STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225288	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Lexington	178 Lowell Street Lexington, MA 02420

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 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. 48671 Based on observation, interview and record review the facility failed to provide a dignified dining experience for one Resident (46) out of a total sample of 37 residents. Findings include: The facility policy titled Dignity, revision date February 2021, indicated the following: - Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. - Residents are treated with dignity and respect at all times. - Individual needs and preferences of the resident are identified through the assessment process. - When assisting with care, residents are supported in exercising their rights. For example, residents are: Provided with a dignified dining experience. Resident #46 was admitted to the facility in October 2019 and has diagnoses that include Cerebral Palsy (condition that affects movement and posture), Parkinson's disease, muscle weakness, tremors, lack of coordination, feeding difficulties, and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/29/24, indicated that on the Brief Interview for Mental Status exam Resident #46 scored an 11 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated Resident #46 requires setup assistance with eating. Review of the current care plans for Resident #46 indicated but was not limited to: Focus: risk for malnutrition r/t (related to) PMHx (past medical history) notable for tremors, Cerebral Palsy, GERD (gastro esophageal reflux disease) and depression - need for adaptive equipment with meals, dated as initiated 10/10/19. Interventions include: (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Encourage and assist as needed to consume foods and/or supplements and fluids offered at and between meals, dated as initiated 10/10/19. On 12/27/24 at 9:20 A.M., the surveyor observed Resident #46 sitting in his/her wheelchair in the bedroom doorway, the over bed table was in front of the Resident. At 9:22 A.M., a staff member delivered the breakfast tray, removed the lid from the oatmeal, peeled opened the cranberry juice, opened the container of milk, and exited the room. The surveyor observed the Resident unsuccessfully trying to adjust him/herself in the wheelchair while holding onto a weighted utensil and attempting to scoop scrambled eggs into his/her mouth. The Resident was unable to gather food onto the utensil. The Resident pushed the tray table forward and lowered his/her head to the breakfast plate and began placing his/her mouth onto the plate and using his/her tongue and hand to eat the scrambled eggs off the lip plate. The Resident repeated this action, and the scrambled eggs fell on to the Resident's shirt, pants, wheelchair, and floor. The Resident attempted to pick up the cranberry juice and his/her hand was shaking and spilling, and juice spilled onto the plate of scrambled eggs and pastry. The Resident unsuccessfully attempted to pick up a small, open container of milk and was shaking and spilled the milk onto the scrambled eggs and pastry. Milk spilled onto the plate, the breakfast tray, on the Resident's clothing and floor. Resident #46 tried picking up the bowl of oatmeal with two hands and to pour oatmeal into his/her mouth but was shaking and had a hard time keeping the bowl to his/her mouth and was able to get only a little oatmeal out of the bowl. The surveyor asked the Resident if he/she was offered any help from staff during meals and the Resident said No. When asked if he/she would like some help Resident #46 said Yes. Throughout the breakfast meal observation, staff did not check in on Resident #46. On 12/27/24 at 1:22 P.M., the surveyor observed Resident #46 sitting in his/her wheelchair in the doorway, the overbed table was in front of the Resident. At 1:29 P.M., a staff member delivered the lunch tray, removed lids from cups and exited the Resident's room. The surveyor observed Resident #46 attempting to eat the lunch meal and had difficulty bringing the juice cup to his/her mouth. The Resident's hands were shaking, and juice spilled from the container. The surveyor remained in the hall outside the Resident's room and no staff checked in on Resident #46 throughout the lunch meal. The Resident was visible through the bedroom doorway. During an interview on 12/30/24 at 8:27 A.M., Nurse #14 said Resident #46 is set-up only for meals but needs help sometimes with eating because he/she can't always keep the food on the spoon or fork because of his/her tremors. Nurse #14 said staff will go in and offer to help during meals just to make sure he/she can eat what is served. During an interview on 12/30/24 at 8:39 A.M., Unit Manager #1 said Resident #46 likes to do things by him/herself and won't always allow staff to help. Unit Manager #1 said staff should be offering to help and check in on the Resident during meals to see if he/she is able to eat because he/she has bad tremors and can't control movements. During an interview on 12/30/24 at 1:38 P.M., the Director of Nursing (DON) said staff should not be dropping off meal trays and leaving Resident #46 without ensuring he/she is able to access the meal and able to eat. The DON said staff should be checking in on Resident #46 and encouraging him/her to eat during the meal and offering assistance if needed. The DON said if the Resident refuses the staff are still expected to offer and check in with the Resident during meals.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on interview and observation, the facility failed to ensure it provided a homelike environment on the [NAME], [NAME], Minuteman, and [NAME] units. Findings include: 1. On 12/27/24 at approximately 2:15 P.M., on the [NAME] unit, the surveyor observed: - Cracked plastic paper towel holders in rooms #27, #28, and in the hallway men's room. - Sagging and broken ceiling tiles in rooms #26, #32, #33 and #35. - Worn wooden side dresser in room [ROOM NUMBER], worn dresser in room [ROOM NUMBER] - Broken bathroom wall measuring approximately 8 x 8 in room [ROOM NUMBER]. 41019 2. During rounds on the [NAME] unit on 12/30/24 at 11:30 A.M., the surveyor observed:: - room [ROOM NUMBER] had cracks along the wallpaper behind the bed closest to the door and along the wall surrounding a communication board. - room [ROOM NUMBER] had a call light device hanging off of the wall by an electrical cord. - room [ROOM NUMBER] had a closet door falling off the hinges. 48671 3. On 12/27/24 at approximately 8:36 A.M., on the Minuteman unit, the surveyor observed: -One four drawer dresser with patches of missing laminate covering peeled off in room [ROOM NUMBER]. -One side dresser with patches of missing laminate covering in room [ROOM NUMBER]. -Large chipped off wood and scratched white paint located on the door trim of room [ROOM NUMBER]. -Sagging ceiling tile trim located on the [NAME] Unit across from the nurses station near the exit sign. -Two Cracked plastic wall mounted hand sanitizer units located in the hall outside of room [ROOM NUMBER] and room [ROOM NUMBER]. The units were not working and failed to dispense hand sanitizer when the surveyor placed a hand under the sensors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/27/24 at approximately 11:54 A.M., on the [NAME] unit, the surveyor observed: -One plastic wall mounted hand sanitizer unit located in the hall outside of dining room. The unit was not working and failed to dispense hand sanitizer when the surveyor placed a hand under the sensor. During an interview with the Maintenance Director on 12/30/24 at 12:27 P.M., he said there is a maintenance tracking program to detail and track items that need repair or replacement. The Maintenance Director said he conducts weekly rounds on each of the units and staff are responsible for reporting additional concerns. He said he was aware of some of the environmental issues on the [NAME] unit, but staff had not reported others, including the broken paper towel holders and broken bathroom wall. During an interview with the Maintenance Director on 12/30/24 at 9:15 A.M., he said hand sanitizer units that are broken or not working should be reported or replaced when they are identified. During an interview with the Administrator on 12/30/24 at 1:00 P.M., he said any broken equipment or equipment that is not working needs to be reported to maintenance and fixed or replaced.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for two Residents (#4 and #139) out of a total sample of 37 residents. Findings include: 1. Resident #4 was admitted to the facility in July 2019 with diagnoses including dementia, bipolar disorder, and anxiety disorder. Review of the facility document titled Documentation Survey Report v2 (where Certified Nurse's Aides document level of assist provided each shift and where that level of assist required by residents, is used to complete the MDS), dated [DATE] indicated that Resident #4 required the following: - Eating: substantial/maximum assist. - Oral hygiene: maximum assist/dependent. - Upper body dressing: maximum assist/dependent. Review of the MDS dated [DATE] indicated the following; - Eating: supervision/touching assistance. - Oral hygiene: partial/moderate assistance. - Upper body dressing: partial/moderate assistance. Review of the facility document titled Documentation Survey Report v2 dated October 2024 indicated that Resident #4 required the following: - Oral hygiene: Dependent. Review of the MDS dated [DATE] indicated the following; - Oral hygiene: Substantial/maximal assistance. During an interview on 12/30/24 at 10:53 A.M., MDS Nurse #1 said that the MDS should reflect what the daily documentation, completed by the CNAs, indicated for the level of assistance the resident required. 2. Resident #139 was admitted to the facility in September 2024 with diagnoses including cellulitis, diabetes, and malnutrition. Review of the progress notes dated 10/6/24 indicated Resident #139 was discharged home with medications and family. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) dated [DATE] indicated Resident #139 was discharged to an acute care hospital. During an interview on 12/30/24, at 10:15 A.M., MDS Nurse #1 said that the MDS was not coded correctly and should have accurately reflected Resident #139 discharged location.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, interview and observation, the facility failed to ensure care plan implementation for four (Resident #52, #17, 442, and #46) of 37 sampled residents. Specifically: 1. For Resident #52, the facility failed to implement the physician order for compression stockings. 2. For Resident #17, the facility failed to implement the physician order for heel protectors. 3. For Resident #442, the facility failed to develop a care plan for eating assistance. 4. For Resident #46, the facility failed to develop a comprehensive falls care plan. Findings include: 1. Resident #52 was admitted to the facility in November 2022, and has active diagnoses which include chronic congestive heart failure, bilateral leg edema and dementia. Review of Resident #52's Minimum Data Set assessment dated [DATE], indicated he/she was dependent on staff for all lower body dressing and putting on/taking off footwear. The Resident had a Brief Interview for Mental Status Score of 3, indicating severe cognitive impairment. Review of Resident #52's care plan dated 12/29/22, indicated he/she was at-risk for alteration in skin integrity related to impaired mobility and bilateral edema. Interventions included: - TED stockings (compression stockings) as ordered. Review of Resident #52's physician order dated 11/9/23, indicated: - [NAME] stockings on morning and off at HS (nighttime). On 12/26/27 at 2:00 P.M., 12/27/24 at 8:55 A.M., and at 10:05 A.M., the surveyor observed Resident #52 lying in bed, and he/she did not have compression stockings on his/her legs. Review of Resident #52's Medication Administration Record (MAR) dated December 2024, indicated: - Apply TED stockings at 6:00 A.M. and remove in the evening. Staff documented compression stocking were applied and removed daily throughout the month, including 12/26/24 and 12/27/24. During an interview with Certified Nurse Aide (CNA) #2 on 12/27/24 at 8:57 A.M., she said she had worked with Resident #52 for many months and had never known him/her to wear compression stockings. CNA #2 said she had not received instruction from licensed nurses to apply compression stocking. (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 with Nurse #3 on 12/27/24 at 9:05 A.M., he said Resident #52 did not wear compression stockings and he was unaware that the Resident had a physician's order for TED/compression stockings. During an interview with the Director of Nurses (DON) on 12/27/24 at 10:52 A.M., she said physician's orders for compression stockings should be followed. 41105 2. Resident #17 was admitted to the facility in December 2016 and has diagnoses that include diabetes and peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/4/24, indicated that on the Brief Interview for Mental Status exam Resident #17 scored a 12 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated that Resident #17 had no behaviors of rejecting care and was dependent on staff for lower body dressing. Review of the current physician orders indicated the following: - Heel protector boots on at all times, may remove for transfers, start date 8/13/24. Review of the most recent Nurse Practitioner progress note, dated 12/11/24, indicated: - Peripheral vascular disease: status post left calcinatory - healed. - Continue protective boots daily. Review of the December 2024 clinical progress notes failed to indicate Resident #17 refused to wear heel protector boots. Review of the Certified Nursing Assistant (CNA) task documentation failed to indicate Resident #17 displayed any behavior of rejecting care in the past 14 days. Review of the current Diabetes care plan included the following intervention: - Diabetic foot care, start date 12/28/16. Review of the current Activities of Daily Living care plan included the following intervention: -Extensive assist with daily bathing, grooming, dressing. Dependent when tired, dated as revised 3/15/21. During an observation and interview on 12/26/24 at 8:43 A.M., the surveyor observed Resident #17 in bed with both heels resting flat on the mattress. Two blue boots were located across the room on top of the Resident's wheelchair. Resident #17 said the boots were supposed to be put on by the staff but had not been. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/24 at 8:11 A.M., the surveyor observed Resident #17 asleep in bed. A bootie was on Resident #17's right foot and his/her left foot was flat on the mattress, with no heel protector boot on. Another bootie was observed across the room on top of Resident #17's wheelchair. On 12/27/24 at 10:18 A.M., the surveyor observed Resident #17 in bed. Resident #17 wore a bootie on the right foot and his/her left foot was flat on the mattress, with no heel protector boot on. Another bootie was observed across the room on top of Resident #17's wheelchair. A sign posted on the wall behind Resident #17's bed indicated blue multipodus boots must be donned at all time (sic). During an interview and observation on 12/30/24 at 8:23 A.M., Resident #17 was lying in bed, awake. The Resident was not wearing heel protector boots on either foot. Resident #17 said that he/she had not worn a heel protector boot on the left foot while in bed for many months. The Resident said he/she used to wear a boot on the left foot at night, but that the boot was lost, and staff had replaced it with a boot that did not fit. Resident #17 said staff eventually stopped applying the left boot. During an interview with Unit Manager #1 on 12/30/24 at 8:33 A.M., she said she was unaware that Resident #17 had a physician's order for bilateral heel protectors. On 12/30/24 at 8:39 A.M., the surveyor and Unit Manager #1 entered Resident #17's room and observed that Resident #17 was not wearing heel protectors on either foot. Across the room a single heel protector was located on top of a wheelchair. During an interview with CNA #2 on 12/30/24 at approximately 9:00 A.M., she said she was unaware that Resident #17 was supposed to wear heel protectors. CNA #2 said she had not received instruction from licensed nursing staff to apply heel protection to Resident #17's heels. During an interview with the Director of Nurses (DON) on 12/27/24 at 10:52 A.M., she said physician's orders should be followed. 45763 3. Resident #442 was admitted to the facility in November 2024 with diagnoses of cerebral palsy and malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #442 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating the Resident was cognitively intact. Review of Resident #442's care plans failed to indicate a care plan outlining the level of assistance the Resident needed for eating. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #442's Occupational Therapy (OT) initial assessment, dated 12/19/24, indicated that Resident #442 presented with impairments in balance, fine motor coordination, gross motor coordination and strength resulting in limitations and/or participation restrictions in the areas of mobility and self-care; the OT initial assessment indicated that Resident #442 required moderate assistance with eating at baseline. Further review of the OT initial assessment indicated that Resident #442 had a bilateral upper extremity tremor, and that the Resident was not able to hold a cup of water in order to sip from a straw, and that the therapist had to hold the cup as the Resident drank from the straw. Review of Resident #442's OT treatment encounter notes, dated 12/19/24, 12/20/24, 12/21,24, 12/22/24, 12/23/24, 12/26/24, 12/27/24, and 12/29/24 indicated the Resident required partial/moderate assistance with eating. On 12/26/24 at 8:20 A.M., the surveyor observed Resident #442 eating breakfast in bed and there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself; the Resident was dropping a significant portion of his/her food on his/her chest where he/she could not retrieve it. On 12/26/24 at 12:14 P.M., the surveyor observed Resident #442 eating lunch in bed and there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself. The Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. On 12/27/24 at 8:18 A.M., the surveyor observed Resident #442 eating breakfast in bed, and there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself. The Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. On 12/27/24 at 12:19 P.M., the surveyor observed Resident #442 eating lunch in bed, and there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself; the Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. On 12/30/24 at 8:10 A.M., the surveyor observed Resident #442 eating breakfast in bed, and there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself; the Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. During an interview on 12/30/24 at 9:49 A.M., Resident #442 said he/she needs assistance with eating as the tremors have gotten worse over the years and that he/she can't keep his/her food on the spoon. (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 12/30/24 at 9:37 A.M., Nurse #13 said he would expect a care plan to be developed outlining the level of assistance Resident #442 needed for eating. Nurse #13 said Resident #442 required only set-up assistance with eating. During an interview on 12/30/24 at 10:55 A.M., the Occupation Therapist (OT) said that the OTs will assess the level of assistance residents need with ADLs, and that Resident #442 required at a minimum standby assistance to moderate/partial assistance with eating. The OT said that she would expect a staff member to be always in the room during a meal period to provide feeding assistance to the Resident. The OT said that she would expect the level of assistance to be included in a care plan. The OT said the level of assistance was outlined in the goals section of the OT therapy notes but she wasn't sure if nurses or Certified Nursing Aides had access to those records as they were in a different system. The OT said that the therapy department would give verbal reports to nurses regarding the level of assistance a resident needed based on their evaluation. During an interview on 12/30/24 at 11:51 A.M., the Director of Nursing (DON) said that if OT determined that a resident needed assistance with eating that this would be included in a care plan and that she would expect the resident to receive the level of assistance determined by the OT. The DON said she did not believe nursing staff had access to therapy documentation as it was stored in a separate system. 48671 4. Resident #46 was admitted to the facility in October 2019 and has diagnoses that include Cerebral Palsy (condition that affect movement and posture) and history of falling. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that on the Brief Interview for Mental Status exam Resident #46 scored an 11 out of a possible 15, signifying moderately impaired cognition. The MDS further indicated that Resident #46 did not have a behavior of rejecting care. Review of the current care plans for Resident #46 indicated: Focus: ADL (activities of daily living) Self-care deficit related to limited ROM (range of motion) related to Cerebral palsy, dated as initiated 10/9/19. Interventions include: - Continual Supervision in Wheelchair, dated as initiated 7/18/22. - Assist w/ (with) wheelchair transportation, dated as initiated 10/9/19. Focus: At risk for falls due to impaired balance/poor coordination, unsteady gait and potential adverse side effects of meds, limited ROM (range of motion) to BUE (bilateral upper extremities) due to tremors, non-compliant w/ attempting independent ambulation. Unable to use w/c (wheelchair) cushion due to the way Resident positions him/herself in w/c, non-compliant w/ sitting up in chair, dated as initiated 10/17/19. Interventions include: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Reinforce wheelchair safety as needed such as locking brakes, dated as initiated 4/23/20. - Provide assistance to transfer and ambulate as needed, dated as initiated: 4/23/20. Review of the current Kardex (form indicating level of care needs), indicated the following: - Mobility: Assist w/ (with) wheelchair transportation. - Reposition w/ assist (assistance) of 1 or 2 staff as needed, bed and chair. - Transfer w/ assist of 1 or 2 staff as needed. On 12/26/24 at 8:25 A.M., the surveyor observed Resident #46 wheeling him/herself in the hallway almost completely sliding out of the wheelchair. There were no staff present in the hall or at the nurse's station throughout the observation. On 12/26/24 at 8:27 A.M., the surveyor observed Resident #46 using his/her feet to wheel him/herself from the hallway into his/her room. Anti-tippers were observed on the wheelchair. The Resident entered the room, went to the bed, and attempted to [NAME] his/her body forward out of chair, and pulling on the call cord as leverage. The Resident then gave up and sat down in the wheelchair. There were no staff present in the hall or at the nurse's station throughout the observation. On 12/26/24 at 8:29 A.M., the surveyor observed Resident #46 twitching and had spastic movements as he/she slid down in the wheelchair until he/she was almost laying down. There were no staff present in the hall or at the nurse's station throughout the observation. On 12/26/24 at 8:35 A.M., the surveyor observed Resident #46 in the hallway almost completely sliding out of the wheelchair. There were no staff present in the hall or at the nurse's station throughout the observation. On 12/27/24 at 8:27 A.M., the surveyor observed Resident #46 sitting in a wheelchair and propelling around the nursing unit. There were no staff present during the observation. The Resident entered another resident's room and sat in the doorway for a few minutes before exiting the room. The surveyor observed Resident #46 wheeling him/herself out into the hall and was completely sliding out of the wheelchair using his/her feet to propel the wheelchair forward. The Resident wheeled down the hall into his/her own room. There were no staff present in the hall or at the nurse's station throughout the observation. On 12/27/24 at 8:37 A.M., the surveyor observed Resident #46 in the hallway almost completely sliding out of the wheelchair. The Resident was twitching and had spastic movements as he/she slid down in the wheelchair until almost laying down. The Resident continued to propel forward using his/her feet to move the wheelchair forward. There were no staff present in the hall or at the nurse's station throughout the observation. (continued on next page)

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Care One at Lexington	178 Lowell Street Lexington, MA 02420

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/24 at 9:05 A.M., the surveyor observed Resident #46 in the hallway almost completely sliding out of the wheelchair. The Resident was twitching and had spastic movements as he/she slid down in the chair until almost laying down. The Resident wheeled him/herself into the doorway of his/her room and began to stand up by placing both hands on the overbed tray table and pulled and shoved the table into the doorway. The wheelchair was rolling as Resident #46 twisted his/her body and abruptly sat in the wheelchair. There were no staff present in the hall or at the nurse's station throughout the observation. On 12/27/24 at 1:29 P.M., the surveyor observed Resident #46 in the hallway almost completely sliding out of the wheelchair. The Resident was twitching and had spastic movements as his/her body slid down in the chair until almost laying down. The Resident wheeled him/herself into the doorway of his/her room and began to stand up placing both hands on the overbed tray table and began to pull and shove the table into the doorway. Resident #46 grabbed the edge of his/her wheelchair and pulled the chair closer to the overbed table and began to push the table with his/her feet into the doorway. There were no staff present in the hall or at the nurse's station throughout the observation. On 12/30/24 at 7:07 A.M., they surveyor observed Resident #46 wheeling him/herself in the hallway almost completely sliding out of the wheelchair. The Resident was twitching and had spastic movements as he/she slid down into the chair until almost laying down. There were no staff present in the hall or at the nurse's station throughout the observation. During an interview on 12/30/24 at 8:18 A.M., Certified Nursing Assistant (CNA) #4 said Resident #46 does not require supervision when in his wheelchair because he/she likes their privacy. During an interview on 12/30/24 at 8:23 A.M., Nurse #14 said Resident #46 requires continuous supervision when in the wheelchair because he/she slides down and is a fall risk. Nurse #14 said staff must observe the Resident because he/she will move around the unit. Nurse #14 said Resident #46 needs constant reminders to not back into anyone and to sit up because he/she slides down but will not use a cushion on the wheelchair. During an interview on 12/30/24 at 8:35 A.M., Unit Manager #1 said Resident #46 needs supervision due to safety and said the Resident will wander all over the unit in his/her wheelchair. Unit Manager #1 said Resident #46 requires supervision and should not be left alone or unsupervised while sitting in the wheelchair and said staff use the care plan and Kardex (form indicating level of care needed) to know what type of care and supervision is needed. Unit Manager #1 said staff are expected to follow care plan interventions. During an interview on 12/30/24 at 1:38 P.M., the Director of Nursing (DON) said staff should not be leaving Resident #46 unsupervised while in the wheelchair and said it is her expectation that staff provide continual supervision and follow the care plan interventions especially if the Resident is known to slide down in his/her wheelchair. The DON Resident #46 can wheel themselves around the unit but needs staff supervision.

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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. 44095 Based on observation, record review and interview, the facility failed to meet professional standards of practice for one Resident (#392) out of a total of 37 sampled residents. Specifically, for Resident #392 the facility failed to ensure nursing clarified a physician's order for ascorbic acid extended release (ER) oral capsule. In addition, from 12/15/24 through 12/26/24, nursing staff documented they administered the medication 25 times. Findings include: Review of the facility policy titled Administering Medications, dated as revised 5/16/24, indicated that medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Resident #392 was admitted to the facility in December 2024 with diagnoses including diabetes, chronic pain, and colitis. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/21/24, indicated that Resident #392 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 14 out of 15. On 12/27/24 at 10:18 A.M., the surveyor observed Nurse #6 prepare to administer medications to Resident #392. Nurse #6 reviewed Resident #392's orders and said she has never seen Ascorbic Acid ER Oral Capsule 500 milligrams as a form of the medication. Nurse #6 said the pharmacy had not delivered the medication and she would have to review the order. Review of Resident #392's physician's order, dated 12/14/24, indicated: - Ascorbic Acid ER Oral Capsule 500 milligrams, give one capsule by mouth two times a day for wound healing. Review of Resident #392's Medication Administration Record, dated December 2024, indicated nursing administered Ascorbic Acid ER Oral Capsule as ordered between 12/15/24 and 12/26/24 for 25 administrations. (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 12/30/24 at 10:05 A.M., Unit Manager #2 said that nursing should have clarified the ascorbic acid ER order to the form on hand and with the physician. Unit Manager #2 said that the facility does not stock ascorbic acid ER. During an interview on 12/30/24 at 12:18 P.M., the Director of Nursing said nursing should have clarified the order for ascorbic acid ER to the form on hand and with the physician.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45763 Based on observation, interview and record review the facility failed to provide assistance with activities of daily living (ADL's) for one Resident (#442) out of a total sample of 37 residents. Specifically, for Resident #442 the facility failed to ensure the Resident received necessary services to maintain good nutrition. Findings Include: Review of the facility policy, titled Activities of Daily Living (ADL), Supporting, revised March 2018, indicated, but was not limited to, the following: - Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: - Dining (meals and snacks). - The resident's response to interventions will be monitored, evaluated and revised as appropriate. Resident #442 was admitted to the facility in November 2024 with diagnoses of cerebral palsy and malnutrition. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #442 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam indicating the Resident was cognitively intact. Review of Resident #442's care plans failed to indicate a care plan outlining the level of assistance the Resident needed for eating. Review of Resident #442's Occupational Therapy (OT) initial assessment, dated 12/19/24, indicated the Resident presented with impairments in balance, fine motor coordination, gross motor coordination and strength resulting in limitations and/or participation restrictions in the areas of mobility and self-care. The OT initial assessment indicated that Resident #442 required moderate assistance with eating at baseline. Further review of the OT initial assessment indicated that Resident #442 had a bilateral upper extremity tremor and was unable to hold a cup of water in order to sip from a straw. The OT assessment indicated the therapist had to hold the cup as the Resident drank from the straw. Review of Resident #442's OT treatment encounter notes, dated 12/19/24, 12/20/24, 12/21,24, 12/22/24, 12/23/24, 12/26/24, 12/27/24, and 12/29/24 indicated the Resident required partial/moderate assistance with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/26/24 at 8:20 A.M., the surveyor observed Resident #442 eating breakfast in bed and there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself. The Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. On 12/26/24 at 12:14 P.M., the surveyor observed Resident #442 eating lunch in bed and there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself. The Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. On 12/27/24 at 8:18 A.M., the surveyor observed Resident #442 eating breakfast in bed, there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself. The Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. On 12/27/24 at 12:19 P.M., the surveyor observed Resident #442 eating lunch in bed, there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself. The Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. On 12/30/24 at 8:10 A.M., the surveyor observed Resident #442 eating lunch in bed, there were no staff members in the room or within eyesight of the Resident. The surveyor observed that Resident #442's hands were trembling, and that the Resident was having difficulty feeding him/herself. The Resident dropped a significant portion of his/her food on his/her chest where he/she could not retrieve it. During an interview on 12/30/24 at 9:49 A.M., Resident #442 said he/she needs assistance with eating as the tremors have gotten worse over the years and that he/she can't keep his/her food on the spoon. During an interview on 12/30/24 at 9:37 A.M., Nurse #13 said the staff know the level of assistance a resident needs based on the verbal nurse report, and that if there was any uncertainty regarding the level of assistance a resident needed with a specific ADL task that nursing would clarify with the rehabilitation department. Nurse #13 said he would expect a care plan to be developed outlining the level of assistance a resident needed for eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/24 at 10:55 A.M., the Occupation Therapist (OT) said that the OTs will assess the level of assistance residents need with ADLs and that Resident #442 requires at a minimum standby assistance to moderate/partial assistance with eating. The OT said that she would expect a staff member to be always in the room during a meal period to provide feeding assistance to the Resident. The OT said that she would expect the level of assistance to be included in a care plan. The OT said the level of assistance was outlined in the goals section of the OT therapy notes but she wasn't sure if nurses or Certified Nursing Aides had access to those records as they were in a different software system. The OT said that the therapy department would give verbal report to nurses regarding the level of assistance a resident needed based on their evaluation. During an interview on 12/30/24 at 11:51 A.M., the Director of Nursing (DON) said that if OT determined that a resident needed assistance with eating that this would be included in a care plan and that she would expect the resident to receive the level of assistance determined by the OT. The DON said she did not believe nursing staff had access to therapy documentation as it was stored in a separate software system.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44095 Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one Resident (#29) out of a total sample of 37 residents. Specially, the facility failed to obtain wound care orders for five days after Resident #29's wound vac (negative pressure wound vacuum, which is a medical device that uses suction to help a wound heal by gently pulling fluid out of it and keeping the edges of the wound together) was placed on hold because the wound was worsening. Finding include: Review of the facility policy titled Medication and Treatment Order, dated as revised July 2016, indicated that orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 3. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis. Resident #29 was admitted to the facility in November 2024 with diagnoses including osteomyelitis of the right ankle and foot, diabetes, and peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/28/24, indicated that Resident #29 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. This MDS indicated Resident #29 had one stage 3 pressure ulcer, and a surgical wound. This MDS indicated Resident #39 received pressure ulcer/ injury care, surgical wound care, application of nonsurgical dressings, and application of dressing to feet. On 12/26/24 at 8:58 A.M., the surveyor observed Resident #29's right foot. The right foot was wrapped in undated gauze. Resident #29 said that nursing is applying Santyl (topical prescription ointment that is used for wound care, helping to break up and remove dead skin and tissue) daily until the wound vac goes back on Saturday 12/28/24. On 12/27/24 at 11:04 A.M., the surveyor observed Resident #29's right foot. The right root was wrapped in gauze and dated 12/26/24. Review of Resident #29's plan of care related to skin break down right heel ulcer, dated 11/21/24, indicated: - Administer treatment per physician's order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wound vac treatment as ordered. Review of Resident #29's physician's order, dated 11/21/24, indicated: - Wound Vac. right heel, every shift for right heel ulcer. Monitor Settings every shift - Keep at 125 mmHg. Review of Resident #29's podiatry note, dated 12/24/24, indicated: - Resident presents to clinic for urgent evaluation given worsening appearance of the wound. Saw infectious disease earlier today. Resident is at rehabilitation and reports wound VAC was stopped on Monday given maceration. Requested urgent evaluation by podiatry given worsening appearance of wound with malodor. Has been applying Santyl daily since the wound VAC was stopped. - Clinical findings discussed with the resident. Gentle excisional debridement to the level of the subcutaneous tissues using a curette. Wound was cleansed with betadine dressing applied. Padding applied to the hallux lesion. Will continue with daily Santyl at home to reduce fibrotic slough, can reapply wound VAC likely Saturday. Review of Resident #29's nursing progress note, dated 12/24/24, indicated: - Wound vac to be restarted on Saturday 12/28/24. Review of Resident #29's nursing progress note, dated 12/25/24, indicated: - Right heel dressing changed per order. Review of Resident #29's Orders - Administration Note, dated 12/28/24 at 2:33 P.M., indicated: - Patient reports he/she hasn't had a wound vac in over a week. No wound vac in place. Review of Resident #29's Physician's orders and Treatment Administration Record (TAR), dated December 2024, failed to included orders for Santyl between 12/24/24 through 12/28/24. During an interview on 12/30/24 at 8:54 A.M., Resident #29 said that his/her wound vac was changed yesterday, 12/29/24. Resident #29 said nursing did not complete dressing changes on 12/27/24 or 12/28/24. Resident #29 said nobody knew what they were supposed to do with the wound. Resident #29 said there were a bunch of nurses who said there was no order, and nobody would do anything about it. During an interview on 12/30/24 at 9:57 A.M., Unit Manager #2 said Resident #29 knows his/her medications, orders, and plan of care. Unit Manager #2 reviewed Resident #29's medical record, physician's orders, and podiatry note. Unit Manager #2 said there were no orders for the use of Santyl while the wound vac was on hold and said there were no dressing orders at all while the wound vac was placed on hold but there should have been. Unit Manager #2 said that use of Santyl requires a physician's order. During an interview on 12/30/24 at 12:29 P.M., the Director of Nursing said nursing should have obtained orders for treatments for Resident #29's wound while the wound vac was on off and on hold. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/24 and again on 1/2/25 the surveyor called and requested interviews from Nurse #7, Nurse #8, Nurse #9, and Nurse #10 all of whom were assigned to care for Resident #29 between 12/24/24 and 12/29/24. Nurse #7, Nurse #8, Nurse #9, and Nurse #10 did not return the surveyor's call.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation, interview, and record review the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for two Residents (#441 and #119) out of a total of 37 sampled Residents. Specifically: 1. For Resident #441, the facility failed to place an order for treatment or monitoring for a known pressure injury on admission. 2. For Resident #119, the facility failed to ensure nursing consistently implemented physician's orders for air mattress settings. Findings include: Review of the facility policy titled Pressure Ulcer/Skin Breakdown - Clinical Protocol, revised March 2014, indicated, but was not limited to, the following: - The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressing (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration. - The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatments, etc. - During resident visits, the physician will evaluate and document the progress of wound healing - especially for those with complicated, extensive, or non-healing wounds. 1. Resident #441 was admitted to the facility in December 2024 with a diagnosis of Alzheimer's disease. There was no Minimum Data Set (MDS) assessment available for Resident #441 at the time of survey. Review of Resident #441's hospital discharge paperwork, dated 12/22/24, indicated that the Resident had a DTPI (deep tissue pressure injury) on his/her coccyx. Review of Resident #441's Norton Plus Skin Risk Assessment, dated 12/23/24, indicated the Resident was at high risk for developing pressure injuries. Review of Resident #441's clinical admission progress note, dated 12/23/24, indicated the Resident had a pressure injury on his/her coccyx and that the wound was present on admission. Review of Resident #441's active physician orders failed to indicate an order to monitor or treat Resident #441's coccyx wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/26/24 at 10:27 A.M., Nurse #11 said that Resident #441 did not have any orders to monitor or treat wounds, preventive or otherwise, because the Resident's skin was intact. During an interview on 12/26/24 at 2:03 P.M., Certified Nursing Aide (CNA) #2 said that she had been unable to visualize Resident #441's coccyx as the Resident currently had a dressing covering his/her coccyx. During an interview and observation on 12/26/24 at 2:28 P.M., two surveyors accompanied Nurse #11 to observe Resident #441's coccyx. A surveyor and Nurse #11 observed that Resident #441 had an undated dressing covering his/her coccyx; Nurse #11 said that he did not know that the Resident had a dressing in place. A surveyor and Nurse #11 observed that Resident #441 had a wound on his/her coccyx. Nurse #11 said that the wound was a pressure injury and measured three centimeters (cm.) by two cm. Nurse #11 said that he had been taking care of the Resident yesterday and today but was not aware that the Resident had a pressure injury. During an interview on 12/26/24 at 2:39 P.M., Unit Manager #4 said that Resident #441 was admitted to the facility with a wound on his/her coccyx. Unit Manager #4 said that the Resident did not have a wound treatment order from the hospital. Unit Manager #4 said that the facility process for residents admitted with a wound was that nursing would initiate an order for treatment and monitoring of the wound. Unit Manager #4 said a treatment order for Resident #441's wound should have been initiated on admission but wasn't. During an interview on 12/30/24 at 9:15 A.M., the physician said she would expect the Unit Manager to look at the wound of a newly admitted resident to ensure that a treatment was available. The physician said that she would expect an order to be placed for the treatment and monitoring of any pressure injury, including a DTPI. During a follow-up interview on 12/30/24 at 10:06 A.M., the physician said she agreed with nursing's previous assessments of the wound, that the wound had not changed since admission based on the nurse description of the wound and that she would recommend a treatment of Santyl (an ointment used to remove damaged tissue from skin ulcers) and dry protective dressing. The physician said she would have expected an air mattress to have been in place since admission. On 12/26/24 at 8:19 A.M., the Surveyor observed Resident #441 in bed, and the Resident was not on an air mattress. Further review of Resident #441's orders indicated that an order for an air mattress was initiated three days after the Resident's admission and after the surveyor had brought the concern to the attention of the facility. During an interview on 12/30/24 at 11:51 A.M. the Director of Nursing (DON) said nurses should not apply treatments without an order and that dressings should be dated. The DON said that Resident #441 should have had an order for treatment and monitoring of his/her DTPI on admission. 44095 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility policy, Support Surface Guidelines, dated as revised September 2013, indicated the purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. - Preparation 1. Review the resident's care plan to assess for any special needs of the resident. - General Guidelines 3. Support surfaces are modifiable. Individual resident needs differ. - Interventions/Care Strategies 6. Monitor for other pressure ulcer risk factors and provide interventions as indicated. Resident #119 was admitted to the facility in February 2024 with diagnoses including dysphagia and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/6/24, indicated that Resident #119 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. This MDS indicated Resident #119 had one unstageable - deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.) Review of Resident #119's plan of care related to alteration in skin integrity, dated 4/22/24, indicated: - Air Mattress - Setting at 150 lbs. Review of Resident #119's physician's order, dated 4/22/24, indicated: - Air mattress to bed check placement and function, Keep Settings at 150 pounds every shift. Review of Resident #119's Norton Plus Skin Risk assessment dated [DATE], indicated he/she was at high risk for pressure ulcers as evidenced by a score of 8. Review of Resident #119's weights in the electronic health record, dated 12/12/24, indicated Resident #119's most recent weight was 164.4 pounds. On 12/26/24 at 8:31 A.M., 12/26/24 at 11:25 A.M., 12/26/24 at 4:07 P.M., and 12/26/24 at 5:09 P.M., the surveyor observed Resident #119 in his/her bed with the air mattress set to 200 pounds. On 12/27/24 at 6:39 A.M., 12/27/24 at 8:01 A.M., 12/27/24 at 12:28 P.M., and 12/27/24 at 3:05 P.M., the surveyor observed Resident #119 in his/her bed with the air mattress set to 200 pounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/24 at 6:36 A.M. and 12/30/24 at 10:58 A.M., the surveyor observed Resident #119 in his/her bed with the air mattress set to 200 pounds. Review of Resident #119's physician's order, dated 10/30/24, indicated: - Consults: Wound Consult evaluation and treat as needed. Review of Resident #119's skin note, dated 12/19/24, indicated: - Resident seen by wound doctor for right buttock pressure. length 0 cm, width 0 cm, depth 0 cm. Status: resolved. Treatment: cleanse w/normal saline apply Triad, leave open to air, every shift and as needed. Review of Resident #119's wound care specialists electronic health record follow up short, dated 12/19/24, indicated: First evaluated on 10/31/24 Context: Moisture Associated Skin Damage (MASD) Associated signs and symptoms: Pain. 10/31/24 - Patient is an [AGE] year old for whom a consult was placed for wounds of the Bilateral Buttocks (BL). BL Buttocks consistent with MASD with denuded skin R greater than (>) L. Will start treatment plan today. 11/14/24 - MASD stable overall now L>R. Will update treatment plan today. 11/27/24 - R buttock now consistent with Deep Tissue Pressure Injury (DTPI). Will update treatment plan today. 12/5/24 - R Buttock DTPI is significantly smaller. Will continue tx. 12/12/24 - R buttock DTPI is slightly smaller. Continue tx. 12/19/24 - DTPI has epithelialized. Will transfer care to Nursing staff. Wound: 3 Location: Right, Buttock Primary Etiology: Pressure Stage/Severity: Deep tissue pressure injury (DTPI) Wound Status: Resolved Odor Post Cleansing: None (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Size: 0 cm x 0 cm x 0 cm. Calculated area is 0 sq cm. Wound Edges: Attached Periwound: Erythema (red), Moist Wound Base: 100% epithelial Exudate: None amount of None Wound Pain at Rest: 0 Wound # 3 Right, Buttock Pressure Treatment Recommendations: 1. Cleanse with wound cleanser. 2. Apply Triad to BL Buttocks. 3. Secure with Leave open to air. 4. Change Every shift, PRN. Review of Resident #119's the N Adv - Skin Check, dated 12/21/24, indicated: - Skin Issues Note: Right buttock pressure. Review of Resident #119's physician's order, dated 12/21/24, indicated: - Cleanse right buttock deep pressure injury with normal saline, apply Triad, leave open to air, every shift for wound and as needed. During an interview on 12/30/24 at 10:55 A.M., Certified Nurse Assistant (CNA) #1 said that Resident #119 has open areas on his/her buttocks. CNA #1 said that she doesn't adjust air mattress settings. During an interview on 12/30/24 at 10:23 A.M., Nurse #2 said that air mattresses are set according to the physician's order. On 12/30/24 at 11:00 A.M., the surveyor observed Resident #119's buttocks with CNA #1, Nurse #2, and the Assistant Director of Nursing (ADON). The ADON said Resident #119's buttocks were red, macerated, excoriated and open. There were 2 shallow open areas of epithelized tissue on the right side of the coccyx, one on the coccyx and one on the left side of the coccyx. The surrounding tissue was red and discolored. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/24 at 12:24 P.M., the Director of Nursing said Resident #119's air mattress is ordered for his/her deep tissue injury and said that nursing should set the air mattress according to the physician's order.

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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. 44095 Based on observation, interview, and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#43), out of a total sample of 37 residents. Specifically, for Resident #43, the facility failed to ensure that they maintained Resident #43's tracheostomy (a surgically created opening in the neck to provide an airway for breathing) and associated respiratory equipment in a clean and sanitary manner to prevent potential contamination and the spread of infection. Findings include: Resident #43 was admitted to the facility in November 2024 with diagnoses including malignant neoplasm of the mouth, dysphagia, and chronic obstructive pulmonary disease (COPD). Review of the most recent Minimum Data Set (MDS) assessment, dated 12/2/24, indicated that Resident #43 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #43 required tracheostomy care. On 12/26/24 at 9:46 A.M., the surveyor observed Resident #43's tracheostomy mask and respiratory equipment, dated 12/17/24. The mask was visibly soiled with dried secretions and lying directly on a cart with books, scissors, headphones, the bedside controller, and miscellaneous papers with writing on them. Review of Resident #43's physician's order, dated 11/25/24, indicated: - Albuterol Sulfate Inhalation Nebulization Solution (2.5 (mg) milligrams/3 mL (milliliters)) 0.083% (Albuterol Sulfate), 3 ml via trach four times a day for COPD. Review of Resident #43's physician's order, dated 11/25/24, indicated: - Budesonide Inhalation Suspension 0.5 mg/2 mL (Budesonide (Inhalation)), 2 ml via trach two times a day for COPD. Review of Resident #43's physician's order, dated 11/25/24, indicated: - Ipratropium Bromide Inhalation Solution 0.02 % (Ipratropium Bromide), 2.5 ml inhale orally four times a day for SOB. Review of Resident #43's plan of care related to respiratory impairment, dated 11/26/24, indicated: - Tracheostomy care per protocol. On 12/26/24 at 3:50 P.M., the surveyor observed Resident #43's trach mask and respiratory equipment now dated as 12/23/24. Resident #43 said that the Respiratory Therapist (RT) changed his/her tubing an hour before. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/27/24 at 11:24 A.M., Nurse #1 said that respiratory equipment is managed by the RT in the facility. During an interview on 12/30/24 at 10:10 A.M., Unit Manager #2 said that respiratory equipment is managed by the RT in the facility. During an interview on 12/30/24 at 9:20 A.M., the RT said he is responsible for changing nebulizer tubing and tracheostomy masks. The RT said that he does not have physician's orders for respiratory equipment changes, but trach masks and tubing are changed at minimum weekly typically on tubing Tuesday, if not sooner. On 12/30/24 at 12:32 P.M., the Director of Nursing was made aware of the surveyor's observations on 12/26/24 of the tracheostomy mask tubing and respiratory tubing dated 12/17/24 and a subsequent observation on 12/26/24 the equipment was dated 12/23/24. The DON said that tracheostomy masks and respiratory tubing should be changed weekly, if not sooner and should be dated with the date that they are changed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on observation, record review, and interview, the facility failed to ensure nursing was competent and had the required skill set to provide necessary care for residents' needs. Specifically: 1. For Resident #391, the facility failed to ensure that nursing was (a) competent to use an insulin pen-injector and (b) competent to administer enoxaparin according to manufacturer's guidelines. 2. For Resident #131, the facility failed to ensure that nursing was competent to accurately measure the external catheter length of a CVC (central venous catheter) and PICC (peripherally inserted central line). 3. The facility failed to ensure agency licensed nursing staff were trained and demonstrated competency related to medication administration techniques. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 1. Resident #391 was admitted to the facility in December 2024 with diagnoses including diabetes, displaced bicondylar fracture of the right tibia, and post-traumatic stress disorder. (a) Review of the insulin glargine subcutaneous solution pen-injector manufacture's guidelines, dated August 2022, indicated the following: Perform a safety test: - Dial a test dose of 2 Units (prime the pen, clear the air). - Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. - Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. - If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Priming an insulin pen means preparing it for insulin injection. 1. Turn the dosage knob to the 2 units indicator. 2. Push the knob all the way to get at least one drop of insulin. 3. Repeat until a drop appears. 4. This ensures the needle is functioning correctly and removes air from the needle and cartridge On 12/27/24 at 8:33 A.M., the surveyor observed Nurse #5 obtain an insulin pen and apply a needle to the insulin pen. Nurse #5 did not clean the pen with alcohol, which placed the Resident at risk for potential infection. On 12/27/24 at 9:11 A.M., the surveyor observed Nurse #5 prepare and administer Resident #391's insulin glargine with a prefilled syringe. Nurse #5 failed to prime the insulin pen resulting in Resident #391 not receiving the correct insulin dose. During an interview on 12/27/24 at 9:25 A.M., Nurse #5 said he was not aware of the need to clean the insulin pen with alcohol prior to use, and he was not aware of the need to prime an insulin pen prior to use. During an interview on 12/27/24 at 2:22 P.M., the Director of Nursing said Nurse #5 should have primed the insulin pen to ensure Resident #391 received the correct dose of insulin glargine. (b) Review of the enoxaparin manufacture's guidelines, dated 2022, indicated the following: 2. When you have chosen the site for your injection, clean the area with an alcohol wipe. Do not rub. Remove the cap from the enoxaparin syringe by pulling it straight off. 4. Take the needle out of the skin at a right angle. Let go of the skin fold and press down lightly on the area with your alcohol wipe. Do not rub the injection site. 5. As you remove the needle from your skin, the entire needle is automatically covered by a protective sleeve. On 12/27/24 at 8:40 A.M., the surveyor observed Nurse #5 preparing medications to administer to Resident #391. Nurse #5 said he was supposed to give Resident #391 an enoxaparin injection. Nurse #5 said he had never given enoxaparin before and began to look all over the medication cart. On 12/27/24 at 8:44 A.M., Nurse #5 said he was unable to locate the enoxaparin injection and he was going to ask Nurse #11 where to find the injection. On 12/27/24 at 8:45 A.M., Nurse #5 returned to the medication cart and found the enoxaparin located at the bottom of the cart. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/24 at 9:12 A.M., the surveyor observed Nurse #5 open the enoxaparin package. He tried to remove the cap from the syringe but was unable. Nurse #5 attempted to push the cap down and was unable. Nurse #5 pushed the cap to the side, and he attempted to pull the cap off and was still unable to remove the cap. Nurse #5 asked the surveyor if the surveyor can tell him how to remove the cap. Nurse #5 then left the Resident's room and found Nurse #12 and Nurse #5 asked her how to remove the cap. Nurse #12 then showed Nurse #5 how to remove the cap from the syringe. On 12/27/24 at 9:13 A.M , the surveyor and Nurse #5 returned to Resident #391's room, and he administered the enoxaparin directly into Resident #391's abdomen without first cleaning the site. Nurse #5 rubbed the site and a bruise immediately formed. Nurse #5 then said, the needle is still out. Nurse #5 then walked the syringe, without the protective sleeve down, covering the needle, down the hall past staff and residents, placing them at risk for injury. During an interview on 12/27/24 at 2:25 P.M., the Director of Nursing said Nurse #5 should have been competent to administer an enoxaparin injection but was not. 45763 2. Review of the facility policy, titled Central Venous Catheter Care and Dressing Changes, revised March 2022, indicated the following: - Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with length documented at insertion. Resident #131 was admitted to the facility in November 2024 with a diagnosis of cancer. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #131 scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating the Resident had moderate cognitive impairment. Review of Resident #131's active physician orders indicated the following: - PICC/midline baseline total catheter length external length *document changes in external length in nurses notes. Baseline arm circumference cm? no routine interval; check PRN (as needed) only every eight hours as needed for assessment (sic.) - initiated 12/13/24. Review of Resident #131's nursing progress note, dated 12/13/24, indicated the Resident returned from the hospital with a CVC (central venous catheter) PICC (peripherally inserted central catheter) line for intravenous (IV) antibiotic therapy. Review of Resident #131's nursing progress note, written by Nurse #11, dated 12/13/24, indicated the Resident's catheter length measured 10 cm (centimeters). Review of Resident #131's medication administration record indicated that Nurse #11 documented 10 cm on 12/14/24 and 12/28/24 for the following order: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dressing: PICC/ Midline/ Tunneled & non tunneled: 24 hours after insertion, then weekly and PRN (As needed). Change needleless connector with weekly dressing change and after blood draw. If securement device is used, change at time of dressing change. One time a day every 7 day(s) for assessment measure external catheter length in cm. During an interview and observation on 12/27/24 at 2:56 P.M., Nurse #11 said he had measured Resident #131's CVC external catheter length when the Resident was readmitted from the hospital. Nurse #11 demonstrated on the Resident in front of the surveyor how he measured the external catheter length; the nurse pointed to and said that he had measured the length from where the catheter exited the skin (insertion site) until the purple clamp, which was roughly 10 cm away from the insertion site. Nurse #11 said that based on how he measures the external length of the catheter that the catheter length looked the same today as it did on admission. Review of Resident #131's nursing progress note, written by Nurse #12, dated 12/27/24 at 9:42 A.M., indicated that the IV dressing was changed and that the external catheter length measured 0 cm. During an interview and observation on 12/27/24 at 3:06 P.M., Nurse #12 demonstrated on the Resident in front of the surveyor how she measured the external catheter length; the nurse pointed to and said that she had measured the length from where the catheter exited the skin (insertion site) until the anchor hub, which was roughly 0 cm. away from the insertion site. Nurse #12 said that when measuring the external catheter, it must be measured from the insertion site to the anchor hub. During an interview on 12/30/24 at 11:51 A.M. the Director of Nursing (DON) said that Nurse #11's method for measuring Resident #131's external catheter length was not correct, and that Nurse #11 required more education. 50338 3. Review of the Facility Assessment Tool, dated 8/26/24, indicated but was not limited to the following: Part 2 Services and Care We Offer Based on our Residents' Needs: - Medications - awareness of limitations; Administration of medications via routes including oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines) intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc. - Infection prevention and control - Identification and containment of infections, prevention of infections. Part 3 Facility Resources Needed to Provide Competent Support for our Resident Population Every day and during Emergencies. - Staff training/education and competencies: An annual education plan is developed for all staff based on job title. SEE ATTACHMENT 2- Education Plan: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2024 Annual Education Plan: This education plan is a tool to aid in the delivery of required training topics and competency assessments. This plan includes resources, tools, and content to meet standards and regulatory requirements, with a distribution of content throughout the year. Orientation Assignments 2024: - Clinical System Topic: Medication Administration Competency. Orientation Assignments 2024 for Nurses included: - Avoiding Common Medication Errors. - Medication Administration. - Insulin Management - Insulin Pen and Pump; Glucometer. Review of the facility document titled Agency Nurse Clinical Orientation Packet , dated 03/2013, indicated the following required competencies must be completed by licensed nurses prior to assignment at the Center: - Medication administration techniques to ensure safety and infection control. - Blood glucose monitoring techniques, quality assurance monitoring, and infection control. - Insulin management standards and the protocol for managing hypoglycemic episodes. Throughout the recertification survey (12/26/24 through 12/27/24 and 12/30/24) the surveyors identified multiple concerns regarding medication administration including: - Failure to clean glucometer. - Failure to appropriately administer enoxaparin (injectable medication to thin blood). - Failure to appropriately use insulin pen injector prior to administering insulin. The surveyor reviewed staff education files for medication administration competencies for two licensed nurses with identified concerns relating to medication administration during the recertification survey. - 0 out of 2 had medication administration competencies completed. During an interview on 12/30/24 at 1:55 P.M., the Scheduler said the document titled Agency Nurse Clinical Orientation Packet is the packet she gives to agency nursing staff when they are scheduled to work in the facility. She said that the Staff Educator would usually provide this packet to agency staff and follow up with its completion, however, there has not been a Staff Educator in the facility for a few months. (continued on next page)

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Care One at Lexington	178 Lowell Street Lexington, MA 02420

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/24 at 3:00 P.M., Nurse #15 said there should be Agency Nurse Clinical Orientation Packets completed for each agency licensed nurse prior to working their shift, but there was not a staff educator employed at this time and she was unable to find the packets. See F760

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44095 Based on observations and interviews, the facility failed to post nursing staff data daily, at the start of each shift, relative to licensed and unlicensed nursing staff directly responsible for resident care per shift and the facility census as required. Specifically, the facility failed consistently post the facility census, total number and hours for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nurse Aides (CNAs), as required. Findings include: Review of the facility policy, Posting Direct Care Daily Staffing Numbers, dated as revised August 2022, indicated the facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. 1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. 2. Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to: assisting with activities of daily living (ADLs), administering medications, supervising care provided by CNAs, and performing nursing assessments. Medication aides, feeding assistants, hospice staff, private duty aides and administrative staff are not calculated in direct care staffing numbers. Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following: a. The name of the facility; b. The current date (the date for which the information is posted); c. The resident census at the beginning of the shift for which the information is posted; d. Twenty-four (24) hour shift schedule operated by the facility; e. The shift for which the information is posted; f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); g. The actual time worked during that shift for each category and type of nursing staff; and h. Total number of licensed and non-licensed nursing staff working for the posted shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	3. Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator. 5. The previous shift's forms are maintained with the current shift form for a total of 24 hours of staffing information in a single location. Once a form is removed, it is forwarded to the office of the director of nursing services (DNS) and filed as a permanent record. 6. Records of staffing information for each shift are kept for a minimum of eighteen (18) months or as required by state law (whichever is greater). On 12/26/24 at 6:57 A.M., the surveyor observed the daily staffing posted at the entrance of the facility, dated 12/24/24. The daily staffing failed to include the facility census. The daily staffing posted failed to include staffing data including the total number and hours for RNs and LPNs, and the total hours for CNAs, as required. On 12/30/24 at 6:37 A.M., the surveyor observed the daily staffing posted at the entrance of the facility, dated 12/27/24. The daily staffing failed to include the facility census. The daily staffing posted failed to include staffing data including the total number and hours for RNs and LPNs, and the total hours for CNAs, as required. During an interview on 12/30/24 at 10:45 A.M., the Receptionist said she receives the staffing from the Staffing Coordinator and posts the staffing at the desk each morning. During an interview on 12/30/24 at 11:49 A.M., the Staffing Coordinator said she fills out the staffing form and leaves the form for the receptionist to post when she is not in the facility. The Staffing Coordinator said she was unaware that the posting required the facility census and total number and hours for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nurse Aides (CNAs). During an interview on 12/30/24 at 12:40 P.M., the Director of Nursing said staff postings should be posted according to regulations. During an interview on 12/30/24 at 1:07 P.M., the Administrator said the staffing sheet should be posted and reflect regulatory requirements.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44095 Based on record review and interviews, the facility failed to provide routine medications to one Resident (#122) out of a total sample of 37 residents. Specifically, for Resident #122, the facility failed to provide modafinil (a non-amphetamine central nervous system stimulant with wakefulness-promoting properties. It is used in the treatment of conditions which cause excessive daytime sleepiness) as ordered by the physician. Findings include: Review of the facility policy titled, Unavailable Medications, dated as revised February 2019, indicated medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. A. The pharmacy staff shall: 1. Call or notify nursing staff that the ordered products is/are unavailable. 2. Notify nursing when it is anticipated that the drugs will become available. 3. Suggest alternative, comparable drug(s) and dosage of drugs that is/are available, which is covered by the resident's insurance. B. Nursing staff shall: 1. Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. 2. Obtain a new order and cancel/discontinue the order for the non-available medication. Resident #122 was admitted to the facility in November 2024 with diagnoses including anxiety, depression, attention-deficit hyperactivity disorder, and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/18/24, indicated that Resident #122 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 12/26/24 at 8:21 A.M., Resident #122 said that the nursing staff do not consistently have his/her modafinil and he/she is not offered any alternative medications when his/her medications are not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #122's physician's order, dated 12/2/24, indicated: - Modafinil Oral Tablet 200 milligrams (modafinil) *Controlled Drug*, give 1 tablet by mouth three times a day for depression. Review of Resident #122's Order - Administrative Note with the following dates and times indicated nursing did not have the Resident's physician's ordered modafinil: 12/15/24 at 1:41 P.M., 12/15/24 at 10:51 P.M., 12/16/24 at 6:01 A.M., 12/16/24 at 3:21 P.M., 12/19/24 at 6:43 A.M., 12/19/24 at 2:43 P.M., 12/19/24 at 10:06 P.M., 12/20/24 at 5:43 A.M., 12/20/24 at 3:10 P.M., and 12/20/24 at 9:05 P.M. During an interview on 12/30/24 at 10:09 A.M., Unit Manager #2 said that she was not sure why nursing did not administer Resident #122 his/her modafinil. Unit Manager #2 said that the medication may have been back ordered. During an interview on 12/30/24 at 12:34 P.M., the Director of Nursing said that Resident #122's modafinil should have been available for administration. The DON said that alternative methods could have been used to obtain a supply of the medication such as bringing in the medication from home or obtaining the medication from an alternative pharmacy.

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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. 44095 Based on record review and interview, the facility failed to ensure recommendations from the Monthly Medication Reviews (MMR) conducted by the consultant pharmacist were addressed by the facility in a timely manner for two Residents (#14 and #29) out of a total sample of 37 Residents. Specifically, 1. For Resident #14, the facility failed to address the pharmacist recommendations. 2. For Resident #29, the facility failed to implement the consultant pharmacist's recommendations once approved by the attending physician. Finding Include: Review of the facility policy, Medication Regime Reviews, dated as revised May 2019, indicated the consultant pharmacist reviews the medication regimen of each resident at least monthly. 1. The consultant pharmacist performs a monthly medication review (MMR) for every resident in the facility receiving medication. 2. Medication regimen reviews are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. 3. Reviews for short-stay individuals (those who are expected to stay for 30 days or less) are done upon admission (or as close to admission as possible) and as needed to identify individuals with potential medication-related issues and for those who may be experiencing adverse consequences from their medications. 5. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: a. medications ordered in excessive doses or without clinical indication; b. medication regimens that appear inconsistent with the resident's stated preferences; c. duplicative therapies or omissions of ordered medications; d. inadequate monitoring for adverse consequences; e. potentially significant drug-drug or drug-food interactions; f. potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences; g. incorrect medications, administration times or dosage forms; or (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. other medication errors, including those related to documentation; 6. The medication regimen and associated treatment goals involve collaboration with the resident (or representative), family members, and the interdisciplinary team (IDT). As such, the MRR includes a review of the resident's (or representative's) stated preferences, the comprehensive care plans and information provided about the risks and benefits of the medication regimen. 8. Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report includes: a. the resident's name; b. the name of the medication; c. the identified irregularity; and d. the pharmacist's recommendation. 1. Resident #14 was admitted to the facility in January 2012 with diagnoses including major depression and traumatic brain injury. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/17/24, indicated that Resident #14 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of 15. This MDS indicated Resident #14 had behaviors that included verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others), and he/she did not reject care. Review of Resident #14's plan of care related to risk of adverse effects related to use of mood stabilizer, dated as initiated 12/19/14, indicated: - Obtain laboratory results as ordered and notify the physician of abnormal values. Review of Resident #14's physician's order, dated 3/23/16, indicated: - Depakote 500 milligrams, give one tablet orally two times a day for mood stabilizer. Review of Resident #14's physician's order, dated 1/4/23, indicated: - Depakote 125 milligrams, give one tablet by mouth in the afternoon for behavioral disturbances. Review of Resident #14's pharmacist progress note, dated 11/6/24, indicated: - Consider Depakote Level. During an interview on 12/27/24 at 2:13 P.M., Nurse #3 said he was unable to find the pharmacist Monthly Medication Review dated 11/6/24. (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 12/30/24 at 11:19 A.M., Unit Manager #3 reviewed Resident #14's medical record with the surveyor. Unit Manager #3 said she will receive the Monthly Medication Review from the Director of Nursing, but she did not recall receiving one for Resident #14 in November 2024. During an interview on 12/27/24 at 2:20 P.M., the Director of Nursing said that all November 2024, monthly medication recommendation reviews should have been addressed. On 12/30/24 at 12:30 P.M., the facility provided the surveyor with the pharmacy recommendation that had not been addressed by the facility: Review of Resident #14's Note to Attending Physician/Prescriber, dated as 11/7/24, indicated: - This resident receives Depakote. Please consider order a valproic acid level and liver function tests every 6 months to monitor therapy. 2. Resident #29 was admitted to the facility in November 2024 with diagnoses including osteomyelitis of the right ankle and foot, diabetes, and peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/28/24, indicated that Resident #29 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #29's physician's order, dated 11/25/24, indicated: - Trazodone HCl oral tablet 50 milligrams (Trazodone HCl), give 1 tablet by mouth as needed for sleep, without a stop date. Review of Resident #29's pharmacy note, dated 12/8/24, indicated: - Trazodone as needed, needs a duration. Review of Resident #29's Note to Attending Physician/Prescriber, dated 12/9/24 and signed by the physician on 12/10/24, indicated the following: - This Resident currently has an order for PRN Trazodone. Further review of the form indicated the Physician agreed with the pharmacist's recommendation and signed the form on 12/10/24, extending the use for 14 days (12/24/24). Review of the record failed to indicate Resident #29's Trazodone order was updated with a stop date. On 12/30/24 at 9:56 A.M., Unit Manager #2 reviewed Resident #29's medical record including the physician's order for Trazodone and the MMR. Unit Manager #2 said she is not sure why the MMR was not implemented by nursing but should have been. During an interview on 12/30/24 at 12:29 P.M., the Director of Nursing said that the MMR should have been implemented by nursing.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44095 Based on observation, record review and interviews, the facility failed to ensure that two Residents (#29 and #391) were free from significant medication errors out of a total sample of 37 residents. Specifically: 1. For Resident #29, nursing staff failed to administer insulin in accordance with the physician's order. 2. For Resident #391, nursing staff failed to prime (prepare insulin for injection) the insulin pen injector resulting in an inaccurate dose of insulin administered. Findings include: Review of the facility policy, Nursing Care of the Older Adult with Diabetes Mellitus, dated as revised November 2020, indicated it provided an overview of diabetes in the older adult, its symptoms and complications, and the principles of glucose monitoring. The policy indicated that for further diabetes education and guidelines, refer to the provider orders and instructions as well as the American Diabetes Association, Standards of Medical Care in Diabetes. Symptoms Associated with Diabetes: 1. Hyperglycemia. Uncontrolled diabetes from lack of insulin or inadequate insulin results in hyperglycemia (blood sugar above target levels). Signs and symptoms of hyperglycemia may include the following: a. Increased thirst; b. Frequent urination; c. Sugar in the urine; d. Fatigue; e. Headache; and f. Blurred vision. Review of the facility policy, Administering Medications, dated as revised 5/16/24, indicated that medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 1. Resident #29 was admitted to the facility in November 2024 with diagnoses including osteomyelitis of the right ankle and foot, diabetes, and peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/28/24, indicated that Resident #29 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #39 received pressure ulcer/ injury care, surgical wound care, application of nonsurgical dressings, and application of dressing to feet. This MDS indicated Resident #29 received insulin. During an interview on 12/27/24 at 11:04 A.M., Resident #29 said that he/she has not received his/her insulin that was due to be administered before breakfast. Resident #29 said he/she has been diabetic for a while, and he/she is starting to feel hyperglycemic (high blood sugar) and is urinating frequently. On 12/27/24 at 11:06 A.M., the surveyor made Nurse #6 aware of Resident #29's concerns. Nurse #6 reviewed her census sheet and said she did not realize Resident #29 was diabetic and she did not obtain his/her blood sugar or administer any insulin yet, but she should have. Review of Resident #29's plan of care related to diabetes, dated 11/21/24, indicated: - Administer medications per physician's orders. Review of Resident #29's physician's order, dated 12/12/24, indicated: - Humalog KwikPen Subcutaneous Solution Pen-injector 100 units/milliliter (Insulin Lispro), inject subcutaneously before meals for diabetes mellitus. Hold Lispro for a fasting sugar (FS) less than 70. Inject 5 units subcutaneously before meals for diabetes mellitus II Hold for blood sugar less than 100. Review of Resident #29's Orders - Administration Note, dated 12/27/24, indicated: - FSB (blood sugar) 345 after breakfast. Review of Resident #29's Medication Administration Record (MAR), dated December 2024, indicated on 12/27/24 at 11:23 A.M., nursing administered Resident #29's 7:30 A.M. scheduled and sliding scale insulin for a blood sugar of 345, 3 hours and 53 minutes after the scheduled time. During an interview on 12/30/24 at 9:55 A.M., Unit Manager #2 said the residents who are diabetic are reviewed during nursing report at change of shift. Unit Manager #2 said that residents who are diabetic, like Resident #29, should receive their insulin as ordered by the physician. Unit Manager #2 said Resident #29 should have had his/her blood sugar obtained and insulin administered before breakfast because that was the physician's order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/27/24 at 2:31 P.M., the Director of Nursing (DON) said that nursing should administer insulin as ordered. The DON said Resident #29 should have had his/her blood sugar obtained and insulin administered before breakfast because that was the physician's order. 2. Review of the insulin glargine subcutaneous solution pen-injector manufacture's guidelines, dated August 2022, indicated the following: Perform a safety test: - Dial a test dose of 2 Units. (prime the pen, clear the air) - Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. - Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. - If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. Priming an insulin pen means preparing it for insulin injection. 1. Turn the dosage knob to the 2 units indicator. 2. Push the knob all the way to get at least one drop of insulin. 3. Repeat until a drop appears. 4. This ensures the needle is functioning correctly and removes air from the needle and cartridge Resident #391 was admitted to the facility in December 2024 with diagnoses including diabetes, displaced bicondylar fracture of the right tibia, and post-traumatic stress disorder. On 12/27/24 at 9:11 A.M., the surveyor observed Nurse #5 prepare and administer Resident #391's insulin glargine with a prefilled syringe. Nurse #5 failed to prime the insulin pen resulting in Resident #391 not receiving the correct dose of the insulin. Review of Resident #391's physician's order, dated 12/19/24, indicated: - Insulin glargine subcutaneous solution pen-injector 100 units/milliliter, inject 20 units subcutaneously one time a day for diabetes. Review of Resident #391's plan of care related to diabetes, dated 12/22/24, indicated: - Administer medications per physician's orders. During an interview on 12/27/24 at 9:25 A.M., Nurse #5 said he was not aware of the need to prime an insulin pen prior to use. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/27/24 at 2:22 P.M., the Director of Nursing said Nurse #5 should have primed the insulin pen to ensure Resident #391 received the correct dose of insulin glargine.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, interviews and policy review, the facility failed to ensure: 1. Medications were properly stored in one of four medication carts and 2. Treatment carts were attended while unlocked, and 3. Medications were labeled, and dated once opened, according to manufacturer's guidelines in one out of four medication storage areas. Findings include: Review of the facility policy titled Medication Labeling and Storage dated revised February 2023 indicated that the facility stores all medications and biologicals in locked compartments. Further review failed to indicate that medications cannot be pre-poured and stored, and un-labeled in the medication cart. 1. On 12/30/24 at 9:43 A.M., the surveyor observed the [NAME] Unit medication cart contained an un-labeled medication cup containing 10 pills. During an interview on 12/30/24 at 9:43 A.M., Nurse #2 said that she ran out of an over-the-counter medication and had to go get it from med storage. Nurse #2 said she put the medication cup in the top drawer of the medication cart and left the unit to get a medication she needed for the resident. Nurse #2 said she was not aware she could not store an unlabeled cup of medications in the medication cart if she had already popped the medications for a resident. 48671 2. On 12/27/24 at 9:44 A.M., the surveyor observed one unlocked treatment cart on the [NAME] Unit. The surveyor was able to obtain access to the treatment cart, which was unattended and located in between resident rooms with multiple residents in the hallway. A plastic basin was observed on top of the treatment cart and contained two opened wound spray bottles and various wound supplies. During an interview on 12/27/24 at 9:54 A.M., Nurse #1 said the treatment cart should be locked and wound supplies should not be left on top of the treatment cart and unattended. During an interview on 12/30/24 at 1:08 P.M., the Director of Nurses said all treatment and medication carts must be locked and supplies should not be stored on top of the treatment cart when left unattended. 3. During an observation of the [NAME] Unit medication storage room on 12/30/24 at 8:00 A.M., the following was observed in the refrigerator: - One opened vial of Tuberculin, Purified Protein Derivative, Diluted Aplisol (used in the detection of infection with Mycobacterium tuberculosi), labeled with an open date of 12/28/24 and an expiration date of 3/22/25. Manufacture instructions indicate to discard 30 days from opened date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/24 at 8:05 A.M., Nurse #2 said she thinks the medication is good for 28 days only but was not sure. During an interview on 12/30/24 at 8:09 A.M., Unit Manager (UM) #2 said the solution is good for 30 days after opening and should have been labeled appropriately. During an interview on 12/30/24 at 1:10 P.M., the Director of Nurses said tuberculin solution is good for 30 days after opening and should be dated correctly.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 44095 Based on record review and interviews, the facility failed to ensure laboratory services were provided for one Resident (#14) out of a sample of 37 residents. Specifically, the facility failed to ensure it obtained Resident #14's Depakote (medication used to treat mood and behavior) serum drug level, per the physician's order. Finding Include: Review of the facility policy, Lab and Diagnostic Test Results - Clinical Protocol, dated as Revised November 2018, indicated: 1. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Resident #14 was admitted to the facility in January 2012 with diagnoses including major depression and traumatic brain injury. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/17/24, indicated that Resident #14 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 8 out of 15. This MDS indicated Resident #14 had behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others), and he/she did not reject care. Review of Resident #14's plan of care related to risk of adverse effects related to use of mood stabilizer, dated as initiated 12/19/14, indicated: - Obtain laboratory results as ordered and notify the physician of abnormal values. Review of Resident #14's physician's order, dated 7/13/18, indicated: - Valproic Acid (Depakote) Level every February and August. Review of Resident #14's physician's order, dated 8/9/23, indicated: - Depakote Level every six months January and July. Review of Resident #14's physician's order, dated 3/23/16, indicated: - Depakote 500 milligrams, give one tablet orally two times a day for mood stabilizer. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's physician's order, dated 1/4/23, indicated: - Depakote 125 milligrams, give one tablet by mouth in the afternoon for behavioral disturbances. Review of Resident #14's electronic health record on 12/27/24, failed to include documentation to support his/her Depakote level was obtained in accordance with the physician's order and plan of care. Review of Resident #14's paper medical record on 12/30/24 with Unit Manager #3 included lab work for a Depakote level on 8/10/23. There were no additional results, therefor nursing had not obtained The Resident's Depakote level for 16 months. Review of Resident #14's - Orders - Administration Note, dated 1/1/24, 1/2/24, and 1/3/24, indicated: - Valproic Acid Level (Feb/Aug), every day shift every 6 month(s) starting on the 1st for 3 day(s) due February. Review of Resident #14's - Orders - Administration Note, dated 3/10/24, 3/11/24, and 3/13/24, indicated: - Depakote level every six months January and July, every day shift every 6 month(s) starting on the 8th for 7 day(s). due July. Review of Resident #14's - Orders - Administration Note, dated 7/1/24, 7/2/24, and 7/3/24, indicated: - Valproic Acid Level (Feb/Aug), every day shift every 6 month(s) starting on the 1st for 3 day(s). due August. Review of Resident #14's - Orders - Administration Note, dated 9/8/24, 9/9/24, 9/10/24, 9/11/24, indicated: - Depakote level every six months January and July, every day shift every 6 month(s) starting on the 8th for 7 day(s). due January. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/24 at 11:17 A.M., Nurse #4 said Resident #14 receives his/her Depakote level every six months. Nurse #4 said that typically when the order showed up on the Medication Administration Record, she would confirm there was a lab slip in for the blood serum level to be drawn. Nurse #4 said she documented on the Orders - Administration Note the months that the level was due and said that the orders were not scheduled correctly in the electronic health record. Nurse #4 said she never confirmed that the Depakote levels were obtained, or lab slips were in place for the laboratory work to be completed for Resident #14's Depakote level. During an interview on 12/30/24 at 11:11 A.M., Unit Manager #3 said nursing should have followed orders by the physician and obtained the Depakote levels as ordered. During an interview on 12/27/24 at 2:19 P.M., the Director of Nursing said nursing should have obtained Resident #14's Depakote level and during the times periods as ordered by the physician.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 45763 Based on observation, interview and record review, the facility failed to ensure staff provided food that accommodated the allergies, intolerances, and preferences of one Resident (#442) out of a total sample of 37 residents. Specifically, the facility failed to ensure that Resident #442, who had an active diagnosis of celiac disease (a chronic autoimmune disorder, triggered by the consumption of gluten, that damages the small intestine and prevents the body from absorbing nutrients from food) was not served food containing gluten (a protein found in some grains, including wheat) despite gluten being listed as an allergen in the Resident's medical record. Findings include: Review of the facility policy, titled Food Allergies and Intolerances, revised August 2017, indicated, but was not limited to, the following: - Residents with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to the allergens. - Assessment and Interventions: o Residents are assessed for a history of food allergies and intolerances upon admission and as part of the comprehensive assessment. o All resident reported food allergies and intolerances are documented in the assessment notes and incorporated into the resident's care plan. Resident #442 was admitted to the facility in November 2024 with diagnoses of cerebral palsy, malnutrition, and celiac disease. Review of the Minimum Data Set (MDS) assessment, dated 11/28/24, indicated that Resident #442 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam indicating the Resident was cognitively intact. Review of the hospital discharge paperwork, dated 12/16/24, indicated Resident #442 had celiac disease. Review of Resident #442's active diagnoses indicated the Resident had celiac disease. Review of Resident #442's active allergies indicated the Resident was allergic to gluten. Review of Resident #442's nutrition evaluation, dated 12/23/24, indicated the Resident was allergic to gluten and had celiac disease. Review of Resident #442's Kardex indicted the Resident was allergic to gluten. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/26/24 at 12:14 A.M., the surveyor observed Resident #442 eating lunch. The Resident was eating minced and moist textured pasta. During an interview and observation on 12/26/24 at 12:20 P.M., the surveyor observed that there was only one pan of minced and moist textured pasta being held on the steam table in the kitchen for lunch service. The cook said he had only cooked and served one type of pasta, which was not a gluten-free pasta, for lunch service that day. During an interview and observation on 12/26/24 at 12:21 P.M., the Food Service Director (FSD) said only one type of pasta was cooked and served for lunch that day and he provided the surveyor with the packaging, including the ingredient list. Review of the pasta ingredient list indicated that the first ingredient (according to Food and Drug Administration regulations ingredients are listed in descending order of their weight, meaning the ingredient used in the greatest amount is listed first) was semolina wheat (a coarse wheat flour derived from durum wheat), and the second ingredient was durum wheat (a species of wheat) flour. On 12/26/24 at 4:44 P.M. the surveyor observed Resident #442 eating dinner. The Resident was eating minced and moist textured bread and mashed potatoes with gravy. During an interview and observation on 12/26/24 at 4:54 P.M., the surveyor observed only one pan of gravy and one pan of minced and moist textured bread on the steam table in the kitchen for dinner service. The cook said that he only made and served one type of gravy for dinner service which was thickened by flour. The cook said he only made and served one type of minced and moist bread which was made from regular bread as there was no gluten-free bread thawed and available for use in the facility. During an interview and observation on 12/26/24 at 4:57 P.M. the FSD said that there was gluten-free bread in the freezer and that the gravy could be thickened with cornstarch instead of flour if needed to accommodate a resident who should not receive gluten. The FSD said there was only one type of bread used to create the minced and moist textured bread for dinner and provided the surveyor with the packaging, including the ingredient list. Review of the bread ingredient list indicated that the first ingredient was whole wheat flour. The FSD said that allergies automatically populate into the tray ticket system from residents' electronic health records. The FSD and surveyor reviewed the list of residents with allergies in the tray ticket system. The list failed to indicate Resident #442's gluten allergy. The FSD said that if a resident had a gluten allergy listed that the resident should not receive gluten containing food such as those containing wheat, including bread, pasta, or gravy thickened with flour. During interviews on 12/26/24 at 5:17 P.M. and 12/27/24 at 10:12 A.M., the Registered Dietitian (RD) said due to the listed allergy and active diagnosis of celiac disease Resident #442 should not receive food items containing flour or wheat. The RD said that if a resident with celiac disease consumed gluten that the resident could experience nutrient malabsorption and gastrointestinal discomfort. The RD said that the gluten allergy was incorrectly categorized on admission as other instead of under the food category and for this reason did not populate into the tray ticket system.

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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. 45763 Based on observation and interview the facility failed to handle food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure that staff did not handle ready-to-eat food with their bare hands. Findings include: Review of the facility's policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices revised November 2022, indicated, but was not limited to, the following: - Contact between food and bare (ungloved) hands is prohibited. - Gloves are worn when directly touching ready-to-eat food. The surveyor made the following observations during the tray line observation on 12/27/24 at 11:36 A.M.: - The cook used his bare hands to transfer four out of the first four ready-to-eat baked potatoes from the steam table onto plates to be served to the residents. During an interview on 12/27/24 at 11:41 A.M., the Food Service Director (FSD) said the cook should not be touching ready-to-eat potatoes with his bare hands and that all the potatoes the cook touched must be discarded.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, interview and observation, the facility failed to ensure accurate documentation of the clinical record for three Residents (#17, #52, #392) of 37 sampled residents. Specifically: 1. For Resident #52, the facility documented compression stocking were applied when they were not. 2. For Resident #17, the facility documented heel protectors were applied when they were not. 3. For Resident #392, the facility failed to ensure nursing obtained a physician's order for a lidocaine (topical prescription medicated patch used for pain) patch that included the location, and the facility failed to ensure that nursing consistently documented the location where the lidocaine patch was applied. 1. Resident #52 was admitted to the facility in November 2022, and has active diagnoses which include congestive heart failure, bilateral leg edema and dementia. Review of Resident #52's Minimum Data Set assessment dated [DATE], indicated he/she was dependent on staff for all lower body dressing and putting on/taking off footwear. The Resident had a Brief Interview for Mental Status Score of 3, indicating severe cognitive impairment. Review of Resident #52's care plan dated 12/29/22, indicated he/she was at-risk for alteration in skin integrity related to impaired mobility and bilateral edema. Interventions included: - TED stockings (compression stockings) as ordered. Review of Resident #52's physician order dated 11/9/23 indicated: - [NAME] stockings on morning and off at HS (nighttime). On 12/26/27 at 2:00 P.M., 12/27/24 at 8:55 A.M., and 10:05 A.M., the surveyor observed Resident #52 lying in bed and not wearing compression stockings. Review of Resident #52's Medication Administration Record (MAR) dated December 2024, indicated: - Apply TED stockings at 6:00 A.M. and remove in the evening. Staff documented compression stocking were applied and removed on a daily basis throughout the month, including 12/26/24 and 12/27/24. During an interview with Certified Nurse Aide (CNA) #2 on 12/27/24 at 8:57 A.M., she said she had worked with Resident #52 for many months and had never known him/her to wear compression stockings. CNA #2 said she had not received instruction from licensed nurses to apply compression stocking to his/her legs. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Nurse #3 on 12/27/24 at 9:05 A.M., he said Resident #52 did not wear compression stockings and he was unaware that the Resident had a physician's order for TED/compression stockings. Nurse #3 and the surveyor reviewed Resident #52's Medication Administration Record dated December 2024, and saw staff had documented they applied and removed compression stockings daily. Nurse #3 said the documentation was inaccurate because Resident #52 did not wear compression stockings. During an interview with the Director of Nurses (DON) on 12/27/24 at 10:52 A.M., she said a physician's orders for compression stockings should be followed. The DON said staff should not be documenting that compression stockings were applied when they were not. 2. Resident #17 was admitted to the facility in December 2016, and has diagnoses which include diabetes and peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/4/24, indicated that on the Brief Interview for Mental Status exam Resident #17 scored a 12 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated that Resident #17 had no behaviors of rejecting care and was dependent on staff for lower body dressing. Review of the current physician orders indicated the following: - Heel protector boots on at all times, may remove for transfers, start date 8/13/24. Review of the most recent Nurse Practitioner progress note, dated 12/11/24, indicated: - Peripheral vascular disease: status post left calcinatory - healed. - Continue protective boots daily. Review of the December 2024 clinical progress notes failed to indicate Resident #17 refused to wear heel protector boots. Review of the Certified Nursing Assistant (CNA) task documentation failed to indicate Resident #17 displayed any behavior of rejecting care in the past 14 days. Review of the current Diabetes care plan included the following intervention: - Diabetic foot care, started 12/28/16. Review of the current Activities of Daily Living (ADL) care plan included the following intervention: - Extensive Assist with daily bathing, grooming, dressing. Dependent when tired, dated as revised 3/15/21. During an observation and interview on 12/26/24 at 8:43 A.M., the surveyor observed Resident #17 in bed with both heels resting flat on the mattress. Two blue boots were located across the room on the Resident's wheelchair. Resident #17 said the boots were supposed to be put on by the staff but had not been. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/27/24 at 8:11 A.M., the surveyor observed Resident #17 asleep in bed. A bootie was on Resident #17's right foot and his/her left foot was flat on the mattress, with no heel protection. Another bootie was observed across the room on the Resident's wheelchair. On 12/27/24 at 10:18 A.M., the surveyor observed Resident #17 in bed. A bootie was on Resident #17's right foot and his/her left foot was flat on the mattress, with no heel protection. The other bootie was observed across the room on Resident #17's wheelchair. A sign posted on the wall behind the Resident's bed indicated blue multipodus boots must be donned at all time (sic). During an interview and observation on 12/30/24 at 8:23 A.M., Resident #17 was lying in bed, awake. The Resident was not wearing heel protector boots on either foot. The Resident said he/she had not worn a heel protector boot on the left foot while in bed for many months. The Resident said she used to wear a boot on the left foot at night, but that boot was lost, and staff had replaced it with a boot that did not fit. The Resident said staff eventually stopped applying the left boot. During an interview with Unit Manager #1 on 12/30/24 at 8:33 A.M., she said she had been working with Resident #17 for several years, and the Resident had not worn heel protection on the left foot for many months. Unit Manager #1 said she was unaware there was a physician's order for bilateral heel protectors. On 12/30/24 at 8:39 A.M., the surveyor and Unit Manager #1 entered Resident #17's bedroom and observed that the Resident was awake, lying in bed. Resident #17 was not wearing heel protectors on either foot. Across the room a single heel protector was located on a wheelchair. During an interview with CNA #2 on 12/30/24 at approximately 9:00 A.M., she said she was unaware that Resident #17 was supposed to always wear a heel protector on the left foot. CNA #2 said she had not received instruction from licensed nursing staff to apply heel protection to the left foot. During an interview with the Director of Nurses (DON) on 12/27/24 at 10:52 A.M., she said physician's orders should be followed. The DON said staff should not be documenting that an order had been completed when it had not. 44095 3. Review of the facility policy, Administering Medications, dated as revised 5/16/24, indicated that medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Resident #392 was admitted to the facility in December 2024, with diagnoses including diabetes, chronic pain, and colitis. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/21/24, indicated that Resident #392 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. On 12/27/24 10:54 A.M., the surveyor observed Nurse #6 prepare and administer a lidocaine patch to Resident #392. Nurse #6 said that there was no location for the lidocaine patch as part of the order. Resident #392 said that the nurses applied it on all different places including the back and shoulder. Review of Resident #392's physician's order, dated 12/14/24, indicated: - Lidocaine Patch 5% apply to skin topically, one time a day for pain management. Apply for only 12 hours in a 24 hour period. May dose - 3 patches. External use only and remove per schedule. Further review of the order failed to indicate a location to apply the patch. Review of Resident #392's Medication Administration Record (MAR), dated December 2024, indicated nursing staff administered Resident #392 his/her lidocaine patch between 12/15/24 and 12/27/24 (13 times), without identifying a location. Further review of the MAR indicated that the location of administration was not recorded. During an interview on 12/30/24 at 10:03 A.M., Unit Manager #2 reviewed Resident #392's order for lidocaine patches and she said that the order was incomplete and required a site location to apply the patch. During an interview on 12/30/24 at 12:19 P.M., the Director of Nursing said lidocaine patch orders should have a location as part of the order.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Lexington	178 Lowell Street Lexington, MA 02420

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 0844 Level of Harm - Potential for minimal harm Residents Affected - Some	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 44095 Based on interviews and review of the Health Care Facility Reporting System (HCFRS-State Agency reporting system), the facility failed to provide written notice to the State Agency of a change in the Director of Nursing (DON) position. Findings include: Review of the facility policy, Administrator/ Director of Nursing Services, Change of, dated as revised April 2007, indicated that the state-licensing agency will be notified of a change of administrator or director of nursing services. 1. Our facility's governing board will notify the state-licensing agency when there has been a change of administrator or director of nursing services. 2. A written notification will be provided to the state-licensing agency at least fourteen (14) days prior to such change taking effect or as may be specified by state regulations. 3. Such notice shall include, but is not necessarily limited to: a. the name of the new administrator or director of nursing services; b. the license number of the new administrator or director of nursing services; c. the date the change will take effect; and d. other information as necessary or as requested by the state-licensing agency. During the facility entrance on 12/26/24 at 7:00 A.M., the Director of Nursing said she was the new Director of Nursing and had been in the role for a little over a month. Review of HCFRS on 12/26/24 failed to indicate the facility submitted a change in Director of Nursing notice, as required. During an interview on 12/30/24 at 12:21 P.M., the Director of Nursing said she was not aware that the facility did not report the change in status when she assumed the role as Director of Nursing. During an interview on 12/30/24 at 1:05 P.M., the Administrator said he should have reported the change in Director of Nursing to the State Agency, but he did not. The Administrator said the Director of Nursing's start date was 11/4/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, interview and observation, the facility failed to follow infection control procedures. Specifically: 1. The facility failed to ensure 2 of 2 nurses cleaned blood glucose meters according to infection control practices. 2. The facility failed to ensure staff wore complete personal protective equipment in rooms designated as requiring enhanced barrier precautions. 3. The facility failed to ensure staff conducted proper handwashing and glove use. 4. The facility failed to ensure it used unexpired hand sanitizer. 44095 Review of the facility policy, Blood Glucose Monitoring, dated as revised [DATE], indicated: Disinfect the meter before and after each use, or when the monitor is visibly soiled as follows: - Use Super Sani-Cloth Germicidal Disposable Wipe (or other commercially prepared pre-moistened wipe which meets CDC guidelines) to wipe down the meter using caution not to get liquid in the test strip and key code ports of the meter - If blood is visibly present on the meter, a 2nd Sani-Cloth(R) germicidal Disposable Wipe must be used. - If the Super-Sani Cloth (or other commercially prepared pre-moistened wipe which meets CDC guidelines) is unavailable, use a 1:10 sodium hypochlorite solution and a soft cloth. 1a. On [DATE] at 8:33 A.M., the surveyor observed Nurse #5 obtain a black case from the medication cart, containing a glucometer, several lancets, alcohol prep pads, 2 x 2 pads, and insulin needle tips for pen injectors. Nurse #5 entered the Resident's room and placed the black case directly on top of his/her uncleaned overbed table. Nurse #5 obtained the Resident's blood sugar and immediately put the glucometer back in the black case without cleaning it, and potentially contaminating the contents of the black case. Nurse #5 then returned the case to the medication cart. During an interview on [DATE] at 9:25 A.M., Nurse #5 said he was not sure how and when to clean glucometers. During an interview on [DATE] at 2:26 P.M., the Director of Nursing said nursing should clean the glucometer with germicidal wipes after use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. On [DATE] at 9:54 A.M., the surveyor observed Nurse #6 gather supplies to obtain a blood sugar. Nurse #6 obtained a blood sugar from a Resident and then she cleaned the glucometer with an alcohol wipe (not a germicidal wipe) and placed the glucometer back into the medication cart, potentially contaminating the contents of the drawer. During an interview on [DATE] at 9:58 A.M., Nurse #6 said she cleaned the glucometer with the alcohol wipe and said she did not have any germicidal wipes. During an interview on [DATE] at 2:26 P.M., the Director of Nursing said nursing staff should clean the glucometer with germicidal wipes after each use. 45763 2. Resident #38 was admitted to the facility in [DATE], with a diagnosis of malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #38 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating moderate cognitive impairment. Further review of the MDS indicated the Resident received 51% or more of his/her calories through a feeding tube. Review of Resident #38's physician orders indicated the following: - JTube (jejunostomy, a surgically created opening in the abdomen terminating in the jejunum, a portion of the small intestine, primarily utilized to provide nutritional formula): NSW (normal saline wash) pat dry apply split gauze every day shift - initiated [DATE]. - Enteral feed (feeding provided via a feeding tube, such as through a jejunostomy) - initiated [DATE]. On [DATE] the surveyor made the following observations on the [NAME] unit: At [DATE] at 10:12 A.M., the surveyor observed a staff member providing toileting assistance to Resident #38 in his/her bathroom. There was no enhanced barrier precaution signage outside of the Resident's room and the staff member was not wearing a gown. During a continuous observation from 11:16 A.M. to 11:25 A.M., the surveyor observed a nurse taking Resident #38's vitals in his/her room, including a blood pressure reading obtained by wrapping a blood pressure cuff around the Resident's arm. There was no enhanced barrier precaution signage outside of the Resident's room and the nurse was not wearing a gown or gloves. The nurse then took the vital signs machine out of Resident #38's room and into another resident's room and proceeded to take the vitals of another resident, including a blood pressure reading obtained by wrapping the same blood pressure cuff previously used on Resident #38. The nurse did not disinfect the vital signs machine or blood pressure cuff between resident use. The surveyor also observed that there were no disinfecting wipes in the spot designated for disinfecting wipes on the vital signs machine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:51 A.M., the Director of Nursing (DON) said she would expect a resident who is receiving enteral nutrition to be on enhanced barrier precautions and that she would expect staff to wear gloves and a gown while providing high contact activities such as providing toileting assistance and taking vitals. The DON said she expected staff to sanitize/disinfect the vital signs machine, including the blood pressure cuff, in between resident use. 48671 3. On [DATE] at 8:29 A.M., the surveyor observed a Certified Nursing Assistant (CNA) on the Minuteman unit exit a resident's room, identified as requiring transmission-based precautions. The CNA wore two gloves and carried a plastic bag of soiled lined. The CNA walked down the hall and used one gloved hand to open the dirty linen container and placed the bag inside. potentially contaminating the lid. The CNA removed both gloves, and without washing her hands, opened the lid to the trash container located in the hall, potentially contaminating the lid. During an interview on [DATE] at 9:09 A.M., the Director of Nursing (DON) said staff should not wear gloves in the hallway and said gloves should be removed properly. The DON said staff are expected to use hand sanitizer when entering and exiting resident rooms, and after doffing gloves. 4. On [DATE] at approximately 8:36 A.M., the surveyor observed the following on the Minuteman Unit: - One wall mounted hand sanitizer unit with an expiration date of [DATE], located in the hall outside room [ROOM NUMBER]. - One wall mounted hand sanitizer unit with an expiration date of [DATE], located in the hall outside room [ROOM NUMBER]. - One wall mounted hand sanitizer unit with an expiration date of [DATE], located in the hall outside room [ROOM NUMBER]. - One wall mounted hand sanitizer unit with an expiration date of [DATE], located in the hall outside room [ROOM NUMBER]. On [DATE] at approximately 8:36 A.M., the surveyor observed the following on the [NAME] Unit: - One wall mounted hand sanitizer unit with an expiration date of [DATE], located in the hall outside of the dining room. During an interview on [DATE] at 9:09 A.M., the Director of Housekeeping said hand sanitizer needs to be replaced if expired. During an interview on [DATE] at 1:00 P.M., the Administrator said hand sanitizer should not be in use if expired and said housekeeping is responsible for replacing and checking the wall mounted units. 41105 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On [DATE] at 8:02 A.M., on the Minuteman Unit, the surveyor observed a sign at the door of a resident room that indicated, STOP ENHANCED BARRIER PRECAUTIONS. Instructions on the sign included gloves and gown for high contact care. A Certified Nursing Assistant (CNA) exited the room wearing gloves on each hand and carrying a soiled brief in the left hand. The CNA was not wearing a gown. With the gloved right hand, the CNA picked up the cover of a trash bin, potentially contaminating its surface, and placed the soiled brief inside. The CNA then removed the gloves, threw them into the trash can, and re-entered the room without cleaning her hands, potentially contaminating the room.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on interview and observation, the facility failed to ensure it had secured hallway handrails on the [NAME] and Minuteman units. Findings include: 48671 Minuteman Unit On 12/27/24 at approximately 9:15 A.M., the surveyor observed: - Handrail end cap detached from rod and metal not secure, located in the hallway near rooms 223-224. On 12/27/24 at approximately 9:37 A.M., the surveyor observed: - Handrail end cap detached and no longer attached to the abutting the wall, located in hallway near room [ROOM NUMBER]. [NAME] Unit On 12/30/24 at approximately 8:58 A.M., the surveyor observed: - Handrail end cap detached and no longer attached to the abutting wall. Another end cap was missing and metal screws were exposed located, located near the sprinkler room. -Handrail end cap detached, and not attached to the wall, located in the hallway near the dining room. During an interview with Maintenance Staff #1 on 12/30/24 at 9:03 A.M., he said staff will report broken handrails to us verbally or by using the online TELS program. Review of the online TELS program failed to indicate any information related to broken, loose or missing handrails in the facility. During an interview with the Maintenance Director on 12/30/24 at 9:09 A.M., he said loose handrails have been an ongoing issue in the facility because they become loose and spin off. He continued to say that he noticed the missing end cap about a week ago and said it was thrown out. The Maintenance Director said he would need to order new ones if he does not have any replacement parts in storage. The Maintenance Director said there have been no staff notifications of broken or missing handrails. The Maintenance Director then showed the surveyor a preventative maintenance worksheet that he uses to track issues he identifies in the facility and said he conducts weekly rounds to track things that need to be fixed. (continued on next page)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the worksheet dated 10/31/24 indicated, handrails needed to be fixed but failed to indicate a completed /closed date as indicated on the form, and was left blank. The Maintenance Director said he did not have the notes from the audit that was done last week because he asked another staff member to complete them and has not received the notes yet. He said the handrails should be fixed when identified and said loose or broken handrails are a safety risk if not secured properly. During an interview with the Administrator on 12/30/24 at 12:57 P.M., he said he would expect any detached, loose, broken or missing handrails to be reported when noticed and fixed or replaced right away.