available. During interviews on 11/15/24 at 10:25 A.M. and 12:06 P.M., the Director of Nursing (DON) reviewed Resident #102's medical record and confirmed that the Resident was not administered Rocephin on 5/27/24 as ordered and the physician should have been notified. During an interview on 11/15/24 at 2:54 P.M., Physician #1 said he was not notified that Rocephin was not available on 5/27/24 and it was not administered to Resident #102 until 5/28/24.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 34145 Based on record review and interview, the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNC-notice issued to a resident who is receiving benefits under Medicare Part A when all covered services end) and a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN -notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) were issued for two Residents (#60 and #163) of three residents reviewed. Specifically, the facility failed: 1. For Resident #60, to issue the SNF ABN notice and NOMNC so the Resident/Resident Representatives could decide if they wished to continue receiving skilled services that may not be paid for by Medicare, and were aware of the financial responsibility they may have to assume; and 2. For Resident #163, to issue the NOMNC so the Resident/Resident Representatives could decide if they wished to continue receiving skilled services that may not be paid for by Medicare, and were aware of the financial responsibility they may have to assume. Findings include: 1. Resident #60 was admitted to the facility in February 2024. Review of the SNF Beneficiary Protection Notification Review form, completed by the facility, indicated Resident #60 received Medicare A Skilled Benefits from 6/3/24 until 8/1/24. The SNF Beneficiary Protection Notification Review form indicated the facility initiated the discharge from Medicare A when benefits were not exhausted and that a NOMNC was not provided. The SNF Beneficiary Protection Notification Review form also indicated that a SNF ABN was not provided. A handwritten notation on the form indicated the social worker never gave them to the Resident or made him/her aware. 2. Resident #163 was admitted to the facility in May 2024. Review of the SNF Beneficiary Protection Notification Review form, completed by the facility, indicated Resident #163 received Medicare A Skilled Benefits from 5/16/24 until 5/21/24. The SNF Beneficiary Protection Notification Review form indicated the discharge from Medicare A when benefits were not exhausted was voluntary (i.e. self-initiated in consultation with physician, family, or Against Medical Advice) and that a NOMNC was not provided. A handwritten notation on the form indicated the social worker failed to communicate discharge to initiate the non-coverage notice. During an interview on 11/18/24 at 2:45 P.M., the Business Office Manager confirmed the required notices were not issued to Residents #60 and #163. She said the social worker that worked at the facility during this time period was responsible for ensuring the SNF ABN and NOMNC notices were provided to Residents as required, but she did not do it. The Business Office Manager said she has taken over responsibility of providing the notices to ensure it gets done.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34145 Based on observation, record review, and interviews, the facility failed to provide a safe environment free from physical abuse, sexual abuse, and neglect for one Resident (#77), from a total sample of 23 residents. Specifically, the facility failed to ensure Resident #77, with severe cognitive impairment and a history of aggression, violence, and sexually inappropriate behaviors toward staff and other residents, did not physically and sexually abuse other residents; and that Resident #77 was protected from being physically abused by other residents. Using the reasonable person concept, a person would experience emotional distress after being hit, unprovoked, and after being sexually abused. Findings include: Review of the facility's policy titled Resident Abuse, Mistreatment, and Neglect Policy and Procedure, last revised 4/2017, indicated but was not limited to: -Purpose: To promote prevention, protection, prompt reporting and interventions in response to alleged, suspected, or witnessed abuse/neglect/exploitation of any resident. -There are many types of abuse, including but not limited to: Neglect: The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Verbal abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Physical abuse: Includes hitting, slapping, pinching, and kicking. Sexual abuse: Includes, but is not limited to sexual harassment, sexual coercion, or sexual assault. -All staff receive training on hire, and ongoing, on courses related to abuse risk and prohibition practices. -All staff members, consultants, contractors, volunteers, and other caregivers who provide care and services on behalf of the Facility are responsible for reporting any incident that may constitute or lead to any form of abuse, neglect, or exploitation of our residents. -During the course of any investigation, the safety and protection of all residents is of utmost priority, and the Facility makes provisions to protect residents from harm during investigations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-All alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than two hours after the allegation is made. -The Facility will analyze allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property through the Quality Assessment and Assurance process to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Resident #77 resides on the Dementia Special Care Unit (DSCU-specialized care to residents with dementia through a combination of additional and on-going dementia care training, expanded activities, and a safe and comfortable physical environment). The DSCU has a total of 38 residents of which 37 have been adjudicated incompetent (inability or unfitness to manage one's affairs because of mental condition) by the court. Of the 37 residents adjudicated incompetent, 14 residents are female and 23 are male. Review of the Minimum Data Set (MDS) assessment, dated 10/15/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 00 out of 15, exhibited both physical behaviors toward others (e.g., hitting, kicking, pushing, scratching, and grabbing) and verbal behaviors toward others (e.g., threatening others, screaming at others, cursing at others) and wandering. The MDS indicated the Resident had an activated Healthcare Proxy (HCP- healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. Review of comprehensive care plans indicated a care plan for Alteration in Behaviors, dated 12/11/21, indicated but was not limited to the following interventions: -Monitor behavioral episodes every shift. -Monitor for changes in behavior, notify physician of changes noted. -Bring to quiet environment. -Observe to identify potential triggers to escalating behavior. -Provide 1:1 for calming and reassurance. -Observe Resident for intrusive behavior while wandering, intervene as necessary. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Set limits with resident in regard to socially inappropriate behavior. -Withdraw attention from resident during attention seeking, acting out, socially inappropriate behavior; give attention during appropriate behavior. -Tell the Resident that the behavior is unacceptable, that you object to the behavior, not the resident. -Assess to determine if the behavior is a sign of an unmet need (need to toilet, thirst, hunger, discomfort, pain, etc.). -Offer alternative ways for the resident to cope with situations that trigger behavior (i.e., relaxation techniques, breathing techniques, etc.) The goal of the care plan, dated 12/11/21, indicated: -Resident will be effectively redirected from aggressive behavior with each episode daily with a stop guard banner placed across his/her doorway to prevent wanderers (sic). -Resident will demonstrate cooperation with care as evidenced by clean and neat appearance. Further review of comprehensive care plans failed to indicate a care plan had been developed with interventions to prevent Resident #77 from physically abusing other residents, being physically abused by other residents, and prevent sexually inappropriate behaviors toward female residents. During an interview with Nurse #13 and Unit Manager (UM) #1 on 11/18/24 at 10:32 A.M., Nurse #13 said Resident #77 has dementia and when he/she first came to the unit, he/she was aggressive and argumentative. She said the Resident is fixated on one particular female resident and follows her around the unit. UM #1 said one of the Resident's baseline behaviors is to wander into female residents' rooms, stand at their bedside watching them and fondle his/her genitals. Neither Nurse #13 nor UM #1 identified this behavior as potential abuse and said they had never reported these behaviors to the Director of Nursing (DON) or Administrator. The Unit Manager reviewed Resident #77's comprehensive care plans and said a care plan had not been developed to address the Resident's sexually inappropriate behaviors. During an interview on 11/18/24 at 1:43 P.M., the Therapeutic Activity Director (TAD) said Resident #77 now resides on the DSCU. She said when he/she resided on the first floor a few months ago, he/she would stand outside women's rooms and egg them on verbally and with sexually inappropriate gestures. During an interview on 11/19/24 at 11:55 A.M., consultant psychiatric Nurse Practitioner (NP) #3 said Resident #77 used to live on the first-floor unit and was moved to the third floor when he/she began to attempt to leave the building. The NP said once the Resident moved to the third floor, he was told the Resident began to exhibit hypersexual behavior and wander into female residents' rooms. He said he tries to speak with staff to get an update on the Resident's behaviors before he sees the Resident, but the challenge is that there is such great turnover in staff, many don't know anything about the Resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/20/24 at 8:55 A.M., Nurse #8 and UM #1 said the only intervention for increased supervision on the unit is purposeful rounding. They defined purposeful rounding as when staff walk around the unit and check in resident rooms. They said there is no schedule for which staff are responsible for purposeful rounding and there is no documentation to confirm it is being done. They said they just assume everyone is doing it. UM #1 said there has not been any increased supervision of Resident #77 in response to his/her ongoing inappropriate sexual behaviors. Review of Resident #77's medical record indicated Resident #77 hit other residents on two occasions (12/14/23 and 2/20/24), was struck by another resident on two occasions (9/25/24 and 10/10/24), and sexually harassed/exhibited sexually inappropriate behaviors toward residents on two occasions (1/3/24 and 2/29/24). Review of the Health Care Facility Reporting System (HCFRS- system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 11/18/24, indicated the facility failed to submit reports of resident-to-resident abuse as required for five of six incidents dated: 12/14/23, 1/3/24, 2/29/24, 9/25/24, and 10/10/24. During an interview on 11/20/24 at 9:50 A.M., the DON said Resident #77 has a history of aggression and sexually inappropriate behaviors. She reviewed Resident #77's medical record with the surveyor as follows: 1. Review of a Nurse's note, dated 12/14/23, indicated Resident #77 was found to be sexually inappropriate this shift and smacked one of the female residents in the butt. Review of the medical record failed to indicate any protective measures were put in place to protect any residents from Resident #77's violent, sexually inappropriate behavior. The DON said she was not notified of this incident. She said it should have been reported to DPH, should have been investigated, and protective interventions put into place to protect other residents from Resident #77's sexually inappropriate behavior, but was not. She said the Resident should probably have been sent out to the hospital via a section 12 (According to https://www.mass.gov, Massachusetts General Law Chapter 123, Sections 12 (a) and 12 (b), controls the admission of an individual to a general or psychiatric hospital for psychiatric evaluation and, potentially, treatment. Section 12(a) allows for an individual to be brought against his or her will to such a hospital for evaluation. Section 12(b) allows for an individual to be admitted to a psychiatric unit for up to three business days against the individual's will or without the individual's consent), and the physician, HCP and police should also have been notified. 2. Review of a Nurse's note, dated 1/3/24, indicated Resident #77 was observed wandering during the night and intrusively entering other residents' (female) rooms and touching his/her privates. Review of the medical record failed to indicate any protective measures were put in place to protect any residents from Resident #77's sexually inappropriate behavior. The DON said she was not notified of this incident. She said it should have been reported to DPH, should have been investigated, and protective interventions put into place to protect other residents from Resident #77's sexually inappropriate behavior, but was not. She said the Resident should have been placed on one-to-one (1:1) supervision, sent out to the hospital via a section 12. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record indicated an interdisciplinary care plan meeting was held on 1/24/24. However, the current Alteration in Behaviors care plan was reviewed and renewed with no new interventions to address Resident #77's sexually inappropriate behaviors. 3. Review of a Nurse's note, dated 2/20/24, indicated a visitor observed Resident #77 hit another resident (severely cognitively impaired) in the head twice. Resident #77 was transferred to the hospital for evaluation via a section 12. Review of the medical record failed to indicate, following the Resident's return to the facility, any protective measures were put in place to protect any residents from being hit by Resident #77. The DON said protective interventions should have been put into place when the Resident returned from the hospital to protect other residents but was not. The DON said the resident that was struck by Resident #77 has severe cognitive impairment, and using the reasonable person concept, the resident would feel frightened and threatened. 4. Review of a Nurse's note, dated 2/29/24, indicated Resident #77 was wandering in the halls and intruding in other residents' rooms during the evening. A resident was heard yelling out and a Certified Nursing Assistant (CNA) entered the room to check on the resident and observed Resident #77 in the resident's room. The resident reported to the CNA that Resident #77 had exposed him/herself while in his/her room. Further review of the medical record failed to indicate law enforcement was notified of the sexual abuse as required. Review of the medical record failed to indicate any protective measures were put in place to protect any residents from Resident #77 exposing him/herself to them. The DON said she was not notified of this incident. She said it should have been reported to DPH, should have been investigated, and protective measures should have been put in place to protect other residents from Resident #77's sexually inappropriate behavior, but was not. She said the police should have been notified and the Resident sent out to the hospital for evaluation. The DON said they probably would not have accepted the Resident back after hospitalization because they are not able to care for his/her behavioral needs. 5. Review of a Nurse's note, dated 9/25/24, indicated Resident #77 was in the hall talking with another resident. The other resident (unidentified) became agitated and punched Resident #77 in the right arm. Review of the medical record failed to indicate the facility implemented any protective measures to protect Resident #77, who is vulnerable (due to severe cognitive impairment and a history of agitation and aggression), and any other residents from being hit by the unidentified resident. The DON said she was not notified of this incident. She said it should have been reported to DPH, should have been investigated, and protective interventions put into place to protect Resident #77 from being hit by the unidentified resident but was not. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Review of a Nurse's note, dated 10/10/24, indicated Resident #77 was struck by another resident (unidentified). Review of the medical record failed to indicate any protective measures were put in place to protect Resident #77, or any other residents from being hit by the unidentified resident. The DON said she was not notified of this incident. She said it should have been reported to DPH, should have been investigated and protective interventions put into place to protect Resident #77 and any other residents from being hit by the unidentified resident but was not. During an interview on 11/20/24 at 10:30 A.M., the DON reviewed a Nurse's note, dated 10/22/24 and written by Nurse #14. The note indicated Resident #77 was sexually inappropriate throughout the day. No other information was documented in the note. At this time, the DON called Nurse #14 in the presence of the surveyor. Nurse #14 said she is an agency nurse and last worked on 10/22/24. She said on that day, the Resident was verbally sexually inappropriate toward staff, kissing female residents' arms, and trying to get females to lay in bed with him/her. Nurse #14 said during the shift, Resident #77 called her over to him/her, grabbed his/her own genitals and shook it at her. The Nurse said she reported the behaviors to staff (could not remember who) and was told it was baseline behavior for the Resident and he/she always does that. At this time, the DON called UM #2 and told her to place Resident #77 on 1:1 supervision immediately and indefinitely. During a telephone interview on 11/20/24 at 11:45 A.M., Resident Representative (RR) #2 said Resident #77 has resided at the facility for a few years. She said Resident #77 has dementia and it causes him/her to do aggressive and sexual behaviors that are not welcomed by the other residents. RR #2 said not long after the Resident was admitted to the facility, the Administrator called her to discuss transferring the Resident to a locked facility due to concerns for other residents' safety. RR #2 said she did not agree to that because the facility was too far away and the Resident's spouse would not be able to visit him/her very often. She said she is very grateful that the Administrator is allowing the Resident to remain in the facility despite their concerns about the safety of other residents. During an interview on 11/20/24 at 3:00 P.M., Nurse #11 said one of Resident #77's baseline behaviors is to stand outside female residents' rooms, sometimes enter their rooms and stare at them. She said this makes the residents uncomfortable and they don't like it. She said she wrote the Nurse's note on 12/14/23 that indicated the Resident was found to be sexually inappropriate and noted to have smacked one of the female residents in the butt. She said she does not recall who the resident was that got hit by Resident #77. Nurse #11 said she did not report it to the supervisor or DON and did not put in place any protective measures or interventions to protect any of the other residents from being assaulted. On 11/20/24 at 3:26 P.M., the surveyor entered the third-floor unit from the stairwell and observed a CNA standing in the hallway entering data into a computer that was mounted on the wall. The CNA was positioned with her back to Resident #77's room which was approximately 40 feet away at the end of the hallway. The surveyor then walked down a perpendicular hallway and observed two nurses and one CNA standing at the nursing station talking. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/20/24 at 3:27 P.M., the surveyor observed Resident #77 in his/her room sleeping in a recliner chair with the door to his/her room open and no stop guard banner placed across his/her doorway to prevent wandering residents from entering as indicated on the care plan. No staff were with the Resident to provide 1:1 supervision. The CNA was still standing in the hallway with her back to Resident #77's room as she entered data into a computer. On 11/20/24 at 3:34 P.M., the surveyor observed Resident #77 standing in the doorway of his/her room looking down the hallway. The CNA was still standing in the hallway with her back to Resident #77's room as she entered data into a computer. A female resident emerged from a room across the hall and was observed walking down the hallway, turning around and walked to Resident #77's room and entered. A few moments later, the female resident exited Resident #77's room. No staff was providing 1:1. On 11/20/24 at 3:40 P.M., the surveyor observed UM #1 walk in the hallway approximately 50 feet away and notice the surveyor. She then approached CNA #10 and whispered in her ear. At this time, CNA #10 walked down the hallway and approached Resident #77 as he/she stood in the doorway of his/her room. The CNA said that she works on the other hallway and was told to go to Resident #77's room to assist him/her with something, but she didn't know what the Resident needed. The CNA was observed walking up and down the hallway and not providing 1:1 supervision to Resident #77. On 11/20/24 at 3:46 P.M., CNA #9 arrived at Resident #77's room. She said she was there to provide 1:1 supervision until the Helping Hands (staff designated to provide supervision to residents) come to take over. She said Resident #77 has sexually inappropriate behaviors toward females. She said the Resident stands outside female residents' rooms and stares at them and they don't like it. During an interview on 11/21/24 at 8:36 A.M., the Administrator said Resident #77 has had physical altercations and sexual behaviors since admission to the facility. He said they tried to transfer the Resident to another facility for the safety of the Resident and other residents, but the Resident's spouse and daughter became upset and were adamant that he/she not be moved. The Administrator said every time the Resident has a behavioral episode, they contact the family and discuss moving him/her, but the family refuses. He said the interdisciplinary team meets every morning and discusses issues that arise with residents, such as Resident #77's behaviors. The Administrator was unable to provide any evidence that the interdisciplinary team has discussed and addressed Resident #77's violent and sexually inappropriate behaviors to prevent the Resident from abusing others and being abused. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 11/21/24 at 10:06 A.M., Social Worker (SW) #1 said that she used to work at the facility full-time for about 14 or 15 months ending in July 2023. She said she started working at the facility again for 15 hours a week on 11/4/24 and has not been notified of any incidents or behaviors involving Resident #77. She said when she was here over a year ago, Resident #77 exhibited aggressive behaviors toward other residents, was threatening, had no boundaries and residents were fearful of him/her. SW #1 said the Resident's presence would make female residents uneasy as he would enter their rooms when they were getting ready for bed. She said the administration wanted to transfer the Resident to another facility due to his/her unmanageable behaviors and for the safety of other residents, but the family declined. She said after the family declined a transfer to another facility, the only interventions put into place were psychiatric medication review, counseling, and increased family visits. The Social Worker said multiple families had come to the administration to complain about the Resident's behaviors. She said she had spoken to RR #2 several times about his/her behaviors and the need to find a safe alternative for the Resident and to prevent an unsavory environment. She said she explained to RR #2 that the Resident's continued behavior may be considered a crime and she wouldn't want her loved one in prison at his/her age. During a telephone interview on 11/22/24 at 3:08 P.M., Physician #4 said Resident #77's anxiety, chronic behavior problems and aggression are not new, and he defers to his NP (#4) and the psychiatric NP to manage the Resident's psychiatric care. He said as far as he is aware, the Resident's inappropriate sexual behaviors are verbal and are directed at staff and visitors. He said he has not been told about any physical behaviors of hitting or being sexually inappropriate with other residents. The surveyor reviewed the six incidents noted above and subsequent interviews with staff with the Physician. He said he was surprised and had not heard of anything like that. He said he recalls being at the nursing station on the second floor and observed Resident #77 speaking in explicit language. He said staff had concerns about the Resident's behavior specifically because there were multiple female residents on the floor that were ambulatory, and he/she was getting into explicit verbal altercations with them. He said he did not think they were doing anything to prevent it from happening. He said he overheard staff at the nursing station discussing their concerns about Resident #77's larger risk of sexual abuse on the unit with him/her living there. He said he does not recall when or who participated in the conversation he overheard. Multiple attempts to contact NP #4 for an interview were unsuccessful. No additional documentation was provided to the survey team by the time of the exit conference. Refer to F607, F609, F610, F740, F741

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). 34145 Based on observation, record review, and interviews, the facility failed to ensure one Resident (#67), out of a total sample of 19 residents, was free from involuntary seclusion, when during the day shift on 1/14/25, staff applied a stop sign banner secured with Velcro strips (fabric and vinyl banner used to deter wandering residents from entering restricted areas) across the entry door to the Resident's room preventing him/her from coming out of their room. Findings include: Review of the facility's policy titled Abuse Prevention Policies and Procedures, revised 11/2024, indicated that facility residents had the right to be free from involuntary seclusion. Resident #67 was admitted to the facility in September 2021 and had diagnoses including unspecified dementia with behaviors, anxiety, and major depression. Review of the Minimum Data Set (MDS) assessment, dated 1/6/25, indicated Resident #67 had both short- and long-term memory problems, severely impaired skills for daily decision making, and behaviors which included wandering. Review of Resident #67's Behavior Plan of Care, reviewed and revised 1/2025, indicated that Resident #67 wandered, was intrusive, and interventions included that staff were to intervene and redirect when wandering. On 1/14/25, the surveyor made the following observations: -10:45 A.M., a fabric and vinyl stop sign that was secured to the door frame with Velcro strips and extended across the entryway to Resident #67's room that he/she shared with two other residents. Two signs were secured to the banner: one was a large, red arrow, and the other had the word Desvio (Portuguese for detour) printed on it. -10:47 A.M., Resident #67 was in his/her room pacing. The Resident approached the doorway and pushed and pulled on the banner to try and remove it but could not pull it off. The Resident bent over at the waist and tried to go under the banner to get out of the room, but the sign became caught on the Resident's head. The Resident turned around and walked toward his/her bed. -10:51 A.M., Resident #67 was in his/her room pacing. The Resident approached the doorway and pushed and pulled on the banner to try and remove it but could not pull it off. The Resident bent over at the waist and tried to go under the banner to get out of the room, but the sign became caught on the Resident's head. The Resident stood in the doorway and stared down the hallway. He/she then turned around and walked toward his/her bed. -10:53 A.M., Resident #67 approached the doorway to his/her room and stared down the hallway. The Resident pushed and pulled on the banner to try and remove it but could not pull it off. He/she then turned around and walked toward his/her bed. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10:55 A.M., laundry staff carrying clothing on hangers, removed one side of the stop sign banner from the doorway, entered the room and closed the door. The laundry staff then exited the room, closed the door and re-applied the stop sign banner across the door. -10:56 A.M., Resident #67 opened the door and pushed and pulled on the banner to try and remove it but could not pull it off. The Resident bent over at the waist and tried to go under the banner to get out of the room, but the sign became caught on the Resident's head. The Resident stood at the doorway and started down the hallway. The Resident then turned around and walked toward his/her bed. -10:58 A.M., Resident #67 approached the doorway and pushed and pulled on the banner to try and remove it but could not pull it off. The Resident's pants were pulled down to his/her knees as he/she stared down the hallway. During an interview on 1/14/25 at 11:00 A.M., CNA #3 removed the stop sign from the Resident's doorway. She said the stop sign across the Resident's doorway is to prevent Resident #77 from entering the room and bothering the resident in the A bed. She said the sign is not intended for any purpose for Resident #67. During an interview on 1/15/25 at 11:17 A.M., Nurse Practitioner #2 said she is not aware of any issue related to Resident #67 that would require a stop sign across the doorway to prevent him/her from leaving the room. During an interview on 1/15/25 at 11:25 A.M., Nurse #4 said the stop sign across Resident #67's doorway is to deter Resident #77 from entering the room and bothering the resident in the A bed. The surveyor reviewed observations of Resident #67's multiple attempts to leave his/her room but was unable to do so because he/she could not remove the banner. Nurse #4 said that the banner could be considered a type of restraint because the resident is unable to remove it and it is preventing him/her from walking and wandering on the unit whenever he/she wants to. During an interview on 1/15/25 at 1:05 P.M., the surveyor shared observations with the Director of Nursing (DON) of Resident #67's multiple attempts to leave his/her room but was unable to do so because he/she could not remove the banner. The DON said the stop sign outside Resident #67's room is so that Resident #77 does not go into the room to bother the resident in the A bed. She said they did not consider how the stop sign would effect the other residents residing in the room. She said since Resident #67 is unable to remove the stop sign banner and it is preventing him/her from leaving his/her room and wander freely, they need to remove it. She said Resident #77 is on one-to-one supervision (1:1) and can be redirected if necessary, so the banner is not needed.

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F 0607 Level of Harm - Actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34145 Based on interviews and record review, the facility failed to implement their abuse policy for one Resident (#77), out of a sample of 23 residents. Specifically, the facility failed to ensure nursing staff notified the Director of Nurses (DON) and Administrator about allegations of physical and sexual abuse; keep residents safe by implementing protective measures to prevent further abuse by Resident #77; keep Resident #77 safe by implementing protective measures to prevent further physical abuse by other residents; report and investigate abuse allegations as required; report allegations to the state agency (SA) and law enforcement; and ensure all staff received required abuse training. Using the reasonable person concept, a person would experience emotional distress after being hit, unprovoked, and after being sexually abused. Findings include: Review of the facility's policy titled Resident Abuse, Mistreatment, and Neglect Policy and Procedure, last revised 4/2017, indicated but was not limited to: -Purpose: To promote prevention, protection, prompt reporting and interventions in response to alleged, suspected or witnessed abuse/neglect/exploitation of any resident. -There are many types of abuse, including but not limited to: Neglect: The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Verbal abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Physical abuse: Includes hitting, slapping, pinching, and kicking. Sexual abuse: Includes, but is not limited to sexual harassment, sexual coercion, or sexual assault. -All staff receive training on hire, and ongoing, on courses related to abuse risk and prohibition practices. -All staff members, consultants, contractors, volunteers, and other caregivers who provide care and services on behalf of the Facility are responsible for reporting any incident that may constitute or lead to any form of abuse, neglect, or exploitation of our residents. -During the course of any investigation, the safety and protection of all residents is of utmost priority, and the Facility makes provisions to protect residents from harm during investigations. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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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 0607 Level of Harm - Actual harm Residents Affected - Some	-All alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than two hours after the allegation is made. -The Facility will analyze allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property through the Quality Assessment and Assurance process to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) assessment, dated 10/15/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 00 out of 15, exhibited both physical behaviors toward others (e.g., hitting, kicking, pushing, scratching, and grabbing) and verbal behaviors toward others (e.g., threatening others, screaming at others, cursing at others) and wandering. The MDS indicated Resident #77 had an activated Healthcare Proxy (HCP- healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. Review of Resident #77's medical record indicated Resident #77 hit other residents on two occasions (12/14/23 and 2/20/24), was hit by another resident on two occasions (9/25/24 and 10/10/24), and sexually harassed/exhibited sexually inappropriate behaviors toward residents on two occasions (1/3/24 and 2/29/24). Review of the Health Care Facility Reporting System (HCFRS- system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 11/18/24, indicated the facility failed to submit reports of resident-to-resident abuse as required for five of six incidents dated: 12/14/23, 1/3/24, 2/29/24, 9/25/24, and 10/10/24. During an interview on 11/20/24 at 9:50 A.M., the Director of Nursing (DON) said Resident #77 has a history of aggression and sexually inappropriate behaviors. She reviewed Resident #77's medical record with the surveyor as follows: 1. Review of a Nurse's note, dated 12/14/23, indicated Resident #77 was found to be sexually inappropriate this shift and smacked one of the female residents in the butt. Review of the medical record failed to indicate any protective measures were put in place to protect any residents from Resident #77's violent and sexually inappropriate behavior. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	The DON said she was not made aware of this incident. She said it should have been reported to DPH, investigated, and protective interventions put into place to protect any of the other residents from Resident #77's sexually inappropriate and violent behavior. She said the Resident should probably have been sent out to the hospital via a section 12 (According to https://www.mass.gov, Massachusetts General Law Chapter 123, Sections 12 (a) and 12 (b), controls the admission of an individual to a general or psychiatric hospital for psychiatric evaluation and, potentially, treatment. Section 12(a) allows for an individual to be brought against his or her will to such a hospital for evaluation. Section 12(b) allows for an individual to be admitted to a psychiatric unit for up to three business days against the individual's will or without the individual's consent), and the physician, HCP and police should also have been notified. 2. Review of a Nurse's note, dated 1/3/24, indicated Resident #77 was observed wandering during the night and intrusively entering other residents' (female) rooms and touching his/her privates. Review of the medical record failed to indicate any protective measures were put in place to protect any residents from Resident #77's sexually inappropriate behavior. The DON said she was not made aware of this incident and it should have been reported to DPH and investigated. She said the Resident should have been placed on 1:1 supervision, sent out to the hospital via a section 12, and protective interventions put in place to protect any of the other residents. 3. Review of a Nurse's note, dated 2/20/24, indicated a visitor observed Resident #77 hit another resident in the head twice. Resident #77 was transferred to the hospital for evaluation via a section 12. Review of the medical record failed to indicate following the Resident's return to the facility, any protective measures were put in place to protect any residents from being hit by Resident #77. The DON said protective interventions should have been put into place when the resident returned from the hospital to protect any of the other residents from Resident #77's violent behavior. 4. Review of a Nurse's note, dated 2/29/24, indicated Resident #77 was wandering in the halls and intruding in other residents' rooms during the evening. A resident was heard yelling out and a Certified Nursing Assistant (CNA) entered the room and observed Resident #77 in the resident's room. The resident reported to the CNA that Resident #77 had exposed him/herself while in his/her room. Further review of the medical record failed to indicate law enforcement was notified of the sexual abuse as required. Review of the medical record failed to indicate any protective measures were put in place to protect any residents from Resident #77 exposing him/herself to them. The DON said she was not made aware of this incident and it should have been reported to DPH, the police notified and the Resident sent out to the hospital for evaluation. She said they should have put protective interventions in place to protect any of the other residents from sexual abuse. The DON said they probably would not have accepted the Resident back after hospitalization because they are not able to care for his/her needs. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	5. Review of a Nurse's note, dated 9/25/24, indicated Resident #77 was in the hall talking with another resident. The other resident (unidentified) became agitated and punched Resident #77 in the right arm. Review of the medical record failed to indicate any protective measures were put in place to protect Resident #77, who is vulnerable (due to severe cognitive impairment and a history of agitation and aggression), and any other residents from being hit by the unidentified resident. The DON said she was not aware of this incident and it should have been reported to DPH, investigated and protective interventions put into place to protect Resident #77 and any of the other residents from physical abuse by the unidentified resident. 6. Review of a Nurse's note, dated 10/10/24, indicated Resident #77 was struck by another resident (unidentified). Review of the medical record failed to indicate any protective measures were put in place to protect Resident #77, or any other residents from being hit by the unidentified resident. The DON said she was not made aware of this incident and it should have been reported to DPH, investigated and protective interventions put into place to protect Resident #77 and any of the other residents from physical abuse by the unidentified resident. During an interview on 11/21/24 at 11:15 A.M., the Staff Development Coordinator (SDC) said there is a total of 163 employees at the facility. Review of mandatory Abuse, Neglect and Exploitation and Behavior training documentation provided by the SDC, including sign-in sheets and course completion documentation from their online training platform, indicated 50 out of 163 (30%) staff completed required Abuse, Neglect and Exploitation training and 24 out of 163 (15%) staff completed Behavior training from November 2023 - November 2024. During a Quality Assurance Performance Improvement (QAPI) interview with the Administrator and DON on 11/21/24 at 1:47 P.M., the Administrator said each department manager is responsible for the quality assessment and assurance process in their department. They bring forward quality deficiencies, develop and implement plans of action to correct them, and monitor for effectiveness and make needed revisions to the action plan. The DON said they conduct performance improvement projects annually including care delivery, reporting, and abuse. The Administrator and DON were unable to provide any evidence of communication and coordination with the QAPI program for corrective action and tracking for cases of physical and sexual abuse. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	During a telephone interview on 11/22/24 at 3:08 P.M., Physician #4 said Resident #77's anxiety, chronic behavior problems and aggression are not new, and he defers to his Nurse Practitioner (NP #4) and the psychiatric NP (#3) to manage the Resident's psychiatric care. He said as far as he is aware, the Resident's inappropriate sexual behaviors are verbal and are directed at staff and visitors. He said he has not been told about any physical behaviors of hitting or being sexually inappropriate with other residents. The surveyor reviewed the six incidents noted above with the Physician. He said he was surprised and had not heard of anything like that. He said he did not think they were doing anything to prevent it from happening. He said that some time ago, he overheard nursing staff on the second floor discussing their concerns about Resident #77's inappropriate sexual behaviors and that he/she was a large risk of sexual assault on the unit. He said he does not recall when he overheard the conversation or who participated in the conversation. Multiple attempts to contact NP #4 for an interview were unsuccessful. No additional documentation was provided to the survey team by the time of the exit conference.

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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 0609 Level of Harm - Actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34145 Based on interviews and record review, the facility failed to report allegations of abuse and neglect for one Resident (#77), out of a sample of 23 residents. Specifically, the facility failed to report five of five allegations of physical abuse, sexual abuse, and neglect to the state agency (SA) and two of five allegations to law enforcement as required. Using the reasonable person concept, a person would experience emotional distress after being hit, unprovoked, and after being sexually harassed and exposed to another person's genitals. Findings include: Review of the facility's policy titled Resident Abuse, Mistreatment, and Neglect Policy and Procedure, last revised 4/2017, indicated but was not limited to: -There are many types of abuse, including but not limited to: Neglect: The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Verbal abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Physical abuse: Includes hitting, slapping, pinching, and kicking. Sexual abuse: Includes, but is not limited to sexual harassment, sexual coercion, or sexual assault. -All staff members, consultants, contractors, volunteers, and other caregivers who provide care and services on behalf of the Facility are responsible for reporting any incident that may constitute or lead to any form of abuse, neglect, or exploitation of our residents. -Immediate action will be taken against anyone who abuses a resident, or anyone fails to report witnessed or suspected abuse in accordance with specified time frames once it becomes known that he/she had prior knowledge of such information. -All alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than two hours after the allegation is made. -The Facility conducts annual notification of covered individuals of their obligation to comply with requirements to report to the State Agency and one or more law enforcement entity, any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the Facility. (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 0609 Level of Harm - Actual harm Residents Affected - Some	Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) assessment, dated 10/15/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 00 out of 15, exhibited both physical behaviors toward others (e.g., hitting, kicking, pushing, scratching, and grabbing) and verbal behaviors toward others (e.g., threatening others, screaming at others, cursing at others), and wandering. The MDS indicated Resident #77 had an activated Healthcare Proxy (HCP- healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. During an interview on 11/18/24 at 10:32 A.M., Unit Manager #1 and Nurse #13 said Resident #77 can be aggressive and sexually inappropriate. Nurse #13 said that these behaviors are a part of having dementia. Unit Manager #1 said one of the Resident's ongoing behaviors is to wander into female residents' rooms, stand at their bedside and fondle his/her genitals. She said she has not reported any episodes of this behavior to the supervisor or Director of Nursing (DON). Review of the medical record indicated documentation of five incidents of physical abuse, sexual abuse, and neglect as follows: 1. Review of a Nurse's note, dated 12/14/23, indicated Resident #77 was found to be sexually inappropriate this shift and smacked one of the female residents in the butt. 2. Review of a Nurse's note, dated 1/3/24, indicated Resident #77 was observed wandering during the night and intrusively entering other residents' (female) rooms and touching his/her privates. 3.Review of a Nurse's note, dated 2/29/24, indicated Resident #77 was wandering in the halls and intruding in other residents' rooms during the evening. A resident was heard yelling out and a Certified Nursing Assistant (CNA) entered the room and observed Resident #77 in the resident's room. The resident reported to the CNA that Resident #77 had exposed him/herself while in his/her room. 4. Review of a Nurse's note, dated 9/25/24, indicated Resident #77 was in the hall talking with another resident. The other resident (unidentified) became agitated and punched Resident #77 in the right arm. 5. Review of a Nurse's note, dated 10/10/24, indicated Resident #77 was struck by another resident (unidentified). Review of the Health Care Facility Reporting System (HCFRS- system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 11/18/24, indicated the facility failed to submit reports of resident-to-resident abuse as required for five of five incidents dated: 12/14/23, 1/3/24, 2/29/24, 9/25/24, and 10/10/24. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/20/24 at 9:50 A.M., the DON reviewed Resident #77's medical record and said all of the allegations of abuse and neglect reviewed should have been identified as such by staff and reported to the SA. She said the incidents that occurred on 12/14/23 and 2/29/24 should have also been reported to law enforcement. The DON said using the reasonable person concept, the residents would feel frightened and threatened. During a telephone interview in the presence of the DON on 11/20/24 at 10:30 A.M., Nurse #14 said she is an agency nurse and hasn't worked at the facility since 10/22/24. She said when she worked on 10/22/24, Resident #77 approached her, removed his/her genitals from their pants and shook it at her. She said she reported it to staff on the unit and was told that the behavior was baseline for the Resident and he/she does it all the time. Nurse #14 said she was told that verbal sexually inappropriate behavior and trying to get into bed with female residents was also baseline behavior for this Resident. During an interview on 11/20/24 at 3:00 P.M., Nurse #11 said one of Resident #77's baseline behaviors is to stand outside female residents' rooms, sometimes enter their rooms and stare at them. She said this makes the residents uncomfortable and they don't like it. She said she wrote the Nurse's note on 12/14/23 that indicated the Resident was found to be sexually inappropriate and noted to have smacked one of the female residents in the butt. She said she does not recall who the resident was that got hit by Resident #77. Nurse #11 said she did not report it to the supervisor or DON and did not put in place any protective measures or interventions to protect any of the other residents from being assaulted. During an interview on 11/21/24 at 8:36 A.M., the Administrator said Resident #77 has had physical altercations and sexual behaviors since admission to the facility. He said he has spoken to the Resident's family after each occurrence. He said all allegations of abuse and neglect should be reported to the SA and/or law enforcement. He could not explain why the above noted allegations were not reported as required. No additional documentation was provided to the survey team by the time of the exit conference.

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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 0610 Level of Harm - Actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 34145 Based on record review and interview, the facility failed to ensure staff thoroughly investigated five allegations of abuse and neglect, put measures in place to prevent further abuse and neglect, and report the results of the investigations for one Resident (#77), out of a total sample of 23 residents. Using the reasonable person concept, a person would experience emotional distress after being hit, unprovoked, and after being sexually abused. Findings include: Review of the facility's policy titled Resident Abuse, Mistreatment, and Neglect Policy and Procedure, last revised 4/2017, indicated but was not limited to: -The Facility has procedures to investigate different types of incidents and to identify the staff member responsible for the initial reporting, investigation of the alleged violations and reporting of results to the proper authorities. -During the course of any investigation, the safety and protection of all residents is of utmost priority, and the Facility makes provisions to protect residents from harm during investigations. Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) assessment, dated 10/15/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 00 out of 15, exhibited both physical behaviors toward others (e.g., hitting, kicking, pushing, scratching, and grabbing) and verbal behaviors toward others (e.g., threatening others, screaming at others, cursing at others), and wandering. The MDS indicated Resident #77 had an activated Healthcare Proxy (HCP- healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. Review of the medical record indicated documentation of five incidents of physical abuse, sexual harassment/sexually inappropriate behavior, and neglect as follows: 1. Review of a Nurse's note, dated 12/14/23, indicated Resident #77 was found to be sexually inappropriate this shift and smacked one of the female residents in the butt. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Some	2. Review of a Nurse's note, dated 1/3/24, indicated Resident #77 was observed wandering during the night and intrusively entering other residents' (female) rooms and touching his/her privates. 3. Review of a Nurse's note, dated 2/29/24, indicated Resident #77 was wandering in the halls and intruding in other residents' rooms during the evening. A resident was heard yelling out and a Certified Nursing Assistant (CNA) entered the room and observed Resident #77 in the resident's room. The resident reported to the CNA that Resident #77 had exposed him/herself while in his/her room. 4. Review of a Nurse's note, dated 9/25/24, indicated Resident #77 was in the hall talking with another resident. The other resident (unidentified) became agitated and punched Resident #77 in the right arm. 5. Review of a Nurse's note, dated 10/10/24, indicated Resident #77 was struck by another resident (unidentified). During an interview on 11/18/24 at 10:32 A.M., Unit Manager #1 (UM #1) and Nurse #13 said Resident #77 can be aggressive and sexually inappropriate. Nurse #13 said that these behaviors are a part of having dementia. Unit Manager #1 said one of the Resident's baseline behaviors is to wander into female residents' rooms, stand at their bedside and fondle his/her genitals. The UM did not identify this behavior as sexual abuse and therefore did not report it to the supervisor or Director of Nursing (DON) to prompt an investigation, and no interventions were put into place to keep any other residents safe. During an interview on 11/20/24 at 9:50 A.M., the DON said she reviewed the five allegations of abuse and neglect documented in the medical record. She said none of the allegations were investigated and no protective measures were put in place during the investigation to prevent further abuse. During a telephone interview in the presence of the DON on 11/20/24 at 10:30 A.M., Nurse #14 said she is an agency nurse and hasn't worked at the facility since 10/22/24. She said when she worked on 10/22/24, Resident #77 approached her, removed his/her genitals from their pants and shook it at her. She said she told nursing staff on the unit and was told that the behavior was baseline for the Resident, and he/she does it all the time. Nurse #14 said she was told that verbal sexually inappropriate behavior and trying to get into bed with female residents was also baseline behavior for this Resident, and no interventions were put into place to protect any residents from Resident #77's sexually inappropriate behavior. During an interview on 11/20/24 at 3:00 P.M., Nurse #11 said one of Resident #77's baseline behaviors is to stand outside female residents' rooms, sometimes enter their rooms and stare at them. She said this makes the residents uncomfortable and they don't like it. She said she wrote the Nurse's note on 12/14/23 that indicated the Resident was found to be sexually inappropriate and noted to have smacked one of the female residents in the butt. She said she does not recall who the resident was that got hit by Resident #77. Nurse #11 said she did not put any protective measures in place or interventions to protect any of the other residents from being assaulted. During an interview on 11/21/24 at 8:36 A.M., the Administrator said Resident #77 has had physical altercations and sexual behaviors since admission to the facility. He said he has spoken to the Resident's family after each occurrence. He said all allegations of abuse and neglect should be investigated. He could not explain why the above noted allegations were not investigated as required. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Some	No additional documentation was provided to the survey team by the time of the exit conference.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43935 Based on record review and interview, the facility failed to ensure a Notice of Transfer/Discharge was issued to one current Resident (#109), out of a total sample of 23 residents and one discharged Resident (#65), out of a sample of two discharge residents and failed to ensure the Ombudsman's office received copies of all resident notice of transfers as required. Findings include: Review of the facility's policy titled Notification of Transfer/Discharge and Bed Hold, dated as reviewed 12/2023, indicated but was not limited to the following: -When a transfer/discharge of a resident occurs to the hospital the social worker is to complete the Notice of intent to transfer resident with less than 30 days' notice and a copy is sent with the resident to the hospital and the social worker is responsible to document the transfer/discharge in the medical record under social services progress notes. The note must include the transfer/discharge date , location, bed hold status and communications with the hospital. During entrance conference on 11/13/24 at 9:02 A.M., the Administrator said the facility did not currently have a full-time social worker and a part-time social worker had started on Monday (11/11/24). 1. Resident #109 was admitted to the facility in May 2024 and had diagnoses including: Parkinson's disease, anxiety, history of falls and urinary tract infection. Review of the Minimum Data Set (MDS) assessment for Resident #109 indicated a Brief Interview for Mental Status (BIMS) was completed on 10/21/24 with a score of 3 out of 15, indicating severe cognitive impairment. Review of the medical record for Resident #109 indicated the Resident was transferred to the hospital for evaluation following a fall in October 2024. The record failed to indicate a Notice of Transfer/Discharge was completed or provided to the Resident or their family. During an interview on 11/20/24 at 8:55 A.M., Nurse #8 reviewed the medical record and could not locate any evidence that a Notice of Transfer/Discharge was completed for Resident #109's hospital transfer in October 2024. During an interview on 11/20/24 at 8:56 A.M., Unit Manager #1 reviewed Resident #109's medical record and could not locate a Notice of Transfer/Discharge for the transfer to the hospital in October 2024. 2. Resident #65 was admitted to the facility in October 2024 following a surgical procedure for necrotizing fasciitis (a severe infection that destroys the skin and underlying tissue and muscle). (continued on next page)

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	225264	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the MDS assessment for Resident #65 indicated a BIMS was completed on 11/1/24 with a score of 15 out of 15, indicating the Resident was cognitively intact. Review of the medical record for Resident #65 indicated the Resident was transferred to the hospital in November 2024 for a potentially dehiscence (a partial or total separation of previously closed wound edges) of their surgical wound. The record failed to indicate a Notice of Transfer/Discharge was completed or provided to the Resident or their family. During an interview on 11/20/24 at 12:21 P.M., the Resident said he/she does not recall the facility providing him/her any document called a transfer notice and had decided to discharge home from his/her hospitalization instead of returning to the facility. During an interview on 11/20/24 at 12:48 P.M., the Ombudsman said she has not received any transfer or discharge notices for this Resident or any other since about the end of August 2024 and she does not know why, but the facility is aware she needs to be aware of these types of events and they used to send them to her sporadically. During an interview on 11/20/24 at 1:45 P.M., the Director of Nurses reviewed the record and said there was no Notice of Transfer/Discharge and the process is supposed to be that the social worker completes the transfer notices and sends them to the Ombudsman office and she was not aware that was not happening as it should be. During an interview on 11/21/24 at 10:32 A.M., the Social Worker said she works part-time in the evenings. She said the Transfer Notices should all be part of the medical record and should be sent to the Ombudsman office at least monthly. She said she was not aware that the facility had issues with this and the notices had not been sent to the Ombudsman office.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on record review and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for three Residents (#64, #25, and #2), out of 23 sampled residents. Specifically, the facility failed: 1. For Resident #64, to ensure the MDS was accurately coded for: a. weight loss of greater than 10% over six months, and b. a Stage 3 wound (full thickness skin loss); 2. For Resident #25, to ensure the MDS was accurately coded for weight loss of greater than 10% over six months; and 3. For Resident #2, to ensure the MDS was accurately coded for a wound. Findings Include: Review of the facility's policy titled MDS Policy and Procedure, last revised March 2024, indicated but was not limited to: - Policy: It is the policy of this facility that all MDS assessments and tracking forms will be completed and submitted according to state and federal regulations. The facility is required to refer to the current CMS Long-Term Care RAI User's Manual for guidance in completing the MDS. 1. Resident #64 was admitted to the facility in May 2018 with diagnoses including a Stage 3 pressure ulcer of right buttocks and dementia. Review of the MDS assessment, dated 11/11/24, indicated Resident #64 had a severe cognitive deficit as evidenced by staff interview and Stage 1 (intact skin with a localized area of non-blanchable redness) pressure ulcer. a. Review of Resident #64's medical record indicated he/she had a significant weight loss of greater than 10% from May 2024 to November 2024, as evidenced by an 11.59 % weight loss (5/6/24 Resident weighed 138 pounds and on 11/7/24 Resident weighed 122 pounds). Further review of Resident #64's MDS assessment, dated 11/11/24, failed to indicate he/she had a 10% weight loss in 180 days. During an interview on 11/19/24 at 2:05 P.M., the Registered Dietitian (RD) said she completed Section K 0300 (weight loss) on the MDS. She said a weight loss of 10% or higher should be coded as a significant weight loss. The RD reviewed Resident #64's weights and said Resident #64 had a significant weight loss over 10% from May 2024 to November 2024 and should have been coded as such on the November MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident #64's current Physician's Orders indicated but was not limited to: - Right Buttock: wound wash, F/B (followed by) Alginate (dressing is a highly absorbent wound care product) F/B Optifoam (foam dressing) change daily and as needed. Review of Resident Diagnoses indicated but was not limited to: - Pressure ulcer of right buttocks, stage 3 Review of Resident #64's Interdisciplinary Progress Note, dated 10/11/24, indicated but was not limited to: - Resolving Stage 3 of the right buttocks. During an interview on 11/20/24 at 8:27 A.M., MDS Nurse #1 reviewed Resident #64's MDS assessment, dated 11/11/24, and the medical record and said Resident #64's right buttock wound was a Stage 3 and should not have been coded as a Stage 1 on the November 2024 MDS. During an interview on 11/20/24 at 11:22 A.M., the Director of Nursing (DON) said the expectation was for the MDS to be completed accurately and to fully represent the Resident's current status. 2. Resident #25 was admitted to the facility in March 2021 with diagnoses including dysphagia (difficulty swallowing), adult failure to thrive (loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and dementia. Review of Resident #25's medical record indicated that on 5/6/24 he/she weighed 88.8 pounds and on 11/6/24 he/she weighed 72 pounds which indicated a significant weight loss of 18.92%. Further review of Resident #25's MDS, dated [DATE], failed to indicate he/she had a 10% weight loss in 180 days. During an interview on 11/19/24 at 2:43 P.M., the RD said she completed Section K 0300 (weight loss) on the MDS. She said a weight loss of 10% or higher should be coded as a significant weight loss. The RD reviewed Resident #25's weights and said Resident #25 had a significant weight loss of over 10% from May 2024 to November 2024 and should have coded the MDS as a significant unplanned weight loss, and she did not. During an interview on 11/20/24 at 11:22 A.M., the DON said the expectation is for the MDS to be completed accurately and fully represent the Resident's current status. 3. Resident #2 was admitted to the facility in May 2022 with diagnoses including bipolar disorder and mood disorder. Review of the MDS assessment, dated 9/9/24, indicated Resident #2 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. During an interview on 11/13/24 at 9:06 A.M., Resident #2 said he/she had a sore on their right foot. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's September Physician's Orders indicated but was not limited to: - Right Medial (towards the middle or center) Foot Wound, normal saline wash pat dry, skin prep (protective film) peri-wound (tissue surrounding a wound) cover with Aquacel AG (dressings are antimicrobial primary dressings) followed by foam dressing, change every Monday, Wednesday, and Friday, start date 6/25/24, discontinued 9/5/24 Further Review of Resident #2's MDS, dated [DATE], Section M (1040) Other Ulcers, Wounds, and Skin Problems- Foot Problems failed to indicate that a wound was present on his/her right foot. During an interview on 11/19/24 at 2:16 P.M., MDS Nurse #1 reviewed Resident #2's medical record and the wound consultant's documentation. MDS Nurse #1 said the treatment to Resident #2 had been discontinued on 9/5/24, but Resident #2 had a dressing change on 9/4/24 which is within the seven day look back period. MDS Nurse #1 said Section M 1040 on Resident #2's MDS should have been completed to include the wound and the MDS was inaccurate. During an interview on 11/20/24 at 11:22 A.M., the DON said the expectation is for the MDS to be completed accurately and fully represent the Resident's current status.

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F 0656 Level of Harm - Actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34145 Based on observation, interview, and record review, the facility failed to ensure staff developed and implemented a comprehensive, person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs to address the behavior care needs of five Residents (#77, #60, #64, #25, and #105) to attain or maintain their highest practicable physical, mental, and psychosocial well-being, out of a total sample of 23 residents. Specifically, the facility failed to ensure comprehensive care plans were developed and implemented: 1. For Resident #77, to address the Resident's physically and sexually abusive behavior and address him/her being physically abused by other residents; 2. For Resident #60, to address a history of hypersexual behaviors; 3. For Resident #64, to address using pillows to prevent falls; 4. For Resident #25, to address transferring in and out of his/her scoot chair (mobility chair that reduces falls and improves comfort for users who propel themselves with their feet) for meals; and 5. For Resident #105, to address wandering. Findings include: Review of the facility's Care Plan Policy, last revised May 2017, indicated but was not limited to: -Each comprehensive care plan is designed to: -Incorporate identified problem areas; -Incorporate risk factors associated with identified problems; -Reflect treatment goals, timetables and that objectives are measurable; -Aid in preventing or reducing declines in the resident's functional status and/or functional levels; -Reflect current recognized standards of practice for problem areas and conditions. -Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. -The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: -When there has been a significant change in the resident's condition; (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	-When the desired outcome is not met; -When the resident has been readmitted to the facility from a hospital stay; and -At least quarterly 1. Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) assessment, dated 10/15/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 00 out of 15, exhibited both physical behaviors toward others (e.g., hitting, kicking, pushing, scratching, and grabbing) and verbal behaviors toward others (e.g., threatening others, screaming at others, cursing at others) and wandering. The MDS indicated the Resident had an activated Healthcare Proxy (HCP- healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. Review of comprehensive care plans indicated a care plan for Alteration in Behaviors, dated 12/11/21, indicated but was not limited to the following interventions: -Monitor behavioral episodes every shift. -Monitor for changes in behavior, notify physician of changes noted. -Bring to quiet environment. -Observe to identify potential triggers to escalating behavior. -Provide 1:1 for calming and reassurance. -Observe Resident for intrusive behavior while wandering, intervene as necessary. -Set limits with resident in regard to socially inappropriate behavior. -Withdraw attention from resident during attention seeking, acting out, socially inappropriate behavior; give attention during appropriate behavior. -Tell the Resident that the behavior is unacceptable, that you object to the behavior, not the resident. -Assess to determine if the behavior is a sign of an unmet need (need to toilet, thirst, hunger, discomfort, pain, etc.). (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	-Offer alternative ways for the resident to cope with situations that trigger behavior (i.e., relaxation techniques, breathing techniques, etc.). Further review of comprehensive care plans failed to indicate a care plan had been developed with interventions to prevent Resident #77 from hitting other residents, being hit by other residents and prevent sexually inappropriate behaviors toward female residents. Review of Resident #77's medical record indicated Resident #77 hit other residents on two occasions (12/14/23 and 2/20/24), was hit by another resident on two occasions (9/25/24 and 10/10/24), and sexually harassed/exhibited sexually inappropriate behaviors toward residents on two occasions (1/3/24 and 2/29/24). During an interview on 11/20/24 at 9:50 A.M., the Director of Nursing (DON) said Resident #77 has a history of aggression and sexually inappropriate behaviors. She reviewed Resident #77's medical record with the surveyor as follows: -Review of a Nurse's note, dated 12/14/23, indicated Resident #77 was found to be sexually inappropriate this shift and smacked one of the female residents in the butt. The DON said she was not notified of this incident. She said a care plan should have been developed to address the Resident's hitting behavior and sexually inappropriate behavior but was not. -Review of a Nurse's note, dated 1/3/24, indicated Resident #77 was observed wandering during the night and intrusively entering other residents (female) rooms and touching his/her privates. The DON said a care plan should have been developed to address the Resident's hitting and sexually inappropriate behaviors to prevent it from recurring but was not. She said using the reasonable person concept, the resident would feel frightened and threatened. Review of the medical record indicated an interdisciplinary care plan meeting was held on 1/24/24. However, the current Alteration in Behaviors care plan was reviewed and renewed with no new interventions to address Resident #77's sexually inappropriate behaviors. -Review of a Nurse's note, dated 2/20/24, indicated a visitor observed Resident #77 hit another resident (severely cognitively impaired) in the head twice. Resident #77 was transferred to the hospital for evaluation via a section 12. (According to https://www.mass.gov, Massachusetts General Law Chapter 123, Sections 12 (a) and 12 (b), controls the admission of an individual to a general or psychiatric hospital for psychiatric evaluation and, potentially, treatment. Section 12(a) allows for an individual to be brought against his or her will to such a hospital for evaluation. Section 12(b) allows for an individual to be admitted to a psychiatric unit for up to three business days against the individual's will or without the individual's consent). The DON said, following the Resident's return from the hospital, a care plan should have been developed to address the Resident's hitting behavior to prevent it from recurring but was not. She said the resident that was struck by Resident #77 has severe cognitive impairment, and using the reasonable person concept, the resident would feel frightened and threatened. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	-Review of a Nurse's note, dated 2/29/24, indicated Resident #77 was wandering in the halls and intruding in other residents' rooms during the evening. A resident was heard yelling out and a Certified Nursing Assistant (CNA) entered the room to check on the resident and observed Resident #77 in the resident's room. The resident reported to the CNA that Resident #77 had exposed him/herself while in his/her room. The DON said a care plan should have been developed to address the Resident's sexually inappropriate behaviors to prevent it from recurring but was not. She said using the reasonable person concept, the resident would feel frightened and threatened. -Review of a Nurse's note, dated 9/25/24, indicated Resident #77 was in the hall talking with another resident. The other resident (unidentified) became agitated and punched Resident #77 in the right arm. The DON said a care plan should have been developed with interventions to protect Resident #77 from being hit by other residents but was not. -Review of a Nurse's note, dated 10/10/24, indicated Resident #77 was struck by another resident (unidentified). The DON said a care plan should have been developed with interventions to protect Resident #77 from being hit by other residents but was not. 2. Resident #60 was admitted to the facility in July 2022 with diagnoses including dementia with behavioral disturbance. Review of the MDS assessment, dated 11/11/24, indicated Resident #60 had moderate cognitive impairment as evidenced by a BIMS score of 8 out of 15, exhibited behavioral symptoms and wandering. Review of Nurse Practitioner (NP) #4's note, dated 2/23/24, indicated Resident #60 has a history of inappropriate sexual behaviors of trying to kiss other residents and grabbing their breasts. Further review of the medical record indicated Resident #60 was sent to the hospital via section 12 on 12/23/23 and 12/26/23 due to hypersexual behaviors (touching other residents). Review of the consultant psychiatric NP #4's note, dated 6/4/24, indicated Resident #60 exhibited some hypersexual behaviors (verbal). Review of comprehensive care plans failed to indicate an active care plan with individualized interventions for the Resident's history of hypersexual behaviors was developed. During a telephone interview on 11/21/24 at 10:06 A.M., Social Worker (SW) #1 said when there is a behavioral incident, it prompts a risk meeting, a care plan should be developed and put into place to assist the Resident and keep other residents safe. 48695 (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	3. Resident #64 was admitted to the facility in May 2018 with diagnoses including contracture of muscle and dementia. Review of the MDS assessment, dated 11/11/24, indicated Resident #64 had a severe cognitive deficit as evidenced by staff interview and was dependent for bed mobility and transfers in/out of bed. Review of Resident #64's Fall Incident Reports, dated 9/2/24, 9/30/24, and 10/14/24, indicated he/she had fallen out of bed on three occasions. The surveyor observed Resident #64 in bed with pillows tucked under a fitted sheet on both sides of his/her torso down to his/her mid-thigh and a floor mat on the right side of his/her bed as follows: -11/13/24 at 11:31 A.M. -11/14/24 at 12:37 P.M. -11/18/24 at 7:30 A.M. Review of Resident #64's care plans did not indicate the floor mat or the pillows for positioning were on the care plan. During an interview on 11/18/24 at 7:30 A.M., Certified Nursing Assistant (CNA) #8 said Resident #64 is unable to transfer out of bed on his/her own, so the pillows are not a restraint. CNA #8 said Resident #64 utilizes the pillows to prevent him/her from sliding out of bed. CNA #8 said the floor mat was utilized to help cushion the ground and reduce injury in the event Resident #64 had a fall. During an interview with observation on 11/18/24 at 7:33 A.M., Nurse #10 and the surveyor observed Resident #64 in bed positioned on his/her back. Resident #64 had two pillows tucked under his/her fitted sheet on both sides of his/her bed and a gray floor mat on the right side of his/her bed. Nurse #10 said the use of the pillows for Resident #64 should be in his/her care plan as they are used as a safety reminder, but it is not. Nurse #10 said the floor mat should be on the care plan but was not. During an interview on 11/20/24 at 11:22 A.M., the DON said the expectation was for care plans to be individualized to each resident and their needs. The DON said Resident #64's care plan should have been updated to include the floor mat and pillows as they are used as a safety reminder, but it was not. 4. Resident #25 was admitted to the facility in March 2021 with diagnoses including unspecified falls and dementia. Review of the MDS assessment for Resident #25, dated 11/4/24, indicated severely cognitively impaired as evidenced by staff interview and was dependent for transfers. The surveyor observed Resident #25 eating in his/her scoot chair at a table in the floor dining room with the tables at his/her chin level as follows: (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	- 11/14/24 at 8:32 A.M. - 11/14/24 at 11:46 A.M. - 11/15/24 at 8:30 A.M. Review of Resident #25's Positioning Care Plan indicated but was not limited to: -Problem: Physical Mobility Impaired Related to increased fall risk, decreased sitting balance and tolerance (9/10/24) -Approach: scoot chair Review of Occupational Therapy Notes, dated 9/16/24, indicated but was not limited to: - Table height at chest level not optimal for meals. Pt (Patient) should transfer to standard arm chair (sic) for meals. During an interview on 11/19/24 at 10:53 A.M., the Certified Occupational Therapist Assistant (COTA) said she had written the recommendation to transfer Resident #25 to an armchair for meals. The COTA said she did not know who updates the nursing care plans but she does not update them. During an interview on 11/19/24 at 10:57 A.M., Nurse #4 and Nurse #5 reviewed Resident #25's care plans. Nurse #4 said Resident #25's care plans were not updated to indicate he/she should be transferred to a standard armchair for meals. Nurse #5 said care plans should be implemented when an intervention is identified. During an interview on 11/21/24 at 9:05 A.M., the Occupational Therapist (OT) said she was the OT treating Resident #25 along with the COTA. The OT said she did not have access to Resident #25's nursing care plan and did not know how to update them. During an interview on 11/21/24 at 11:41 A.M., MDS Nurse #2 said the MDS Department would only update care plans for new diagnoses or if something was triggered while doing the MDS. MDS Nurse #2 said she would tweak a care plan if she noticed something was missing. MDS Nurse #2 said usually the nurses on the units would update resident specific care plans to add interventions for equipment. MDS Nurse #2 reviewed Resident #25's care plans and said Resident #25's care plans were not updated to include an intervention to transfer to a standard armchair for meals but should have been. During an interview on 11/21/24 at 12:28 P.M., Nurse #7 said usually the Unit Managers, or the DON would update care plans. Nurse #7 said nurses can update care plans but don't always have time to. During an interview on 11/20/24 at 11:22 A.M., the DON said the expectation was for care plans to be individualized to each resident and their needs. The DON said anyone can update the care plan. The DON said Resident #25's care plan should have been updated to indicate he/she should be transferred to a standard armchair for meals but it was not. 48362 (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	5. Resident #105 was admitted to the facility in August 2024 with diagnoses including dementia, depression and anxiety. Review of Resident #105's MDS assessment, dated 8/27/24, indicated the Resident had a severe cognitive impairment as evidenced by a BIMS score of 1 out of 15. Further review of the MDS assessment indicated Resident #105 had wandering behaviors and was able to ambulate without an assistive device at a supervision level. On 11/13/24 at 8:17 A.M., the surveyor observed the following: - Resident #105 wandering on the unit without an assistive device. - Resident #105 having periods of stopping by staff members while wandering on the unit. - Resident #105 tearful at times while walking up and down the hallways of the unit. - Resident #105 was redirected by staff and continued wandering up and down the unit's hallways. On 11/18/24 at 9:44 A.M., the surveyor observed the following: - Resident #105 wandering on the unit without an assistive device. - Resident #105 having periods of stopping by staff members while wandering on the unit. - Resident #105 was redirected by staff and continued wandering up and down the unit's hallways. On 11/18/24 at 12:39 P.M., the surveyor observed the following: - Resident #105 wandering on the unit without an assistive device. - Resident #105 having periods of stopping by staff members while wandering on the unit. - Resident #105 was redirected by staff and continued wandering up and down the unit's hallways. Review of Resident #105's nursing progress notes indicated he/she: - frequently wanders on the unit; - had periods of increased anxiety, restlessness and weepiness while wandering on the unit; and - had periods of confusion while wandering on the unit, requiring redirection by staff. Review of Resident #105's medical record failed to indicate an individualized comprehensive care plan related to wandering. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/19/24 at 11:49 A.M., Unit Manager (UM) #1 said comprehensive care plans are developed on admission and updated at least on a quarterly basis. UM #1 said comprehensive care plans can be updated more frequently if new areas of concern or changes in status are identified and should identify areas specific to the resident. UM #1 said Resident #105 constantly wanders up and down the hallways of the unit and at times needs to be redirected. UM #1 said Resident #105's wandering behaviors should be identified on a comprehensive care plan. UM #1 reviewed Resident #105's comprehensive care plans and said there was not currently one related to wandering. During an interview on 11/19/24 at 12:12 P.M., the DON said comprehensive care plans should be individualized to a resident's status and areas of concern and can be updated by any nursing staff member; care plans are typically updated at least quarterly. The DON said if a new concern arises before a quarterly review, it should be immediately identified on the comprehensive care plan. The DON said comprehensive care plan should always be implemented for behaviors such as wandering.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on interview and record review, the facility failed to provide care and services consistent with professional standards of practice for two Residents (#102 and #65), out of a total sample of 23 residents. Specifically, the facility failed to ensure: 1. For Resident #102, injection sites for intramuscular (IM-injection deep into muscle tissue) antibiotic medication were rotated to prevent potential adverse effects; and 2. For Resident #65, a physician's order was obtained to transfer the Resident to the hospital for an evaluation following identification of a change in condition to the Resident's surgical wound. Findings include: 1. According to the National Institute of Health, July 2019, it is crucial to rotate injection sites when administering medications to prevent the development of lumps or hardened tissue under the skin, known as lipohypertrophy, which can interfere with proper medication absorption; this means moving the injection site to a different area of the body with each injection, such as between the abdomen, thigh, and upper arm, while ensuring to space injections at least one finger width apart within each area. Resident #102 was admitted to the facility in September 2023 and had diagnoses including a history of urinary tract infections (UTI). Review of the Minimum Data Set (MDS) assessment, dated 11/7/24, indicated Resident #102 had both short- and long-term memory problems and severely impaired skills for daily decision making according to a staff assessment. Review of the medical record indicated a physician's order for Rocephin (antibiotic used to treat UTIs) IM 1 gram (gm) for three days for a UTI (5/27/24). Review of the May 2024 Medication/Treatment Administration Records (MAR/TAR) failed to identify injection sites for the administration of the IM antibiotic. Review of May 2024 Nurse's notes failed to identify injection sites for the administration of the IM antibiotic. During an interview on 11/15/24 at 9:26 A.M., Nurse #6 said the Nurse's notes should include the site where the IM injection was given, but they do not. During an interview on 11/15/24 at 9:56 A.M., Unit Manager #1 reviewed Resident #102's medical record and said IM injection sites should always be rotated and documented and neither the notes nor MAR/TAR indicate that was done. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/24 at 10:25 A.M., the Director of Nursing (DON) reviewed Resident #102's medical record and said the IM Rocephin order should have included that the IM injection site was to be rotated, and the area assessed with each injection. She said the order doesn't include that but it should. She said the electronic medical record has the capability for a drop-down menu to trigger the injection site and assessment, but it wasn't entered that way. She said at the very least, it should have been documented in a Nurse's note. 43935 2. Review of the facility's policy titled Physician Services, dated as revised April 2013, indicated but was not limited to the following: -The medical care of each resident is under the supervision of a Licensed Physician Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. 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. Resident #65 was admitted to the facility in October 2024 following a surgical procedure for necrotizing fasciitis (a severe infection that destroys the skin and underlying tissue and muscle). Review of the MDS assessment for Resident #65 indicated a Brief Interview for Mental Status was completed on 11/1/24 with a score of 15 out of 15, indicating the Resident was cognitively intact. Review of the medical record for Resident #65 indicated the Resident was transferred to the hospital on 11/1/24 for a potential dehiscence (a partial or total separation of previously closed wound edges) of their surgical wound. The record failed to indicate a physician's order was in place for the transfer of the Resident to the hospital. During an interview on 11/20/24 at 11:55 A.M., the Regional Nurse said the facility does not have a policy on obtaining physician's orders. During an interview on 11/20/24 at 1:22 P.M., the Medical Records Coordinator said the Resident was transferred out of the facility to the hospital and then discharged . She reviewed the medical record and said there was no order in the record for Resident #65 to be transferred out of the facility to the hospital. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 1:45 P.M., the DON said staff are required to obtain physician's orders for transfers out of the facility. She reviewed the physician's orders for Resident #65 and said there was no order for the Resident to be transferred to the hospital as there should have been.

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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. 43935 Based on record review and staff interview, the facility failed to document the recapitulation of the Resident's stay that included his/her course of illness/treatment for one Resident (#112), of two closed records reviewed. Findings include: Review of the facility's policy titled Medical Records Procedures, dated as reviewed 1/2024, indicated but was not limited to the following: - Following a resident's discharge, medical records shall give all forms needing a physician signature or date to the Director of Nurses (DON); if the physician or Medical director is in the facility and the DON is not available then medical records is responsible to follow through with obtaining signatures and dates as needed - In the event the forms are incomplete, it is the Medical directors responsibility to get attending physicians to visit the facility and close out the charts within 14 days of discharge as required by state law. Resident #112 was admitted to the facility in September 2024 and discharged in October 2024 following a brief stay for chronic obstructive pulmonary disease (COPD). During an interview on 11/20/24 at 8:59 A.M., Resident #112 said he/she signed out against medical advice (AMA) after a brief stay to manage their COPD. The Resident said he/she wanted to return home to their pets and significant other and was feeling better. The Resident said he/she had managed their illness at home in the past and felt he/she was ready for discharge. Review of the closed medical record failed to indicate a recapitulation of the Resident's stay was completed by the Attending Physician. During an interview on 11/20/24 at 10:51 A.M., the Medical Records Coordinator reviewed the medical record for Resident #112 and said there were no physician notes or recapitulation of the Resident's stay but she would double check for any potentially un-filed documents for the Resident. During a follow up interview on 11/20/24 at 12:30 P.M., the Medical Records Coordinator said she found an admission note written by the physician; a recapitulation of the Resident's stay had not been completed by the physician as it should have been, even though the Resident discharged more than 30 days ago.

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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 interview, the facility failed to ensure antibiotic treatment was administered as ordered by the physician for one Resident (#102), out of a total sample of 23 residents. Specifically, the facility failed to access the facility's electronic medication dispensing system to obtain intramuscular (IM-injection deep into muscle tissue) antibiotic medication prescribed to treat a urinary tract infection (UTI) which resulted in a delay in treatment. Findings include: Resident #102 was admitted to the facility in September 2023 and had diagnoses including a history of UTIs. Review of the Minimum Data Set (MDS) assessment, dated 11/7/24, indicated Resident #102 had both short- and long-term memory problems and severely impaired skills for daily decision making according to a staff assessment. Review of a Physician's note, dated 5/20/24, indicated Resident #102 presented with nausea and vomiting which the physician indicated was unusual for the Resident. The note indicated he would order a urinalysis with culture and sensitivity and screening chemistry and blood count. Review of a Nurse's note, dated 5/27/24 at 5:36 A.M., indicated Resident #102's urine results came back positive for a UTI. The physician was notified and gave an order for IM injection of Rocephin 1 gram (gm) once a day for three days. Review of a Physician's note, dated 5/27/24, indicated Resident #102 was seen by the physician and almost a week after the labs were ordered, the results were in and were consistent with a UTI caused by Escherichia coli (E. Coli- a group of bacteria that can cause infections in your urinary tract). The physician indicated he initiated an empirical treatment with Rocephin 1 gm IM daily for three days. Review of the medical record indicated a telephone order (T.O.), dated 5/27/24, for Rocephin IM 1 gm every night at 6:00 P.M. Review of a Nurse's note, dated 5/27/24 at 2:30 P.M., indicated the pharmacy informed the nurse that there was only one medication run secondary to the holiday and it would arrive on the evening run. The nurse indicated there was no access to the electronic medication dispensing system, and she changed the medication administration time in the computer. The note failed to indicate the nursing supervisor or Director of Nursing (DON) was notified of the need to access the electronic medication dispensing system to obtain the Rocephin that was unavailable from the pharmacy to administer it as ordered by the physician. Review of a Nurse's note, dated 5/27/24 at 8:33 P.M., indicated the Rocephin had not arrived from the pharmacy, and the Resident was unable to start the medication. The Nurse's note failed to indicate any nursing staff attempted to access the medication from the electronic medication dispensing system. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurse's note, dated 5/28/24 at 7:53 P.M., indicated Resident received Rocephin IM on 5/28/24. During an interview on 11/15/24 at 9:26 A.M., Nurse #6 said she wrote the note dated 5/27/24. She said the pharmacy could not deliver the Rocephin due to the holiday, and no one was in the building that had access to the electronic medication dispensing system. She said she remembered speaking to a supervisor, but could not remember who, and was told they did not have access to the system. Nurse #6 said she did not notify the physician that the medication was not available, could not access the electronic medication dispensing system, and was not administered as ordered. During an interview on 11/15/24 at 9:56 A.M., Unit Manager #1 reviewed Resident #102's medical record and said there is always someone here that can access the electronic medication dispensing system. She said the process is that if a medication is not available from the pharmacy, the physician is to be notified, then nursing will access the medication from the electronic dispensing system or obtain an order to hold the medication and start it when it is available. During interviews on 11/15/24 at 10:25 A.M. and 12:06 P.M., the Director of Nursing (DON) reviewed Resident #102's medical record and said there are several nurses that have access to the medication dispensing system, and if there is no one in the building with access, the expectation is that the supervisor or DON will be contacted to access the medication dispensing system. The DON said the physician would then be notified that it was retrieved from the system. The DON obtained and reviewed the nursing schedule and a list of nurses who had access to the medication dispensing system and said there was no one in the facility on 5/27/24 that had access to the electronic medication dispensing system. She reviewed an inventory list of medications available in the medication dispensing system and said there were three 1 gm vials of Rocephin available in the system on 5/27/24. The DON reviewed Resident #102's medical record and confirmed that the Resident was not administered Rocephin on 5/27/24 as ordered. During an interview on 11/15/24 at 2:54 P.M., Physician #1 said Rocephin is in the electronic medication dispensing system and should have been accessed to administer the medication to Resident #102 on 5/27/24 as ordered.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, document review, and interview, the facility failed to ensure one Resident (#72), who was identified as being a high risk for skin breakdown, out of a total sample of 23 residents, received the care and services per professional standards of practice to help prevent the development of a facility acquired Stage III (full thickness tissue loss) right heel pressure ulcer and promote optimal wound healing. Specifically, the facility failed to implement recommendations made by the Wound Care Specialist timely and develop and implement a care plan that identified risk factors as well as interventions designed to reduce or prevent the development of pressure related ulcers/injuries. Findings include: Review of the facility's policy titled Pressure Injury Policy, revised July 2024, indicated but was not limited to the following: -On admission or re-admission, the licensed nurse will assess the resident's skin to identify and document existing skin areas. -The licensed nurse will assess each resident's risk for skin breakdown by completing a Norton Plus Pressure Ulcer Scale Form on admission, re-admission, and monthly. If the assessment identified the resident is at risk for skin breakdown, the nurse will implement a care plan to include preventative measures. Stage 3 Pressure Injury: Full thickness skin loss -Full thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar (dead tissue) may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscure the extent of tissue loss this is an unstageable pressure injury. Review of the facility's policy titled Preventive Skin Care Protocol, revised August 2024, indicated but was not limited to the following: Purpose: -To identify adults at risk and to define early intervention for prevention of pressure injury. Goals: -To identify at-risk residents who need prevention and to identify specific factors placing them at risk. -To identify resident specific protocols to reduce risk. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Weekly, residents with alterations in skin integrity will be reviewed by the management team and plan of care including current treatment, effectiveness of treatment, need to revise treatment, nutritional needs and other aspects of care potentially affecting wound healing. -Evaluate new admissions to determine if they are at high risk for the development of pressure injury as well as residents at high risk for development of pressure injury per the Norton Plus Assessment. Determine if preventative protocol is required. Ongoing Assessments: -All residents are to be assessed once each week by the licensed nurse during skin rounds. The results of this hands-on physical skin check are to be recorded on the resident's record. All noted Stage I-Stage IV areas are to be recorded on the skin care treatment sheet per the pressure injury policy. -Resident Severely at Risk: Norton Scale Score = 15 or less Resident #72 was admitted to the facility in July 2024 and had diagnoses including muscle weakness, need for assistance with personal care, unsteadiness on feet, unspecified abnormalities of gait and mobility, acute embolism and thrombosis of deep veins of right upper extremity, type 2 diabetes mellitus with diabetic neuropathy, obesity, and presence of other cardiac implants and grafts. Review of the admission Physician's Progress Note, dated 7/29/24, indicated Resident #72 had a history of peripheral artery disease, type 2 diabetes mellitus, and non-healing wounds and the Resident's skin was warm and dry. Review of the Admission/Re-Admission Nursing Assessment, dated 7/26/24, indicated but was not limited to the following: Skin Condition Comments: -Healed areas bilateral lower extremities, skin dry. No open areas noted. General Skin Condition: -Dry, warm Review of the admission Weekly Skin Assessment, dated 7/26/24, indicated Resident #72 had no pre-existing skin problems or any new skin problems. Review of the admission Norton Plus Pressure Ulcer Scale (Norton Scale), dated 7/26/24, indicated Resident #72 had an assessment score of 8 which indicated he/she was a high risk for the development of pressure related ulcers/injuries. Review of the Resident's medical record failed to indicate a care plan had been developed and implemented upon admission to include preventative measures once the Resident was determined to be a high risk for the development of pressure related ulcers/injuries per the Norton Scale assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 8/1/24, indicated Resident #72 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, was not a risk for developing pressure ulcers, had no unhealed pressure ulcers, and was frequently incontinent of urine and stool. The MDS indicated the Resident was dependent on staff for toileting, showering, bathing, personal hygiene, sitting to lying, lying to sitting, rolling left to right, chair to bed transfers, and putting on and taking off footwear. Resident #72 also required substantial to maximum assist with toilet transfers and upper and lower body dressing. Review of the Norton Scale, dated 8/2/24, indicated Resident #72 had an assessment score of 6 which indicated the Resident was a higher risk for pressure ulcer development since the previous assessment on 7/26/24 (a lower score indicates a higher risk). A care plan was not developed or implemented to include preventative measures. Review of the Norton Plus Pressure Ulcer Scale, dated 9/1/24, indicated Resident #72 had an assessment score of 9 which indicated the Resident was a high risk for pressure ulcer development. A care plan was not developed or implemented to include preventative measures. Review of Weekly Skin Assessments, dated 8/5/24, 8/13/24, 8/20/24, 8/27/24, and 9/4/24, did not identify any alteration in skin integrity to the Resident's right heel. Review of the Weekly Skin Assessment, dated 9/11/24, completed by Unit Manager (UM) #2, indicated a new skin problem as follows: -half dollar size open area right heel, wound bed dry, edges macerated, no odor, no pain, surrounding skin fragile Review of the medical record failed to indicate UM #2, after identifying an open area on the Resident's right heel, developed a plan of care to include the problem, goals and desired outcomes, specific interventions to achieve those goals, a plan to evaluate and monitor the effectiveness of interventions, or any other aspects of care potentially affecting wound healing. During a telephone interview on 11/20/24 at 8:43 A.M., with the Director of Nursing (DON) and UM #2, UM #2 said that when she identified the right heel pressure area on 9/11/24 during the skin check, she forgot to develop a care plan with interventions for preventive measures. Review of the Wound Care Specialist's initial visit note, dated 9/12/24, indicated but was not limited to the following: Patient was seen for a pressure ulcer right heel. Will update treatment plan. Educated patient and nursing on the importance of offloading and treatment plan. Will recommend offloading boots. Please follow facility pressure ulcer prevention protocol. -Duration: First evaluated on 9/12/24 -Primary Etiology: Pressure -Stage/Severity: Stage III (continued on next page)

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Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound Status: New -Size: 4 centimeters (cm) x 4 cm x 0.3 cm Assessment/Plan: Avoid friction/sheer/traumatic forces. Facility pressure ulcer prevention protocol. Offload heels per facility protocol. Offload pressure/reposition patient every two hours. Review of the Wound Care Specialist's visit note, dated 10/3/24, indicated but was not limited to the following: Patient was seen for a pressure ulcer right heel. Wound has remained stable in size. Will update treatment plan due to odor and erythema. Will recommend wound culture and sensitivity. Educated patient and nursing on the importance of offloading and treatment plan. Will recommend offloading boots and offloading shoes based on therapy's recommendations. Please follow facility pressure ulcer prevention protocol. -Primary Etiology: pressure -Stage/Severity: Stage 3 -Wound Status: Worsening -Odor Post Cleansing: Malodorous -Wound Base: 100% slough (yellow/white material in wound bed) -Peri wound: Erythema (redness) -Size: 3.5 cm x 3.5 cm x 0.3 cm Assessment/Plan: Avoid friction/sheer/traumatic forces. Facility pressure ulcer prevention protocol. Offload heels per facility protocol. Offload pressure/reposition patient every two hours. Wound culture and sensitivity on heel. Review of a Nurse Progress Note, dated 10/3/24, indicated but was not limited to the following: -Wound MD in to see resident. Wound deteriorated since last week, large area of necrotic dark tissue, foul odor, no pain, minimal drainage. Recommendation for wound culture and start antibiotic. Orders in place to offload right heel with free boot at all times. Review of current Physician's Orders indicated the following: -May have off-loading boot to right heel as recommended by wound care specialist NP every shift, 10/4/24 (22 days after initial recommendation) -Heel free boot to be worn at all times while in bed every shift, 10/3/24 -Ammonium Lactate 12% lotion topical every day on 2-10 shift, 9/22/24 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Offload right heel at all times every shift, 9/20/24 -Skin check day shift, weekly on Thursday, 9/20/24 Review of a Nurse Progress Note, dated 10/6/24, indicated but was not limited to the following: -Labs reported to Nurse Practitioner (NP) for wound culture, +MRSA. Antibiotic changed. Review of the medical record failed to indicate preventative protocol recommendations made by the Wound Care Specialist were initiated and implemented timely to promote wound healing and help prevent any worsening of the existing right heel pressure ulcer and new ulcers from developing. Review of Resident #72's Comprehensive Care Plans failed to indicate a care plan had been developed and implemented for the Resident's risk of or actual development of a right heel Stage III pressure ulcer until 10/4/24, three months after being identified as a high risk for pressure ulcer development upon admission and 23 days after the area was first identified on 9/11/24. During an observation with interview on 11/18/24 at 10:47 A.M., the surveyor observed Resident #72's right heel pressure ulcer with Nurse #3 who said the Resident had a pressure ulcer there but wasn't sure what stage it was. She said she thought the Resident came in with it. She said the Resident needed some assistance with turning and repositioning. Resident #72 said he/she got it from rubbing against his/her shoe. The wound was approximately 4 cm x 4 cm x unstageable (depth is obscured by eschar in the wound bed). The surrounding skin was thick, dry, and scaly. There was no drainage observed. During an interview on 11/19/24 at 11:10 A.M., the surveyor reviewed Resident #72's medical record with Nurse #3 who said the Resident was admitted in July 2024 and there was no care plan in place upon admission to help prevent pressure ulcers from forming. She said the 7/26/24 Norton Scale indicated the Resident was a high risk for developing pressure ulcers and a care plan should have been put into place but wasn't. She said the first documentation about the wound she could find was from a 9/11/24 skin assessment and the wound consultant was there the next day. She said the wound had deteriorated per a 10/3/24 nurse's note with necrotic (dead) tissue and antibiotic therapy was ordered. Nurse #3 said if a resident is identified as being a high risk for developing pressure ulcers upon admission, orders are put into place for prevention and a care plan put into place to prevent any pressure ulcers or pressure injuries from occurring. During an interview on 11/19/24 at 1:01 P.M., the Director of Nursing (DON) said she could not locate a care plan, current or resolved, for the Resident's skin until October but would keep looking. She said at this time, the Resident did not have a care plan in place upon admission to prevent any skin alteration. During an interview on 11/19/24 at 1:49 P.M., the DON said there was no care plan in place upon admission for skin prevention, I can't find one. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/19/24 at 3:25 P.M., the Wound Care Specialist said she saw Resident #72 for the first time on 9/12/24 and staged the right heel pressure ulcer (PU) as a 3. She said the wound ended up getting infected with MRSA and the Resident was started on antibiotics. She said the wound has since gotten smaller in size, but the slough dried out and is stable eschar (dead tissue) now with the current wound treatment ordered. She said she wasn't sure if the PU was new for the Resident, but it was the first time she was notified to see the resident. She said she started at the facility in August 2024 and the first time she met the Resident was on 9/12/24. She said she's pretty sure she was the only wound physician at the facility since the end of July. She said her recommendations had included an offloading boot and offloading in general. She said she didn't know of any pre-existing conditions at this time. During an interview on 11/20/24 at 8:22 A.M., the DON said the Resident was admitted in July 2024 and did not have any skin issues when he/she came in. She said the Norton Scale is used to assess for a resident's risk of developing pressure ulcers and the Resident had a [NAME] done on the day of admission and was a high risk. She said if the Resident was considered a high risk for developing pressure ulcers, then he/she should have had a care plan with preventative measures implemented to offload the pressure to prevent any unavoidable pressure ulcers. She said not having these along with the Resident's co-morbidities could have led to the development of his/her pressure area. The DON said the care plan was not developed and implemented until 10/4/24 but was first identified on a 9/11/24 skin assessment. She said when the nurse first identified it, she should have initiated a care plan and put preventative measures in place, but it wasn't done until 10/4/24. She said the Resident has only seen the Wound Care Specialist. She said the facility used to use another wound consultant, but they never saw this Resident for any skin issues. The DON said she was made aware on 9/11/24 that the Resident had a wound and asked for him/her to be seen by a wound specialist and followed for wound care and she had notified the physician but didn't initiate a care plan for it. She said the Resident had a new pressure ulcer wound that was acquired in the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42742 Based on record review and interview, the facility failed to ensure services to assess urinary incontinence were implemented for one Resident (#63), out of a total sample of 23 residents. Specifically, the facility failed to perform a bladder scan (procedure that uses ultrasound to measure the amount of urine in the bladder and determine how well the bladder is emptying) for Resident #63's new complaints of urinary incontinence, retention, and dribbling per physician's orders. Findings include: Review of the facility's policy titled Urinary Continence and Incontinence-Assessment and Management, revised September 2010, indicated but was not limited to the following: -The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. -Management of incontinence will follow relevant clinical guidelines. -The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. Resident #63 was admitted to the facility in May 2024 with diagnoses including type 2 diabetes mellitus and essential hypertension. Review of the Minimum Data Set (MDS) assessment, dated 10/28/24, indicated Resident #63 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 and was occasionally incontinent of urine. During an interview on 11/13/24 at 1:01 P.M., Resident #63 said he/she had had bouts of urinary urgency and frequency for three months now and feels like he/she has to go really bad but then can't and just dribbles after. Resident #63 said his/her urinary flow wasn't good. Review of a physician's Telephone Order, dated 11/13/24, indicated the following: -Bladder scan after void x 1 Review of the 11/1/24 through 11/30/24 Treatment Administration Record (TAR) indicated the following: -11/13/24 bladder scan after void x1 every day on 2-10 shift, stop date 11/13/24, stop time 11:00 P.M. Further review of the TAR failed to indicate the bladder scan was performed as ordered as evidenced by no nursing initials representing completion of the treatment. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record failed to indicate any documentation that the bladder scan had been completed per physician's orders or that the physician had been notified with a rationale that it wasn't. During an interview on 11/18/24 at 12:14 P.M., Nurse #3 said she was not aware of any urinary issues, but the Resident did have a new order on 11/13/24 for a urology referral and a one-time order bladder scan. She said the bladder scan order had been discontinued but did not see anywhere that it was done. She said she just found out today that the Resident was having urinary issues including difficulty with incontinence and dribbling. Nurse #3 said the Resident had no complaints of this the previous week. During an interview on 11/18/24 at 12:38 P.M., the surveyor reviewed the medical record with Unit Manager (UM) #2 who said she wasn't sure about the bladder scan and looked to see if she could find a note about it but couldn't locate one. She said it was supposed to be done. She said the TAR showed the letter M but had no idea what that meant, and it did not correlate with any nurses' initials. UM #2 said maybe it meant missing. During an interview on 11/18/24 at 4:36 P.M., the Director of Nursing (DON) said the M meant missing documentation. She said there was no documentation to support that the bladder scan was done per physician's orders and that the nurse either forgot to do it or didn't check the flow sheet. She said if it wasn't documented, then it wasn't done. During an interview on 11/19/24 at 9:51 A.M., the surveyor explained the bladder scan procedure to Resident #63 who said no one had done the procedure on him/her. During an interview on 11/19/24 at 2:23 P.M., Physician #2 said she had just seen the Resident the previous Wednesday and he/she was having urinary incontinence, dribbling, and feeling like the bladder was full. She said she ordered a bladder scan and was not made aware that the bladder scan had not been done. She said the Resident was a good historian and would know if it had been done. During an interview on 11/20/24 at 7:40 A.M., UM #2 said, after surveyor intervention, she spoke with the nurse who said she wasn't able to get the bladder scan and asked the nurse to come in and write a late entry note on it that it wasn't done. UM #2 said she could not locate anywhere that the physician had been notified. During an interview on 11/20/24 at 8:34 A.M., the DON said she was made aware and followed up on it and asked the nurse to come in and write a late entry note that the bladder scan was not completed. She said the nurse said it wasn't done because the Resident wasn't in the facility, he/she was outside, and that's why the TAR had missing documentation, because she didn't do it. The DON said the note was not entered until after surveyor intervention. She said the bladder scan should have been obtained per physician's orders and a note written as to why it wasn't with a rationale, the physician should have been notified, and follow up completed with any new order or communications. She said there was no documentation of attempts to perform the bladder scan or re-attempts made. The DON said the Resident had complaints of dribbling and incontinence at times.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 34145 Based on record review and interviews, the facility failed to ensure the Physician signed and dated all orders for one Resident (#102), out of a total sample of 23 residents. Findings include: According to the Centers for Medicare and Medicaid Services (April 2024), a handwritten signature is defined as a mark or sign the ordering or prescribing physician or non-physician practitioner (NPP) makes on a document signifying knowledge, approval, acceptance, or obligation. Resident #102 was admitted to the facility in September 2023 and had diagnoses including dementia, depression, and bipolar disorder (a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking, and behavior). Review of the entire medical record (electronic and paper) indicated the physician last signed the Resident's orders in January 2024. There were no additional orders signed by the physician/physician extender. Review of a three-ringed binder, labeled with Physician #1's name on it at the third-floor nursing station indicated unsigned physician's orders from February 2024 to October 2024. During an interview on 11/15/24 at 9:26 A.M., the surveyor reviewed the three-ringed binder with Nurse #6. She confirmed the binder had unsigned physician's orders from February 2024 to October 2024. She said orders in the binder are waiting to be signed by the physician, but he does not come into the facility very often. During an interview on 11/15/24 at 10:25 A.M., the Director of Nursing (DON) said she was aware Resident #102's physician was behind in signing his orders. During an interview on 11/15/24 at 2:54 P.M., Physician #1 said if the orders are in the Residents' chart, he signs them. If they are not in the chart, then he doesn't. He said he was not aware of a three-ringed binder labeled with his name on it on the third-floor unit.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 48695 Based on record reviews and interviews, for one Resident (#83) out of 23 sampled residents, the facility failed to ensure the Resident was seen by the Physician at least every 30 days for the first 90 days after admission and at least every 60 days thereafter, with alternate visits by a Nurse Practitioner (NP) as indicated. Findings include: Review of the facility's policy titled Physician Services, last revised April 2013, indicated but was not limited to: - Policy: The medical care of each resident is under the supervision of a Licensed Physician. Policy Interpretation and Implementation: - The Physician will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage. - Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current regulations and facility policy. Resident #83 was admitted to the facility in March 2022 with diagnoses including hypertension, diabetes, and dementia. Review of Resident #83's medical record indicated he/she was seen by the Physician on 3/4/24, as evidenced by a Physician's Progress Note. Further review of the medical record failed to indicate Resident #83 was seen by the Physician after 3/4/24. During a telephonic interview on 11/20/24 at 12:28 P.M., Physician #4 said he had seen Resident #83 after 3/4/24, but could not recall when. Physician #4 said he would have his office fax over all of Resident #83's visits summaries from 1/1/24 to 11/20/24. Review of Resident #83's Physician visits provided to the surveyor on 11/20/24 at 2:21 P.M., indicated there was a 224-day span from the last physician's visit to the next one as evidenced by a Physician's Progress Note dated 10/14/24. During an interview on 11/20/24 at 4:06 P.M., the Director of Nursing (DON) said the Physician should see residents every 30 days for the first 90 days after admission then the resident should be seen at least every 60 days thereafter alternating visits with the NP. The DON said at a minimum the Physician should have seen Resident #83 every 120 days. The DON said the expectation was for residents to be seen in a timely manner.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42742 Based on record review and interview, the facility failed to utilize the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week, with no nurse staffing waivers in place as required placing all residents at risk for not having their clinical needs met either directly by the RN or indirectly by the Licensed Practical Nurse (LPN) of Certified Nurse Aides (CNA) that the RN was responsible for overseeing with the provision of resident care. Findings include: During the Entrance Conference interview on 11/13/24 at 9:02 A.M., the Administrator and Director of Nursing (DON) said the facility did not have any nurse waivers in place. Review of the 11/1/24 through 11/18/24 as worked nursing schedules provided by the Staff Scheduler failed to indicate that an RN worked at least eight consecutive hours each day, seven days a week, in the facility without a waiver of nurse staffing requirements on the following days: -Saturday, 11/2/24 -Sunday, 11/3/24 -Saturday, 11/9/24 -Sunday, 11/10/24 -Saturday, 11/16/24 -Sunday, 11/17/24 During an interview on 11/18/24 at 1:51 P.M., the Staff Scheduler said there was an RN who had worked, but not at least eight consecutive hours each day. She said the DON comes in though if there's an issue and was usually there but wasn't on the schedule. She said the weekends are the time when they only have one RN. The surveyor requested the DON's punch cards for 11/2/24, 11/3/24, 11/9/24, 11/10/24, 11/16/24, and 11/17/24. Review of the DON's punch cards for the requested dates did not indicate any hours worked. During an interview on 11/20/24 at 8:17 A.M., the DON said the facility needed to have an RN for at least eight consecutive hours a day and did not meet the requirement for the dates reviewed.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 42742 Based on observation and interview, the facility failed to ensure Nurse staffing information posted included the current date and actual hours worked per shift for licensed and unlicensed staff including Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aides (CNA), as required. Findings include: On 11/18/24 at 6:38 A.M., the surveyor observed a Nurse staffing document posted in the main lobby on top of the receptionist's desk. The information on the document was as follows: Date: 11/14/24 Total Census: 112 Day Shift Staffing Totals: RN: 1, LPN: 6, CNA: 11 Evening Shift Totals: RN: blank, LPN: 6, CNA: 13 1/2 Night Shift Totals: RN: 1, LPN: 2, CNA: 6 The daily staffing report had not been updated from 11/14/24 until 11/18/24, after surveyor intervention, and failed to include staffing data including the total hours worked for RNs, LPNs, and CNAs as required. The staffing report indicated the number of licensed and unlicensed staff only. During an interview on 11/18/24 at 6:38 A.M., the Housekeeping Manager was at the receptionist's desk and said the staffing report was dated 11/14/24 but should be updated daily and was the only place that she knew of where it was posted. During an interview on 11/18/24 at 8:22 A.M., the Director of Nursing (DON) said it should have been updated daily but wasn't. During an interview on 11/18/24 at 8:46 A.M., the Staff Scheduler said she was in charge of posting the staffing while the new staffing coordinator was going through orientation. She said she goes up every morning to change it but hadn't changed it since 11/14/24 though had them filled out for over the weekend. She said no one must have swapped it out since 11/14/24, that's what it looked like, and hadn't been up yet this day to change it. The Staff Scheduler said when she posts the staffing, it doesn't include the total hours worked for RNs, LPNs, or CNAs, just the total number of staff. During an interview on 11/19/24 at 12:25 P.M., the Staff Scheduler said she was told by the Administrator to not include staffing total hours, just a total of how many were working. During an interview on 11/20/24 at 8:17 A.M., the DON said the staffing report should be posted daily and include the total number of LPNs, RNs, and CNAs with the total number of hours worked for each shift.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 34145 Based on observation, record review, and interview, the facility failed to provide effective and appropriate treatment and services to attain the highest practicable mental and psychological well-being for one Resident (#77), with a known history of conduct disorder, dementia with behavioral disturbance, and major depression, out of a total sample of 23 residents. Specifically, the facility failed to develop, implement, and update the plan of care to meet the Resident's behavioral needs, resulting in wandering intrusively into other residents' rooms; standing at female residents' bedsides and fondling his/her genitals; exposing him/herself to another resident; physically assaulting and being physically assaulted by other residents. Using the reasonable person concept, a person would experience emotional distress after being hit, unprovoked, and after being sexually abused. Findings include: Review of the facility's policy titled Behavior Management and Response Guidelines, last revised 12/2023, indicated but was not limited to: -Physical aggression is the act of one person physically harming another person for any reason, right or wrong: i.e., hitting, kicking, slapping, pinching, biting, etc. -Any resident who verbally threatens others then refuses verbal redirection from staff is at high risk for assault. All threats toward another resident should be considered real and steps taken to protect the other resident from harm. -Pay particular attention to demented, wandering residents, residents attempting to elope. These residents are more likely to impulsively assault others. -Residents who intrude on other residents' personal areas or who agitate others are more likely to be assaulted than other residents. -A resident may be considered appropriate or one-to-one (1:1) supervision status when he/she presents with an acute problem such as assaultive. -On initiating 1:1, the nurse shall assign a staff member to remain with the resident at all times. This staff member shall not leave the resident unless relieved by another staff member or the nurse removes the resident from 1:1 status. -The assigned staff member shall monitor and supervise the resident at all times, and is responsible for maintaining the resident's safety and welfare. -The assigned staff shall be responsible for documenting the resident's behaviors/activities/unusual events at least each hour. Documentation shall be made using a Behavioral Tracking Sheet, countersigned by the nurse, and placed in the nurses notes section of the resident's chart. (continued on next page)

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Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Sexual behavior becomes a problem when a resident acts out his/her behavior toward an unconsenting resident, when it is directed toward staff members or visitors. During an interview on 11/13/24 at 9:02 A.M., the Administrator and Director of Nursing (DON) said their Social Worker's last day in the facility was 10/26/24. They said a new Social Worker (SW #1) started on 11/4/24 and works 15 hours a week on Tuesdays, Thursdays, and Saturdays from 5:00 P.M. to 10:00 P.M. Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Resident #77 resides on the Dementia Special Care Unit (DSCU- specialized care to residents with dementia through a combination of additional and on-going dementia care training, expanded activities, and a safe and comfortable physical environment). The DSCU has a total of 38 residents of which 37 have been adjudicated incompetent (inability or unfitness to manage one's affairs because of mental condition) by the court. Of the 37 residents adjudicated incompetent, 14 residents are female and 23 are male. Review of the Minimum Data Set (MDS) assessment, dated 10/15/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 00 out of 15, exhibited both physical behaviors toward others (e.g., hitting, kicking, pushing, scratching, and grabbing) and verbal behaviors toward others (e.g., threatening others, screaming at others, cursing at others) and wandering. The MDS indicated the Resident had an activated Healthcare Proxy (HCP- healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. Review of the medical record indicated the last social service history quarterly assessment was conducted on 6/18/23. The assessment indicated Resident #77 had delusions/hallucinations, history of psychiatric concerns, was socially inappropriate, verbally abusive, and intrusive. Review of comprehensive care plans indicated a care plan for Alteration in Behaviors, dated 12/11/21, indicated but was not limited to the following interventions: -Monitor behavioral episodes every shift. -Monitor for changes in behavior, notify physician of changes noted. -Bring to quiet environment. -Observe to identify potential triggers to escalating behavior. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Provide 1:1 for calming and reassurance. -Observe Resident for intrusive behavior while wandering, intervene as necessary. -Set limits with resident in regard to socially inappropriate behavior. -Withdraw attention from resident during attention seeking, acting out, socially inappropriate behavior; give attention during appropriate behavior. -Tell the Resident that the behavior is unacceptable, that you object to the behavior, not the resident. -Assess to determine if the behavior is a sign of an unmet need (need to toilet, thirst, hunger, discomfort, pain, etc.). -Offer alternative ways for the resident to cope with situations that trigger behavior (i.e., relaxation techniques, breathing techniques, etc.). The goal of the care plan, dated 12/11/21, indicated: -Resident will be effectively redirected from aggressive behavior with each episode daily with a stop guard banner placed across his/her doorway to prevent wanderers (sic). -Resident will demonstrate cooperation with care as evidenced by clean and neat appearance. Further review of comprehensive care plans failed to indicate a care plan had been developed with interventions to prevent Resident #77 from physically assaulting other residents, being physically assaulted by other residents, and prevent sexually inappropriate behaviors toward female residents. During an interview with Nurse #13 and Unit Manager (UM) #1 on 11/18/24 at 10:32 A.M., Nurse #13 said Resident #77 has dementia and when he/she first came to the unit, he/she was aggressive and argumentative. She said the Resident is fixated on one particular female resident and follows her around the unit. UM #1 said one of the Resident's baseline behaviors are to wander into female residents' rooms, stand at their bedside watching them, and fondle his/her genitals. Neither Nurse #13 nor UM #1 identified this behavior as potential abuse, never reported these behaviors to the DON or Administrator and interventions were not put in place to address the behaviors. The Unit Manager reviewed Resident #77's comprehensive care plans and said a care plan had not been developed to address the Resident's sexually inappropriate behaviors. During an interview on 11/18/24 at 1:43 P.M., the Therapeutic Activity Director (TAD) said Resident #77 now resides on the Dementia Special Care Unit. She said when he/she resided on the first floor a few months ago, he/she would stand outside women's rooms and egg them on verbally and with sexually inappropriate gestures. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/19/24 at 11:55 A.M., the consultant psychiatric Nurse Practitioner (NP #3) said Resident #77 used to live on the first-floor unit and was moved to the third floor when he/she began to attempt to leave the building. The NP said once the Resident moved to the third floor, he was told the Resident began to exhibit hypersexual behavior and wander into female residents' rooms. He said he tries to speak with staff to get an update on the Resident's behaviors before he sees the Resident, but the challenge is that there is such great turnover in staff, many don't know anything about the Resident. During an interview on 11/20/24 at 9:50 A.M., the DON said Resident #77 has a history of aggression and sexually inappropriate behaviors. She reviewed Resident #77's medical record with the surveyor as follows: 1. Review of a Nurse's note, dated 12/14/23, indicated Resident #77 was found to be sexually inappropriate this shift and smacked one of the female residents in the butt. The DON said she was not notified of this incident and no interventions were put in place to address and manage the Resident's violent behavior, and sexually inappropriate behavior to meet his/her behavioral needs. 2. Review of a Nurse's note, dated 1/3/24, indicated Resident #77 was observed wandering during the night and intrusively entering other residents (female) rooms and touching his/her privates. The DON said she was not notified of this incident and no interventions were put in place to address and manage the Resident's intrusive wandering and sexually inappropriate behavior to his/her behavioral needs. Review of the medical record indicated an interdisciplinary care plan meeting was held on 1/24/24. However, the current Alteration in Behaviors care plan was reviewed and renewed with no new interventions to address Resident #77's sexually inappropriate behaviors. 3. Review of a Nurse's note, dated 2/20/24, indicated a visitor observed Resident #77 hit another resident (severely cognitively impaired) in the head twice. Resident #77 was transferred to the hospital for evaluation via a section 12. (According to https://www.mass.gov, Massachusetts General Law Chapter 123, Sections 12 (a) and 12 (b), controls the admission of an individual to a general or psychiatric hospital for psychiatric evaluation and, potentially, treatment. Section 12(a) allows for an individual to be brought against his or her will to such a hospital for evaluation. Section 12(b) allows for an individual to be admitted to a psychiatric unit for up to three business days against the individual's will or without the individual's consent). The DON said no interventions were put into place when the resident returned from the hospital to address and manage the Resident's violent behavior and meet his/her behavioral needs. 4. Review of a Nurse's note, dated 2/29/24, indicated Resident #77 was wandering in the halls and intruding in other resident's rooms during the evening. A resident was heard yelling out and a Certified Nursing Assistant (CNA) entered the room to check on the resident and observed Resident #77 in the resident's room. The resident reported to the CNA that Resident #77 had exposed him/herself while in his/her room. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON said she was not notified of this incident and no interventions were put into place to address and manage the Resident's sexually inappropriate behavior and meet his/her behavioral needs. 5. Review of a Nurse's note, dated 9/25/24, indicated Resident #77 was in the hall talking with another resident. The other resident (unidentified) became agitated and punched Resident #77 in the right arm. The facility failed to implement protective measures to protect Resident #77, who is vulnerable (due to severe cognitive impairment and a history of agitation and aggression), from the unidentified resident's violent behavior. The DON said she was not notified of this incident and no interventions were put into place to address and manage the Resident's violent behavior and to meet his/her behavioral needs. 6. Review of a Nurse's note, dated 10/10/24, indicated Resident #77 was struck by another resident (unidentified). The DON said she was not notified of this incident and no interventions were put into place to protect Resident #77 from physical abuse by another resident to meet Resident #77's behavioral needs. The DON reviewed a Nurse's note, dated 10/22/24 and written by Nurse #14, that indicated Resident #77 was sexually inappropriate throughout the day. No other information was documented in the note. The DON called Nurse #14 at 10:30 A.M. in the presence of the surveyor. Nurse #14 said she is an agency nurse and last worked on 10/22/24. She said on that day, the Resident was verbally sexually inappropriate toward staff, kissing female residents' arms, and trying to get females to lay in bed with him/her. Nurse #14 said during the shift, Resident #77 called her over to him/her, grabbed his/her own genitals and shook it at her. The Nurse said she reported the behaviors to staff (could not remember who) and was told it was baseline behavior for the Resident and he/she always does that. The DON said staff should have identified the Resident's behavior as sexually inappropriate and developed a care plan with interventions to meet the Resident's behavioral needs. At this time, the DON called Unit Manager #2 and told her to place Resident #77 on 1:1 supervision immediately and indefinitely. During an interview on 11/20/24 at 3:00 P.M., Nurse #11 said one of Resident #77's baseline behaviors is to stand outside female residents' rooms, sometimes enter their rooms and stare at them. She said this makes the residents uncomfortable and they don't like it. She said she wrote the Nurse's note on 12/14/23 that indicated the Resident was found to be sexually inappropriate and noted to have smacked one of the female residents in the butt. She said she does not recall who the resident was that got hit by Resident #77. Nurse #11 said she did not report it to the supervisor DON and did not put in place any protective measures or interventions to protect any other residents from being assaulted. On 11/20/24 at 3:26 P.M., the surveyor entered the third-floor unit from the stairwell and observed a Certified Nursing Assistant (CNA) standing in the hallway entering data into a computer that was mounted on the wall. The CNA was positioned with her back to Resident #77's room which was approximately 40 feet away at the end of the hallway. The surveyor then walked down a perpendicular hallway and observed two nurses and one CNA standing at the nursing station talking. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/20/24 at 3:27 P.M., the surveyor observed Resident #77 in his/her room sleeping in a recliner chair with the door to his/her room open and no stop guard banner placed across his/her doorway to prevent wandering residents from entering as indicated on the care plan. No staff were with the Resident to provide 1:1 supervision. The CNA was still standing in the hallway with her back to Resident #77's room as she entered data into a computer. On 11/20/24 at 3:34 P.M., the surveyor observed Resident #77 standing in the doorway of his/her room looking down the hallway. The CNA was still standing in the hallway with her back to Resident #77's room as she entered data into a computer. A female resident emerged from a room across the hall and was observed walking down the hallway, turning around, and walked to Resident #77's room and entered. A few moments later, the female resident exited Resident #77's room. No staff was providing 1:1 supervision. On 11/20/24 at 3:40 P.M., the surveyor observed Unit Manager #1 walk in the hallway approximately 50 feet away and notice the surveyor. She then approached CNA #10 and whispered in her ear. At this time, CNA #10 walked down the hallway and approached Resident #77 as he/she stood in the doorway of his/her room. The CNA said that she works on the other hallway and was told to go to Resident #77's room to assist him/her with something, but she didn't know what the Resident needed. The CNA was observed walking up and down the hallway and not providing 1:1 supervision to Resident #77. On 11/20/24 at 3:46 P.M., CNA #9 arrived at Resident #77's room. She said she was there to provide 1:1 supervision until the Helping Hands (staff designated to provide supervision to residents) come to take over. She said Resident #77 has sexually inappropriate behaviors toward females. She said the Resident stands outside female residents' rooms and stares at them and they don't like it. During an interview on 11/21/24 at 8:36 A.M., the Administrator said Resident #77 has had physical altercations and sexual behaviors since admission to the facility. He said they tried to transfer the Resident to another facility for the safety of the Resident and other residents, but the Resident's spouse and daughter became upset and were adamant that he/she not be moved. He said the interdisciplinary team meets every morning and discusses issues that arise with residents, such as Resident #77's behaviors. The Administrator was unable to provide any evidence that the interdisciplinary team has discussed and addressed Resident #77's violent and sexually inappropriate behaviors to prevent the Resident from abusing others and being abused. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview 11/21/24 at 10:06 A.M., Social Worker (SW) #1 said that she used to work at the facility full-time for about 14 or 15 months ending in July 2023. She said she started working at the facility again for 15 hours a week on 11/4/24. She said since returning to the facility, she has been tasked with conducting audits of PASARRs (Preadmission Screening and Resident Review) to get the facility's medical records up to date, and has not been notified about any behaviors, has not participated in any discussions, assessments, care plan development or care plan revision for Resident #77. She said when she was here over a year ago, Resident #77 exhibited aggressive behaviors toward other residents, was threatening, had no boundaries and residents were fearful of him/her. SW #1 said the Resident's presence would make female residents uneasy as he would enter their rooms when they were getting ready for bed. She said the administration wanted to transfer the Resident to another facility due to his/her unmanageable behaviors and for the safety of other residents, but the family declined. She said after the family declined a transfer to another facility, the only interventions put into place were psychiatric medication review, counseling, and increased family visits. The surveyor reviewed the allegations of physical abuse of another resident on two occasions (12/14/24 and 2/20/24), having been struck by another resident on two occasions (9/25/24 and 10/10/24), and having sexually harassed/abused other residents on two occasions with SW #1. She said staff should have appropriately addressed these behaviors to meet the Resident's behavioral needs. During a telephone interview on 11/22/24 at 3:08 P.M., Physician #4 said Resident #77's anxiety, chronic behavior problems and aggression are not new, and he defers to his Nurse Practitioner (NP #4) and the psychiatric NP to manage the Resident's psychiatric care. He said as far as he is aware, the Resident's inappropriate sexual behaviors are verbal and are directed at staff and visitors. He said he has not been told about any physical behaviors of hitting or being sexually inappropriate with other residents. The surveyor reviewed the six incidents noted above and subsequent interviews with staff with the Physician. He said he was surprised and had not heard of anything like that. He said he did not think they were doing anything to prevent it from happening. He said he recalls being at the nursing station on the second floor and observed Resident #77 speaking in explicit language. He said staff had concerns about the Resident's behavior specifically because there were multiple female residents on the floor that were ambulatory, and he/she was getting into explicit verbal altercations with them. He said he overheard staff at the nursing station discussing their concerns about Resident #77's larger risk of sexual abuse on the unit with him/her living there. He said he does not recall when or who participated in the conversation he overheard. Multiple attempts to contact NP #4 for an interview were unsuccessful. No additional documentation was provided to the survey team by the time of the exit conference. Refer to F949

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 34145 Based on record reviews and interviews, for one Resident (#77), out of a total sample of 23 residents, the facility failed to provide appropriate and sufficient staff to provide behavioral health care services as indicated in the facility assessment. Specifically, for Resident #77 with a known history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, physically abusing other residents, being physically abused by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents, the facility failed to ensure staff had appropriate competencies and skill sets to effectively manage his/her behavioral health needs, including developing non-pharmacological interventions. Findings include: Review of the facility's policy titled Resident Abuse, Mistreatment, and Neglect Policy and Procedure, last revised 4/2017, indicated but was not limited to: -The facility provided training on orientation and ongoing to all staff on the Abuse Prevention Policies and Procedures including training on issues relating to abuse risk and prohibition practices such as: -Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents; see Behavioral Management Policy. -What constitutes abuse, neglect, exploitation, and misappropriation of resident property Review of the facility's policy titled Behavior Management and Response Guidelines, last revised 12/2023, indicated but was not limited to: -Physical aggression is the act of one person physically harming another person for any reason, right or wrong: i.e., hitting, kicking, slapping, pinching, biting, etc. -Any resident who verbally threatens others then refuses verbal redirection from staff is at high risk for assault. All threats toward another resident should be considered real and steps taken to protect the other resident from harm. -Pay particular attention to demented, wandering residents, residents attempting to elope. These residents are more likely to impulsively assault others. -Residents who intrude on other residents' personal areas or who agitate others are more likely to be assaulted than other residents. -A resident may be considered appropriate or one-to-one (1:1) supervision status when he/she presents with an acute problem such as assaultive. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On initiating 1:1, the nurse shall assign a staff member to remain with the resident at all times. This staff member shall not leave the resident unless relieved by another staff member or the nurse removes the resident from 1:1 status. -The assigned staff member shall monitor and supervise the resident at all times, and is responsible for maintaining the resident's safety and welfare. -The assigned staff shall be responsible for documenting the resident's behaviors/activities/unusual events at least each hour. Documentation shall be made using a Behavioral Tracking Sheet, countersigned by the nurse, and placed in the nurses notes section of the resident's chart. -Sexual behavior becomes a problem when a resident acts out his/her behavior toward an unconsenting resident, when it is directed toward staff members or visitors. Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Resident #77 resides on the Dementia Special Care Unit (DSCU- specialized care to residents with dementia through a combination of additional and on-going dementia care training, expanded activities, and a safe and comfortable physical environment). The DSCU has a total of 38 residents of which 37 have been adjudicated incompetent (inability or unfitness to manage one's affairs because of mental condition) by the court. Of the 37 residents adjudicated incompetent, 14 residents are female and 23 are male. Review of the Minimum Data Set (MDS) assessment, dated 10/15/24, indicated Resident #77 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 00 out of 15, exhibited both physical behaviors toward others (e.g., hitting, kicking, pushing, scratching, and grabbing) and verbal behaviors toward others (e.g., threatening others, screaming at others, cursing at others) and wandering. The MDS indicated the Resident had an activated Healthcare Proxy (HCP- healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. Review of the medical record indicated documentation of six incidents of physical abuse, sexual abuse, and neglect as follows: 1. Review of a Nurse's note, dated 12/14/23, indicated Resident #77 was found to be sexually inappropriate this shift and smacked one of the female residents in the butt. 2. Review of a Nurse's note, dated 1/3/24, indicated Resident #77 was observed wandering during the night and intrusively entering other residents (female) rooms and touching his/her privates. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Review of a Nurse's note, dated 2/20/24, indicated a visitor observed Resident #77 hit another resident in the head twice. Resident #77 was transferred to the hospital for evaluation via a section 12. According to https://www.mass.gov, Massachusetts General Law Chapter 123, Sections 12 (a) and 12 (b), controls the admission of an individual to a general or psychiatric hospital for psychiatric evaluation and, potentially, treatment. Section 12(a) allows for an individual to be brought against his or her will to such a hospital for evaluation. Section 12(b) allows for an individual to be admitted to a psychiatric unit for up to three business days against the individual's will or without the individual's consent). 4. Review of a Nurse's note, dated 2/29/24, indicated Resident #77 was wandering in the halls and intruding in other resident's rooms during the evening. A resident was heard yelling out and a Certified Nursing Assistant (CNA) entered the room and observed Resident #77 in the resident's room. The resident reported to the CNA that Resident #77 had exposed him/herself while in his/her room. 5. Review of a Nurse's note, dated 9/25/24, indicated Resident #77 was in the hall talking with another resident. The other resident (unidentified) became agitated and punched Resident #77 in the right arm. 6. Review of a Nurse's note, dated 10/10/24, indicated Resident #77 was struck by another resident (unidentified). During an interview on 11/20/24 at 9:50 A.M., the Director of Nursing (DON) reviewed Resident #77's medical record and said all of the allegations of abuse and neglect reviewed should have been identified as such by staff, non-pharmacological interventions put in place, and care plans developed after each incident to address and meet the Resident's behavioral care needs to keep the Resident and any other residents safe. During an interview with Nurse #13 and Unit Manager (UM) #1 on 11/18/24 at 10:32 A.M., Nurse #13 said Resident #77 has dementia and when he/she first came to the unit, he/she was aggressive and argumentative. She said the Resident is fixated on one particular female resident and follows her around the unit. UM #1 said one of the Resident's baseline behaviors is to wander into female residents' rooms, stand at their bedside watching them and fondle his/her genitals. Neither Nurse #13 nor UM #1 identified this behavior as potential abuse and did not develop any new interventions to address the behavior. The Unit Manager reviewed Resident #77's comprehensive care plans and said a care plan had not been developed to address the Resident's sexually inappropriate behaviors. During an interview on 11/19/24 at 11:55 A.M., the consultant psychiatric Nurse Practitioner (NP) #3 said Resident #77 used to live on the first-floor unit and was moved to the third floor when he/she began to attempt to leave the building. The NP said once the Resident moved to the third floor, he was told the Resident began to exhibit hypersexual behavior and wander into female residents' rooms. He said he tries to speak with staff to get an update on the Resident's behaviors before he sees the Resident, but the challenge is that there is such great turnover in staff, many don't know anything about the Resident. NP #3 said he provides staff with guidance on how to manage the Resident's behaviors, but he is not sure about follow through because staff are always different. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/20/24 at 9:50 A.M., the DON reviewed Resident #77's medical record. A Nurse's note, dated 10/22/24 and written by Nurse #14, indicated Resident #77 was sexually inappropriate throughout the day. No other information was documented in the note. The DON called Nurse #14 at 10:30 A. M. in the presence of the surveyor. Nurse #14 said she is an agency nurse and last worked on 10/22/24. She said on that day, the Resident was verbally sexually inappropriate toward staff, kissing female residents' arms, and trying to get females to lay in bed with him/her. Nurse #14 said during the shift, Resident #77 called her over to him/her, grabbed his/her own genitals and shook it at her. The Nurse said she reported the behaviors to staff (could not remember who) and was told it was baseline behavior for the Resident and he/she always does that. The DON said staff should have identified the Resident's behavior as sexually inappropriate and developed a care plan with interventions to meet the Resident's behavioral needs. During an interview on 11/20/24 at 3:00 P.M., Nurse #11 said one of Resident #77's baseline behaviors is to stand outside female residents' rooms, sometimes enter their rooms and stare at them. She said this makes the residents uncomfortable and they don't like it. She said she wrote the Nurse's note on 12/14/23 that indicated the Resident was found to be sexually inappropriate and noted to have smacked one of the female residents in the butt. She said she does not recall who the resident was that got hit by Resident #77. Nurse #11 said she did not report it to the supervisor or DON and did not put in place any protective measures or interventions to address the behaviors and protect any of the other residents from being assaulted. During an interview on 11/21/24 at 8:36 A.M., the Administrator said Resident #77 has had physical altercations and sexual behaviors since admission to the facility. He said the interdisciplinary team meets every morning and discusses issues that arise with residents, such as Resident #77's behaviors. The Administrator was unable to provide any evidence that the interdisciplinary team has discussed and addressed Resident #77's violent and sexually inappropriate behaviors to meet his/her behavioral needs and prevent the Resident from abusing others and being abused. During a telephone interview 11/21/24 at 10:06 A.M., Social Worker (SW) #1 said that she used to work at the facility full-time for about 14 or 15 months ending in July 2023. She said she started working at the facility again for 15 hours a week on 11/4/24. She said since returning to the facility, she has been tasked with conducting audits of PASARRs (Preadmission Screening and Resident Review) to get the facility's medical records up to date, and has not been notified about any behaviors, has not participated in any discussions, assessments, care plan development or care plan revision for Resident #77. She said when she was here over a year ago, Resident #77 exhibited aggressive behaviors toward other residents, was threatening, had no boundaries and residents were fearful of him/her. SW #1 said the Resident's presence would make female residents uneasy as he would enter their rooms when they were getting ready for bed. She said the administration wanted to transfer the Resident to another facility due to his/her unmanageable behaviors and for the safety of other residents, but the family declined. She said after the family declined a transfer to another facility, the only interventions put into place were psychiatric medication review, counseling, and increased family visits. The surveyor reviewed with SW #1 the allegations of physical assault of another resident on two occasions (12/14/24 and 2/20/24), having been struck by another resident on two occasions (9/25/24 and 10/10/24), and having sexually harassed/abused other residents on two occasions. She said staff should have addressed these behaviors and developed care plans to meet the Resident's behavioral needs. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/21/24 at 11:15 A.M., the Staff Development Coordinator (SDC) said for a training to be considered effective, she holds herself and the facility to a 75% education threshold. She said there is a total of 163 employees at the facility. Review of mandatory Abuse, Neglect and Exploitation and Behavior training documentation provided by the SDC, including sign-in sheets and course completion documentation from their online training platform, 24 out of 163 (15%) staff completed Behavior training from November 2023 - November 2024. During a follow up interview on 11/21/24 at 2:03 P.M., the SDC said she provided all in-services from November 2023 to current in the facility. She reviewed the completion rate for Behavioral health trainings, and said it was low and she would expect that they would have been in better shape than that with their training compliance. She said the completion percentage was not acceptable and more work appears to be needed to ensure staff are completing trainings. During a telephone interview on 11/22/24 at 3:08 P.M., Physician #4 said Resident #77's anxiety, chronic behavior problems and aggression are not new, and he defers to his Nurse Practitioner (NP #4) and the psychiatric NP to manage the Resident's psychiatric care. He said as far as he is aware, the Resident's inappropriate sexual behaviors are verbal and are directed at staff and visitors. He said he has not been told about any physical behaviors of hitting or being sexually inappropriate with other residents. The surveyor reviewed the six incidents noted above and subsequent interviews with staff with the Physician. He said he was surprised and had not heard of anything like that. He said he overheard staff at the nursing station discussing their concerns about Resident #77's larger risk of sexual abuse on the unit with him/her living there. He said he did not think they were doing anything to address the Resident's behaviors to prevent it from happening. No additional documentation was provided to the survey team by the time of the exit conference. Refer to F949

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 34145 Based on interview and record review, the facility failed to ensure staff developed and implemented a comprehensive, person-centered care plan to address the dementia care needs of one Resident (#79) to attain or maintain their highest practicable physical, mental, and psychosocial well-being, out of a total sample of 23 residents. Findings include: Review of the facility's policy titled Care of Residents with Dementia, last revised February 2017, indicated but was not limited to the following: General: -Residents will receive ongoing comprehensive assessment for evaluation of cognitive function, physical changes associated with the disease process, and all other areas affected by the disease process. -A comprehensive care plan will be developed for all residents, and care planning will focus on needs identified through the assessment process. Care planning will be individualized to a resident's unique needs. -Care plans will be implemented, monitored, evaluated, and revised as a resident's needs evolve. Resident #79 was admitted to the facility in September 2021 with diagnoses including dementia. Review of the Minimum Data Set (MDS) assessment, dated 11/6/24, indicated Resident #79 had severely impaired cognitive skills for daily decision making as evidenced by a staff assessment, exhibited behavioral symptoms, and had a diagnosis of dementia. Review of Resident #79's medical record failed to indicate an active care plan with individualized interventions for his/her diagnosis of dementia. During an interview on 11/15/24 at 1:50 P.M., Unit Manager #1 said the MDS nurses initiate dementia care plans upon admission to the facility. During an interview on 11/19/24 at 2:13 P.M., the MDS Coordinator said the MDS department is responsible for developing comprehensive care plans as triggered by the MDS assessment process. She said Resident #79 did not have a care plan developed for the Resident's dementia care needs. She said they did an audit yesterday and found that several residents were missing care plans.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48695 Based on record review and interview, the facility failed to act promptly upon recommendations made by the Consultant Pharmacist during the monthly Medication Regimen Reviews (MRR) for two Resident (#2 and #77), out of a total sample of 23 residents. Specifically, the facility failed: 1. For Resident #2, to ensure the Pharmacist reviewed and reported irregularities related to the administration of Clonazepam (a benzodiazepine medication used to treat anxiety); and 2. For Resident #102, to ensure the physician reviewed and addressed gradual dose reduction (GDR) recommendations for the antipsychotic medication Seroquel. Findings include: Review of the facility's policy titled Medication Regimen Review, last revised 6/1/24, indicated but was not limited to: -The consultant pharmacist will conduct MRRs if required under a Pharmacy Consultant Agreement and will make recommendations based on the information made available in the resident's health record. -The facility and consultant pharmacist will follow guidance outlined in the Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix PP and current practice guidelines, for appropriate provision of pharmaceutical care. Review of the facility's policy titled Psychotropic Medication Use, last revised 9/15/24, indicated but was not limited to: - PRN (as needed) orders for psychotropic medications should be limited to no more than 14 days. Each resident who is taking a PRN psychotropic drug will have his or her prescription reviewed by the physician/prescriber every 14 days and reviewed by the pharmacist at least monthly. 1. Resident #2 was admitted to the facility in May 2022 with diagnoses including bipolar disorder and mood disorder. Review of the Minimum Data Set (MDS) assessment, dated 9/9/24, indicated Resident #2 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15 and had received anti-anxiety medication. Review of Resident #2's current Physician's Orders indicated but was not limited to: -Clonazepam 0.5 milligrams (mg) every 12 hours as needed (PRN), dated 8/2/24 Further review of Resident #2's medical record failed to indicate the Clonazepam order had a stop date. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's Pharmacist's MMR failed to indicate any irregularities with his/her Clonazepam order on the following dates: -11/12/24 -10/7/24 -9/19/24 -8/15/24 During a telephonic interview on 11/20/24 at 10:01 A.M., Pharmacist #1 said she reviews residents' records and checks for psychotropic medications without a stop date. Pharmacist #1 said she should have picked on Resident #2 not having a stop date on his/her PRN Clonazepam but she did not. 34145 2. Resident #102 was admitted to the facility in September 2023 and had diagnoses including dementia, depression, and bipolar disorder (a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking, and behavior). Review of the MDS assessment, dated 11/7/24, indicated Resident #102 had both short- and long-term memory problems and severely impaired skills for daily decision making according to a staff assessment, and received antipsychotic medication. Review of current Physician's Orders indicated but was not limited to: -Seroquel 100 mg every night at 8:00 P.M. (11/10/23) Review of November 2023 through November 2024 Medication Administration Record indicated the order for Seroquel was administered as ordered by the physician. Review of the consultant pharmacist's MMRs indicated recommendations dated 7/2/24, 9/19/24, and 11/13/24 for the physician to re-evaluate continued use of Seroquel at its current dose. Further review of the medical record failed to indicate Resident #102's physician addressed and documented a response to the pharmacist's repeated recommendations to re-evaluate the current dose of Seroquel. During an interview on 11/15/24 at 2:54 P.M., Resident #102's physician said he did not address the pharmacist's recommendation for a GDR of Seroquel.

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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 record review and interview, the facility failed to ensure two Resident's (#2 and #102) drug regimen was free from unnecessary psychotropic medications, out of a total sample of 23 residents. Specifically, the facility failed: 1. For Resident #2, to ensure as needed (PRN) psychotropic medication was limited to 14 days, or extended beyond 14 days with a documented clinical rationale and duration; and 2. For Resident #102, to ensure a gradual dose reduction (GDR) of the antipsychotic medication Seroquel was attempted, unless clinically contraindicated and documented in the medical record, in an effort to discontinue the drug. Findings include: Review of the facility's policy titled Psychotropic Medication Use, last revised 9/15/24, indicated but was not limited to: - PRN orders for psychotropic medications should be limited to no more than 14 days. Each resident who is taking a PRN psychotropic drug will have his or her prescription reviewed by the physician/prescriber every 14 days and reviewed by the pharmacist at least monthly. - If the physician/prescriber believes that it is appropriate for a PRN psychotropic order (excluding antipsychotics) to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration of use. 1. Resident #2 was admitted to the facility in May 2022 with diagnoses including bipolar disorder and mood disorder. Review of the Minimum Data Set (MDS) assessment, dated 9/9/24, indicated Resident #2 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15 and had received anti-anxiety medication. Review of Resident #2's current Physician's Orders indicated but was not limited to: -Clonazepam (anti-anxiety medication) 0.5 milligrams (mg) every 12 hours as needed, dated 8/2/24 Further review of Resident #2's medical record failed to indicate the Clonazepam order had a stop date. Review of the medical record indicated Clonazepam 0.5 mg every 12 hours as needed was administered on the following occasions: -November 2024: 11/15, 11/16, 11/17 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-October 2024: 10/9, 10/16, 10/20, 10/29 -September 2024: 9/4, 9/7, 9/9, 9/14 During an interview on 11/19/24 at 10:42 A.M., Nurse #5 and Nurse #4 said PRN psychotropic medications should have a stop date and an order to re-evaluate the need for the PRN medication. Nurse #5 and Nurse #4 reviewed Resident #2's physician's orders and said Resident #2 should have had a stop date for the Clonazepam but did not. During an interview on 11/19/24 at 10:59 A.M., Nurse Practitioner (NP) #3 said PRN psychotropic medications should have a stop date and should be re-evaluated to ensure the medication continued to be needed. During a telephonic interview on 11/19/24 at 12:57 P.M., Physician #1 said he did not check to see if Resident #2 had a stop date for his/her Clonazepam. Physician #1 said he should have put a stop date for Resident #2's Clonazepam and re-evaluated it, but he did not. During a telephonic interview on 11/20/24 at 10:01 A.M., Pharmacist #1 said she reviews residents' records and checks for psychotropics without a stop date. Pharmacist #1 said Resident #2 should have had a stop date for his/her anti-anxiety medication. During an interview on 11/20/24 at 11:22 A.M., the Director of Nursing (DON) said PRN psychotropic medications should have an order for a stop date. Resident #2 should have had a stop date for the Clonazepam but did not. 34145 2. Resident #102 was admitted to the facility in September 2023 and had diagnoses including dementia, depression, and bipolar disorder (a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking, and behavior). Review of the MDS assessment, dated 11/7/24, indicated Resident #102 had both short- and long-term memory problems and severely impaired skills for daily decision making according to a staff assessment and received antipsychotic medication. The assessment indicated no GDR has been attempted, and the physician has not documented a GDR is clinically contraindicated. Review of current Physician's Orders indicated but was not limited to: -Seroquel 100 mg every night at 8:00 P.M. (11/10/23) Review of the consultant psychiatric NP's (#3) progress notes included but was not limited to: -4/23/24: Clinical assessment: GDR Rationale: Could attempt dose reduction of Seroquel to 75 mg at bedtime (HS-hour of sleep), Plan/Recommendations: Decrease Seroquel to 75 mg HS. Review of April 2024 through November 2024 Medication Administration Record indicated the order for Seroquel was administered as ordered by the physician. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record failed to indicate Resident #102's physician addressed and documented a response to the psychiatric clinician's recommendation to decrease the dose of Seroquel from 100 mg at HS to 75 mg at HS. During an interview on 11/15/24 at 2:54 P.M., Resident #102's Physician said he did not follow up on the NP's recommendation for a GDR of Seroquel, has not attempted a GDR, and did not document a clinical rationale to decline a GDR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 43935 Based on observations and interview, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed: 1. To ensure medications were not stored in a medication cup in the top drawer of the medication cart in one medication cart out of three observed carts; and 2. To ensure treatment carts were locked when not in direct supervision of a licensed nurse on one of three units. Findings include: Review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals, dated as revised 8/1/24, indicated but was not limited to the following: - facility should ensure that all medications and biologicals are stored for each resident in the containers in which they were originally received - 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 Review of the facility's policy titled General Dose Preparation and Medication Administration, dated as revised 4/30/34, indicated but was not limited to the following: - Dispose of unused medication portions in accordance with facility policy 1. On 11/14/24 at 10:20 A.M., the surveyor observed the low side medication cart on the third floor with Nurse #2. Upon opening the top drawer of the medication cart, a small clear plastic cup was observed in the right-hand section filled with a dark, almost black powdery substance. During an interview on 11/14/24 at 10:22 A.M., Nurse #2 said the cup contained Resident #104's morning medications that the Resident refused. She said the Resident doesn't like to take their morning medications and she was storing them to give them to the Resident later. She said without looking at the medication administration record (MAR) she would not know what was in the cup. She said it is her normal process to keep the medications and try again later and she would not dispose of them just because the Resident declined them at this time. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 10:46 A.M., the Director of Nurses (DON) said if medications are poured and then a resident declines them, then the nurse is supposed to dispose of the medications, notify the physician, and document the refusal in the medical record. She was made aware of the surveyor's observations on the third floor in the medication cart and said saving pre-poured medications is not an acceptable practice and does not meet the facility's expectation of acceptable practice for medication administration or storage. 48362 2. The surveyor made the following observations on: - 11/13/24 at 8:15 A.M., a treatment cart was unlocked and unattended on the Third Floor Unit. - 11/13/24 at 8:18 A.M., a treatment cart was unlocked and unattended on the Third Floor Unit with multiple residents walking up and down the hallway where the treatment cart was located. Nurse #1 was in a resident room assisting with the breakfast meal and Unit Manager (UM) #1, who was working as a nurse assigned to a cart, was in the main dining room on the unit assisting with mealtime. - 11/13/24 at 8:40 A.M., a treatment cart was unlocked and unattended on the Third Floor Unit with multiple residents walking up and down the hallway where the treatment cart was located. Multiple residents were observed to stop and stand in front of the treatment cart before being redirected by staff. - 11/13/24 at 9:22 A.M., a treatment cart was unlocked and unattended on the Third Floor Unit with multiple residents walking up and down the hallway where the treatment cart was located. Nurse #1 and UM #1 were observed to be administering medications and not in line of sight of the treatment cart. - 11/13/24 at 9:35 A.M., a treatment cart was unlocked and unattended on the Third Floor Unit with multiple residents walking up and down the hallway where the treatment cart was located. During an interview on 11/13/24 at 10:06 A.M., UM #1 said the Third Floor Unit has one treatment cart and it should only be unlocked when a staff member is gathering supplies. UM #1 and the surveyor reviewed the observations of the treatment cart. UM #1 said the treatment cart should always be locked when not in use. During an interview on 11/18/24 at 2:50 P.M., the DON said all treatment and medication carts should be locked when not in use by a staff member. The surveyor reviewed the observations made on the Third Floor Unit with the DON. The DON said the Third Floor Unit has a large population of residents with dementia and the treatment cart on that unit should never be left unlocked and unattended.

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Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Ensure thickened beverage items were properly dated and stored in three of three kitchenettes; and 2. Ensure staff were not eating in one of three kitchenettes. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised ,d+[DATE], indicated but was not limited to the following: ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety The surveyor made the following observations: On [DATE] at 8:32 A.M. and at 12:26 P.M. Second Floor Kitchenette: - One opened container of thickened apple juice refrigerated, dated [DATE], manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened water refrigerated, dated [DATE], manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Two opened containers of lactose free milk refrigerated, undated, manufacturer label stated: Once opened consume within 14 days - Four opened containers of thickened cranberry juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One opened container of thickened water refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened orange juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened apple juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened dairy beverage refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened apple juice at room temperature, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; and - Three opened containers of thickened water at room temperature, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; On [DATE] at 12:33 P.M. Third Floor Kitchenette: - Three opened containers of thickened dairy beverage refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Two opened containers of thickened apple juice at room temperature, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Three opened containers of thickened cranberry juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; and - Two opened containers of thickened water refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; On [DATE] at 12:43 P.M. First Floor Kitchenette: - Three opened containers of thickened water at room temperature, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Four opened containers of thickened water refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Three opened containers of thickened dairy beverage refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Two opened containers of lactose free milk refrigerated, undated, manufacturer label stated: Once opened consume within 14 days; - Two opened containers of thickened cranberry juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One unopened container of yogurt, expiration date [DATE]. On [DATE] at 7:22 A.M. Third Floor Kitchenette: - Three opened containers of thickened dairy beverage refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Two opened containers of thickened apple juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Four opened containers of thickened cranberry juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; and - Two opened containers of thickened water refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Two opened containers of thickened water frozen, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration. Storage and handling: Do not freeze. - One opened container of light cream, undated with date opened, best by date [DATE], manufacturer label stated: For best quality, enjoy within 14 days of opening; On [DATE] at 7:35 A.M. Second Floor Kitchenette: - One opened container of thickened apple juice frozen, dated [DATE], manufacturer label stated: After opening may be kept up to 7 days under refrigeration; . Storage and handling: Do not freeze. - One opened container of thickened water refrigerated, dated [DATE], manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Two opened containers of lactose free milk refrigerated, undated, manufacturer label stated: Once opened consume within 14 days - Five opened containers of thickened cranberry juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened water refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened orange juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened apple juice refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of thickened dairy beverage refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One opened container of thickened apple juice at room temperature, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; and - Three opened containers of thickened water at room temperature, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; On [DATE] at 7:49 A.M. First Floor Kitchenette: - Three opened containers of thickened water at room temperature, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - Four opened containers of thickened water refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened containers of thickened dairy beverage refrigerated, undated, manufacturer label stated: After opening may be kept up to 7 days under refrigeration; - One opened container of lactose free milk refrigerated, undated, manufacturer label stated: Once opened consume within 14 days; and - One unopened container of yogurt, expiration date [DATE]. During an interview on [DATE] at 10:37 A.M., Dietary Aide #1 and the surveyor observed the Third Floor Kitchenette and Second Floor Kitchenette. Dietary Aide #1 said it was her job to stock the kitchenettes with cookies and snacks, as well as thickened juices, milk, and water. Dietary Aide #1 said she did not specifically check if thickened juices, milk, and water were opened but she does check and remove expired items. During an interview on [DATE] at 1:26 P.M., the Food Service Director (FSD) and surveyor toured the three kitchenettes and observed opened, undated containers of thickened liquids, expired yogurt and light creamer, room temperature thickened liquids, as well as frozen thickened liquids. The FSD said his expectation was for all thickened liquids to be stored according to the manufacturer's recommendations and for refrigerators to be checked for expired items and if expired items were present then they should have been discarded. The FSD said his expectation was for staff to label thickened liquids on the date opened and rotate them to ensure they were used per manufacturer's recommendations. 2. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised ,d+[DATE], indicated but was not limited to the following: Employee accommodations ,d+[DATE].11 Designated Areas. Because employees could introduce pathogens to food by hand-to-mouth-to-food contact and because street clothing and personal belongings carry contaminants, areas designated to accommodate employees' personal needs must be carefully located. Food, food equipment and utensils, clean linens, and single-service and single-use articles must not be in jeopardy of contamination from these areas. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:40 P.M., the FSD and surveyor observed two staff members in the Second Floor Kitchenette eating pizza. The two staff members placed their pizza on a Styrofoam plate and covered them with a Styrofoam plate and walked out of the kitchenette leaving the pizza on a shelf with snack supplies used for residents. During an interview on [DATE] at 1:42 P.M., the FSD said staff should never eat in the kitchenettes and the floor kitchenettes are for residents only, not for staff. The FSD said there was a staff dining room for employees to eat in. During an interview on [DATE] at 2:08 P.M., the Director of Nursing (DON) said the expectation was for employees to eat in the staff dining room. The DON said it was unacceptable for staff to eat in the kitchenettes on the unit and store food there as those are for residents only.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 42742 Based on interview and record review, the facility failed to ensure Administration effectively utilized their resources to provide for the behavioral needs for one Resident (#77), who had a known history of aggressive and sexually inappropriate behaviors and provide a safe environment to protect other residents from physical abuse, sexual abuse, and neglect. Findings include: During the recertification survey conducted on 11/13/24 through 11/15/24 and 11/18/24 through 11/21/24, the survey team determined the facility provided substandard care and identified numerous care concerns. The survey team determined the facility failed to provide residents a safe environment free from physical abuse, sexual abuse, and neglect. Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. Further review of the medical record indicated the Resident was moved to different units following each behavioral incident. Review of Resident #77's medical record indicated Resident #77 hit other residents on two occasions (12/14/23 and 2/20/24), was struck by another resident on two occasions (9/25/24 and 10/10/24), and sexually harassed/exhibited sexually inappropriate behaviors toward residents on two occasions (1/3/24 and 2/29/24). During an interview on 11/20/24 at 9:50 A.M., the Director of Nursing (DON) said she was aware that Resident #77 had a history of aggression and sexually inappropriate behaviors. During an interview on 11/21/24 at 8:36 A.M., the Administrator said Resident #77 has had physical altercations and inappropriate sexual behaviors since admission to the facility. He said they tried to transfer the Resident to another facility for the safety of the Resident and other residents, but the Resident's spouse and daughter became upset and were adamant that he/she was not moved. The Administrator said every time the Resident has a behavioral episode, they contact the family and discuss moving him/her, but the family refuses. The Administrator was unable to provide any evidence that the interdisciplinary team has discussed and addressed Resident #77's violent and sexually inappropriate behaviors and any interventions were put into place to prevent the Resident from abusing others and being abused. Review of the facility's policy titled Resident Abuse, Mistreatment, and Neglect Policy and Procedure, last revised 4/2017, indicated but was not limited to: (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-All staff receive training on hire, and ongoing, on courses related to abuse risk and prohibition practices. -The Facility will analyze allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property through the Quality Assessment and Assurance process to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. Review of the Facility Assessment, dated as last updated on 12/26/23 and last reviewed with the Quality Assurance Performance Improvement (QAPI) Committee on 6/20/24, failed to indicate education/trainings and competencies necessary for staff for the care of the residents. During an interview on 11/21/24 at 10:44 A.M., the Administrator reviewed the Facility Assessment with the surveyor which failed to indicate what education/trainings and competencies were necessary for the facility staff to complete. He said he was unsure if the facility had a training plan but would provide one to the survey team if one could be found. He provided the survey team with print outs of all the staff training that had been completed on their web-based training system in the last 12 months. In addition, a list of all staff was provided to the survey team that totaled 163 staff members. During an interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) reviewed all staff training documentation from November 2023 to November 2024. The training documentation indicated 50 out of 163 staff (30%) completed Abuse training and 24 out of 163 staff (15%) completed Behavior training from November 2023 - November 2024. She reviewed the completion rate for Behavioral health trainings, and said it was low and she would expect that they would have been in better shape than that with their training compliance. She said the completion percentage was not acceptable and more work appears to be needed to ensure staff are completing trainings. During an interview with the Administrator and DON on 11/21/24 at 1:47 P.M., the Administrator said he heads the QAPI program and the committee meets quarterly (full committee) and monthly (facility department heads). The DON said issues can be brought forward and presented by each department. Any time there is an issue, an action plan is put into place within 48 hours and within 30 days, they will present an update to the QAPI committee. She said they see if there are measurable outcomes, and if not, will go back to the drawing board. The Administrator reviewed Performance Improvement Projects (PIP) conducted within the past six months. The Administrator and DON failed to analyze the incidents involving abuse and neglect through the Quality Assessment and Assurance process to determine what changes were needed, if any, to policies and procedures to prevent further occurrences.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 43935 Based on document review and interview, the facility failed to conduct and implement a comprehensive facility wide assessment that was inclusive of resources necessary to provide both emergency and day to day care of the population the facility currently serves, including their short-term, long-term, and dementia specialty care residents. Findings include: Review of the Centers for Medicare and Medicaid Services Quality Safety Oversight (QSO) Memorandum: QSO-24-13-NH, Titled: Revised Guidance for Long-Term Care Facility Assessment Requirements, dated: June 18, 2024, indicated but was not limited to the following: - new provisions become effective 90 days after publication and must be implemented by August 8, 2024 - new requirements specify that the facility assessment must include an evaluation of diseases, conditions, physical or cognitive limitations of the resident population, acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and any other pertinent information about the resident population as a whole that may affect the services the facility must provide - the assessment of the resident population should drive staffing decisions and inform the facility about what skills and competencies staff must possess in order to deliver the necessary care required by the residents being served - In conducting the facility assessment, the facility must ensure active involvement from key individuals, such as the facility's leadership (including management and members of the facility's governing board), and direct care staff (e.g., nurses and nurse assistants), and also solicit input from residents and families The facility assessment must address or include the following: - care required by the resident population, using evidence-based, data-driven methods that considers the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident - staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population Review of the Facility Assessment tool, provided by the facility, dated as last updated on 12/26/23 and last reviewed with the Quality assurance performance improvement committee on 6/20/24, indicated but was not limited to the following: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Persons involved in completing the assessment: This section indicated that the Administrator, Director of Nurses (DON) and Medical Director were the only three individuals involved in completing the facility assessment. Section 1: Resident Profile 1.4 Describe the process to make admission or continuing care decisions for persons that have diagnoses or conditions that you are less familiar with and have not previously supported. 1.6 Describe ethnic, cultural or religious factors or personal resident preferences that may potentially affect the care provided to residents by your facility. Examples may include activities, food and nutritional service, languages, clothing preferences, access to religious services, or religious-based advanced directives. 1.7 Describe other pertinent facts or descriptions of the resident population that must be taken into account when determining staffing and resources needed. These sections were blank and without any facility specific information. Section 3: Facility resources needed to provide competent support and care for our resident population every day and during emergencies. 3.3 Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across the staff assignments. 3.4 Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. 3.5 Describe how you evaluate what policies and procedures may be required in the provision of care, and how you ensure those meet current professional standards of practice. 3.6 Describe your plan to recruit and retain enough medical practitioners. 3.7 Describe how the management and staff familiarize themselves with what they should expect from medical practitioners and other healthcare professionals related to standards of care and competencies. These sections were blank and without any facility specific information. 3.12 Provide your facility-based and community based risk assessment, utilizing an all hazards approach (an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and natural disasters) This section indicated to review the attached Hazard Vulnerability Analysis and Summary, however there was no attachment to the facility assessment. Attachment 1: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This was a pre-populated Rules and regulations print out of the federal register explaining the pertinent pieces of the assessment to be completed, dated 10/4/16 Attachment 2: Sample process for conducting a facility assessment There were no further attachments to the facility assessment for review. During an interview on 11/21/24 at 10:44 A.M., the Administrator said the facility assessment tool dated as reviewed with the QAPI committee on 6/20/24 was the current accurate facility assessment. He said he was aware that guidance required numerous changes to the facility assessment to be implemented by August 2024 and he thought the assessment reviewed with the QAPI committee in June 2024 met all those requirements. The Administrator and the surveyor reviewed several sections with missing information including the education/training and competencies section being incomplete and he said he would have to look into what happened and discuss it with the Director of Nurses (DON). During an interview on 11/21/24 at 12:11 P.M., the Administrator said the DON would review the Facility Assessment with the surveyor. The DON said the provided Facility assessment dated as reviewed with the QAPI committee on 6/20/24 was the most recent and up to date facility assessment. She said the document was created by the Administrator and herself and then later a copy was provided for review to the Medical Director. She said there were no other staff or governing body members involved in the creation or revision of the Facility Assessment but the staff are encouraged to come forward and offer suggestions for improvement, as are residents and family members, but they would not really know what the creation of a facility assessment would entail. The DON reviewed the numerous blank areas of the facility assessment and said the main focus was on ensuring the current census acuity information was in the assessment and the other sections were blank and incomplete. The DON reviewed the attachments and said there was no hazardous vulnerability analysis or summary attached or incorporated into the facility assessment. The DON reviewed the QSO memo (QSO-24-13-NH) and said the current Facility assessment did not appear to meet the requirements and many areas were incomplete. During a follow up interview on 11/21/24 at 2:37 P.M., the Administrator said the facility Hazardous Vulnerability Analysis and Summary were part of their disaster plan and they were not going to recreate it for the Facility assessment and did not incorporate it into the Facility assessment as required, but the facility does have one in the Emergency preparedness disaster plan. He said he did review the new QSO and thought the Facility assessment would have covered the new requirements but he can see how the guidelines have not been met.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48695 Based on observation, document review, and interview, the facility failed to maintain accurate medical records in accordance with professional standards and practices for four Residents (#25, #64, #83, and #102), out of 23 sampled residents. Specifically, the facility failed: 1. For Resident #25, to ensure that: a. his/her medical records contained a copy of his/her Health Care Proxy Form (HCP, health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions) and HCP Activation Form, and b. documentation of physician visits was part of the medical record in a timely manner; 2. For Resident #64, to ensure that documentation of physician visits was part of the medical record in a timely manner; 3. For Resident #83, to ensure that documentation of physician visits was part of the medical record in a timely manner; and 4. For Resident #102, to ensure documentation of physician visits was available in the medical record. Findings include: Review of the facility's policy titled Physician Services, last revised April 2013, indicated but was not limited to: - The physician will perform pertinent timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and to ensure adequate alternative coverage. - Physician orders and progress notes shall be maintained in accordance with current OBRA regulations and facility policy. Review of the facility's policy titled Medical Records Procedure, last revised January 2024, indicated but was not limited to: -Medical records are started upon admission and are comprised of Admission and Nursing forms. All forms are placed in the resident's chart according to the order of the medical record. -Physician Progress Notes: a. Medicare Certification/Recertification Form (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. One year of physician progress notes c. Hospice notes 1. Resident #25 was admitted to the facility in March 2021 with diagnoses including unspecified falls and dementia. a. Review of Resident #25's current Physician's Orders indicated but was not limited to: -HCP invoked as of 3/5/21, dated 4/8/22 Review of the medical record failed to include a copy of the HCP Form and/or HCP Activation Form. During an interview on 11/20/24 at 11:22 A.M., the Director of Nursing (DON) said Resident #25's medical record did not contain his/her HCP Form and HCP Activation Form but should have. The DON said the expectation is for all medical records to be complete. b. Review of Resident #25's medical record indicated he/she was seen by the Physician on 6/28/24 and 10/24/24, as evidenced by a Physician's Progress Notes, indicating there was a 118-day span from one Physician visit to the next. During an interview on 11/18/24 at 1:28 P.M., Physician #1 said he sees Resident #25 monthly, but he does not send his notes over to the facility until he has a chance to review them and sign them. Physician #1 said most of his notes are similar and he should send them over more frequently but does not. During an interview on 11/21/24 at 8:39 A.M., the Medical Records Clerk said Physician #1 usually does not send his notes over until he has signed them. The Medical Records Clerk said she usually has to call Physician #1 to have him send his notes over. The Medical Records Clerk said physicians' notes should be in the residents' medical records but are not always. During an interview on 11/20/24 at 4:06 P.M., the DON said the expectation was for Physician Visit Notes and their Physician Extender's Notes to be filed in residents' records in a timely manner. 2. Resident #64 was admitted to the facility in May 2024 with diagnoses including dementia and Alzheimer's disease. Review of Resident #64's medical record indicated he/she was seen by the Physician on 2/29/24 and 10/1/24, as evidenced by a Physician's Progress Notes, indicating there was a 215-day span from one Physician visit to the next. During a telephonic interview on 11/19/24 at 4:21 P.M., Physician #3 said he saw the Resident on 6/20/24. Physician #3 said he and his Physician Extender would fax over their notes in a timely manner, but he is not sure what happens when they are faxed over. Physician #3 said it was his expectation for his notes to make it to Resident #64's medical record. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 8:39 A.M., the Medical Records Clerk said Physician #3 and his Physician Extender faxed their notes over and they should be in the residents' medical records but are not always. During an interview on 11/20/24 at 4:06 P.M., the DON said the expectation was for Physician's Visit Notes and their Physician Extender's Notes to be filed in residents' records in a timely manner. 3. Resident #83 was admitted to the facility in March 2022 with diagnoses including hypertension, diabetes, and dementia. Review of Resident #83's medical record indicated he/she was seen by the Physician on 3/4/24, as evidenced by a Physician's Progress Note. Further review of the medical record failed to indicate Resident #83 had been seen by the Physician after 3/4/24. Further Review of the medical record indicated Resident #83 was last seen by the Physician Extender on 5/21/24 as evidenced by a Physician's Extender Note dated 5/21/24. During a telephonic interview on 11/20/24 at 12:28 P.M., Physician #4 said he had seen Resident #83 after 3/4/24 but could not recall when. Physician #4 said he would have his office fax over all of Resident #83's visits summaries from 1/1/24 to 11/20/24. Physician #4 said he and his Physician Extender would usually fax or email their notes and they should be in Resident #83's medical record in a timely manner. Review of Resident #83's Physician visits provided to the surveyor on 11/20/24 at 2:21 P.M. indicated there was a 224-day span from the last physician visit to the next one as evidenced by a Physician's Progress Note dated 10/14/24. Review of Resident #83's Physician Extender's visit notes provided to the surveyor on 11/20/24 at 2:21 P.M. indicated he/she had been seen on the following days: -10/16/24 -9/27/24 -9/4/24 -8/21/24 -8/10/24 -7/25/24 -6/5/24 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 8:39 A.M., the Medical Records Clerk said Physician #4 and his Physician Extender fax or email their notes over to the facility. The Medical Records Clerk said the Physician's and his Physician Extender's notes should be in residents' medical records but are not always. During an interview on 11/20/24 at 4:06 P.M., the DON said the expectation was for Physician Visit Notes and their Physician Extender's Notes to be filed in residents' records in a timely manner. 34145 4. Resident #102 was admitted to the facility in September 2023 and had diagnoses including a history of urinary tract infections, dementia, and bipolar disorder. Review of Resident #102's entire medical record indicated the Resident had been seen by the Physician on three occasions since September 2023: 6/14/24, 10/25/24, and 10/20/24. No other physician progress notes were in the medical record. During an interview on 11/15/24 at 9:56 A.M., Unit Manager #1 said all physician notes should be in either the paper or electronic medical record. She reviewed the entire medical record for Resident #201 and said no additional physician notes were in the medical record. During an interview on 11/15/24 at 10:25 A.M. and 2:26 P.M., the DON said all the physician's notes that have been sent by his office are in the medical record. The DON said she asked the medical records department to search overflow documentation for physician's notes for Resident #102, and she said they found nothing. She said she called Physician #1's office and requested his progress notes be sent to the facility. During an interview on 11/15/24 at 2:54 P.M., Physician #1 said there were no additional physician progress notes in the facility, and he needed to have his office send over his notes.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 42742 Based on interview and document review, the facility failed to ensure the binding Arbitration Agreement presented to residents as part of the admission packet was explained to the resident and/or his/her representative in a form and manner that he/she understands for two Residents (#63 and #84), out of three sampled residents, that had signed arbitration agreements in the facility. Findings include: Review of the facility's policy titled Arbitration Procedure, revised May 2024, indicated but was not limited to the following: Purpose: To meet regulatory compliance. Scope: To be followed by all Social Workers and/or any staff involved in the admissions process with oversight by the Executive Director. Procedure: Upon admission, the admission packet to be used contains an arbitration agreement. This agreement is to be explained to the resident and or responsible party. If the resident/responsible party is in agreement and chooses binding arbitration, then they must sign, and date where indicated. During the Entrance Conference interview on 11/13/24 at 9:02 A.M. with the Administrator and Director of Nursing (DON), the surveyor requested a list of residents, who were currently residing in the facility, that had entered into a binding arbitration agreement on or after 9/16/19. Review of a list of residents, provided by the Administrator on 11/15/24 at 11:55 A.M., who were currently residing in the facility indicated a total of 109 residents/representatives had entered into a binding arbitration agreement on or after 9/16/19. During an interview on 11/14/24 at 3:40 P.M., the Administrator said when a resident is admitted he, the social worker, or medical records will review the agreement with the resident/representative to sign. During an interview on 11/18/24 at 7:35 A.M., the Administrator said the February 2022 version of the Arbitration Agreement provided to the surveyor was the current version the facility was using. He said the separate Advantages of Arbitration document is reviewed with the residents before they sign the agreement to explain it to them but was not part of the actual agreement. The surveyor requested three Residents' (#63, #72, and #84) signed arbitration agreements for review. Review of two of three facility documents titled Arbitration Agreement indicated: -Resident #63 and Social Worker (SW) #2 signed the agreement on 5/8/24 -Resident #84 and SW #2 signed the agreement on 10/5/24 (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/18/24 at 9:47 A.M., the surveyor reviewed the signed Arbitration Agreement with Resident #63 who said he/she was their own person and never saw the Administrator or SW #2 regarding the agreement and didn't even know what it was. The Resident said he/she did not recall anyone explain it to him/her and could not picture him/herself signing it if it's something he/she wouldn't do. Resident #63 said he/she didn't know what they signed or that it was to give up their right to litigation in a court proceeding and if it came down to it, they would want the right to have their own lawyer. Resident #63 said the agreement was not explained to him/her before signing it in a manner that he/she could understand. During an interview on 11/18/24 at 10:34 A.M., the surveyor reviewed the signed Arbitration Agreement with Resident #84 who said he/she was their own person and didn't even know what arbitration was and asked the surveyor for an explanation. The Resident said he/she did not recall anyone explaining it to him/her including the Administrator or SW #2 and said it would be unprofessional for him/her to have signed the agreement without understanding it. The Resident said no one explained it to him/her that they could remember and did not know what he/she had signed. During an interview on 11/18/24 at 3:39 P.M., the Administrator said arbitration is explained to the residents and if they get admitted late, he or the Social Worker will stay to explain it to them. He said he had no documentation to support whether or not residents/representatives who had signed the agreement fully understood it and couldn't do a note on everyone. He said he had no additional documentation for Resident #63 or Resident #84 to establish the fact that the Residents understood what they were signing. During an interview on 11/19/24 at 12:44 P.M., SW #2 said she started at the facility on 1/8/24 and left sometime in October 2024. She said she did a lot of admissions and was aware that the agreement was part of the admission packet towards the back but did not personally review the Arbitration Agreement with the residents or educate them on it. She said she would just give them the packet, ask them to read it, and would just have them sign everything when she came back. SW #2 said she did not discuss what arbitration was or review the Advantages of Arbitration document with the residents as the Administrator had indicated. She said she wasn't even aware that she was responsible for these, but if a resident didn't want to sign, they didn't have to. SW #2 verified it was her signature on Resident #63 and Resident #84's agreements but didn't recall signing them with the Residents. During an interview on 11/19/24 at 2:09 P.M., the Administrator said the expectation was to educate the residents prior to signing the agreement and said they are doing that.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 42742 Based on document review and interview, the facility failed to ensure their arbitration agreement provides for the selection of a neutral arbitrator agreed upon by both parties. Findings include: Review of the facility's policy titled Arbitration Procedure, revised May 2024, indicated but was not limited to the following: Purpose: To meet the regulatory requirements. During the Entrance Conference interview on 11/13/24 at 9:02 A.M. with the Administrator and Director of Nursing (DON), the surveyor requested a list of residents, who were currently residing in the facility, that had entered into a binding arbitration agreement on or after 9/16/19. Review of a list of residents, provided by the Administrator on 11/15/24 at 11:55 A.M., who were currently residing in the facility indicated a total of 109 residents/representatives had entered into a binding arbitration agreement on or after September 16, 2019. Review of the Arbitration Agreement in use by the facility, last revised February 2022, failed to indicate the residents or their representatives had the right to the selection of a neutral arbitrator agreed upon by both parties. During an interview on 11/18/24 at 7:35 A.M., the Administrator said the February 2022 version of the Arbitration Agreement provided to the surveyor was the current version the facility was using. The surveyor requested a copy of three Residents (#63, #72, and #84) signed arbitration agreements for review. During an interview on 11/18/24 at 3:39 P.M., the surveyor reviewed the Arbitration Agreement with the Administrator who said the selection of a neutral arbitrator was not included on it. During an interview on 11/19/24 at 2:09 P.M., the Administrator said he wanted to read the Arbitration Agreement again and did not believe the selection of a neutral arbitrator was required per the Massachusetts Department of Public Health (DPH). The surveyor informed the Administrator arbitration was a federal regulation and not state. During an interview on 11/19/24 at 2:17 P.M., the Administrator said the facility follows the American Arbitration Association (AAA) in regard to a neutral arbitrator and said mention of the AAA was on the agreement. Further review of the Arbitration Agreement in use by the facility indicated but was not limited to the following: (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It is understood and agreed by (the Facility) and (Resident, or Resident's Authorized Representative) that any legal dispute, controversy, demand or claim (hereinafter 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 place agreed upon by the parties, or in the absence of such agreement, at the facility, in accordance with the American Arbitration Association (AAA) Alternative Dispute Resolution Service Rules of Procedure for Arbitration which are hereby incorporated into this agreement and not by a 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 agreement paragraph referencing the AAA failed to explicitly state that residents or their representatives had the right to the selection of a neutral arbitrator agreed upon by both parties. During an interview on 11/20/24 at 7:32 A.M., the surveyor reviewed the signed Arbitration Agreement, dated 10/5/24, with Resident #84 who said he/she was his/her own person and had never heard of the AAA and didn't know if it was a website or not. Resident #84 said he/she was not familiar with the internet or the web. The surveyor asked the Resident to attempt to locate the AAA on his/her cellular device. On the third attempt the Resident was able to locate a website but asked the surveyor Now what do I do?. The Resident was unable to navigate the website to locate any information in regard to the selection of a neutral arbitrator. The Resident said he/she should not have to be referred to a website if that's what it was, and the arbitration agreement should have been printed out in words that he/she could understand and was never explained to him/her. During an interview on 11/20/24 at 7:45 A.M., the surveyor reviewed the signed Arbitration Agreement, dated 5/8/24, with Resident #63 who said he/she was his/her own person and hadn't heard of the AAA and had no clue if it was a website or not. The Resident said he/she did not have access to a computer and wouldn't know how to use it anyway. The Resident said he/she had a cellular device but would have to ask someone to help look it up. The Resident said he/she would expect that the agreement itself would be in words he/she could understand and explained to him/her and not have to be referred to a website to be educated on what it was.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 42742 Based on interview and document review, the facility failed to implement and maintain a Quality Assurance and Performance Improvement (QAPI) program which addressed the full range of care and services, was comprehensive and data-driven, and focused on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility failed to ensure an ongoing QAPI program was implemented and maintained and addressed identified priorities including ongoing identified concerns of physical and sexual abuse involving Resident #77. Findings include: Review of the facility's policy titled Quality Assessment and Assurance Procedure, revised April 2013, indicated but was not limited to the following: -Quality Assessment and Assurance (QAA) Committee meeting is held quarterly and is chaired by the Executive Director. The committee will identify quality deficiencies, develop, and implement plans of action to correct the quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plans. -Quality Assessment and Assurance is a management process that is ongoing, multi-level, comprehensive and facility wide. It deals with full range of services offered by the facility, including the full range of departments. It encompasses all managerial, administrative, clinical, and environmental services, as well as the performance of outside (contracted) providers and suppliers of care and services. The purpose is continuous evaluation of facility systems with the objective of: 1. Keeping systems functioning satisfactorily and consistently including maintain current practice standards. 2. Preventing deviation from care processes from arising, to the extent possible. 3. Discerning issues and concerns, if any, with facility systems and determining if issues/concerns are identified. 4. Correcting inappropriate care processes. -The Chief of Operations shall review the facility's Quality Assessment and Assurance program with the Executive Director at their quarterly performance review. -The Corporate Compliance Officer will review all compliance issues that have occurred during this quarter. If policy or practice needs to be altered or changed, a procedure and in-service will be developed for compliance. Review of the facility's policy titled Resident Abuse, Mistreatment, and Neglect Policy and Procedure, last revised 4/2017, indicated but was not limited to: (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Facility will analyze allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property through the Quality Assessment and Assurance process to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. Resident #77 was admitted to the facility in September 2021 and had diagnoses including conduct disorder, major depression, and dementia with behavioral disturbance. Review of the medical record indicated Resident #77 has a history of agitation, aggression, ongoing intrusive wandering into other residents' rooms, hitting other residents, being hit by other residents, and sexually inappropriate behaviors (including indecent exposure) toward female staff and residents. Further review of the medical record indicated the Resident was moved to different units following each behavioral incident. Review of Resident #77's medical record indicated Resident #77 hit other residents on two occasions (12/14/23 and 2/20/24), was struck by another resident on two occasions (9/25/24 and 10/10/24), and sexually harassed/exhibited sexually inappropriate behaviors toward residents on two occasions (1/3/24 and 2/29/24). During an interview on 11/20/24 at 9:50 A.M., the Director of Nursing (DON) said she was aware that Resident #77 had a history of aggression and sexually inappropriate behaviors. During an interview on 11/21/24 at 8:36 A.M., the Administrator said Resident #77 has had physical altercations and inappropriate sexual behaviors since admission to the facility. He said they tried to transfer the Resident to another facility for the safety of the Resident and other residents, but the Resident's spouse and daughter became upset and were adamant that he/she was not moved. The Administrator said every time the Resident has a behavioral episode, they contact the family and discuss moving him/her, but the family refuses. The Administrator was unable to provide any evidence that the interdisciplinary team has discussed and addressed Resident #77's violent and sexually inappropriate behaviors and any interventions were put into place to prevent the Resident from abusing others and being abused. During a QAPI interview with the Administrator and DON on 11/21/24 at 1:47 P.M., the Administrator said he heads the QAA program, and the committee meets quarterly (full committee) and monthly (facility department heads). The Administrator said the QAA committee reports its activities to the governing body (GB) including meeting minutes and audit reports and if any follow up is needed, and the GB will reach out to him. He said the GB is aware of happenings in the facility including any new regulations, policies, trends, or thresholds. The DON said issues can be brought forward and presented by each department. Any time there is an issue, an action plan is put into place within 48 hours and within 30 days, they will present an update to the QAA committee. She said they see if there are measurable outcomes, and if not, will go back to the drawing board. The Administrator reviewed Performance Improvement Projects (PIP) conducted within the past six months including a mock survey, expired medications, medications not dated, narcotic drawers unlocked, falls, pressure ulcers, care plans, and incomplete psychotropic medication consents. The PIPs failed to indicate the QAA committee, after having identified concerns with physical and sexual abuse, developed and implemented plans of action to correct the quality deficiencies, including monitoring the effect of implemented changes and making any needed revisions to action plans, policies, and procedures to help ensure the safety of Resident #77 as well as the safety of other residents residing in the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observation, interview and record review, the facility failed to maintain an infection 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, the facility failed to: 1. Maintain a complete and accurate system of surveillance and analyze their collected surveillance data to identify any trends of actual or potential infections within the facility to validate the effectiveness of their program; 2. Maintain a written water management plan and documentation to ensure a facility risk assessment was conducted to identify where Legionella (bacteria that can cause Legionnaires' disease, a serious type of pneumonia) and other opportunistic waterborne pathogens could grow and spread in the facility's water system; and 3. Failed to ensure staff performed proper hand hygiene with glove use during a Resident's (#72) dressing change. Findings include: Review of the facility's policy titled Infection Prevention and Control Policy, dated last revised 10/2024, included but was not limited to: - Purpose: to maintain an infection control and prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. - A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards. - A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. - When and to whom possible incidents of communicable diseases or infection should be reported. 1. During an interview on 11/14/24 at 12:15 P.M., the Infection Preventionist (IP) said the facility uses McGeer criteria for surveillance of illnesses to determine if an illness rises to the level of infection. The IP said she completes the surveillance line listing sheets monthly and then sends them to the lab. Review of McGeer criteria, currently in use by the facility, indicated but was not limited to the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Syndrome: Urinary Tract Infection (UTI) without indwelling catheter Criteria: Must fulfill both 1 and 2 1. At least one of the following sign or symptom Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate Fever or leukocytosis, AND greater than 1 of the following: Acute costovertebral angle pain or tenderness, Suprapubic pain Gross hematuria, New or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency * If no fever or leukocytosis, then greater than 2 of the following: Suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency 2. At least one of the following microbiologic criteria 50,000 cfu/mL of no more than 2 species of organisms in a voided urine sample 20,000 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter Syndrome: Pneumonia Criteria: Must fulfill 1, 2, AND 3. 1. Chest X-ray with pneumonia or a new infiltrate 2. At least one of the following criteria: New or increased cough, new or increased sputum production, O2 sat (oxygen saturation) <94% on room air, or >3% decrease from baseline O2 sat, new or changed lung exam abnormalities, pleuritic chest pain, respiratory rate =25 breaths/min 3. At least one of the following criteria Fever, leukocytosis, acute mental status change, acute functional decline Syndrome: Cellulitis, soft tissue, or wound infection (Skin) Criteria: Must fulfill at least 1 of the criteria. 1. Pus at wound, skin, or soft tissue site (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	August 2024: Resident #51's Surveillance Line Listing was completed as follows: - Category: Pneumonia (PNU) - Date of Onset: 8/30/24 - Symptoms: Abnormal Diagnostic Report (DX) - Culture Date: BLANK - Site: BLANK - Results: BLANK - Treatment: Azithromycin - Infection Cleared: YES - End Date: 9/30/24 - Final Status: HAI - Counted: YES During an interview on 11/19/24 at 10:56 A.M., the IP and Director of Nursing (DON) reviewed the documentation with the surveyor. The DON said Resident #51 did not have enough signs and symptoms documented on their McGeer evaluation to meet the definition of Pneumonia and the surveillance line listing was incomplete and inaccurate. The DON said the line listing should not be blank under the culture date, site and result sections as that information would be used to track and trend infections in the facility. September 2024: Resident #97's Surveillance Line Listing was completed as follows: - Category: Urinary Tract Infection without Indwelling Catheter (UTI) - Date of Onset: 9/10/24 - Symptoms: Abnormal Diagnostic Report (DX), Agitation, Confusion - Culture Date: BLANK - Site: BLANK - Results: BLANK (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Treatment: Macrobid 100 milligrams (MG) - Infection Cleared: YES - End Date: 9/15/24 - Final Status: HAI - Counted: YES Further review of the medical record failed to indicate a urinalysis and culture were obtained. During an interview on 11/19/24 at 11:01 A.M., the IP and DON reviewed the documentation with the surveyor. The DON said Resident #97 did not have enough signs and symptoms documented on their McGeer evaluation to meet the definition of UTI without Indwelling Catheter and the surveillance line listing was incomplete and inaccurate. The DON said confusion and agitation both meet the symptom of change in mental status and are not two different symptoms. The DON said the line listing should not be blank under the culture date, site and result sections as that information would be used to track and trend infections in the facility. Resident #40's Surveillance Line Listing was completed as follows: - Category: Skin; Cellulitis, Soft Tissue, Wound Infection - Date of Onset: 9/16/24 - Symptoms: Redness, Swelling, Pain - Culture Date: BLANK - Site: BLANK - Results: BLANK - Treatment: Doxycycline 100 MG - Infection Cleared: YES - End Date: 9/23/24 - Final Status: HAI - Counted: YES (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/24 at 11:05 A.M., the IP and DON reviewed the documentation with the surveyor. The DON said Resident #40 did not have enough signs and symptoms documented on their McGeer evaluation to meet the definition of a skin condition and the surveillance line listing was incomplete and inaccurate. The DON said in order to meet McGeer criteria the documentation should have indicated a fourth symptom. The DON said the line listing should not be blank under the culture date, site and result sections as that information would be used to track and trend infections in the facility. October 2024: Resident #42's Surveillance Line Listing was completed as follows: - Category: PNU - Date of Onset: 10/5/24 - Symptoms: Congestion, DX - Culture Date: BLANK - Site: BLANK - Results: BLANK - Treatment: Levofloxacin 500 MG x five days - Infection Cleared: YES - End Date: BLANK - Final Status: HAI - Counted: YES During an interview on 11/19/24 at 11:08 A.M., the IP and DON reviewed the documentation with the surveyor. The DON said Resident #42 did not have enough signs and symptoms documented on their McGeer evaluation to meet the definition of pneumonia and the surveillance line listing was incomplete and inaccurate. The DON said in order to meet McGeer criteria the documentation should have indicated more symptoms. The DON said the line listing should not be blank under the culture date, site and result sections as that information would be used to track and trend infections in the facility. The DON said the end date should not be left blank if the Resident is no longer receiving treatment for the pneumonia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/24 at 11:10 A.M., the IP and the DON said the three months of surveillance reviewed with the surveyor were inaccurate and incomplete. The DON said because the surveillance line listings did not meet the symptom criteria as it relates to McGeer and those examples should not have been counted in the facility infection rate. The DON said there should never be information blank on a completed surveillance line listing as that is how the facility would track and trend infections. The DON said infections in the facility need accurate surveillance. 2. Review of Centers for Medicare & Medicaid Services (CMS) Memorandum titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease, revised July 2018, indicated but was not limited to the following: - In manmade water systems, Legionella can grow and spread to susceptible hosts, such as persons who are at least [AGE] years old, smokers, and those with underlying medical conditions such as chronic lung disease or immunosuppression. Legionella can grow in parts of building water systems that are continually wet, and certain devices can spread contaminated water droplets via aerosolization. Examples of these system components and devices include: - Hot and cold-water storage tanks - Water heaters - Water-hammer arrestors - Pipes, valves, and fittings - Expansion tanks - Water filters - Electronic and manual faucets - Aerators - Faucet flow restrictors - Showerheads and hoses - Centrally-installed misters, atomizers, air washers, and humidifiers - Non-steam aerosol-generating humidifiers - Eyewash stations - Ice machines - Hot tubs/saunas - Decorative fountains (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cooling towers - Medical devices (such as CPAP machines, hydrotherapy equipment, bronchoscopes, heater-cooler units) CMS expects Medicare and Medicare/Medicaid certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, non-tuberculous mycobacteria, and fungi) could grow and spread in the facility water system. Review of the facility's Water Management Binder, provided by the facility, included a Water Management Plan dated 1/1/22, 1/1/21, 11/8/18. Further review of the Water Management Binder failed to include a Water Management Plan for 2023 or 2024. Review of the Water Management Plan dated 1/1/22 said the elements of the program need to be reviewed at least once per year. During an interview on 11/19/24 at 3:00 P.M., the Administrator said he was currently in charge of the Water Management Plan. The Administrator said the current Water Management Plan was in the binders provided to the surveyor. The Administrator and surveyor reviewed the Water Management Plan. The Administrator said the plan was reviewed but the date was not changed. The Administrator said all other information was accurate. The Administrator and the surveyor reviewed the Water Management Program Team on the Water Management Plan dated 1/1/22. The Administrator said the Director of Nursing (DON) listed on the Water Management Plan had not worked in the facility since the end of 2022. The Administrator said the facility did not have an accurate or specific water management plan. 42742 3. Resident #72 was admitted to the facility in July 2024 and had diagnoses including muscle weakness, need for assistance with personal care, type 2 diabetes mellitus with diabetic neuropathy, and obesity. Review of current Physician's Orders indicated the following: -Right heel: paint with Betadine, allow to dry, apply ABD, secure with Kling wrap daily (every day on day shift) and (every shift as needed), 11/15/24 Review of Lippincott Nursing Procedures, Eight Edition, indicated but was not limited to the following: Hand Hygiene is a general term used by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) to refer to hand washing, antiseptic hand washing, and antiseptic hand rubbing. Hand hygiene is the single most important procedure in preventing infection. Using an alcohol-based hand sanitizer is appropriate for decontaminating the hands before putting on gloves, after removing gloves, and wound dressings (if hands aren't visibly soiled). Always perform hand hygiene before putting on gloves to avoid contaminating the gloves with microorganisms from your hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation with interview on 11/18/24 at 10:47 A.M., the surveyor observed Nurse #3 perform Resident #72's right heel pressure ulcer dressing change. Nurse #3 removed the old dressing, disposed of it, then removed and discarded her gloves. Nurse #3 put on a new pair of gloves without first performing hand hygiene. Nurse #3 then cleansed the wound with saline and 4 x 4 gauze, disposed of the gauze, then applied Betadine to the heel using Q-tip applicators. Nurse #3 did not change her gloves and perform hand hygiene in between. During an interview on 11/18/24 at 11:12 A.M., Nurse #3 said she should have performed hand hygiene in between changing her gloves after disposing of the old dressing and should have changed her gloves after cleansing the wound but didn't. During an interview on 11/20/24 at 8:21 A.M., the Director of Nursing (DON) said Nurse #3 should have performed hand hygiene prior to putting on new gloves after disposing of the old dressing and changed her gloves and performed hand hygiene after cleansing the wound and prior to applying the Betadine.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48362 Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program. Findings include: Review of the facility's policy titled Antibiotic Stewardship, last revised 12/2023, indicated but was not limited to the following: - Purpose: to monitor antibiotic use to decrease unnecessary antibiotic utilization. - Appropriate indications for use of antibiotics include: (a.) Criteria met for clinical definition of active infection; and (b.) Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending). - The Infection Preventionist (IP) or designee, will review all antibiotic starts within 48 hours to determine if continued therapy is justified, justified with needed intervention, or not justified. - At the conclusion of the review, the provider will be notified of the review findings and recommendations. His or her response will be documented as follows: (a.) agree to make change; (b.) needs to discuss with team before making changes; or (c.) will not make changes because: (1) he or she does not agree with recommendations; and/or (2) team does not agree with recommendations. - All resident antibiotic regimens will be documented on facility-approved antibiotic surveillance tracking form. During an interview on 11/14/24 at 12:15 P.M., the Infection Preventionist (IP) said the facility uses the pre-defined McGeer criteria to determine if an illness or set of symptoms rise to the level of an infection. The IP said antibiotic usage is tracked on the facility illness surveillance sheets which also indicate whether or not an illness meets infection criteria. Review of the facility surveillance sheets for August, September and October 2024 indicated but were not limited to the following: August 2024: Resident #51 had a respiratory concern with an onset date of 8/30/24. The surveillance indicated the concern did not rise to the level of infection as determined by facility criteria, however an antibiotic was prescribed for four days. Review of Resident #51's medical record, including physician and nurse practitioner progress notes from 8/2024 to 9/2024, failed to indicate a reasoning for continued antibiotic usage even though the symptoms did not meet McGeer criteria. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	September 2024: Resident #97 had a urinary concern with an onset date of 9/10/24. The surveillance indicated the concern did not rise to the level of infection as determined by facility criteria, however an antibiotic was prescribed for five days. Review of Resident #97's medical record, including physician and nurse practitioner progress notes from 9/2024, failed to indicate a reasoning for continued antibiotic usage even though the symptoms did not meet McGeer criteria. Further review of Resident #97's medical record indicated the antibiotic was started prophylactically for an increase in agitation and behaviors. Furthermore, the record indicated Resident #97 had recommendations to increase Zyprexa to 5 milligrams (mg) daily and as needed (PRN) which were approved by the nurse practitioner. Review of the medical record also failed to indicate an urinalysis and culture were obtained until 9/23/24 when the antibiotic was completed. Resident #40 had a skin concern with an onset date of 9/16/24. The surveillance indicated the concern did not rise to the level of infection as determined by facility criteria, however an antibiotic was prescribed for seven days. Review of Resident #40's medical record, including physician and nurse practitioner progress notes from 9/2024, failed to indicate a reasoning for continued antibiotic usage even though the symptoms did not meet McGeer criteria. October 2024: Resident #42 had a respiratory concern with an onset date of 10/5/24. The surveillance indicated the concern did not rise to the level of infection as determined by the facility, however an antibiotic was prescribed for five days. Review of Resident #42's medical record, including physician and nurse practitioner progress notes from 10/2024 failed to indicate a reasoning for continued antibiotic usage even though the symptoms did not meet McGeer criteria. During an interview on 11/19/24 at 10:45 A.M., the IP said she reviews any residents with signs or symptoms and/or new orders for antibiotics on a daily basis. The IP said she reviews nursing progress note documentation as well as has discussions in morning meeting daily to identify residents who meet criteria for the surveillance line listing. The IP said the information is placed on the surveillance line listing and reviewed with the interdisciplinary team. During an interview on 11/19/24 at 10:50 A.M., the Director of Nursing (DON) said physicians and nurse practitioners need to identify when they believe continued antibiotic stewardship is warranted if a Resident's symptoms do not meet McGeer criteria. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/24 at 10:55 A.M., the IP, DON and the surveyor reviewed all the findings for Resident #51, Resident #97, Resident #40 and Resident #42. The DON and IP said there was no documentation in the medical records for the individual Residents that indicated the need for continued antibiotic usage. The DON said the medical record should identify why continued antibiotic usage was required despite not meeting criteria. The DON and IP said the antibiotic stewardship program was not being followed.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 43935 Based on documentation review and interview, the facility failed to ensure direct care staff received mandatory effective communications training. Findings include: Review of the Facility Assessment, dated as reviewed by the Quality Assurance Performance Improvement committee on 6/20/24, failed to indicate Effective Communications Training was required. During an interview on 11/21/24 at 10:44 A.M., the Administrator provided the survey team with printouts of all the staff training that had been completed on their electronic training system in the last 12 months. He said he did not believe it was possible to obtain the content of the classes to provide to the surveyor. In addition, a list of all staff was provided to the survey team that totaled 163 staff members. During an interview on 11/21/24 at 11:26 A.M., the Director of Nurses (DON) provided the survey team with the electronic training system learning annual curriculum for skilled nursing facilities. She said she believes the curriculum is specific to the company, not the facility. She said no one had been able to locate the content of the training in print form. Review of the electronic training system curriculum indicated the following: All staff to complete: HIPAA (Health insurance portability and accountability act), social media and electronic communications Communication with people with Dementia In addition, Therapy staff to complete: Communicating Effectively Review of the facility's in-service and education records 11/1/23 through 11/21/24 on effective communication indicated the following: - 78 staff members out of 163 total staff completed communication training Completion rate of effective communication courses = 48% (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said she provided all in-services from November 2023 to current in the facility. The SDC reviewed the completion rate for the effective communication training and said she would expect that they would have been in better shape than that with their training compliance. She said the completion percentage was not acceptable.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 43935 Based on document review and interview, the facility failed to ensure all staff received training on Resident's Rights. Findings include: Review of the facility policy titled: Abuse Prevention policies and procedures, dated as revised: 4/2017, indicated but was not limited to the following: - The facility provides training on orientation and ongoing to all staff on Abuse prevention, including trainings on issues related to abuse risk and prohibition practices such as: Resident's Rights. During an interview on 11/21/24 at 10:44 A.M., the Administrator provided the survey team with printouts of all the staff training that had been completed on their electronic training system in the last 12 months. He said he did not believe it was possible to obtain the content of the classes to provide to the surveyor. In addition, a list of all staff was provided to the survey team that totaled 163 staff members. During an interview on 11/21/24 at 11:26 A.M., the Director of Nurses (DON) provided the survey team with the electronic training system learning annual curriculum for skilled nursing facilities. Review of the electronic training system curriculum indicated the following: All staff to complete: - Essentials of Resident's Rights Review of the facility's in-service and education records from 11/1/23 through 11/21/24 for Resident's Rights indicated the following: - 16 staff members out of 163 total staff completed Resident's Rights training. - Completion rate of Resident's Rights training courses = 10%. During an interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said she provided all in-services from November 2023 to current in the facility. The SDC said the completion rate for Resident's Rights training was shockingly low and she would expect that they would have been in better shape than that with their training compliance. She said the completion percentage was not acceptable.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 43935 Based on document review and interview, the facility failed to ensure all staff were trained in standards, policies, and procedures for the facility's abuse prevention and reporting protocols. Findings include: Review of the facility's policy titled Abuse Prevention Policies and Procedures, dated as revised 4/2017, indicated but was not limited to the following: - The facility provides training on orientation and ongoing to all staff on Abuse prevention, including trainings on issues related to abuse risk and prohibition practices. - The facility conducts trainings on how to recognize and manage burnout, frustration and stress that may lead to abuse. - The facility may provide trainings in varied ways including online learning with competency testing, group in-service trainings, one on one and skills labs. During an interview on 11/21/24 at 10:44 A.M., the Administrator provided the survey team with printouts of all the staff training that had been completed on their electronic training system in the last 12 months. He said he did not believe it was possible to obtain the content of the classes to provide to the surveyor. In addition, a list of all staff was provided to the survey team that totaled 163 staff members. During an interview on 11/21/24 at 11:26 A.M., the Director of Nurses (DON) provided the survey team with the electronic training system learning annual curriculum for skilled nursing facilities. Review of the electronic training system curriculum indicated the following: All staff to complete: - Elder abuse: the Elder Justice act - Preventing, Recognizing and Reporting Abuse - Employee Wellness and Managing Stress Review of the facility's in-service and education records from 11/1/23 through 11/21/24 for abuse trainings indicated the following: - 50 staff members out of the 163 total staff completed this training in the last 12 months. - Completion rate of Abuse training courses = 30%. (continued on next page)

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	225264	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of New Bedford	397 County Street New Bedford, MA 02740

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said she provided all in-services from November 2023 to current in the facility. The SDC reviewed the completion rate for Abuse trainings and said it was low and she would expect that they would be in better shape than that with their training compliance. She said the completion percentage was not acceptable.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 43935 Based on documentation review and interview, the facility failed to provide training and education to their staff to outline elements and goals of the facility's Quality Assurance Performance Improvement (QAPI) program. Findings include: During an interview on 11/21/24 at 10:44 A.M., the Administrator provided the survey team with printouts of all the staff training that had been completed on their electronic training system in the last 12 months. He said he did not believe it was possible to obtain the content of the classes to provide to the surveyor. In addition, a list of all staff was provided to the survey team that totaled 163 staff members. During an interview on 11/21/24 at 11:26 A.M., the Director of Nurses (DON) provided the survey team with the electronic training system learning annual curriculum for skilled nursing facilities. Review of the electronic training system curriculum indicated the following: All staff to complete: - Implementation of QAPI Programs in Nursing Facilities Review of the facility's in-service and education records from 11/1/23 through 11/21/24 for QAPI trainings indicated the following: - 17 staff members out of 163 total staff completed this training in the last 12 months. - Completion rate of QAPI training courses = 10%. During an interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said she provided all in-services from November 2023 to current in the facility. The SDC reviewed the completion rate for QAPI training and said it was shockingly low and she would expect that they would have been in better shape than that with their training compliance. She said the completion percentage was not acceptable.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 43935 Based on document review and interview, the facility failed to ensure all staff were trained on standards, policies, and procedures for the facility's infection prevention and control program. Findings include: During an interview on 11/21/24 at 10:44 A.M., the Administrator provided the survey team with printouts of all the staff training that had been completed on their electronic training system in the last 12 months. He said he did not believe it was possible to obtain the content of the classes to provide to the surveyor. In addition, a list of all staff was provided to the survey team that totaled 163 staff members. During an interview on 11/21/24 at 11:26 A.M., the Director of Nurses (DON) provided the survey team with the electronic training system learning annual curriculum for skilled nursing facilities. Review of the electronic training system curriculum indicated the following: All staff to complete: - About Infection Control and Prevention - Basics of Personal Protective Equipment - Understanding Bloodborne Pathogens - Basics of Hand Hygiene Review of the facility's in-service and education records from 11/1/23 through 11/21/24 for Infection Control trainings indicated the following: - 50 staff members out of 163 total staff completed this training in the last 12 months. - Completion rate of Infection Control training courses = 32%. During a follow up interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said she provided all in-services from November 2023 to current in the facility. The SDC reviewed the completion rate for Infection Control trainings and said she would expect that they would be in better shape than that with their training compliance. She said the completion percentage was not acceptable.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 43935 Based on document review and interview, the facility failed to provide their staff training on the facility ethics standards, policies, and procedures. Findings include: During an interview on 11/21/24 at 10:44 A.M., the Administrator provided the survey team with printouts of all the staff training that had been completed on their electronic training system in the last 12 months. He said he did not believe it was possible to obtain the content of the classes to provide to the surveyor. In addition, a list of all staff was provided to the survey team that totaled 163 staff members. During an interview on 11/21/24 at 11:26 A.M., the Director of Nurses (DON) provided the survey team with the electronic training system learning annual curriculum for skilled nursing facilities. Review of the electronic training system curriculum indicated the following: All staff to complete: - Basics of Corporate Compliance Review of the facility's in-service and education records from 11/1/23 through 11/21/24 for Corporate Compliance training failed to indicate that any current active staff had completed Corporate Compliance training in the last 12 months. During a follow up interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said she provided all in-services from November 2023 to current in the facility. The SDC reviewed the lack of training for Corporate Compliance and said she was unaware that it was a required training and did not have any further records to provide.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 43935 Based on document review and interview, the facility failed to maintain records of certified nurse aide (CNA) trainings for continuing competency that included no less than 12 hours of mandatory trainings per year for each CNA employed by the facility for five out of five CNAs reviewed. Findings include: During an interview on 11/21/24 at 10:44 A.M., the Administrator provided the survey team with printouts of all the staff training that had been completed on their electronic training system in the last 12 months. He said he did not believe it was possible to obtain the content of the classes to provide to the surveyor. During an interview on 11/21/24 at 11:26 A.M., the Director of Nurses (DON) provided the survey team with the electronic training system learning annual curriculum for skilled nursing facilities. Review of the electronic training system curriculum indicated the following: All staff to complete annually for a total of 22.75 hours: - HIPPA Basics, About infection control and prevention, Providing customer service, Preventing and managing accidents, Dementia Care (Understanding the world of dementia), Managing elopement, Natural disasters and workplace emergencies, Introduction to Trauma informed care, Alzheimer's disease and related disorders: behaviors, Implementation of QAPI programs in Nursing facilities, Lockout/Tagout, Minimizing slips, trips and falls, Prevention of back injuries, Basics of personal protective equipment, Elder abuse, Natural disaster: Hurricanes, Resident Rights, Tuberculosis, HIPPA do's and don'ts of social media and electronic communication, Sexual harassment, Using oxygen safely, Being survey ready, Cultural competence, Workplace violence, Bloodborne pathogens, Communication with people with Dementia, Dementia Care (Actions and reactions), The process of aging, Employee wellness and managing stress, Basics of corporate compliance, Hazardous chemicals (safety data sheets and labels), Basics of hand hygiene, Fire safety, LGBTQ and Aging, Preventing Recognizing and Reporting abuse. CNAs to complete annually for a total of 5 additional hours: - Using mechanical lifts safely, Bathing the difficult patient, Documentation of activities of daily living, Your body at 80, Catheter and perineal care, Resident to resident bullying, Restorative nursing framework for CNAs. During an interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said she does not track CNA training hours and is newer to the role and did not know that was a requirement. She said she does not log the training time and does not keep any records of training time for any staff. She said she relies on the electronic learning system to track and document the total hours for all staff annually, but she does not have the access to add in any in-person in-services and can only pull up individual people to determine if they have 12 hours of training annually. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/21/24 at 2:48 P.M., the survey team requested proof of 12 hours of CNA training time for five individual CNAs (#2, #3, #10, #12 and #13) whom had interacted with the survey team throughout the survey process. During an interview on 11/21/24 at 3:20 P.M., the DON said she does not believe the facility can provide the survey team with any proof of the 12 hours of training, as required, for the CNAs that were requested, but the SDC was going to come speak to the survey team. During an interview on 11/21/24 at 3:25 P.M., the SDC said the five requested CNAs had not likely completed 12 hours of training time in the last 12 months as required and she could not provide any documents to the survey team that would indicate how much training time any of those particular CNAs had completed. She said she now understands that the facility is out of compliance with the training requirements for CNAs and the training program is a work in progress.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 43935 Based on documentation review and interview, the facility failed to provide behavioral health training and education to their staff. Findings include: Review of the Facility Assessment, dated as reviewed by the Quality Assurance Performance Improvement committee on 6/20/2024, failed to indicate behavioral health trainings were required in accordance with the regulations. During an interview on 11/21/24 at 10:44 A.M., the Administrator reviewed the Facility Assessment with the surveyor which failed to indicate what education/trainings and competencies were necessary for the facility staff to complete. He said he was unsure if the facility had a training plan but would provide one to the survey team if one could be found. He provided the survey team with printouts of all the staff training that had been completed on their electronic training system in the last 12 months at this time. He said he did not believe it was possible to obtain the content of the classes to provide them to the surveyor. In addition, a list of all staff was provided to the survey team that totaled 163 staff members. During an interview on 11/21/24 at 11:26 A.M., the Director of Nurses (DON) provided the survey team with the electronic training system learning annual curriculum for skilled nursing facilities. Review of the electronic training system curriculum indicated the following: All staff to complete: - Dementia Care (Understanding the World of Dementia) - Alzheimer's Disease and Related Disorders: Behaviors - Communication with People with Dementia - Dementia Care (Actions and Reactions) Review of the facility's in-service and education records on from 11/1/23 through 11/21/24 for behavioral health trainings indicated the following: - 24 of the 163 total staff completed some form of behavioral health training. - Completion rate of behavioral health training courses = 15%. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview on 11/21/24 at 2:03 P.M., the Staff Development Coordinator (SDC) said she provided all in-services from November 2023 to current in the facility. The SDC reviewed the completion rate for Behavioral health trainings and said it was low and she would expect that they would have been in better shape than that with their training compliance. She said the completion percentage was not acceptable.