STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Place Healthcare	193-195 Pleasant Street Attleboro, MA 02703

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46562

Based on record review and interview, the facility failed to ensure a [NAME] Treatment Plan (court approved treatment plan for the administration of antipsychotic medications) was active and current for administration of an antipsychotic medication for one Resident (#66), out of 24 sampled residents.

Findings include:

Resident #66 was admitted to the facility in [DATE] with diagnoses which included psychosis, major depressive disorder, and anxiety.

Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #66 had a Guardian and received antipsychotic medications on a routine basis.

Review of the medical record indicated Resident #66 was found to be incapable of taking care of him/herself by reason of mental illness and Guardianship was appointed on [DATE] by the Commonwealth of Massachusetts Probate and Family Court. Subsequent review of the medical record indicated the court issued an expansion of the Guardianship on [DATE] and authorized administration of antipsychotic medication via a [NAME] Treatment Plan, which expired on [DATE] at 9:00 A.M.

Review of Resident #66's Physician's Orders indicated but was not limited to:

-Zyprexa (antipsychotic) 2.5 milligrams (mg) by mouth one time daily, dated [DATE]

Review of the September, October, and [DATE] Medication Administration Records (MAR) indicated Resident #66 was administered Zyprexa as ordered.

During an interview on [DATE] at 1:59 P.M., Nurse #7 said Resident #66 had a Guardian and a [NAME]. Nurse #7 said Resident #66 received Zyprexa daily.

During an interview on [DATE] at 2:12 P.M., Unit Manager #2 said Resident #66 had a [NAME] for the administration of Zyprexa. Unit Manager #2 said she was not sure where Resident #66 stood with his [NAME] renewal at this time, because the Social Service Department handled the [NAME] renewals.

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:05 P.M., Social Worker #1 said residents with a Guardian should have an active [NAME] Treatment Plan in place when they are receiving antipsychotic medications. Social Worker #1 said the facility was in the process of renewing Resident #66's [NAME] Treatment Plan, but at this time there was no court date scheduled. During an interview on [DATE] at 12:53 P.M., Social Worker #1 said the facility sent the required paperwork to the facility lawyer to be processed on [DATE] and then again in May. Social Worker #1 said, in August, the facility lawyer told the facility the required documentation needed to be resubmitted because it was no longer valid. Social Worker #1 said the facility psych provider restarted the required paperwork and it had been resubmitted at that time. Social Worker #1 said on [DATE] she contacted the facility lawyer for an update but had not received one at this time. Social Worker #1 said the court hearing had not been scheduled. During an interview on [DATE] at 4:32 P.M., the Administrator said [NAME] Treatment Plans should be renewed annually when a resident has a Guardian and is receiving antipsychotic medications. The Administrator said the facility had some issues with getting required documentation completed for the renewal of Resident #66's [NAME] Treatment Plan but was working with the facility lawyer to get it done. On [DATE] at 12:43 P.M., the surveyor called the facility lawyer and left a message. As of the end of survey, on [DATE], the survey team did not receive any additional evidence that the required paperwork for a [NAME] Treatment Plan had been completed and submitted to the courts.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46562 Based on observation, interview, and record review, the facility failed to develop and implement an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs for one Resident (#33), out of 24 sampled residents. Specifically, the facility failed to ensure a comprehensive care plan was developed and implemented to address his/her cancer treatment. Findings include: Review of the facility's policy titled Comprehensive Person-Centered Care Plans, dated as revised January 2024, indicated but was not limited to: -A comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial and functional needs is developed for each resident. -Evaluation of residents is ongoing and care plans are revised as information about the resident and the resident's conditions change. Resident #33 was admitted to the facility in March 2018 with diagnoses which included lung and rectal cancer. Review of the Minimum Data Set (MDS) assessment, dated 9/19/24, indicated Resident #33 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #33's medical record indicated he/she was undergoing chemotherapy for treatment of lung cancer. Review of Resident #33's care plan failed to indicate a care plan for his/her cancer and chemotherapy had been developed. During an interview on 11/4/24 at 2:47 P.M., Nurse #7 said Resident #33 had lung and rectal cancer and was followed by the cancer center. Nurse #7 said Resident #33 was receiving chemotherapy to treat the cancer. During an interview on 11/5/24 at 9:44 A.M., Nurse #7 said care plans should be updated with significant changes to a residents' treatment plan or medication orders. During an interview on 11/6/24 at 1:23 P.M., Nurse #8 said care plans were managed by the facility management team but should be updated as the treatment plans change and should reflect the resident's current status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 11:45 A.M., Unit Manager #2 said care plans should be comprehensive and reflect the resident's care and current treatment plans. Unit Manager #2 said Resident #33 did not have a care plan for his/her cancer treatment, but he/she probably should especially because of the potential side effects. During an interview on 11/6/24 at 3:03 P.M., the Director of Nurses (DON) said care plans should be updated and reflect the resident's treatment plans. The DON said there should have been a care plan for Resident #33's cancer and cancer treatments.

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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 46562

Based on observation, interview, and record review, the facility failed to ensure professional standards of care were met for two Residents (#33 and #18), of 24 sampled residents. Specifically, the facility failed:

1. For Resident #33, to ensure his/her Dexamethasone (a corticosteroid to treat/prevent inflammation) orders were accurately transcribed, administered, and documented; and

2. For Resident #18, to administer Propranolol (a medication that affects the heart and circulation and is used to treat conditions such as heart rhythm disorders and other heart or circulatory conditions) in accordance with prescriber orders.

Findings include:

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.

Review of the facility's policy titled Administering Medications, dated as revised September 2024, indicated but was not limited to:

-Medications are administered in accordance with prescriber orders

-The individual administering the medication records the administration in the resident's Medication Administration Record (MAR)

Review of the facility's policy titled Medication and Treatment Orders, dated as revised September 2024, indicated but was not limited to:

-All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order

1. Resident #33 was admitted to the facility in March 2018 with diagnoses which included lung and rectal cancer.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 9/19/24, indicated Resident #33 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #33's Physician's Orders indicated but were not limited to: -Dexamethasone 4 milligrams (mg) by mouth every 12 hours as needed for anti-inflammatory, 10/21/24 - 11/5/24 -Dexamethasone 4 mg by mouth two times per day for anti-inflammatory for one day, 10/30/24 Review of Resident #33's Consultation/Clinic Referral, dated 10/21/24, indicated but was not limited to: -start Dexamethasone 4 mg twice daily the day before, the day of, and the day after chemotherapy Review of Resident #33's Cancer Institute After Visit Summary, dated 10/22/24, indicated he/she had an upcoming appointment for chemotherapy on 10/29/24. Review of Resident #33's October Medication Administration Record (MAR) failed to indicate he/she had received Dexamethasone 4 mg twice daily on 10/28/24 or 10/29/24. Review of Resident #33's Nurse's Note, dated 10/29/24, indicated the Cancer Institute called and informed the nurse that Resident #33 should receive Dexamethasone 4 mg twice daily the day before, the day of, and the day after chemotherapy. Further review of Resident #33's Nurse's Note, dated 10/29/24, indicated Resident #33's had a new order for Dexamethasone 4 mg twice a day to be administered on 10/30/24. Review of Resident #33's Cancer Institute After Visit Summary, dated 10/29/24, indicated he/she had an upcoming appointment for chemotherapy on 11/5/24. On 11/5/24 at 12:30 P.M., the surveyor reviewed Resident #33's November MAR which failed to indicate he/she had received Dexamethasone 4 mg twice daily on 11/4/24 and had not received any doses on 11/5/24. During an interview on 11/5/24 at 1:59 P.M., Nurse #7 said Resident #33 had chemotherapy today. Nurse #7 said he/she had received his/her Dexamethasone on 11/4/24 and 11/5/24 but he did not sign the medication off and did not document the administration in the MAR. During an interview on 11/5/24 at 2:12 P.M., Unit Manager #2 said Resident #33 should have received Dexamethasone 4 mg twice daily on 10/28/24, 10/29/24, 10/30/24, 11/4/24 and a dose that morning. Unit Manager #2 said the Resident should have received nine doses of Dexamethasone thus far. Unit Manager #2 and the surveyor reviewed the Dexamethasone card and only six doses were missing. Unit Manager #2 said the facility would not have had anywhere else to get the medication so doses may have been missed. (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 11/5/24 at 2:32 P.M., Unit Manager #2 said she reviewed Resident #33's medical record and the six administered doses of Dexamethasone occurred on 10/30/24 (twice), 11/4/24 (twice) and one dose in the morning on 11/5/24. Unit Manager #2 said she could not account for the sixth dose. Unit Manager #2 said there was no evidence the the Resident received his/her Dexamethasone on 10/28/24. Unit Manager #2 said the medication order should not have been transcribed as as needed and should have been scheduled so that doses would not be missed. Unit Manager #2 said all medications should be documented in the MAR at the time of administration. During an interview on 11/6/24 at 10:50 A.M., the Director of Nurses (DON) said the Dexamethasone order for Resident #33 should have been entered differently and that record review indicated he/she missed some doses. The DON said the nurses should sign off the medication in the MAR at the time of the administration. 49428 2. Resident #18 was admitted to the facility in September 2022 with diagnoses including transient ischemic attack (brief blockage of blood flow to the brain), cerebral infarction (stroke), and chronic atrial fibrillation (afib, a condition characterized by an irregular and often very rapid heart rhythm which can lead to blood clots in the heart and increase the risk of stroke, heart failure and other heart-related complications). Review of the MDS assessment, dated 8/8/24, indicated Resident #18 had a BIMS score of 13 out of 15, indicating the Resident was cognitively intact. Review of Resident #18's current Physician's Orders indicated but was not limited to the following: -Propranolol tablet, 10 mg, give one tablet by mouth one time a day. Hold if systolic blood pressure is less than 100 (8/15/24). Review of Resident #18's September 2024 MAR indicated but was not limited to the following: 9/5/24: systolic blood pressure = 99, Propranolol administered; 9/6/24: systolic blood pressure = 94, Propranolol administered; 9/23/24: systolic blood pressure = 98, Propranolol administered; 9/24/24: systolic blood pressure = 98, Propranolol administered; 9/29/24: systolic blood pressure = 99, Propranolol administered. During an interview on 11/6/24 at 9:07 A.M., Nurse #8 reviewed Resident #18's Propranolol order. Nurse #8 said the Resident's blood pressure should be taken prior to administering the Propranolol. Nurse #8 said Propranolol should not be given if Resident #18's systolic blood pressure is less than 100. Nurse #8 and the surveyor reviewed the Resident's September 2024 MAR. Nurse #8 said the MAR indicated Resident #18 received Propranolol on 9/5/24, 9/6/24, 9/23/24, 9/24/24, and 9/29/24 when the Resident's systolic blood pressure was less than 100. Nurse #8 said the Propranolol should not have been administered on these dates per physician's order. (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 11/6/24 at 9:09 A.M., Unit Manager (UM) #2 reviewed Resident #18's September 2024 MAR and said the Resident should not have received Propranolol on the days his/her systolic blood pressure was less than 100. UM #2 reviewed the Resident's nursing notes from September 2024 but did not find documentation that the physician ordered the Propranolol to be administered outside of the parameters noted in the physician's order. During an interview on 11/6/24 at 1:50 P.M., the DON said nursing is to follow physician's orders, if Resident #18's systolic blood pressure was below 100, then the Propranolol should not have been administered.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations, interviews and record review the facility failed to ensure the environment was free from accident hazards for Residents on the secure unit ([NAME]) and for two Residents (#105 and #79) in a total sample of 24 residents. Specifically, the facility failed: 1. To ensure hazardous items (bleach wipes, razors, medications) were not accessible to cognitively impaired residents on the secure unit; 2. For Resident #105, assessed at a high risk for elopement/wandering, to ensure the Resident was provided the indicated intervention of a wander guard; and 3. For Resident #79, to ensure that alcohol brought in by family was securely stored. Findings include: 1. During the entrance conference on 11/3/24 at 9:15 A.M., the Director of Nurses (DON) said the facility had a secure unit, the [NAME] (Alzheimer's Friendly Unit). On 11/4/24 at 11:11 A.M., the surveyor observed the bathroom/shower room on the unit with an unsecured cabinet with a container of bleach wipes. A child safety lock was observed hanging from one of the cabinet door handles, unlocked. During an interview on 11/6/24 at 10:10 A.M., Unit Manager #1 said the child safety lock on the cabinet in the shower room should be maintained in the locked position. She said residents should not have had access to bleach wipes and the bleach wipes were stored in the shower room so things could be wiped down after each resident use. She said the cabinet door had a child safety lock on it to prevent the residents from being able to get in it. On 11/4/24 at 11:15 A.M., the surveyor was able to open the key padded door to the soiled utility room without a code. The surveyor observed a sharps container with two shaving razors sticking out and easily accessible. On 11/4/24 at 3:01 P.M., the surveyor was able to open the unsecured door to the soiled utility room without a code and the razors continued to be protruding from the sharps container. On 11/5/24 at 10:22 A.M., the surveyor was able to open the unsecured door to the soiled utility room without a code and the razors continued to be protruding from the sharps container. During an interview on 11/5/24 at 1:45 P.M., Certified Nursing Assistant (CNA) #3 said she was not sure what the process was for the sharps container being emptied and the Unit Manager would know. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 1:48 P.M., Unit Manager #1 said the CNAs should tell the nursing staff when the sharps containers are full so that they are able to be moved to another room to be collected by the maintenance department. The surveyor and the Unit Manager went to the [NAME] soiled utility room. The Unit Manager said the keypad to the door should not allow access without the code and the room should be secure. She said the razors should not be sticking out of the sharps container and that the container was full. During an observation with interview on 11/5/24 at 2:45 P.M., the surveyor observed the medication cart on the [NAME] to be unlocked and unattended with three residents (two who were able to ambulate independently) sitting next to the medication cart. Nurse #4 returned to the medication cart at 2:50 P.M. and said the medication cart should have been locked. During an interview on 11/6/24 at 10:10 A.M., Unit Manager #1 said the medication carts should be locked whenever they were unattended for patient safety, especially on the [NAME] unit because the residents were cognitively impaired. She said everything should be locked and out of residents reach and should not be accessible. 2. Review of the facility's policy titled Wandering, Unsafe Resident, dated as revised in November 2017 indicated the following: -staff would identify residents who were at risk for harm because of unsafe wandering (including elopement) -staff would assess at-risk individuals for potential correctable risk factors related to unsafe wandering -resident's care plan would indicate the resident was at risk for elopement and interventions to try to maintain safety would be included Resident #105 was admitted to the facility in October 2024 with a diagnosis of dementia. Review of the Social Service Evaluation, dated 10/19/24, indicated Resident #105 scored 4 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Resident #105 resided on the secure unit. Review of the care plans for Resident #105 indicated a risk for elopement. Review of the Hospital Discharge Summary indicated Resident #105 had left their home, was missing for two days and was found at a train station and had been placed on a one to one at the hospital for wandering. The discharge summary indicated the Resident would get disoriented and elope from home with three events of attempt for elopement. On 11/3/24 at 11:30 A.M., the surveyor observed Resident #105 dressed, groomed, ambulating independently and wearing a winter coat. The Resident was observed walking around the unit, with no purpose of destination. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/3/24 at 12:47 P.M., the surveyor observed Resident #105 walking around the unit and said out loud I'm thinking of leaving. On 11/4/24 at 9:08 A.M., the surveyor observed Resident #105 walking around the unit and wearing a large winter coat. On 11/4/24 at 11:08 A.M., the surveyor observed Resident #105 approach a housekeeper at the exit door for the unit. The Resident told the housekeeper that he/she lost their keys. The housekeeper exited the unit, and the Resident asked the surveyor what he/she should do without their keys. Review of the nursing admission assessment (Nursing Evaluation), dated 10/15/24, indicated Resident #105 was a high risk for elopement with an intervention for a wander alert (wander guard). Review of the nursing progress notes indicated the following: 10/15/24: Resident wanting to go home several times, pacing unit 10/16/24: wandering behavior 10/18/24: wanders unit; attempts made to pack clothes up into pillowcase and states he/she was going home During an interview on 11/4/24 at 3:20 P.M., Nurse #2 said the facility process for residents at risk for elopement was to add them to the Wander guard book. She said there was a book on each unit. The surveyor and the Nurse attempted to find the Wander guard book on the [NAME] unit and were unable to locate it. Review of the Wander guard book on the A unit included a picture and demographic information for residents from all units who were at risk for elopement. Review of the book failed to include information regarding Resident #105. There was an empty Wander guard book labeled [NAME] on the A unit. During an interview on 11/4/24 at 3:25 P.M., the Assistant Director of Nurses said the DON had been working on updating all of the Wander guard books for the units and she was not sure why the book labeled [NAME] was empty. During an interview on 11/4/24 at 3:40 P.M., Nurse #2 said Resident #105 was a newer admission to the facility who had confusion and would often ask to go home. The Nurse said the Resident did not have a wander guard but probably should. The Nurse verified the orders in the medical record and was unable to find an order to indicate the Resident had a wander guard. During an interview on 11/4/24 at 4:00 P.M., the DON said he had been re-organizing the Wander guard books and had needed to add all residents to the [NAME] unit book. He said the process was for each unit to have a Wander guard book that contained all facility residents who were at risk for elopement. He said all residents who were at risk for elopement had wander guards and if a newly admitted resident was at risk for elopement they were added to the book and provided a wander guard. He checked the Wander guard book and confirmed Resident #105 was not in the book. He requested to review the Resident record and follow up with the surveyor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/4/24 at 4:35 P.M., the DON said the nurse who had completed the admission assessment might have thought the Resident was at risk for elopement, but as of this time, the Resident had not attempted to go out of the doors. He said the interdisciplinary team (IDT) had not been notified the Resident was at risk for elopement and a wander guard had not been initiated. During an interview on 11/5/24 at 8:38 A.M., the DON said the nurse who had completed the admission assessment should have completed the intervention of a wander guard. 49424 3. Resident #79 was admitted to the facility in September 2022 with diagnoses including cerebral infarction, insomnia, and Type II Diabetes. Review of the Minimum Data Set (MDS) assessment, dated 10/3/24, indicated Resident #79 was cognitively intact as evidenced by a BIMS score of 15 out of 15. During an interview with an observation on 11/3/24 at 10:37 A.M., the surveyor observed that Resident #79 had two brown paper bags of alcohol visible on his/her nightstand and windowsill. The Resident said he/she had a doctor's order for four ounces every night because it helps him/her sleep. The Resident said the nurse was informed of the alcohol being in his/her room. Resident #79 said it was delivered by family on 11/2/24 at 2:00 P.M. The surveyor observed wine (two one-liter bottles, one four pack, and two four packs). In the bag there were a total of 23 6-ounce bottles. The Resident said he/she received one 6-ounce bottle of red wine from the bag last evening. On 11/3/24 at 12:30 P.M., the surveyor observed CNA #2 tell Nurse #9 that Resident #79 was asking for the nurse to take the wine and secure it. CNA #2 said Resident #79 wanted me to remind you to not forget about it. Nurse #2 verbalized acknowledgement to CNA #2. On 11/3/24 at 1:32 P.M., the surveyor observed Resident #79's roommate walking in the room and talking with Resident #79. Further investigation indicated Resident #79's roommate had a history of substance use disorder. During an observation with an interview on 11/3/24 at 1:40 P.M., Resident #79 said he/she told Nurse #10 and CNA #2 to take the wine in his/her room and secure it in the medication room. Resident #79 pointed to the bags and bottles of wine in the room. Resident #79 said Nurse #9 was aware of the alcohol in the room and he provided him/her with their nightly wine from the bag last evening. During an interview with an observation on 11/3/24 3:01 P.M., Resident #79 said Nurse #9 was looking for a spot to put the wine but since there was more than usual, he wouldn't be able to put in all in the medication cart. The surveyor observed two one-liter bottles of wine on the Resident's windowsill at the following times: -11/04/24 at 07:11 A.M. -11/04/24 at 09:00 A.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Garden Place Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 193-195 Pleasant Street Attleboro, MA 02703	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/04/24 at 12:30 P.M. -11/04/24 at 03:50 P.M. -11/05/24 at 07:20 A.M. During an interview on 11/4/24 at 10:59 A.M., Resident #79's family member said he wasn't sure why they let the Resident keep the alcohol in their room which was brought in on Saturday. During an interview on 11/5/24 at 7:21 A.M., Nurse #3 said alcohol should not be kept with the residents in their room for safety reasons. He said alcohol requires a physician's order and should be secured in the medication cart or secured in the medication storage room. During an interview on 11/5/24 at 7:25 A.M., CNA #1 said the nurse is the only person that can give a resident alcohol like beer or wine. She said it cannot be kept in their room. During an interview with observation on 11/5/24 at 7:45 A.M. with Unit Manager #2 and Resident #79, Unit Manager #2 said the family was responsible for providing the alcohol to Resident #79. She said the process should be the nurse counts how much is brought in and it is taken immediately and secured in the medication room. She said there should be no alcohol in any resident's room. The Unit Manager asked the Resident if there was any additional wine and the Resident said he/she had told the nurse there were two bigger bottles after he took the smaller ones. Unit Manager #2 said alcohol was treated like medication with specific orders and nursing needed to know how much was given and at what time. She said there are risks with keeping alcohol in the room such as the Resident could drink an unknown amount, or another resident could drink the alcohol. She said she was aware the Resident's roommate had a history of substance use disorder. She said there should be a nursing note which included the amount of alcohol brought in by family and when it was brought in. During an interview on 11/6/24 at 8:12 A.M., Nurse #10 said he took the small bottles of wine out of the Resident's room and secured them in the medication cart at 7:30 P.M on 11/3/24. He said the resident did not report how much wine was brought in and he did not write a note regarding the securing of the alcohol. He said he was aware that residents should not have alcohol in their room. During an interview on 11/5/24 at 9:13 A.M., the DON said alcohol should not be left unsecured as residents could drink it without supervision. He said the process was not followed and the alcohol should be secured because it is considered a medication and was documented on the Medication Administration Record (MAR). He said a licensed nurse was the only person who can provide alcohol to a resident. During an interview on 11/5/24 at 10:01 A.M., the Regional Nurse said the expectation was all alcohol should be secured in the medication room and there should be a physician's order to give it. There should be no instance where there are bottles of alcohol unsecured at the bedside.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations, interviews, and records reviewed, the facility failed to provide pain management interventions for one Resident (#105) with tooth pain, out of 24 sampled residents. Specifically, for Resident #105, the facility failed to provide prescribed, as needed, pain relief for tooth pain. Findings include: Resident #105 was admitted to the facility in October 2024 with diagnoses of toothache and aphthous ulcer (or canker sore- a small shallow ulcer that occurs on the lining of the mouth). Review of the Hospital Discharge Summary indicated Resident #105 had a toothache and aphthous ulcer. The discharge summary indicated the Resident complained of right lower tooth pain, dental caries (cavities) noted and had a aphthous ulcer on the left upper palate. The plan was to continue to monitor, use Tylenol, Lidocaine mouthwash, home benzocaine ointment for pain control and a referral for outpatient dental at discharge. Review of the care plans indicated Resident #105 had dental caries and to refer to the dentist as needed. Review of the Nurse Practitioner's Progress Note, dated 10/16/24, indicated Resident #105 frequently complained of right lower tooth pain and to continue Tylenol as needed and a dental referral was needed. Review of the nursing progress notes indicated the following: 10/18/24: Tylenol given for complaint of pain to right gum area 10/18/24: Seen by physician with new order to have dental evaluation; form faxed to in-house consultant dentist 10/23/24: Resident with complaint of mouth pain, Tylenol given, referral sent this week to in-house consultant dentist, new order for Orajel (topical treatment used to relieve mouth pain) four times per day as needed 10/24/24: Resident with complaint of mouth pain to right lower jaw, visible swelling, tender to touch, Tylenol given 10/25/24: given Tylenol for complaint of toothache, right lower jaw 10/30/24: complaining of right sided facial pain, right cheek edematous, given Tylenol 10/31/24: Resident complained of gum/mouth pain, new order for Ibuprofen 400 milligrams (mg) every eight hours as needed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/1/24: Resident complains of mouth pain Review of the Nurse Practitioner Progress Note, dated 11/1/24, indicated the Resident had tooth/gum pain with a new order for Lidocaine Viscous 2% 15 milliliters swish and spit (used to relieve mouth pain) every four hours as needed, to continue Orajel, continue Tylenol and Ibuprofen as needed and the referral to the dentist was pending. On 11/3/24 at 11:30 A.M., Resident #105 approached the surveyor and said he/she had a toothache. The surveyor brought the Resident to Nurse #1. The surveyor observed Resident #105 tell Nurse #1 that he/she had a toothache, the nurse asked the Resident to demonstrate where the toothache was, the Resident opened their mouth and pointed, the Nurse responded oh, you have a black tooth. On 11/3/24 at 1:15 P.M., the surveyor observed Resident #105 walking on the unit with a tube of toothpaste in his/her hand. The Resident was observed placing toothpaste on his/her finger and rubbing the right inside of their mouth. On 11/4/24 at 11:00 A.M., the surveyor observed Resident #105 walking down the hall with his/her fingers in the right side of their mouth. On 11/4/24 at 2:34 P.M., the surveyor observed Resident #105 tell another resident My tooth is killing me. Review of the Medication Administration Record (MAR) indicated Orajel- give one application by mouth every 6 hours as needed for pain, was ordered on 10/23/24. The MAR indicated as of 11/4/24 (13 days) the Orajel was not administered to Resident #105. Review of the MAR indicated an order for Ibuprofen 400 mg every 8 hours for pain was implemented on 10/31/24. The MAR indicated as of 11/4/24 (5 days) the Ibuprofen was not administered to Resident #105. Review of the MAR indicated Lidocaine Viscous 2%, give 15 ml every four hours as needed for mouth pain swish and spit was ordered on 11/1/24. The MAR indicated as of 11/4/24 the Lidocaine Viscous was not administered to Resident #105. Review of the MAR on 11/4/24 indicated Tylenol 650 mg was last administered on 10/30/24 (6 days prior). The MAR failed to indicate any Tylenol, Ibuprofen, Orajel or Lidocaine Viscous were used from 10/31 through 11/4/24, including nothing administered on 11/3/24 when the Resident complained of tooth pain to the nurse. During an interview on 11/4/24 at 3:55 P.M., Nurse #1 said Resident #105 complained of tooth pain on 11/3/24 and she had given the Resident Tylenol 650 mg. She said she had not documented this in a nursing progress note. She said she had not documented this on the MAR because all residents had standing order for as needed Tylenol, so she did not think she needed to document this. She said the Tylenol did not work on 11/3/24 because the Resident kept coming back to the nurse and complaining of pain. She said she was unable to find the Lidocaine Viscous or the Orajel and had not administered any Ibuprofen. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 10:30 A.M., Nurse #4 said she worked at the facility one time per week and was aware the Resident had tooth pain. She said she knew there was an order for Orajel, but she had not been able to find it. She said she did not know anything about the Lidocaine Viscous. The surveyor and the nurse observed the medication cart. The nurse was unable to locate either pain relief medication. The surveyor was able to find a box for the Lidocaine Viscous with the Resident's name on it. The nurse said she did not know this was in the medication cart as the bottle was inside a box and not distinguished as a liquid. During an interview on 11/5/24 at 10:35 A.M., Unit Manager #1 said the Orajel should have been in the medication cart. Unit Manager #1 checked the medication cart and was unable to locate the Orajel. During an interview on 11/5/24 at 10:50 A.M., Unit Manager #1 said the Lidocaine was delivered to the facility on [DATE] at 2:57 A.M. so she was not sure why it had not been administered to Resident #105. She said she was not sure why Nurse #1 had been unable to find it on 11/3/24 because it was available in the medication cart. She said the nurses should be reading the orders for as needed medications and administering if the Resident was complaining of pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 50740 Based on interview and record review, the facility failed to ensure staff implemented dialysis care and services consistent with professional standards of practice for one Resident (#412), out of 24 sampled residents. Specifically, the facility failed to assess and monitor the Resident's left Arteriovenous (AV) fistula (a surgically connected artery and vein used for long term dialysis) site. Findings include: Review of the facility's policy titled Hemodialysis Access Care, revised November 2017, indicated but was not limited to the following: Care of AVFs (arterio-venous fistula, dialysis access created by surgically connecting an artery and a vein) and AVGs (arterio-venous graft, a synthetic or animal-derived tubing to connect the artery and vein) -Care involves the primary goals of preventing infection and maintaining patency of the catheter (preventing clots). -Do not use the access site arm to take blood samples, administer IV fluids or give injections. -Do not use the access arm to take blood pressure. Check the patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access. Care Immediately Following Dialysis Treatment -The dressing change is done in the dialysis center post-treatment. -If the dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. Documentation The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (interventions if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #412 was admitted to the facility in September 2024 with diagnoses including dependence on renal dialysis and end stage renal disease (ESRD). Review of Resident #412's Minimum Data Set (MDS) assessment, dated 10/18/24, indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Further review of the MDS indicated Resident #412 received dialysis treatment. Review of Resident #412's current Physician's Orders indicated the Resident had dialysis three times weekly. On 11/4/24 at 12:38 P.M., the surveyor observed Resident #412's left arm AV fistula site, which was open to air. Review of Resident #412's Care Plan indicated but was not limited to the following: Focus: [Resident] needs dialysis r/t (related to) diagnosis of ESRD Intervention: -Monitor/document/report PRN any s/sx (signs/symptoms) of infection to access site: Redness, swelling, warmth or drainage. -Monitor/document/report PRN for s/sx of the following: Bleeding, hemorrhage, bacteremia, septic shock. -Protect access site from injury. Site: Right Arm; Avoid constriction on affected arm. No BP on limb with shunt/CV (central venous) dialysis catheter. Focus: Potential for complications related to hemodialysis for diagnosis of end stage renal failure Interventions: -Check shunt site for s/s (signs/symptoms) infection, pain, or bleeding daily and PRN (as needed) -Monitor shunt site by palpating for thrill & auscultating for bruit daily. Notify physician of absence of thrill or bruit. -Protect access site from injury. Site: [blank] -Avoid constriction on affected arm, such as carrying purse and constrictive clothing ? no BP (blood pressure) on limb with shunt/CV dialysis catheter Resident #412's Care Plan failed to indicate the correct location of the Resident's AV fistula and care of the access site. Further review of the Physician's Orders indicated but were not limited to the following: -Dialysis log vital signs and weight every Tue, Thu, Sat for dialysis monitoring (10/28/24) (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Orders failed to indicate orders for the care of the Resident's AV fistula. Review of Resident #412's Progress Notes failed to indicate the facility routinely monitored and/or provided care for the Resident's left AV fistula. Further review of the Progress Notes indicated that on the following dates, the Resident's blood pressure was obtained from the left arm, the arm in which the Resident's AV fistula is located: -10/10/24, -10/11/24, -10/13/24, -10/16/24, -10/18/24, -10/20/24, -10/21/24, -10/22/24, -10/23/24, -10/24/24, -10/25/24, -10/26/24, -10/29/24, -10/30/24, -10/31/24, -11/1/24, -11/2/24, and -11/3/24 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/4/24 at 12:38 P.M., Resident #412 said that he/she has an AV fistula in his/her left arm. The Resident said that the staff at the dialysis center apply a bandage to his/her access sites on his/her left arm when he/she finishes his/her dialysis treatment and that he/she removes the bandage himself/herself the next day. The Resident said that the nurses at the facility do not check the AV fistula site or check the dressing. During an interview on 11/4/24 at 12:45 P.M., Unit Manager #1 said Resident #412 should have orders for care and monitoring of the AV fistula site and orders for removal/care of the dressing on the access sites. During an interview on 11/6/24 at 12:30 P.M., the Director of Nursing said that Resident #412 should have had a physician's order in place to monitor the dialysis access site and for dressing care and the facility's nurses should be monitoring and caring for the Resident's access site.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 36542 Based on interview and record review, the facility failed to assess a history of trauma and failed to assess for triggers to avoid potential re-traumatization for one Resident (#105) with a history of trauma, out of a total sample of 24 residents. Findings include: Review of the facility's policy titled Trauma Informed Care, dated as revised in October 2019, indicated the following: -as part of the comprehensive assessment, identify history of trauma or interpersonal violence when such information is provided to the facility. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. Resident #105 was admitted to the facility in October 2024 with diagnoses of dementia, post-traumatic stress disorder (PTSD) and poly substance use disorder (PSUD). Review of the Social Service Evaluation, dated 10/19/24, indicated Resident #105 scored 4 out of 15 on the Brief Interview for Mental Status indicating severe cognitive impairment. Review of the Hospital Discharge Summary indicated Resident #105 had a diagnosis of PTSD. Review of the medical record included the diagnosis of PTSD. Review of the Social Service Evaluation, dated 10/19/24, indicated the Resident had not identified any trauma and a trauma care plan was not initiated. Review of the Behavioral Health Group note, dated 10/21/24, indicated Resident #105 had a diagnosis of PTSD, denied any trauma history and that Resident was a poor historian. The note indicated it was unclear where the PTSD diagnosis originated. During an interview on 11/5/24 at 10:45 A.M., Social Worker #1 said she had not completed the Social Service Evaluation for Resident #105. She said following the surveyor inquiry she reviewed the record and Resident #105 did have a diagnosis of PTSD and she was not sure why this was not reflected on the evaluation. She said the Resident should have been assessed for the trauma history and any triggers. During an interview on 11/6/24 at 8:00 A.M., Social Worker #2 said she had completed the evaluation for Resident #105, and she had not seen the diagnosis of PTSD. She said she did not review the hospital discharge paperwork for residents as this was clinical information and as the Social Worker she did not review clinical information. She said she had spoken with the Resident on 10/19/24 and had called the family as the Resident was asking to leave but had not asked the family about any history of trauma.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46562 Based on interview and record review, the facility failed to act upon recommendations made by the Consultant Pharmacist during the monthly Medication Regimen Reviews (MRR) for one Resident (#6), out of a total sample of 24 residents. Specifically, the facility failed to act on the consultant pharmacist's recommendation to consider obtaining a lab to monitor the efficacy of Levothyroxine (a hormone used to treat thyroid disorder). Findings include: Review of the facility's policy titled Medication Regimen Review, dated August 2020, indicated but was not limited to: -Recommendations are acted upon and documented by the facility staff and/or the prescriber -The prescriber accepts and acts upon recommendations or rejects and provides an explanation for disagreeing Resident #6 was admitted to the facility in August 2022 with diagnoses which included thyroid disorder. Review of Resident #6's medical record indicated he/she was seen by the Consultant Pharmacist in January 2024 and recommendations were made. The surveyor was unable to locate the January 2024 Consultant Pharmacist's recommendation in Resident #6's record. After inquiry, the facility provided Resident #6's January 2024 Consultant Pharmacist Recommendation to Prescriber Form. The document indicated but was not limited to: -Resident #6 was receiving a medication that may benefit from laboratory monitoring -The pharmacist recommended a lab be drawn on the next convenient day and then annually thereafter -The physician/prescriber response section was blank During an interview on 11/6/24 at 3:01 P.M., Unit Manager #2 said the Director of Nurses (DON) received the monthly pharmacist recommendations and distributed them to the prescribers. During an interview on 11/6/24 at 3:03 P.M., the DON said the monthly pharmacy recommendations should be reviewed by the prescriber and evidence should be maintained in the resident's medical record. The DON said the facility had no evidence that Resident #66's January recommendations were reviewed by the prescriber. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 2:38 P.M., the Administrator said the facility should follow the policy and ensure pharmacy recommendations were reviewed.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 36542 Based on observations, interviews, and records reviewed, the facility failed to provide timely dental services for one Resident (#105), of 24 sampled residents. Specifically, for Resident #105, the facility failed to initiate a timely dental appointment for tooth pain. Findings include: Review of the facility's policy titled Dental Services, dated as revised November 2017, indicated but was not limited to: -Routine and 24-hour emergency dental services are provided to residents through a contract agreement, referral to the resident's personal dentist, referral to a community dentist or referral to other health care organizations that provide dental services. DEFINITIONS for S483.55(b) [F791] Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. Resident #105 was admitted to the facility in October 2024 with a diagnosis of dementia. Review of the Hospital Discharge Summary indicated Resident #105 had a toothache and an aphthous ulcer (or canker sore- a small shallow ulcer that occurs on the lining of the mouth). The discharge summary indicated the Resident complained of right lower tooth pain, dental caries (cavities) noted and had a aphthous ulcer on the left upper palate. The plan was to continue to monitor, use Tylenol, Lidocaine mouthwash, home benzocaine ointment for pain control and a referral for outpatient dental at discharge. Review of the care plans indicated Resident #105 had dental caries and to refer to the dentist as needed. Review of the Nurse Practitioner's (NP) Progress Note, dated 10/16/24, indicated Resident #105 frequently complained of right lower tooth pain and to continue Tylenol as needed and a dental referral was needed. Review of the nursing progress notes indicated the following: 10/18/24: Tylenol given for complaint of pain to right gum area 10/18/24: Seen by physician with new order to have dental evaluation; form faxed to in-house consultant dentist (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Garden Place Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 193-195 Pleasant Street Attleboro, MA 02703	

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/23/24: Resident with complaint of mouth pain, Tylenol given, referral sent this week to in house consultant dentist, new order for Orajel (topical treatment used to relieve mouth pain) four times per day as needed 10/24/24: Resident with complaint of mouth pain to right lower jaw, visible swelling, tender to touch, Tylenol given 10/25/24: given Tylenol for complaint of toothache, right lower jaw 10/30/24: complaining of right sided facial pain, right cheek edematous, given Tylenol 10/31/24: Resident complained of gum/mouth pain, new order for Ibuprofen 400 milligrams (mg) every eight hours as needed 11/1/24: Resident complains of mouth pain Review of the NP's Progress Note, dated 11/1/24, indicated the Resident had tooth/gum pain with a new order for Lidocaine viscous 2% 15 milliliters swish and spit every four hours as needed, to continue Orajel, continue Tylenol and Ibuprofen as needed and the referral to the dentist was pending. On 11/3/24 at 11:30 A.M., Resident #105 approached the surveyor and said he/she had a toothache. The surveyor brought the Resident to Nurse #1. The surveyor observed Resident #105 tell Nurse #1 that he/she had a toothache, the nurse asked the Resident to demonstrate where the toothache was, the Resident opened their mouth and pointed, the Nurse responded oh, you have a black tooth. During an interview on 11/4/24 at 12:25 P.M., the Director of Nurses (DON) said he was responsible for coordinating the in-house consultant dental services. He said the dentist had visited the facility on 9/18/24 (prior to the Resident's admission) and there was no schedule for the next visit at this time. He said the consultant dental services would tell the facility when they were coming, usually every 60 to 90 days. He said there was a community dentist in the area who the facility could refer residents to and there were no concerns with wait times for appointments. When the surveyor inquired about a dental appointment for Resident #105 the DON said, They just got here. He said he would have to review what the plan was for the Resident to see a dentist and if the Resident had been referred to a community dentist since the in-house consultant dental services had no scheduled appointment. During an interview on 11/4/24 at 1:58 P.M., the DON said the nursing staff had sent a referral to the in-house consultant dental services on 10/18/24 and at this time there was no indication of when they would come to the facility. He said following the surveyor inquiry the facility made an appointment with a community dentist for Resident #105 to be seen on 11/7/24, three weeks after the Resident was admitted with a plan for a referral to the dentist. During an interview on 11/5/24 at 10:36 A.M., Unit Manager #1 said she had spoken to the family of Resident #105 on the previous day (11/4/24). She said the family identified that Resident #105 had previously seen a dentist for the ill-fitting dentures which may be causing aphthous ulcer and the family was okay with a second opinion and for a dentist to address the separate issue of the toothache.

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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. 49428 Based on observation and interview, the facility failed to follow their policy and 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 food items were properly dated and stored in the main kitchen and kitchenettes; 2. Ensure four of four ice machines were maintained in a clean and sanitary condition; and 3. Ensure one of three unit kitchenettes was maintained in a clean and sanitary condition. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 3-501.17 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. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. (continued on next page)

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	225267	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. 6-501.12 (A) Physical facilities shall be cleaned as often as necessary to keep them clean. Review of the facility's policy titled Food and Supply Storage, revised 06/2018, indicated but was not limited to: Policy: Food, non-food items, and supplies used in food preparation and service shall be stored in such a manner as to maintain safety and sanitation of the food or supply for human consumption as outlined in the Federal Drug Administration Food Code, state regulations, and city/county health codes. 1. General guidelines: a. Storerooms are well-lit, adequately ventilated, clean and dry; b. Storeroom walls and floors are solid, cleanable, in good repair and rodent proof. 2. Labeling and rotating food: a. Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by dates. 1) Follow recommendations from the manufacturer when indicated on the product for storage time and storage location; 2) Follow city, county, or state food storage guidelines. Review of the facility's policy titled Ice Production and Handling, revised 06/2018, indicated but was not limited to: Policy: Ice is produced and handled in a manner to minimize contamination. Guidelines: f. Keep equipment clean, including draining, cleaning, and sanitizing internal components of the ice machine as needed and according to the manufacturer's specifications, cleaning schedules, and preventative maintenance schedules. This may include but is not limited to: -removing the build-up of mineral scale from the ice machine's water systems and sensors; -sanitizing the ice machine's water system and ice storage bin or dispenser. 1. On 11/3/24 at 7:57 A.M., the surveyor observed the following in the main kitchen: (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 dated as opened 9/9, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. -two opened containers of thickened dairy drink with no opened date, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. -one opened container of thickened orange juice dated 11/15, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. On 11/3/24 at 8:55 A.M., the surveyor observed the following in the Unit A kitchenette: -one opened container of thickened apple juice dated as opened 9/20, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. -one opened container of thickened cranberry juice dated as opened 10/8, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. On 11/3/24 at 9:22 A.M., the surveyor observed the following in the Unit C kitchenette: -one opened container of thickened dairy drink dated as opened 10/18, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. -one opened container of thickened dairy drink dated as opened 10/17, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. -one opened container of thickened lemon water with no opened date, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. On 11/5/24 at 11:40 A.M., the surveyor observed the following in the main kitchen: -two opened containers of thickened juice with no opened date, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. -one opened container of thickened dairy drink with no opened date, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. -one opened container of thickened lemon water dated 10/16-11/16, manufacturer label stated: after opening, may be kept up to seven days under refrigeration. During an interview on 11/6/24 at 10:29 A.M., Nurse #10 said any containers of thickened liquids must be dated when opened. During an interview on 11/6/24 at 2:12 P.M. with the Food Service Director (FSD) and the Corporate FSD, the FSD said he expected all thickened liquids to be dated with the opened date and discarded seven days after opening and for staff to follow the manufacturer's instruction to discard containers of thickened liquids after seven days of opening. 2. The surveyor made the following observations: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/3/24 at 7:57 A.M.: Main kitchen ice machine with orange-brown growth on interior flap and observed condensation dripping from the orange-brown growth onto the ice; vendor sticker indicated 7/24; -11/3/24 at 9:03 A.M.: Unit A kitchenette ice machine with several areas of dark spots in the interior, specifically one interior component had black growth at the bottom and water was observed dripping from black growth onto the ice; vendor sticker indicated 7/24; -11/3/24 at 9:22 A.M.: Unit C kitchenette ice machine with an internal component (white in color) that had areas of orange growth; observation of orange growth that had transferred from the white component to another internal component below it; ice was just inches below both components; vendor sticker indicated 7/24. On 11/6/24 at 2:47 P.M., the FSD, the Director of Maintenance (DOM) and the surveyor observed orange-brown colored growth on interior components of main kitchen the ice machine, with water dripping from the growth onto the ice. The FSD and the DOM said all ice machines are serviced and cleaned every three months by a vendor and the vendor had written the last date of service on the ice machine which read 7/24. The FSD and the DOM said the ice machines in the main kitchen and on the resident units are not cleaned by the facility and are only cleaned by the vendor every three months. During an interview on 11/6/24 at 2:52 P.M., the FSD observed the Unit A ice machine with the surveyor and observed several black splotches in the interior. The FSD wiped the splotches with a paper towel to identify if it was a stain or growth. The black splotches were removed by the paper towel. During an interview on 11/6/24 at 2:58 P.M., the Administrator said the ice machines are cleaned every three months by a vendor and there was no cleaning schedule for the facility to clean the machines between vendor visits. The Administrator observed the growth in the ice machine and said there should be no growth inside the ice machines. During an interview on 11/6/24 at 3:10 P.M., the FSD observed the Unit C ice machine with the surveyor and observed several black colored splotches on the interior of the ice machine. The FSD wiped the black splotches with a napkin to determine if they were growth or discoloration. The black splotches were removed by the paper towel. During an interview on 11/6/24 at 3:20 P.M., the FSD observed the Unit B ice machine with the surveyor and observed black, brown, yellowish growth littered throughout the internal compartment and components. The FSD said the Unit B ice machine should be free of any growth. 3. On 11/3/24 at 8:57 A.M., the surveyor observed the following in the Unit A kitchenette: -An open floor drain used as drainage for the ice machine; -The open floor located next to ice machine and toaster; -Black and brown growth on the drain grate; -Greenish-white slimy substance on drain grate; -Black growth around the floor drain grate; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Black growth between floor tiles around and adjacent to the floor drain; -Black growth where floor meets wall, adjacent to the floor drain; -Extremely warm air temperature in the kitchenette; -Dozens of dead drain flies on floor next to drain. On 11/6/24 at 12:25 P.M., the surveyor observed the following in the Unit A kitchenette: -The open floor located next to ice machine and toaster; -Black and brown growth on the drain grate; -Greenish-white slimy substance on drain grate; -Black growth around the floor drain grate, which the surveyor could easily wipe away with a napkin; -Black growth between floor tiles around and adjacent to the floor drain; -Black growth where floor meets wall, adjacent to the floor drain; -Extremely warm air temperature in the kitchenette; -Damp smell close to the drain. During an interview on 11/6/24 at 3:00 P.M., the Administrator said the ice machine used to be over the drain and the ice machine was moved recently as to not cover the drain. The Administrator said the drain was also replaced with a larger drain to better meet the drainage needs of the ice machine. The DOM and Administrator observed the open floor drain and said it needed to be cleaned and the tile and area surrounding the drain needed to be replaced in order to remove the black growth. The Administrator said the floor in the kitchenette should be clean and clear of any growth.