STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225286	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam East Rehab and Nursing	464 Main Street Agawam, MA 01001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, record review, and interview, the facility failed to provide three Residents (#1, #56, and #49) with a dignified dining experience, out of a total sample of 19 residents. Specifically, the facility failed to ensure that: 1. Resident #1 was awake and alert prior to bringing him/her into the dining room during meal service, and provided assistance as required per the Resident's care plan. 2. Resident's #56 and #49 were provided with timely assistance as required per the Resident's care plans. Findings include: 1. Resident #1 was admitted to the facility in October 2020 with diagnoses including Type II Diabetes Mellitus (non-insulin-dependent diabetes) and Dementia. Review of Resident #1's care plan indicated: -Encourage oral intake of food and fluids - initiated 11/2/20 -Resident is independent with eating, when increased fatigue provide assist of one to ensure proper intake if allowed, cueing throughout meal may be needed - initiated 4/19/24 During an interview and observation on 12/11/24 from 9:03 A.M. through 9:23 A.M., the surveyor observed Unit Manager (UM) #1 deliver Resident #1's breakfast tray to the Resident while he/she was asleep in bed. The surveyor further observed that Resident #1 was difficult to arouse requiring UM #1 to provide feeding assistance without much participation from the Resident. UM #1 was observed to encourage the Resident to open his/her eyes, chew, and swallow the food. UM #1 said the Resident was very tired today, and she thought he/she might not be feeling well. On 12/12/24 from 8:03 A.M. through 9:45 A.M., the surveyor observed the following: -At 8:03 A.M., Resident #1 was seated in his/her wheelchair, leaning forward, asleep at the nurses station. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 8:08 A.M., Resident #1 was brought into the Unit dining room and placed at a table. The Resident was arousable, but not awake and alert. -At 8:43 A.M., Resident #1 was seated in his/her wheelchair, at a table in the dining room, asleep. >Resident #1 had a plate of untouched food, a bowl of untouched oatmeal, and two untouched drinking cups full of liquid in front of him/her. >At this time, 26 Residents and seven staff were in the dining room. >Staff were providing assistance with eating, supervision, cueing and other needs to other residents in the dining room. >No staff were observed encouraging Resident #1 to wake up, encouraging him/her to eat or to provide any assistance with his/her meal. The surveyor exited the dining room briefly. -At 8:52 A.M., the surveyor re-entered the dining room and observed another resident seated to the right of Resident #1, to be eating the contents of Resident #1's plate, and 95% of the breakfast meal was gone. During an interview at the time, the surveyor asked Nurse #4 if Resident #1 had eaten his/her breakfast, she looked over and said she believed Resident #1 had eaten. The surveyor shared the observation that the resident seated to the right of Resident #1 was eating the food off the Resident's plate. Nurse #4 observed the resident to be eating off Resident #1's plate, and immediately removed Resident #1's plate that was eaten from the table, leaving a bowl of untouched oatmeal and two untouched cups of liquids. -At 9:00 A.M., Nurse #4 removed the uneaten bowl of oatmeal as Resident #1 remained asleep. The surveyor asked Nurse #4 if Resident #1 had eaten any of the oatmeal and she said it did not appear that he/she had eaten any. Nurse #4 said she was not sure if any staff sat with the Resident to provide assistance with his/her breakfast meal. -At 9:02 A.M., UM #1 said she could not say who, if anyone sat with the Resident during breakfast service to encourage or assist with eating. The surveyor relayed to UM #1 that the surveyor did not observe any staff encourage the Resident to wake up during the breakfast meal service or assist with eating, prior to his/her table mate eating his/her food. UM #1 said that she thought the Resident was typically independent with eating, that he/she was not feeling well, and required additional assistance the last two days but did not receive the assistance during the meal service today when he/she should have. -At 9:45 A.M., Certified Nurses Aide (CNA) #4 was observed providing Resident #1 with assistance to eat breakfast (62 minutes after the breakfast meal was served on the unit). Resident #1 was dependent on CNA #4 to feed him/her. -Resident #1 was alert and accepting of food. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview immediately following the observation, CNA #4 said that she requested a new plate from the kitchen after learning that Resident #1 had not eaten his/her breakfast. CNA #4 said the Resident would almost always eat 100% of his/her food when CNA #4 provided the assistance for Resident #1. CNA #4 said that she had been assisting Resident #1 with his/her meals for a few months and that occasionally the Resident would eat on their own but most of the time he/she required assistance. Please refer to F657 42741 2a. Resident #56 was admitted to the facility in May 2024 with a diagnoses including a history of a transient ischemic attack (stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body) affecting the left side, dysphagia (trouble swallowing), and unspecified Dementia with agitation. Review of Resident #56's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #56 was severely cognitively impaired as evidenced by a Brief Interview of Mental Status score of 3 out of 15. Review of Resident #56's care plan titled Neuromuscular Impairment, Weakness, initiated 5/29/24, indicated the following interventions: -Eating: requires limited to extensive assistance of (1) staff for eating, initiated 5/29/24. Review of Resident #56's Kardex (information on how to provide daily care for a resident utilized by CNAs), dated 12/12/24, indicated the following: -Eating: requires limited to extensive assistance of one (1) staff for eating. Review of the most recent Dietary Evaluation Assessment, effective date 12/4/24, indicated the Resident needed to be assisted and provided with verbal cueing while eating. Review of the Nurse Practitioner's (NP) Progress Note, dated 12/10/24, indicated the Resident was fed all meals. During the initial dining observation of the breakfast meal on 12/11/24 from 8:35 A.M. to 9:30 A.M., the surveyor observed the following: -Resident #56 was seated at a table with five other residents. -Resident #56's breakfast tray was placed in front of him/her at 9:09 A.M. The breakfast tray remained covered with a lid and Resident #56 was observed trying to take the top off his/her tray. A CNA uncovered the Resident's tray and scrambled eggs and whole slices of toast were observed on the tray. Resident #56 was observed attempting to eat his/her toast by picking up the whole piece of bread with a fork. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 9:17 A.M., Resident #56 was observed to be sitting looking at his/her food. He/she had only taken one bite of the toast and consumed no other food from his/her plate. -At 9:19 A.M. to 9:22 A.M., Resident #56 was observed to be sleeping and staff from across the table kept repeating his/her name attempting to wake him/her up to eat. -At 9:30 A.M., a staff member sat next to Resident #56 and began to assist him/her with his/her meal which he/she actively ate with assistance. The surveyor observed that the staff member did not reheat the Resident's food which had been sitting in front of him/her for 21 minutes, prior to assisting the Resident. On 12/11/24 from 5:10 P.M. to 5:59 P.M., the surveyor observed the following during the dinner meal: -Resident #56 was seated at a table with five other residents. -Resident #56 was observed at 5:23 P.M., trying to take the drink that belonged to the resident sitting next to him/her. A staff member redirected Resident #56, asked for Resident #56's tray from the meal cart, and set it up in front of him/her. Resident #56 immediately took a cup containing a protein shake and drank it. -At 5:27 P.M., Resident #56 was observed seated at the table with untouched food and made no attempts to feed him/herself. -At 5:30 P.M., a staff member tried cueing Resident #56 to eat from across the table but Resident #56 did not attempt to feed him/herself. -From 5:33 P.M. until 5:37 P.M, Resident #56 was observed falling asleep at the dining table. -At 5:37 P.M., a staff member was observed rubbing Resident #56's shoulder to wake him/her up and the staff member offered him/her a drink which Resident #56 refused. The staff member did not offer him/her any assistance with his/her meal. -At 5:47 P.M., a staff member was observed sitting down in a chair next to Resident #56 and began assisting him/her with his/her meal. Prior to beginning to assist the Resident, the staff member did not reheat the Resident's food which had been sitting in front of him/her for 24 minutes. 2b. Resident #49 was admitted to the facility in January 2024 with diagnoses including Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) and unspecified Dementia with mood disturbance. Review of Resident #49's most recent MDS Assessment, dated 10/17/24, indicated Resident #49: -was severely cognitively impaired as evidenced by a BIMS score of 00 out of 15. -was dependent on staff for eating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #49's care plan titled Aspiration Precautions Due to Diet Texture Alteration, initiated 12/2/24 indicated the following interventions: -one to one (1:1) feed for all meals, initiated 12/2/24 Review of Resident #49's Kardex dated 12/12/24, indicated the following: -Eating/Dietary/Nutrition: 1:1 feed for all meals Review of the most recent Dietary Evaluation Assessment, effective 10/14/24, indicated the Resident needed to be fed, prompted, and provided with verbal cueing while eating. On 12/11/24 from 5:10 P.M., to 5:59 P.M., the surveyor observed the following during the dinner meal: -Resident #49 was seated at a table with five other residents. -At 5:26 P.M., Resident #49 received his/her tray and the tray remained covered in front of him/her. -At 5:29 P.M., another resident at Resident #49's table encouraged Resident #49 to uncover his/her meal and asked why Resident #49 had his/her food covered. Resident #49 did not respond. -At 5:32 P.M., the residents on both sides of Resident #49 were assisted with their meals. -At 5:34 P.M., Resident #49 attempted to grab the ice cream that was covered in front of him/her. Resident was re-directed by staff to not touch the ice cream. -At 5:36 P.M., Resident #49 attempted to uncover his/her meal and was re-directed by a staff member to not touch the cover on his/her meal. -At 5:40 P.M., Resident #49 was seen intently observing the residents on either side of him/her being assisted with their meals. -At 5:42 P.M., Resident #49 reached for the cover of his/her meal. A staff member held up a finger cueing him/her to wait. -At 5:46 P.M., UM #2 picked up Resident #49's meal, brought it to the microwave and reheated it, brought it back to Resident #49, and began assisting him/her with the meal (20 minutes after the Resident was served their dinner meal). Resident #49 was observed actively eating with UM #2 feeding him/her. During an interview following the dinner meal on 12/11/24 at 6:09 P.M., UM #2 said there were seven residents in the dining room who needed assistance with the dinner meal. UM #2 said multiple residents needing assistance had to wait 20 or more minutes to be assisted during the dinner meal. UM #2 said the residents should not have had to wait that long and if a resident did wait his/her meal should have been re-heated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/24 at 10:04 A.M., the Director of Nursing (DON) said all residents in the facility should be provided with a hot meal and Resident #56's dinner meal on 12/11/24 should have been re-heated prior to a staff member assisting him/her. The DON said Resident's #56 and #49 should not have to wait 20 minutes to be assisted with their meals. The DON further said the residents who needed to be assisted with dining should have been seated in a way that allowed staff members to assist all the assistive dining residents at once, so no residents waited for an extended period of time.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37400 Based on interview, and record review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN: notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) were issued with the required information for two Residents (#47 and #22), out of three applicable residents reviewed. Specifically, the facility failed to issue the SNF ABN notices to Residents #47 and #22, so the Resident/Resident Representative could decide if they wished to continue receiving skilled services that may not be paid for by Medicare, and were aware of the financial responsibility they may have to assume. Findings include: 1. Resident #47 was admitted to the facility in August 2024. Review of the clinical record indicated Resident #47 received Medicare Part A skilled services from 8/28/24 through 10/17/24. Further review of the clinical record indicated: -A SNF ABN form was provided to the Resident Representative and initialed on 10/15/24. -the sections on the form that were to be completed by the facility and indicated the financial responsibility of the Resident/Resident Representative were left blank. -Resident #47 remained in the facility after Medicare Part A skilled benefits ended. 2. Resident #22 was admitted to the facility in April 2024. Review of the clinical record indicated Resident #22 received Medicare Part A skilled services from 4/24/24 through 6/20/24. Further review of the clinical record indicated: -A SNF ABN form was provided to the Resident Representative and initialed on 6/14/24. -the sections on the form that were to be completed by the facility and indicated the financial responsibility of the Resident/Resident Representative were left blank. -Resident #22 remained in the facility after Medicare Part A skilled benefits ended. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 12/12/24 at 3:32 P.M., Social Worker (SW) #1 said when Medicare Part A skilled services end, she receives notification of what notices to provide to the Resident/Resident Representative and one of the forms includes the SBF ABN form. SW #1 said she would contact the Resident/Resident Representative and explain why they were being discharged from Medicare Part A skilled services, and would provide the SNF ABN if applicable, which notifies the Resident/Resident Representative of the financial costs that they may be responsible for once skilled services end. SW #1 reviewed the SNF ABN forms for Resident #47 and Resident #22 and said the forms were not completed with the estimated amounts that the Residents would be responsible for. SW #1 said the forms should have been filled out with the financial amounts, so the Resident/Resident Representative knew this information. SW #1 said the SNF ABN forms for Resident #47 and Resident #22 were not completed appropriately.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, record review, and interview, the facility failed to ensure that the care plan was reviewed and revised by the interdiciplinary team pertaining to Activities of Daily Living (ADL) for one Resident (#1) out of a total sample of 19 residents. Specifically, for Resident #1, the facility failed to: 1. update the ADL care plan after Resident #1 had documented decline in his/her ability to independently feed him/herself and required maximum assistance more frequently. 2. review and revise the care plan with the input of the interdisciplinary team as required. Findings include: Resident #1 was admitted to the facility in October 2020 with diagnoses including Type II Diabetes Mellitus (non-insulin-dependent diabetes) and Dementia. 1. Review of Resident #1's care plan indicated the following: -Encourage oral intake of food and fluids -initiated 11/2/20 -Resident is independent with eating, when increased fatigue provide assist of one to ensure proper intake if allowed, cueing throughout meal may be needed -initiated 4/19/24 Review of the Certified Nurses Aide's (CNA)s Documentation Report for eating for September 2024 through December 2024, indicated the following level of assistance was required for Resident #1 during the 7:00 A. M. to 3:00 P.M. shift (breakfast and lunch meals): >Coding key as follows: 1= Dependent - helper does all of the effort 2= Substantial/Maximal assistance - helper does more than half the effort -September 2024: Resident #1 required substantial/maximal assistance or was dependent for 23 out of 30 days documented. -October 2024: Resident #1 required substantial/maximal assistance or was dependent for 27 out of 31 days documented. -November 2024: Resident #1 required substantial/maximal assistance or was dependent for 29 out of 29 days documented. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-December 2024: Resident #1 required substantial/maximal assistance or was dependent for 10 out of 10 days documented. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #1 required substantial/maximal assistance while eating. On 12/11/24 from 9:03 A.M. through 9:23 A.M., the surveyor observed the following: -Unit Manager (UM) #1 deliver Resident #1's breakfast tray in the Resident's room. -UM #1 adjust Resident #1's positioning in the bed to assist him/her with eating breakfast. -Resident #1 was difficult to arouse. -UM #1 held the utensil and brought the food to Resident #1's mouth. Resident #1 required maximum assistance of UM #1 (Resident #1 did not participate in feeding him/herself). -UM #1 had to frequently encourage the Resident to open his/her eyes, chew, and swallow the food. During an observation and interview on 12/12/24 at 9:45 A.M., CNA #4 provided Resident #1 with assistance while eating breakfast and the Resident was dependent on CNA #4 to feed him/her. CNA #4 said the Resident would almost always eat 100% of his/her food when CNA #4 provided the assistance for Resident #1. CNA #4 said that she had been assisting Resident #1 with his/her meals for a few months and that occasionally the Resident would eat on their own but most of the time he/she required assistance. During an interview on 12/12/24 at 10:36 A.M., UM #1 said that after reviewing Resident #1's level of assistance required during meals, the care plan should have been updated to reflect the changes (in requiring assistance with meals) the Resident experienced from September 2024 through December 2024. During an interview on 12/12/24 at 2:36 P.M., MDS Nurse #2 said that the Resident had a change in his/her level of assistance required while eating over the last few months and that she would expect for a Resident who went from a partial assist to a dependent assist while eating, the care plan would be updated and at this time the care plan had not been updated. 2. Review of the last sign in sheet available in the medical record for Resident #1 indicated the last care plan meeting was held on 6/20/24. Review of the September 2024 Care Plan meeting schedule indicated an interdisciplinary care plan team meeting was scheduled on 9/19/24 at 1:45 P.M. During an interview on 12/12/24 at 2:26 P.M., UM #1 provided the most recent copy of the care plan meeting available for Resident #1 that was dated 6/20/24. UM #1 said that she was not able to locate any evidence that any care plan meetings for Resident #1 had occurred since 6/20/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/24 at 2:36 P.M., MDS Nurse #1 reviewed the care plan meeting schedule and noted that Resident #1 had a care plan meeting scheduled for 9/19/24. MDS Nurse #1 said that she attended the care plan meetings and takes many notes. The surveyor and MDS Nurse #1 reviewed the notebook used by MDS Nurse #1 for care plan meetings and was unable to find any documented evidence that an interdisciplinary care plan meeting occurred on 9/19/24 as scheduled for Resident #1.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45435 Based on observation, interview, and record review, the facility failed to ensure that activities of daily living (ADLs) were performed for one Resident (#4) out of a total sample of 19 residents. Specifically, the facility failed to provide assistance with removing facial hair for Resident #4, when the Resident was dependent on staff for grooming care and needs. Findings include: Resident #4 was admitted to the facility in September 2021, with diagnoses including Unspecified Dementia and Depression. Review of the facility's policy titled Activities of Daily Living (ADL), effective 1/2024 indicated: -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Review of the Resident's ADL care plan, last revised 12/8/23, indicated the Resident required assist/dependent for ADL care. Review of Resident #4's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of six out of a total possible score of 15. -had not exhibited any episodes of rejection of care. -required substantial/maximal assistance (helper does more than half the effort) for personal hygiene (the ability to maintain personal hygiene including combing hair, shaving, applying makeup, washing/drying face and hands). Review of Resident #4's Kardex (a brief overview of the Resident's care needs), undated, printed on 12/12/24, indicated the Resident required limited to extensive assistance for personal hygiene (grooming). On 12/11/24 at 8:44 A.M., the surveyor observed Resident #4 sitting in the dining room, dressed and wearing socks and shoes. The surveyor further observed that Resident #4 had facial hair, approximately two inches long, sparsely distributed under his/her chin. On 12/11/24 at 2:36 P.M., the surveyor observed the Resident sitting at a table with two other residents during a trivia activity. The Resident was dressed, wearing socks and shoes, and long facial hair remained under his/her chin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225286	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam East Rehab and Nursing	464 Main Street Agawam, MA 01001

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24 at 8:45 A.M., two surveyors observed Resident #4 sitting at a table in the dining room, dressed, and wearing socks and shoes. The Resident was observed with long facial hair remaining under his/her chin. Review of the Certified Nurses Aide (CNA) Documentation Report for December 2024, indicated the Resident received personal hygiene assistance every day and required substantial/maximal assistance. During an interview on 12/12/24 at 9:02 A.M., CNA #1 said that the CNAs were responsible to shave residents with facial hair as needed. CNA #1 said that she was familiar with Resident #4's care and had provided care to the Resident earlier that morning. CNA #1 described how she had performed care for Resident #4 and said that the Resident was not resistive to care and did not reject care. The surveyor and CNA #1 observed the Resident in the dining room with facial hair still remaining. CNA #1 said that she could see the long hair on his/her chin, and that he/she should have been shaved. CNA #1 was unable to recall when she had last shaved the Resident to remove facial hair. On 12/12/24 at 9:09 A.M., the surveyor and Nurse #1 and the surveyor observed Resident #4 sitting in the dining room with long facial hair. Nurse #1 said that the facial hair looked like it had been there for quite some time. Nurse #1 further said that she had not worked on the unit for the past two weeks and that CNA #1 had told her about the facial hair, but there were no razors on the unit at this time. Nurse #1 said that she called Central Supply, but there was no answer, so she added razors to the supply need list. Nurse #1 further said the process for getting supplies was that staff from the unit add the supplies needed to the list and the Central Supply Clerk comes to get the list every day. During an interview and observation on 12/12/24 at 9:17 A.M., the surveyor and the Central Supply Clerk observed that the Central Supply Room had multiple boxes of razors. The Central Supply Clerk said that she restocks the units on Monday, Wednesday, and Friday as well as requesting the Nurses to write the supplies that are needed on the Supply list. The Central Supply Clerk said that she saw a couple of razors on the unit yesterday when she was delivering supplies. The Central Supply Clerk said that the facility does not use a par level system (a system that identifies the number of items to be kept in stock) but that if a unit ran out of an item, the Nurses had a key to the Central Supply Room and the item could be obtained from there. During an interview on 12/13/24 at 1:15 P.M., the Director of Nursing (DON) said that unwanted facial hair should be removed as part of grooming and that staff education has been initiated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation, interview, and record review, the facility failed to ensure that necessary respiratory care and services in accordance with professional standards of practice were in place for one Resident (#54) out of a total sample of 19 residents. Specifically, for Resident #54, the facility failed to ensure that: 1. Physician's orders were in place at the time of admission to address liter flow (LPM - flow of oxygen that is received from an oxygen delivery device), monitoring of respiratory status, and for care and services of oxygen equipment. 2. a person-centered respiratory care plan was created within seven days of the admission Minimum Data Set (MDS) Assessment completion. Findings include: Review of the facility policy titled Oxygen Administration and Storage, revised 3/8/24, indicated the following: -To ensure staff follow safety guidelines and regulation for storage and use of oxygen. -Verify provider's order for the procedure. -Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: *Signs or symptoms of cyanosis (i.e. blue tone to he skin and mucous membranes); *Signs or symptoms of hypoxia (i.e. rapid breathing, rapid pulse rate, restlessness, confusion); *Signs or symptoms of oxygen toxicity (i.e. tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); *Vital signs; *Lung sounds; *Atrial blood gases and oxygen saturation . -The nasal canula or mask should be changed weekly or when soiled. -The extension tubing (the tube used to lengthen the cannula, but is not connected directly to the resident) should be changed monthly or when soiled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Filters should be removed and cleaned by rinsing with clear, cool water weekly to maximize flow rate of clean air. Resident #54 was admitted to the facility in September 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe). 1. Review of the most recent comprehensive MDS assessment dated [DATE] indicated Resident #54 utilized oxygen. Review of Resident #54's baseline care plan dated 9/6/24, indicated: -the Resident was on oxygen therapy -did not include: >the LPM that Resident #54 utilized. >how the staff should be monitoring the respiratory status of the Resident. >information on how the staff would provide the care and services of the Resident's oxygen equipment. Review of Resident #54's Physician's orders from 9/6/24 through 12/12/24 indicated the following: -Oxygen at 4 LPM via nasal cannula, no humidification, every shift, post treatment evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds, start date of 9/16/24. -Clean filter on oxygen concentrator weekly as needed for maintenance .start date of 11/27/24. -Oxygen tubing change weekly. Label each component with date and initials every night shift ever Sunday . start date of 11/27/24. During an observation on 12/11/24 at 9:57 A.M., the surveyor observed Resident #54 lying in bed receiving oxygen via nasal cannula. The Resident's oxygen concentrator was set on 4 LPM, and he/she had extension tubing coiled at bedside. During an interview on 12/11/24 at 3:08 P.M., Nurse #3 said if a Resident was admitted to the facility on oxygen, Physician's orders should be in place for the LPM the Resident needs, care and services of the oxygen equipment, and monitoring of the Resident's respiratory status, and that these orders should be in place on the day of admission. During an interview on 12/12/24 at 9:24 A.M., Unit Manager (UM) #2 said Physician's orders should be put into place at the time of admission for Resident's who utilize oxygen and these orders should include the LPM the Resident needed and care and services for oxygen equipment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 12/12/24 at 9:35 P.M., UM #2 said she reviewed Resident #54's chart and the orders for LPM that the Resident utilized and assessing the Resident's respiratory status had not been put into place until a week and a half after the Resident's admission to the facility. UM #2 also said orders for the care of the Resident's respiratory equipment had not been put into place until the end of November 2024. UM #2 further said Resident #54 had been utilizing oxygen since the day he/she was admitted to the facility and these orders should have been put into place at the time he/she was admitted to the facility. UM #2 said she could not be sure of how often the Resident's oxygen equipment had been changed from admission to November when the orders were put into place because there was no documentation to support that it was done on a regular basis. 2. Review of Resident #54's care plan indicated a respiratory care plan was created on 11/25/24, greater than two months from the time the Resident was admitted to the facility. During an interview on 12/12/24 at 11:00 A.M., the MDS Nurse said a comprehensive respiratory care plan for a Resident on oxygen should be created shortly after the Resident is admitted to the facility. During a follow-up interview on 12/12/24 at 11:13 A.M., the MDS Nurse said Resident #54's comprehensive respiratory care plan was not created until 11/25/24, more than two months after the Resident had been admitted to the facility, and should have been created shortly after the Resident was admitted .