STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225271	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Rehabilitation and Healthcare Center	6 Hale Street Newburyport, MA 01950

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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** Based on observations, record reviews and interviews, the facility failed to ensure food was stored and distributed in accordance with professional standards of food safety to prevent the possible spread of foodborne illness in at risk residents. Specifically, 1. a. The facility failed to ensure food stored in the walk-in refrigerator was not stored and available after the use by date, b. The facility failed to ensure a loaf of bread was not stored after the use by date on one of three nourishments kitchens, and 2. Dietary Staff #1 a. failed to contain facial hair with a beard cover while in the food distribution area. Dietary Staff #1 failed to change his gloves and perform hand hygiene after resting his gloved hands on his facial hair and his nose and proceeded to pick up plate pallets and place them on multiple meal trays in preparation for the meal service line, potentially contaminating the meal trays. b. Dietary Staff #2 failed to properly dispose of used gloves during the lunch meal distribution. Dietary Staff #1 removed his gloves from both hands and placed the gloves onto the tray line. Findings include: Review of the facility's policy, titled Food Receiving and Storage, dated November 2022, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices. ?Refrigerated/Frozen Storage' included but was not limited to the following:1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) 7. Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen, or discarded. 1 a] During an observation of the main kitchen's walk-in refrigerator on 8/26/2025 at 7:20 A.M. the surveyor observed the following:-A tray with multiple covered individual servings bowls of fruit dated 8/21/25, 8/22/25, and 8/23/25. -A loosely wrapped pan of cooked burgers with congealed white substance dated 8/23/25-A pan of cooked pasta noodles, wrapped and dated 8/21/25-A plastic wrapped opened package of turkey deli meat dated 8/10/25.-A shallow pan of peas covered in loose plastic dated 8/19/25.-Nine covered cups of individually poured milk with no visible date. During an observation and interview on 8/26/25 at 7:31 A.M., The Food Service Director said food stored in the walk-in refrigerator was available for use. The FSD said all prepared food should be labeled with a use by date. The FSD said stored food should be used within three days. The FSD said the food stored in the walk-in refrigerator with dates of 8/19/25, through 8/22/25 should have been thrown out. The FSD said the turkey deli meat dated 8/10/25 should have been labeled with a use by date and should not have been in the refrigerator. 1b.) During observation of the [NAME] Unit Nourishment kitchen on 8/27/2025 8:33 A.M., the tag on one loaf of white bread indicated use by 8/26/25. During an interview on 8/27/25 at 2:07 P.M., the FSD said food should not be stored in the nourishment kitchens beyond the use by date. 2a.) During an observation of the meal service preparation on 8/27/25 at 11:39 A.M., the following observations were made: Dietary Staff #1 was observed to have facial hair that was not contained. Dietary Staff #1 was standing in the food distribution line area. Dietary Staff #1 rested his elbows on the shelf of the tray line and rested his head on his gloved hands resulting in his facial hair and nose having direct contact with his gloved hands. Dietary Staff #1 then proceeded to touch the plate warmer pallets and placed them on multiple meal trays. 2b.) During the tray distribution Dietary Staff #2 removed his gloves from his hands and placed the gloves directly onto the tray line shelf. The (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	FSD was present and was made aware and directed Dietary Staff #2 to wash his hands. The FSD said the used gloves should not have been placed on a clean area. During an interview on 8/27/25 at 2:07 P.M., the FSD said Dietary Staff #1 should not have rested his gloved hands on his facial hair and nose while waiting for the tray line to begin. The FSD said he expected Dietary Staff with facial hair to cover with a beard cover when in food preparation areas and during food distribution. The FSD said Dietary Staff #1 should not have touched the plate pallets after touching his facial hair and nose with his gloved hands.

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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 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. Based on observation, record review and interview, the facility failed to ensure treatment and care was provided in accordance with standards in quality of care for one Resident (#12), out of a total sample of 25 residents. Specifically, for Resident #12, who has a known risk and care planned for the risk of bruising, bleeding and skin tears, the facility failed to identify areas of injury on his/her lower right leg. Findings include:Resident #12 was admitted to the facility in May 2024 with diagnoses that include, but are not limited to unspecified dementia, bipolar disorder, delusional disorders and heart disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/16/25, indicated Resident #12 had a staff assessment for mental status that indicated Resident #12 as having severe cognitive impairment. Further, the MDS indicated Resident #12 required substantial/maximal assistance for shower/bathing and was dependent on lower body dressing. During an observation on 8/26/25 at 10:35 A.M., Resident #12 was in his/her bed. Resident #12's lower legs were exposed, and yellow fading areas were observed going down his/her right shin. There was also a scrape-like red area on his/her shin. Resident #12 did not respond to the surveyor's greeting. During an observation on 8/26/25 at 3:34 P.M., Resident #12 was observed up and dressed and sitting in his/her wheelchair in his/her room. Resident #12 was wearing jogger pants, and his/her lower extremities were covered and could not be observed. Resident #12 did not respond to the surveyor's greeting. During an observation on 8/27/25 at 12:28 P.M., Resident #12 was sitting up in his/her wheelchair. Resident #12 had yellow fading areas on his/her right lower extremity, and a pea sized red area, consistent with a scab on his/her right shin. Review of Resident #12's active care plans indicated the following:-Focus I am at risk for bruising/bleeding/skin tear r/t (related to) ASA (aspirin) therapy, dated 8/20/25, with interventions including but not limited to Inspect skin for bruising/unusual bleeding/petechiae (small spots from bleeding blood vessels) daily during care, dated 8/20/25. Review of progress notes dated 8/18/25 through 8/26/25 failed to indicate any entries regarding any discoloration or alteration to Resident #12's lower right leg. Review of Resident #12's physician's orders indicated the following:-Weekly skin check, complete weekly skin check under assessments tab every day shift every Mon (Monday) for monitoring, dated 5/23/25. Review of the weekly skin checks under the assessment tab indicated Resident #12's skin intact on a weekly skin check V-2 dated 8/18/25. There were no further weekly skin checks assessments under the assessment tab. Review of the Treatment Administration Record (TAR) indicated the weekly skin check dated 8/25/25 as checked off as administered. Review of the progress notes failed to indicate a note that Resident #12 refused the weekly skin check dated 8/25/25. During an observation and interview on 8/28/25 at 7:55 A.M., the surveyor and Certified Nursing Assistant (CNA) #4 observed Resident #12's lower right leg. CNA #4 said Resident #12 had lower leg bruises on his/her right leg and that they had been there and that the nurses knew about the bruises. CNA #4 said she cared for Resident #12 on Tuesday (8/26/25) and they were there. CNA #4 said Resident #12 moved around in his/her wheelchair and bumped into things and that is how they happened. During an observation and interview on 8/28/2025 at 7:58 A.M., Nurse #1 observed Resident #12 with the surveyor present. Resident #12 was on his/her right side, and this limited Nurse #1's observation of his/her right lower leg. Nurse #1 said she could see some discoloration of the right leg and said a green bruise which could be a newer area was on the back of Resident #12's left calf. Further, Nurse #1 said when a nurse does a skin check it is head to toe and that it is documented on an assessment and not just checked off as administered. During an interview on 8/28/25 at 8:13 A.M., Charge Nurse #2 said when staff tell her that a resident has a skin injury, they start a risk report and will obtain statements, call the provider and family, get a treatment or order to monitor the area. Charge Nurse #2 said in the past Resident #12 has had injuries to his/her hands from wheeling around in his/her wheelchair. Charge Nurse #2 said she was not aware of any skin issues or injuries for Resident #12's lower right leg. At this time Unit Manger #1 entered the interview and said she was not aware of any skin issues for Resident #12. Unit Manager (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 said if a resident refuses a skin check the nurse doing the skin check would not check it off as administered. During an interview on 8/28/25 at 10:35 A.M., Nurse #6 said she signed off on the weekly skin check on 8/25/25, but did not document under the assessment, and that she did not see and was not informed of any skin issues. Nurse #6 said she worked yesterday (8/27/25) and no one brought it to her attention that Resident #12 had discoloration on his/her lower right leg. Nurse #6 said if staff see any bruises they are to report it immediately. Nurse #6 said yellow bruises are a sign of older bruises and that black and purple are likely newer bruises. During an interview on 8/28/25 at 9:33 A.M., the Director of Nursing (DON) said weekly skin checks are to be documented on the weekly skin assessment. The DON said she would expect that staff to report skin injuries seen during care to the nurse.

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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. Based on observations, interviews and record review, the facility failed to maintain professional standards in managing and caring for urinary catheter devices for one Resident (#54) out of a total sample of 25 residents. Specifically, the facility failed to ensure the urinary catheter drainage bag was not directly touching the floor.Findings include:Review of the facility policy titled Catheter Care, Urinary, revised August 2022, indicated:-The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.-Infection Control: Be sure the catheter tubing and drainage bag are kept off the floor.Resident #54 was admitted to the facility in July 2025 with diagnoses including obstructive uropathy (a condition in which the flow of urine is blocked) and dementia.Review of the most recent Minimum Data Set (MDS) assessment, dated 7/18/25, indicated Resident #54 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. This MDS also indicated Resident #54 had an indwelling urinary catheter. Review of Resident #54's physician's order, initiated 8/13/25, indicated:-Foley catheter (indwelling urinary catheter) care, every shift, initiated 8/13/25.Review of Resident #54's plan of care related to his/her indwelling urinary catheter, revised 7/15/25, indicated:-Provide catheter privacy bag and ensure that bag is not touching the floor.On 8/26/25 at 8:47 A.M., the surveyor observed Resident #54 in bed being assisted to eat by a staff member. He/she had a urinary catheter drainage bag which was attached to the bed frame by a privacy bag, and approximately half of it was directly touching the floor.On 8/26/25 at 10:45 A.M. and at 12:15 P.M., the surveyor observed Resident #54 in bed. He/she had a urinary catheter drainage bag which was attached to the bed frame by a privacy bag, and approximately half of it was directly touching the floor.On 8/26/25 at 12:24 P.M., the surveyor observed Resident #54 in bed. His/her health care proxy (HCP) was present and said she was concerned about how staff cares for his/her indwelling urinary catheter because he/she has had frequent urinary tract infections. Resident #54 had a urinary catheter drainage bag which was attached to the bedframe by a privacy bag, and approximately half of it was directly touching the floor.On 8/26/25 at 4:47 P.M., the surveyor observed Resident #54 in bed. He/she had a urinary catheter drainage bag attached to the bedframe by a privacy bag, and approximately a third of it was directly touching the floor.During an interview on 8/27/25 at 7:42 A.M., Certified Nurse Assistant (CNA) #1 said when Resident #54 is in bed the urinary catheter drainage bag should be attached to the bedframe by the privacy bag. CNA #1 said the privacy bag straps should be shortened to prevent the urinary catheter drainage bag from touching the floor. CNA #1 said the urinary catheter drainage bag and privacy bag should never directly touch the floor.During an interview on 8/27/25 at 7:47 A.M., Unit Manager #1 said Resident #54's urinary catheter drainage bag and privacy bag should never directly touch the floor because of the risk for infection. Unit Manager #1 said Resident #54 cannot adjust the height of his/her bed without assistance. Unit Manager #1 said Resident #54 was currently being treated for a urinary tract infection.Review of Resident #54's nurse progress note, dated 8/25/25, indicated:-Urine culture greater than 100,000 pseudomonas aeruginosa (a type of bacteria) n.o (new order) for ceftriaxone (an antibiotic medication) 1 gram daily x 7 days per NP (nurse practitioner).Review of Resident #54's provider progress note, dated 8/26/25, indicated a diagnosis of a urinary tract infection and that the urine culture collected prior to procedure positive.During an interview on 8/27/25 at 8:07 A.M., the Director of Nursing (DON) said Resident #54's urinary catheter drainage bag and dignity bag should never directly touch the floor and should be always elevated off the floor.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure for one Resident (#12), out of 7 residents reviewed for nutrition, out of a total sample of 25 residents, that a severe weight loss experienced by Resident #12 was addressed timely. Specifically, Resident #12's documented weight on 6/3/25 was 126.2 pounds and on 7/2/25 Resident #12's documented weight was 112.4 pounds, which is a body weight loss of 11.22 percent, which meets the criteria for severe weight loss. The clinical record failed to indicate a weight was retaken to confirm the weight loss, and the Registered Dietitian (RD) failed to conduct a nutritional assessment timely. A nutritional assessment by the RD was conducted 7/16/25, which was 14 days after Resident #12 experienced severe weight loss. Findings include: Review of the facility's policy entitled Weight Assessment and Interventions with a revision dated March 2022 included but not limited to the following:Residents weights are monitored for undesirable or unintended weight loss or gain.1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. 2. Weights are recorded in each unit's weight record chart and in the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing. 4. Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow the individual weight trends over time. 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss+(usual weight-actual weight)/ (usual weight) x 100}: a.1 month-5% weight loss is significant; greater than 5% is severe, b.3 months- 7.5% weight loss is significant; greater than 7.5 percent is severe. c. 6 months-10% weight loss is significant; greater than 10% is severe. Resident #12 was admitted to the facility in May 2024 and has diagnoses that include, but are not limited to unspecified dementia, bipolar disorder, delusional disorders and heart disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/16/25, indicated Resident #12 had a staff assessment for mental status indicating Resident #12 as having severe cognitive impairment. Further, the MDS indicated Resident #12 required set up/cleanup assistance for eating, is 63 inches in height, weighs 112 pounds, and experienced a loss of 5% or more in the last month or loss of 10% in the last 6 months and is not on a physician-prescribed weight-loss regimen. During an observation on 8/26/25 at 10:35 A.M., Resident #12 was observed in his/her bed. Resident #12 did not respond to the surveyors greeting. During an observation on 8/27/25 at 7:59 A.M., Staff was observed in Resident #12's room and said the Resident's name 'you got to eat'. At 8:00 A.M., the tray was on the bedside table, and the Resident was in bed. On 8/27/25 at 8:41 A.M., Nurse #6 said I tried to feed Resident #12, he/she did not want to eat, so I got him/her some yogurt which he/she likes. Review of Resident #12's physician's orders indicated the following:-Regular Diet regular texture, regular thin liquids consistency dated 8/11/25.-Fortified foods dated 8/11/25-Offer yogurt twice a day at 2 PM (SIC) and HS (hour of sleep) document % consumed. Dated 8/11/25. Review of the physician's orders failed to indicate an order to obtain Resident #12s' weight. Review of the weight summary in Resident #12's electronic medical record indicated the following:-6/3/25 at 13:18 (1:18 P.M.) 126.6 (pounds) chair scale-7/2/25 at 14:18 (218 P.M.) 112.4 (pounds) chair scale (a 11.22 % of total body weight loss, which is severe)There was no documented weight to confirm the severe weight loss.-7/17/25 at 14:05 (2:05 P.M.) 117.8 (pounds) chair scale. This weight was 15 days after the 11.22 % severe weight loss was recorded in Resident #12's medical record and is a 6.95 % weight loss from 6/3/25.-7/24/25 14:13 (2:13 P.M.) 114.5 (pounds) chair scale-7/31/25 13:40 (1:40 P.M.) 112.8 (pounds)chair scale-8/1/25 10:38 A.M., 112.6 (pounds) chair scale-8/7/25 14:38 (2:38 P.M.) 111.6 (pounds) chair scale.No further weights were documented. Review of Resident #12's clinical record indicated a care plan with the following focus, Resident is at risk for malnutrition related to polypharmacy, limited mobility, need for therapeutic diet, weight changes, variable intakes, BMI (body (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mass index) 23, medical conditions: dementia, bipolar disorder, HTN (hypertension) emphysema, CAD (coronary artery disease) HLD (hyperlipidemia), dysphagia, anemia, dated as initiated 4/18/25, indicated: Goal: Gradually gain weight to healthy BMI parameters for population, Free from significant weight change, maintain meal intake of greater than 75 percent at 2-3 meals daily, no signs or symptoms of dehydration, skin will remain free of pressure injury comply with ordered diet, Labs WNL (within normal limits) revision on 8/7/25. The Care Plan goals for Resident #12 were revised 25 days after Resident #12 experienced a severe weight loss. Review of the interventions included but were not limited to: Provide fortified foods, dated 7/16/25 (14 days after the severe weight loss was documented in Resident #12's medical record), Alert RD to any decline in intake dated 4/22/25 monitor weights 4/22/25 Review of Resident #12's medical record indicated a Nutrition assessment dated [DATE], which was 14 days after Resident 12's documented severe weight loss. Comments: 1 month 6/3/25 126.2 # (pounds) (-10.9 % loss)3 months 4/2/25 128.8 # (-12.7 % loss)6 months 1/6/25 134# (-16.1 % loss)Assessment Comments/Summary (Resident) presents with significant weight loss x 1/3/6 months. Reweight requested to confirm accuracy. If weight loss confirmed, would be unplanned undesirable; etiology not clear. BMI 19.9 low for population. No fortified food or nutritional supplements on order. Recommending fortified foods with all meals. Review of the Nurse Practitioner encounter note, dated 7/15/25, (13 days after the documented weight of 112.4 pounds) indicated the weight of 126.2 and did not indicate or note that Resident #12 experienced a significant weight loss. Review of IDT (interdisciplinary team) note, dated 7/8/25, 6 days after Resident #12's documented severe weight loss indicated the following: Discussed patient with IDT team at risk meeting. Weight loss of 13 pounds noted. Discussed a re-weigh. The note was entered by an occupational therapist. The next recorded weight was documented on 7/17/25, 9 days after the IDT note dated 7/8/25. During an interview on 8/28/25 at 10:30 A.M., Nurse #6 said she was not aware Resident #12 was having any weight loss, but she only works two days a week. Nurse #6 said Resident #12 loves yogurt and blueberries and that Resident #12 did not eat too much yesterday and she ordered him/her a sandwich at lunch and fed him/her some pudding. Nurse #6 said fortified foods come up on a resident's meal tray from the kitchen. Nurse #6 said the nurses are responsible for making sure residents are weighed. Nurse #6 said if there is a loss then the resident is to be reweighed within a day or two to determine if the weight is accurate. During an interview on 8/28/25 at 1:19 P.M., Unit Manager #1 said the weight book they keep on the unit did not have any further weights or reweight for Resident #12 after the 7/2/25 entry and just had the weights listed in the electronic medical record. Unit Manager #1 said Resident #12 used to tool around in his/her wheelchair and help him/herself to yogurts in a manic way, which resulted in weight gain in the past. Unit Manager #1 said the behavior of eating yogurt changed about one month ago, and he/she was not eating as much as before. Unit Manager #1 said if a resident had a 3-pound weight change they will reweigh the resident within a few days to confirm the weight loss. Unit Manager said it is possible the next weight was obtained on 7/16/25. Unit Manager said they liberalized Resident #12's diet and added fortified foods around 7/16/25, which was 14 days after the documented severe weight loss. During an interview on 8/28/25 at 1:01 P.M., the Assistant Director of Nursing said Resident #12 had weight loss and that that a reweigh should have been obtained within a day or 2 of the documented weight loss. The ADON said when a resident has weight loss they are followed in a risk meeting with the team, and they take directions from the RD. During an interview on 8/28/25 at 12:23 P.M. the Registered Dietitian said the RD who covers the building was not available for interview and that she could speak to the process for monitoring resident's weights and nutritional status. The RD said obtaining resident's weights is entered as an order and specific to a resident's needs. The RD said residents will have nutritional assessments on admission, quarterly and with any identified changes or concerns. The RD said a weight report is pulled from the medical record which identifies any weight concerns. The RD said there is a strong focus on any weight changes over one month and a 6-month lookback. The RD said if a resident has a weight change including a gain or loss of 5% the team is responsible for the reweigh (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within 24 to 48 hours to confirm if it is a true weight change. The RD said the dietitian then would be notified by nursing and would complete an assessment to determine if it is unplanned and undesirable. For Resident #12 the RD reviewed the entries in the electronic medical record and said Resident #12 did have a weight loss and that there was no documented reweight taken after the 7/2/25 documented weight until 7/17/25. The RD said Resident #12's weight loss would be triggered as being significant. The RD said a nutritional assessment would be important to identify new interventions and monitor improvements to combat weight loss. The RD said she believes the delay of obtaining a reweight to confirm Resident #12's weight loss impacted having a nutritional assessment and implementing interventions timely.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observations, interview and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC: a flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV]), consistent with professional standards of practice for one Resident (#110) out of a total sample of 25 Residents. Specifically, the facility failed to change the PICC line dressing and measure the external length of the catheter as indicated in the physician's orders. Findings include:Review of facility policy titled Central Venous Catheter Care and Dressing Changes, dated as revised October 2024, indicated the following:-The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter- related infections that are associated with contaminated, loosened, soiled or wet dressings.-1. Assess central venous access devices with each infusion and at least daily:-2. Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion.-3. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled).-5. Change the dressing if it becomes damp, loosened or visibly soiled and:-a. at least every 7 days-c. immediately if the dressing or site appears compromised. Resident #110 was readmitted to the facility in August 2025 with diagnoses that included presence of left artificial knee joint, encephalopathy and muscle weakness. Review of Resident #110's most recent Minimum Data Set (MDS) Assessment, dated 8/7/25 indicated a brief interview for mental status score of 15 out of 15, indicating intact cognition. On 8/26/25 at 7:53 A.M., the surveyor observed Resident #110 up and dressed in his/her wheelchair. The Resident had a PICC line to his/her right upper arm. The dressing was dated 8/20/25 and was peeling and lifting at the corners of the dressing. On 8/27/25 at 1:00 P.M., the surveyor observed the Resident in his/her room. A PICC line was observed to the right arm, and the dressing was dated 8/20/25, with the corners of the PICC line dressing lifting. On 8/28/25 at 7:26 A.M., the surveyor observed Resident #110 in his/her room up in his/her wheelchair. The Resident had a PICC line to his/her right arm. The dressing was dated 8/20/25 with the corners peeling and lifting. There was a piece of tape along one edge, taping down the dressing. Review of Resident #110's active PICC line care plan, dated 6/20/25, indicated the following:-Focus: I have a Single Lumen Central Line Catheter.-Interventions: Change dressing, injection caps and extension tubing weekly. Monitor every Shift and report any abnormalities to PCP, and treatments as ordered. Review of physician's orders indicated the following:- PICC Line Dressing/Connector(s): change and date PICC line dressing and change needless connector(s). Measure external PICC catheter. every night shift every Wed (Wednesday) for treatment, dated 8/13/25. Review of the August 2025 Treatment Administration Record (TAR) indicated that the PICC line dressing had been changed on 8/13, 8/20 and 8/27, despite an observation on 8/28/25 which indicated a PICC line dressing in place dated 8/20/25. Further Review of the TAR failed to indicate external catheter length was measured on 8/20 or 8/27. Review of Resident #110's progress notes failed to indicate external catheter length was measured and documented on 8/20 or 8/27. During an interview on 8/28/25 at 7:40 A.M., Charge Nurse #1 said that for every resident who admits with a PICC line she will ensure that the facility receives the insertion report as well as placement confirmation. She said that an order set is entered into the medical record for dressing changes on admission and weekly, as well as on an as needed basis. She said that part of the dressing change includes monitoring the external length of the catheter, which will assist in assessing whether or not the PICC line has migrated, or placement is compromised. She further said that if a nurse signs off that a dressing change is completed, she expects that it was completed, and if it was not, then it should not be signed off as such. During an interview on 8/28/25 at 7:47 A.M., Unit Manager #2 said that PICC line dressing changes should be completed as indicated in physician's orders; not completing dressing changes could increase the risk of infection. She further said that the (continued on next page)

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	225271	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Rehabilitation and Healthcare Center	6 Hale Street Newburyport, MA 01950

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as needed order should have been implemented for a peeling and lifting dressing. Unit Manager #2 also said an external catheter length should also be documented to confirm placement and that the PICC line has not migrated. During a phone interview on 8/28/25 at 10:20 A.M., Nurse #3 said that she was assigned to care for Resident #110 on 8/27/25. She said that she did not perform a PICC line dressing change. She said that she did administer IV medication for the Resident but does not recall noticing the date of the dressing or that it was peeling or lifting in the corners. During an interview on 8/28/25 at 9:27 A.M., the Director of Nurses (DON) said that a PICC line should be assessed at least every shift, and she would expect that dressing changes are being completed at least every 7 days and as needed. The DON said that part of the dressing change includes measuring the external catheter length to confirm that the PICC line has not migrated or dislodged from its placement. She said that if a PICC line dressing begins to lift or peel it increased the risk for infection and should be changed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interviews and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#26) out of sample of 25 residents. Specifically, the facility failed to obtain a physician's order for oxygen administration. Findings include:Review of facility policy titled Oxygen Administration, dated as Revised October 2010, indicated the following:-Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Resident #26 was admitted in May 2025 with diagnoses that include gastrointestinal hemorrhage, acute respiratory failure, muscle weakness and pressure ulcer stage 3. Review of the most recent Minimum Data Set (MDS) Assessment, dated 8/12/25, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. The MDS further indicated the use of continuous oxygen therapy. On 8/26/25 at 8:02 A.M., the surveyor observed Resident #26 awake in bed. The Resident was receiving oxygen via nasal cannula at 2 liters per minute (lpm). On 8/27/25 at 12:30 P.M. and 1:36 P.M., the surveyor observed Resident #26 awake in bed. The Resident was receiving oxygen via nasal cannula at 2 lpm. Review of Resident #26's active physician's orders failed to indicate orders for oxygen administration. Review of the weights and vital signs portal in the electronic medical record indicated that beginning 8/12/25 Resident #26 was documented as using oxygen via nasal cannula. During an interview on 8/27/25 at 1:38 P.M., the Charge Nurse said that if a resident is receiving oxygen there should be an order for administration. She said Resident #26 is receiving oxygen, but when she reviewed the medical record, she said there was no order for it. She said that the Resident was started on oxygen around 8/12/25 when he/she was diagnosed with pneumonia. During an interview on 8/28/25 at 7:57 A.M., Unit Manager #2 said that there needs to be a physician's order for oxygen administration, but that Resident #26 did not have one until it was brought to the facility's attention. During an interview on 8/28/25 at 9:26 A.M., the Director of Nurses said that the administration of oxygen requires a physician's order and would expect that if a resident is receiving oxygen there would be a physician's order.

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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. Based on observations, interviews, and record review the facility failed to provide care and services consistent with professional standards of practice for one Resident (#41) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 25 residents. Specifically, The facility failed to ensure ongoing assessment of the Resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.The facility failed to ensure an emergency kit including clamps were kept with the Resident in case of emergency related to a tunneled hemodialysis catheter (a plastic tube used for exchanging blood between a patient and a hemodialysis machine).Findings include: Review of the facility policy titled ?End-Stage Renal Disease, Care of a Resident with', dated September 2010, indicated residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.-If there is major bleeding from site (post dialysis), apply pressure to insertion site and contact emergency services and dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive. Review of the facility policy titled ?Hemodialysis Catheters-Access and Care of' dated June 2025, indicated: Documentation-The nurse should document in the resident's medical record every shift as follows:1. Location of catheter.2. Condition of catheter (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. Resident #41 was admitted to the facility in August 2025 with diagnoses including chronic kidney disease, stage 5 and dependence on renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/9/25, indicated that Resident #41 was cognitively intact as evidenced by a Brief Mental Status (BIMS) score of 13 out of 15. This MDS indicated Resident #41 received hemodialysis. On 8/27/25 at 7:30 A.M., the surveyor observed dialysis access site to the right upper chest covered with undated bordered gauze. Resident #41 said that the nurse did not provide any care to assess the site upon his/her return from dialysis. Review of Resident #41's physician's order, dated 8/26/25, failed to indicate orders to monitor/assess the resident for any complications and to document in medical record. Review of Resident #41's plan of care related to hemodialysis, dated 8/3/25, indicated interventions including:-avoid blood pressure, blood work, and IV insertion on the affected arm.-check and change dressing daily at access site. Document.-monitor/document/report to physician (MD) as needed (PRN) and signs and symptoms of infection to access site: redness, swelling, warmth, or drainage.-monitor/document/report to MD PRN for signs and symptoms of the following: bleeding, hemorrhage, bacteremia, or septic shock.-obtain vital signs and weight per protocol. Report significant changes in pulse, respirations, and blood pressure immediately. Review of Resident #41's nursing progress notes, dated 8/2/25 through 8/26/25, failed to indicate observation and care of Resident #41's hemodialysis catheter or of Resident #41's condition pre- and post-dialysis. Review of Resident #41's Treatment Administration Record (TAR) and Medication Administration Record (MAR), dated 8/26/25, failed to indicate orders to monitor/assess site right chest port for any complications. Review of Resident #41's nursing admission assessment, dated 8/2/25, indicated he/she had right chest port for dialysis. On 8/26/25 at 8:57 A.M., Resident #41 was observed lying in his/her bed. The surveyor did not observe emergency clamps or pressure dressings in the Resident's room. On 8/27/25 at 7:30 A.M., Resident #41 was observed lying in his/her bed. The surveyor did not observe emergency clamps or pressure dressings in the Resident's room. During an interview on 8/27/25 at 7:36 A.M., Nurse #5 said that she had cared for Resident #41 last week and that he/she has a fistula in his/her right arm and care for him/her included checking for bruit and thrill in right arm access site and upon return from dialysis, a pressure wrap must be kept on site for 24 hours. She said that complications to the right arm access site could include bleeding and there should be clamp and dressing supplies in the Resident's room so that pressure can be applied but was not sure if they (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were there now. She said she documents an assessment on her residents every shift. During an interview on 8/27/25 at 9:35 A.M., Unit Manager #2 said that Resident #41's access for dialysis is a right chest port. She said the port must be kept covered. She said that the care of Resident #41 includes making sure his/her dialysis book is kept up to date and that they monitor any recommendations from dialysis, document any findings at dialysis including pre- and post-weights, update care plan, assess site every shift. She said there should be orders to assess the site. She said that there should be an order for no blood pressure on the arm on side where dialysis catheter is and that complications could include dislodgement, inflammation, or redness of the access site and there should be gauze, pressure dressing, and tape available for an emergency. She said there should be a clamp available in case of bleeding, but I don't have a clamp. During an interview on 8/27/25 at 11:36 A.M., the Director of Nursing (DON) said that a resident receiving dialysis should have a dialysis binder to communicate with the dialysis center. If the resident has a port there should be orders to check the site, maybe a dressing change and to visually assess site and document. She said that complications could include infection, or port could be compromised or dislodged. She said she would need to check on the protocol for emergency kit for external port and was not sure about the education provided to staff for a resident receiving dialysis. She said she would expect nursing staff to monitor access site before and after dialysis and to document in medical record, including signing on MAR or TAR. During an interview on 8/27/25 at 12:01 P.M., the DON said that another complication of a renal dialysis catheter could be bleeding. She was unable to provide a policy for emergency care of hemodialysis catheter. She said that Resident #41 has an emergency kit in his/her top drawer of his/her room and that she checked it herself. The surveyor went to room with DON and observed the emergency kit in Resident's top drawer with gauze in bag. The DON said the gauze would be used to apply pressure if there was bleeding at the catheter site. The DON was unaware that a clamp should be included in the emergency kit for a resident with a hemodialysis catheter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to implement Enhanced Barrier Precautions for a central dialysis catheter for one Resident (#41), with a central dialysis catheter port, out of a total sample of 25 residents.Findings include:Review of the facility policy, titled ?Enhanced Barrier Precautions', dated December 2024, indicated: Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents.-EBPs refer to infection prevention and control interventions designed to reduce the transmission of MDROs during high contact resident care activities.-EBPs apply when a resident has a wound or indwelling medical device.-indwelling medical devices include central lines, catheters, feeding tubes, and tracheostomies.-EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities.-Examples of high-contact resident care activities requiring the use of gown and gloves for EBP include:a. dressing.b. bathing.c. providing hygiene or grooming.d. transferringe. providing bed mobility.f. changing linens.g. changing briefs or assisting with toileting.h. device care or use.-Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required. Resident #41 was admitted to the facility in August 2025 with diagnoses including chronic kidney disease, stage 5 and dependence on renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/9/25, indicated that Resident #41 was cognitively intact as evidenced by a Brief Mental Status (BIMS) score of 13 out of 15. This MDS indicated Resident #41 receives hemodialysis. This MDS also indicated that he/she required assistance with all personal care and mobility and that he/she had incontinence. On 8/26/25 at 8:57 A.M., the surveyor observed that the facility failed to post any signs on the door or wall outside Resident #41's room indicating he/she required EBPs. Review of Resident #41's entire medical record, dated 8/26/25, failed to indicate an order or documentation of the use of EBPs. On 8/27/25 at 12:03 P.M., Certified Nursing Aide (CNA) #2 said she had cared for Resident #41 before, and she had not used EBPs to care for that Resident. On 8/27/25 at 7:36 A.M., Nurse #5 said that Resident #41 should have sign for EBPs posted outside of his/her room. She said that she had not used EBPs to care for Resident. On 8/27/25 at 9:35 A.M., Unit Manager #2 said that Resident #41 should have EBPs for care related to open access (central line). She said that she had not used EBPs to care for Resident. On 8/27/2025 at 11:56 A.M., the Assistant Director of Nursing (ADON) said a resident with a port should have EBPs as it is an open line. On 8/27/25 at 11:36 A.M., the Director of Nursing (DON) said that Resident #41 should have EBP if he/she has a port as it is an open line. The DON said that the need for EBPs is communicated by a sign and a precaution cart outside of the Resident's room.