STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225290	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hannah Duston Healthcare Center	126 Monument Street Haverhill, MA 01832

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review, policy review and interview the facility failed to ensure two Residents (#14 and #97) were free from restraints out of a total sample of 23 residents. Specifically, the facility failed to: 1. identify and assess the use of side rails in conjunction with a scoop mattress as a potential restraint for Resident #14. 2. identify and assess the use of pillows wedged up against the side rails extending to the knees, as a potential restraint for Residents #97. Findings include: Review of the facility policy titled Guidelines for the Use of a Restraint, dated as revised November 2016, indicated that the definition of a restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Also included as restraints are facility practices that meet the definition of a restraint, such as: using side rails that keep a resident from voluntarily getting out of bed. Further review indicated that before initiating any device that has the potential to act as a restraint, the facility will conduct a comprehensive assessment utilizing the Restraint/Positioning Assessment form. 1. Resident #14 was admitted to the facility in June 2023 with diagnoses including dementia with anxiety and ataxia (impaired coordination). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that resident #14 scored a 9 out of 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairment. Further review indicated that Resident #14 is dependent for all activities of daily living except for eating and does not use restraints. On 5/28/24 at 7:44 A.M., Resident #14 was observed laying in bed with a scoop mattress (elevated sides). The indentations on the sides of the mattress, used to allow for exit of the bed, were blocked by the use of 1/4 rails. The surveyor also observed the foot of the bed to be elevated. (continued on next page)

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

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/24 at 7:44 A.M., Resident #14 said that he/she has fallen and is not supposed to get out of bed alone. Resident #14 said that the side rails prevent him/her from getting out of bed. On 5/29/24, at 7:50 A.M., the surveyor observed Resident #14 laying in bed with a scoop mattress. The indentations on the sides of the mattress, used to allow for exit of the bed, were blocked by the use of 1/4 rails. Review of the facility incident report dated 4/21/24, indicated Resident #14 attempted to get out of bed without assist and fell to the floor. Review of the nurse's note dated 4/25/24, indicated Resident #14 fell trying to ambulate without assist on 4/21/24. Review of the medical record failed to indicate a care plan for the use of restraints. Further review failed to indicate a doctor's order for the use of restraints or an assessment to determine if the side rail/scoop mattress combination acts as a restraint for Resident #14. During an interview on 5/29/24, at 7:50 A.M., Certified Nurse's Aide (CNA) #4 said that Resident #14 is capable of swinging his/her legs out of the bed but that Resident #14's upper body is weak and can't support him/her standing. During an interview on 05/30/24 at 8:50 A.M., the Director of Nursing said that anyone that has a device that could act as a restraint should be assessed to determine if the device does indeed act as a restraint for that person. 2. Resident #97 was admitted to the facility in June 2023 with diagnoses including dementia, stroke with right sided hemiplegia (paralysis of one side) and hemiparesis (weakness of one side). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #97 was unable to complete the Brief Interview for Mental Status exam secondary to severe cognitive impairment. Further review indicated that Resident #97 requires substantial assistance from staff for mobility and does not use restraints. On 5/28/24, at 8:30 A.M., the surveyor observed Resident #97 laying in bed with side rails on both sides of the bed extending down to the Resident's thigh and pillows wedged up against the side rails extending down to Resident #97's knees. On 5/29/24, at 7:45 A.M., the surveyor observed Resident #97 laying in bed with side rails on both sides of the bed extending down to the Residents thigh and pillows wedged up against the side rails extending down to Resident #97's knees. Review of the medical record failed to indicate a care plan for the use of restraints. Further review failed to indicate a doctor's order for the use of restraints or an assessment to determine if the side rail/pillow placement combination acts as a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 7:16 A.M., the surveyor and Certified Nurse's Aide (CNA) #4 observed Resident #97 laying in bed with side rails on both sides of the bed extending down to the Resident's thigh and pillows wedged up against the side rails extending down to Resident #97's knees. CNA #4 asked Resident #97 to remove the pillows. Resident #97 tried to lift his/her right arm with his/her left arm to remove the pillow but was unable. During an interview on 5/30/24 at 7:16 A.M., CNA #4 said that the pillows could act as a restraint for Resident #97. CNA #4 then said that Resident #97 does attempt to get out of bed without assist. During an interview on 5/30/24 at 8:50 A.M., the Director of Nursing said that anyone that has a device that could act as a restraint should be assessed to determine if the device does indeed act as a restraint for that person.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review, policy review and interviews, the facility failed to implement their abuse prohibition policy for one Resident (#97) out of a total sample of 23 residents. Specifically, for Resident #97, the facility failed to ensure nursing immediately reported an allegation of potential abuse (bruise of unknown origin) to the Director of Nursing or Administrator, as required. Findings include: Review of the facility policy titled Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and Exploitation, dated October 2022 indicated that possible indicators of abuse include but are not limited to an injury that is suspicious because the source of the injury is not observed . Further review indicated that when alleged violations involving abuse .including injuries of unknown source the following procedure should be followed: Immediately notify the Administrator or Director of Nursing in the Administrators absence. Resident #97 was admitted to the facility in June 2023 with diagnoses including dementia, stroke with right sided hemiplegia (paralysis of one side) and right sided hemiparesis (weakness of one side). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #97 was unable to complete the Brief Interview for Mental Status exam secondary to severe cognitive impairment. Further review indicated that Resident #97 requires substantial assistance from staff for mobility. Review of a facility incident report dated 9/9/23, indicated that Resident #97 sustained a bruise with skin tear of unknown origin to the left upper arm. Review of the nurse's note dated 9/9/23 at 3:51 A.M., indicated that Resident #97 started screaming at 2:00 A.M. on 9/9/23, and one the Certified Nurse's Aids (CNA) told the nurse the Resident was bleeding. The nurse observed a 7 centimeter (cm) x 5 cm round bruise on the left upper arm, hard to touch with a small skin tear that was bleeding and a dressing was applied. Review of the facility document titled Event Report dated 9/9/23, at 3:49 A.M., indicated Resident #97 was observed to have a black/blue/purple bruise on the left upper arm of unknown etiology. Review of the nurse's note dated 9/9/23, at 2:44 P.M., indicated that Resident #97 had a noticeable bleed on the left upper arm which had some seep through bleeding on the dressing. During an interview on 5/29/24 at 9:07 A.M., the Director of Nursing (DON) said that she was not informed of the bruise/skin tear of unknown etiology and had she been informed a full investigation would have been completed, including staff statements.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview, the facility failed to report an allegation of potential abuse/neglect to the state agency as required for one Resident (#97) out of a total of 23 sampled residents. Findings include: Review of the facility policy titled Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and Exploitation, dated October 2022 indicated that possible indicators of abuse include but are not limited to an injury that is suspicious because the source of the injury is not observed . Further review indicated that when alleged violations involving abuse .including injuries of unknown source the following procedure should be followed: Immediately notify the Administrator or Director of Nursing in the Administrators absence. Initiate an investigation, identifying and interviewing all involved persons including all staff on the unit, documenting all interviews. Further review indicated that an initial report will be submitted via the web to the Health Care Facility Reporting System (HCFRS). Resident #97 was admitted to the facility in June 2023 with diagnoses including dementia, stroke with right sided hemiplegia (paralysis of one side) and right sided hemiparesis (weakness of one side). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #97 was unable to complete the Brief Interview for Mental Status exam secondary to severe cognitive impairment. Further review indicated that Resident #97 requires substantial assistance from staff for mobility. Review of the facility incident report dated 9/9/23, indicated that Resident #97 sustained an bruise with skin tear of unknown origin to the left upper arm. Review of the nurse's note dated 9/9/23 at 3:51 A.M., indicated that Resident #97 started screaming at 2:00 A.M. on 9/9/23 and one of the Certified Nurse's Aids (CNA) told the nurse the Resident was bleeding. The nurse observed a 7 centimeters (cm) x 5 cm round bruise on the left upper arm, hard to the touch, with a small skin tear that was bleeding and a dressing was applied. Review of the facility document titled Event Report dated 9/9/23, at 3:49 A.M., indicated Resident #97 was observed to have a black/blue/purple bruise on the left upper arm of unknown etiology. Review of the nurse's note dated 9/9/23, at 2:44 P.M., indicated that Resident #97 had a noticeable bleed on the left upper arm which had some seep through bleeding on the dressing. Review of the state agency reporting system failed to indicate that the bruise and skin tear of unknown etiology was reported as required. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/24, at 9:07 A.M. the Director of Nursing (DON) said that she was not informed of the bruise/skin tear of unknown etiology and had she been informed a full investigation would have been completed, including staff statements. The DON said that because it was an injury on unknown origin, it should have been reported to the state agency.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review, policy review and interviews, the facility failed to thoroughly investigate an injury of unknown origin and failed to maintain evidence that a thorough investigation was completed for one Resident (#97) out of a total sample of 23 residents. Findings include: Review of the facility policy titled Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and Exploitation, dated October 2022 indicated that possible indicators of abuse include but are not limited to an injury that is suspicious because the source of the injury is not observed . Further review indicated that when alleged violations involving abuse .including injuries of unknown source the following procedure should be followed: Immediately notify the Administrator or Director of Nursing in the Administrators absence. Initiate an investigation, identifying and interviewing all involved persons including all staff on the unit, documenting all interviews. Resident #97 was admitted to the facility in June 2023 with diagnoses including dementia, stroke with right sided hemiplegia (paralysis of one side) and right sided hemiparesis (weakness of one side). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #97 was unable to complete the Brief Interview for Mental Status exam secondary to severe cognitive impairment. Further review indicated that Resident #97 requires substantial assistance from staff for mobility. Review of the facility incident report dated 9/9/23, indicated that Resident #97 sustained an bruise with skin tear of unknown origin to the left upper arm. Review of the nurse's note dated 9/9/23 at 3:51 A.M., indicated that Resident #97 started screaming at 2:00 A.M. on 9/9/23 and one of the Certified Nurse's Aids (CNA) told the nurse the Resident was bleeding. The nurse observed a 7 centimeter (cm) x 5 cm round bruise on the left upper arm, hard to touch with a small skin tear that was bleeding and applied a dressing. Review of the facility document titled Event Report dated 9/9/23, at 3:49 A.M., indicated Resident #97 was observed to have a black/blue/purple bruise on the left upper arm of unknown etiology. Review of the nurse's note dated 9/9/23, at 2:44 P.M., indicated that Resident #97 had a noticeable bleed on the left upper arm which had some seep through bleeding on the dressing. During an interview on 5/29/24 9:07 A.M., the Director of Nursing (DON) said that she was unable to find an investigation of the bruise and skin tear of unknown origin. The DON also said that she was not informed of the bruise/skin tear of unknown etiology and had she been informed a full investigation would have been completed, including staff statements and an attempt to determine the origin of the injury.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 49880 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately completed to reflect the status of one Resident (#92) out of a total sample of 23 residents. Specifically, the facility failed to indicate on the MDS assessment that Resident #92 was on hospice services. Findings Include: Resident #92 was admitted to the facility in December 2023 with diagnoses that include chronic kidney disease, neoplastic (malignant) related fatigue and severe protein- calorie malnutrition. Review of Resident #92's most recent MDS indicated a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating that the Resident has severe cognitive impairment. The MDS failed to indicate that Resident #92 was on hospice services. Review of Resident #92's physician orders indicated the following: -May be evaluated by Hospice, dated 4/10/24. -May be admitted to Hospice, dated 4/11/24. Review of Resident #92's care plan, revised 5/7/24, indicated he/she is on hospice services. During an interview on 5/30/24 at 8:43 A.M., the MDS Nurse said that the reason for completing the MDS on 4/23/24 was due to a significant change (electing hospice services). The MDS Nurse and the surveyor reviewed the MDS assessment together. The MDS Nurse said that hospice should be checked off in section O of the MDS assessment and that the assessment was not accurate. During an interview on 5/30/24 at 11:44 A.M., the Director of Nurses (DON) said that she would expect the MDS to be coded correctly indicating that Resident #92 is on hospice services.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview for one Resident (#99), out of a total sample of 23 residents, the facility failed to ensure baseline care plans were developed and implemented within 48 hours of admission. Findings include: Review of the Facility's policy titled 'Interdisciplinary Care Planning' dated as November 2017, indicated the following: 1. The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care within professional standards of quality care. 2. Baseline care plan must: a. Be developed within 48 hours of admission. b. Include the minimum healthcare information necessary to properly care for a resident including but not limited to: 1. Initial goals based on admission orders, ii. Physician's orders, iii. Dietary orders iv. Therapy services v. Social Service vi. PASARR recommendation, if applicable. Resident #99 was admitted to the facility in May 2024 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, urinary tract infection, depression, insomnia, and unsteadiness on feet. Review of the comprehensive Minimum Data Set assessment dated [DATE], indicated Resident #99 had a score of 15 out of 15 on the Brief Interview for Mental Status, indicating he/she is cognitively intact. Review of the Admission Observation Report, completed by a nurse, dated 5/14/24 indicated Resident #99 reported he/she had a fall in the last month, and Resident #99 expresses experiencing pain or hurting in his/her left hip. Review of the John Hopkins Fall Risk Assessment tool dated 5/14/2024 indicated Resident #99 had a fall risk score of 19, level: high risk (greater than 13 points=High Fall Risk). Review of Resident #99's care plans failed to indicate a baseline care plan was developed for Resident #99's high fall risk, nor was a care plan developed for Resident #99's pain. During an interview on 5/30/24 at approximately 9:20 A.M., Unit Manager #3 said when a resident is admitted the nurse who does the nursing admission assessment will put in the baseline care plans. Unit Manager #3 said baseline care plans should include fall risk, pain, and any other care plans specific to a resident's diagnoses, behaviors or other care needs. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 11:16 A.M. the Director of Nursing said baseline care plans are developed upon admission and within 48 hours. The DON said the baseline care plans include basic care plans per diagnoses, behaviors and specialty needs and risks including falls.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observations, record review, policy review and interviews, the facility failed to develop and implement a comprehensive person-centered care plan with individualized interventions for two Residents (#108 and #64) out of a total sample of 23 residents. Specifically, 1. For Resident #108, the facility failed to develop care plans for activities of daily living, risk for falls and psychoactive medication use. 2. For Resident #64, the facility failed to implement the plan of care for air mattress settings. Findings Include: Review of the facility's policy titled, Interdisciplinary Care Planning, dated as revised 11/2017 indicated the following: Comprehensive Care Plans. 3. The care plan process is not limited to developing a written plan but also addresses the ongoing execution of care, treatment, and services. The plan is continually reevaluated and modified to ensure the resident's needs are met. The plan includes the following: *Integrating the assessment findings into the care-planning process, *Developing a plan of care, treatment, and services that includes resident goals that are reasonable and measurable, *Regularly reviewing the care plan and modifying the plan as deemed necessary, *Documenting the plan of care, treatment, and services; dating and updating the documents appropriately, *Monitoring the effectiveness of the care planning and provision of services, *Involving residents and their representative in the planning process. 4. Comprehensive care plans are developed by the interdisciplinary team representing all appropriate health care workers: *As soon as possible after admission to address key clinical areas, *No later than 7 calendar days after the completion of the Comprehensive MDS (Minimum Data Set) for additional triggered areas, *Quarterly, *With a change in resident status, *per regulatory mandates. 1. Resident #108 was admitted to the facility in April 2024 with diagnoses that include but not limited to anoxic brain damage, saddle embolus of pulmonary artery (Saddle pulmonary embolism (SPE) is a rare type of acute pulmonary embolism (PE) that can lead to sudden hemodynamic collapse and death), congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation, hypertension, constipation and dysphagia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #108 scored a 15 out of 15 on the Brief Interview for Mental Status exam (BIMS), and requires substantial to maximal assistance for bathing, and substantial to maximal assistance for personal hygiene. (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 5/28/24 at 10:01 A.M., Resident #108 said he/she came to the facility for rehabilitation and said he/she has made some progress but still needs assistance and uses his/her call bell to request assistance from staff. Review of the MDS Section V- Care Area Assessment Summary, dated 5/7/2024 and signed by an RN (registered nurse) coordinator indicated Resident #108 triggered in the following care areas with the decision to proceed with a care plan: -ADL Functional/Rehabilitation Potential -Falls -Psychotropic Drug Use Review of the CAA summary report dated 5/7/24 indicated the Analysis of findings indicated the following: - CAA 5. Activities of Daily Living -Resident (#108) currently requires moderate-substantial to dependent assist with ADLs (activities of daily living) related to his/her recent hospital stay with an anoxic brain injury dt (due to) cardiac arrest with respiratory failure and hypoxia. He/she is weak and deconditioned and is here for rehab to return to PLOF (prior level of function) and return home if able. Will proceed to care plan. -CAA 11. Falls- Resident (#108) is on an antidepressant to help manage his/her depression and insomnia, which increases his/her risk for falls. His/her fall risk assessment score is 14, which indicates a high risk for falls. His/her gait and balance are unsteady. Will proceed to care plan due high risk. -CAA 17. Psychotropic Medication Use - Resident (#108) was admitted here on an anti-psychotic and anti-depressant to help manage his/her depression and insomnia. These medications put him/her at risk for adverse effects and for falls. Will proceed to care plan. Review of the care plans developed for Resident #108 failed to indicate care plans for ADLs, falls and psychotropic medication use were developed and implemented. During an interview on 5/30/24 at 7:51 A.M., Unit Manager #3 said care plans are developed upon admission and with the MDS schedule. Unit Manager #3 said the MDS nurse completes the MDS assessment and communicates with the team to put in the care plans to the medical record that are needed per resident's assessment. Unit Manager #3 said any resident who is on psychotropic medication should have a care plan developed. Further, Unit Manager #3 reviewed Resident #108's care plans and said he/she should have an ADL care plan and a care plan for risk for falls. 49880 2. Review of facility policy titled Pressure Injury Prevention and Treatment Program, dated February 2022, indicated a person-centered plan of care establishing measurable goals and systematic review will be established and reviewed with the resident and or family. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hannah Duston Healthcare Center	126 Monument Street Haverhill, MA 01832

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #64 was admitted to the facility in September 2021 with diagnoses including vascular dementia, type 2 diabetes, depression and moderate protein- calorie malnutrition. Review of Resident #64's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 indicating that Resident #64 has a severe cognitive impairment. The MDS further indicated that Resident #64 is dependent for rolling left to right in bed. The MDS further indicated that Resident #64 has one or more unhealed pressure ulcers, a stage 2 pressure ulcer, and is at risk for developing pressure ulcers/ injuries. On 5/28/24 at 7:49 A.M., the surveyor observed Resident #64 laying in bed on his/her back. The Resident's air mattress was set at 160. On 5/28/24 at 1:32 P.M., the surveyor observed Resident #64 laying in bed on his/her back. The Resident's air mattress was set at 160. On 5/29/24 at 7:11 A.M., the surveyor observed Resident #64 laying in bed on his/her left side. The Resident's air mattress was set at 160. on 5/29/24 at 11:13 A.M., the surveyor observed Resident #64 laying in bed on his/her back. The Resident's air mattress was set at 160. Review of Resident #64's physician orders, dated 4/14/23, indicated: alternating pressure air mattress set to patients weight of 128 pounds, check function and placement daily. Review of Resident #64's most recent [NAME] Assessment (an assessment to determine pressure ulcer risk) resulted in a score of 5 indicating that Resident #64 is at high risk for skin breakdown and development of pressure ulcers. Review of Resident #64's skin integrity care plan, dated 4/8/23, indicated approaches that included pressure reducing mattress on bed. During an interview on 5/29/24 at 11:00 A.M., the Director of Nurses (DON) said that she would expect the mattress to be set according to the Resident's weight and physician's orders. During an interview on 5/30/24 at 7:30 A.M., Unit Manager #1 said that nurses should check the order and the mattress settings to ensure that the settings are correct.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed to prevent constipation and implement the bowel management protocol for one Resident (#108) out of a total sample of 23 residents. Specifically, for Resident #108, with a known diagnosis of constipation, while also having physician's orders for narcotics to treat pain, (which contributes to risk for constipation), the facility failed to implement the bowel management protcol and failed to have monitored that Resident #108 had no documented bowel movements from 5/19/24 through 5/27/24. Findings include: Review of the facility's policy, entitled 'Bowel Management Protocol', dated revised 9/2020 indicated the following: This facility is committed to providing a comprehensive, interdisciplinary, and science-based approach to bowel management. Although aging increases the potential for incontinence and constipation, this facility has developed systems and procedures to assure: *Assessments are timely and appropriate *Interventions are defined, implemented, monitored, and revised, as appropriate, in accordance with current standards of practice * Changes in condition are recognized, evaluated, reported to the practitioner, and addressed Procedure: 1. The resident is evaluated: a. At the time of admission, b. with a change is status such as a change in cognition, decline in physical ability or decline in bowel function. 2. The resident's medication regimen is reviewed to identify those medications that may contribute to bowel management concerns such as narcotic analgesics, bowel stimulants, antibiotics, etc. 3. The following protocol has been adopted at this facility to manage. It may be overridden by any physician or authorized practitioner at any time, or as requested by the resident (with physician order) in the course of provision of care. a. If the resident has no bowel movement in two (2) days, give MOM (milk of magnesia) 30 ml by mouth at bedtime. b. If the resident has not had a bowel movement, give Bisocodyl (Dulcolax) suppository on the 11-7 shift. c. If still no bowel movement, give a Fleet's enema on the 7-3 shift. 4. The nurse should check nightly to review the resident's bowel status to ensure optimum care. 5. Other medications such as Colace, Senna, Miralax, etc may be added to the resident's specific bowel regimen at the discretion of the practitioner. 6. Use caution in dialysis residents who may be fluid restricted when ordering bowel medication requiring mixture with water or other liquids (examples: Miralax, Metamucil, Benefiber, etc.) 7. Residents should be encouraged to drink sufficient fluids and eat sufficient dietary fiber. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #108 was admitted to the facility in April 2024 with diagnoses that include but not limited to anoxic brain damage, saddle embolus of pulmonary artery (Saddle pulmonary embolism (SPE) is a rare type of acute pulmonary embolism (PE) that can lead to sudden hemodynamic collapse and death), congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation, hypertension, dysphagia and constipation. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #108 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS), and required substantial to maximal assistance for bathing, and substantial to maximal assistance for personal hygiene. Further, the MDS indicated that Resident #108 was coded as frequently incontinent of bowel. During an interview on 5/28/24 at 10:01 A.M., Resident #105 was observed sitting up in a chair. Resident #108 said he/she had been asking for a suppository and the nurses told him/her they do not have an order and he/she must wait for the doctor. Resident #108 said he/she had a hard time moving his/her bowels because it was hard, and the CNA helped to get it out. Resident #108 said he/she has been asking for the suppository for about five days. During a subsequent interview on 5/28/24 at 1:38 P.M., Resident #108 again said he/she has been asking for a suppository for days and could not understand why he/she needed to wait for the doctor, as he/she is having difficulty moving his/her bowels. Review of Resident #108's current physician's orders included the following: -bisacodyl (a laxative) OTC (over the counter) tablet, delayed release, 5 mg; amt (amount)1 tab; oral once a day PRN (as needed), 4/29/2024. -Fleet enema (sodium phosphates) OTC enema; 19-7 gram/118/ml; amt: 1 enema; rectal Once a day- PRN, 4/29/2024. -oxycodone-Schedule II (a narcotic medication, used to treat pain) tablet; 5 mg; amt: 7.5 mg; oral Special Instructions: pain control three times a day 6:00 AM 2:00 PM, 10:00 PM, 5/20/2024 -oxycodone- Schedule II tablet; 5 mg; amt: 7.5 mg; oral Special Instructions: pain control One a day PRN. -docusate sodium (a laxative) OTC capsule; 100 mg; oral twice a day 9:00 A.M., 9:00 P.M. 5/29/24. -polyethylene glycol 3350 OTC powder 17 gram/dose gastric tube once a day 5/29/24. The orders failed to indicate Resident #108 had physician's orders for the bowel management protocol including milk of magnesia and the Bisocodyl (Dulcolax) suppository. Review of Resident #108's care plans failed to indicate a care plan for constipation or interventions including the bowel management protocol, or other individualized interventions was developed and implemented. Review of the document in Resident #108's medical record titled 'Output: Bowel Movement' indicted the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/18/24 5:56 A.M., Bowel Movement: Large. 5/19/24 and 5/20/24, no bowel output documentation. 5/21/24 1:10 A.M. Bowel Movement: None. 5/22/24 and 5/23/24, no bowel output documentation. 5/24/24 1:27 A.M. Bowel Movement: None. 5/25/24 1:30 A.M. Bowel Movement: None. 5/25/24 1:42 P.M. Bowel Movement: None. 5/26/24, no bowel output documentation. 5/27/24 12:41 A.M. Bowel Movement: None 5/28/24 9:21 P.M., Bowel Movement: Large. The bowel movement output documentation indicated Resident #108 had no documented bowel movements from 5/19/24 through 5/27/24 for a total of 9 days. Review of the May 2024 Medication Administration Record (MAR) indicated Resident #108 was administered bisacodyl tablet delayed release 5 mg once a day PRN on 5/22/24. A nursing note dated 5/28/24 at 3:25 P.M., indicated: One time order of a rectal suppository given. Results pending. Complaints of constipation for a week. Hemorrhoids noted. (SIC) Review of the nursing progress notes dated from 5/18/24 through 5/27/24 failed to indicate that nursing addressed that Resident #108 exceeded two days without a bowel movement and failed to indicate the physician or nurse practitioner was notified prior to 5/28/24 to implement the bowel management protocol. During an interview on 5/29/24 at 11:46 A.M., Certified Nursing Assistant (CNA) #6 said Resident #108 was blocked up and has been constipated for a few days. CNA #6 said Resident #108 was having difficulty moving his/her bowels. CNA #6 said he helped Resident #108 by applying pressure on his/her buttocks the day before yesterday (5/27/24). CNA #6 said he told the nurse Resident #108 was constipated but could not recall when and which nurse he told. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/24 at 5:17 P.M., Nurse #2 said she worked over the weekend and said Resident #108 complained of having gas and did not mention being constipated. Nurse #2 said that the CNAs document bowel movements and if a resident is not documented as having a bowel movement, it should pop up for the nurse to review. Nurse #6 said if a resident does not have a bowel movement over 72 hours the bowel protocol is followed, which includes providing a laxative first, and if no results, then a suppository and if no results an enema. Nurse #6 reviewed Resident #108's medical record and said prior to last evening, 5/28/24, the last documented bowel movement was 5/18/24. Nurse #6 said Resident #108 is at risk for constipation due to being on pain medication. Nurse #6 then reviewed Resident #108's orders and said he/she did not have the bowel protocol orders and a one-time suppository was ordered on 5/28/24. Resident #108 went 9 days without a documented bowel movement and staff were aware that he/she was having difficulty moving his/her bowels. During an interview on 5/30/24 at 8:01 A.M., Unit Manager (UM) #3 said the bowel management protocol is put in as an order on admission for residents. UM #3 said Resident #108 was at risk for constipation due to the use of pain medications. UM #3 said a care plan was not developed for the risk for constipation, nor was the bowel management protocol orders put in place for Resident #108 and that the nursing staff should have been monitoring and aware that Resident #108 did not have a bowel movement for several days. During an interview on 5/30/24 at 11:27 A.M., the Director of Nursing said bowel movements should be monitored and if there is no bowel movement the bowel management protocol should be implemented.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to identify and address a new onset of limited range of motion for one Resident (#18) out of a total of 23 sampled residents. Findings include: On 5/30/24 the Administrator informed the the surveyor that the facility does not have a policy regarding limited range of motion or contracture management. Review of the National Library of Medicine articles titled Range of Motion and Limited Range of Motion 9/20/22, indicated: Range of motion (ROM) means the extent or limit to which a part of the body can be moved around a joint or a fixed point; the totality of movement a joint is capable of doing. Range of motion of a joint is gauged during Passive ROM (assisted) PROM or Active ROM (independent) AROM. ROM is usually assessed during a physical therapy assessment or treatment. Normal values depend on the body part, and individual variations. The purpose of ROM exercises are prevention of the development of adaptive muscle shortening, contractures, and shortening of the capsule, ligaments, and tendons. When a joint does not move, fully and easily in its normal manner, it is considered to have a limited range of motion. Resident #18 was admitted to the facility in October 2018 with diagnoses including dementia and arthritis. A diagnosis of dysphagia was added to his/her clinical record in January 2024. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #18 scored two out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS indicated Resident #18 is dependent on staff for eating, transfers and dressing. Additional review of Resident #18's MDS' dated 10/10/23, 1/9/24, and 4/9/24, indicated he/she had no upper extremity (shoulder, elbow, wrist, hand) impairments. On 5/28/24 at 8:04 A.M., the surveyor observed Resident #18 seated in his/her wheelchair in the Pentucket dining room. Resident #18's hands were closed into fists. When asked if he/she could open his/her hands, Resident #18 opened his/her right hand but not his/her left hand. Resident #18 was only able to move his/her fingers slightly on his/her left hand. Resident #18 then attempted to use his/her right hand to pull back his/her fingers on the left hand but was unsuccessful. Review of Resident #18's clinical record indicated that Resident #18 had not been screened, (to determine if he/she could benefit from therapy services) or received services with either Physical Therapy (PT) or Occupational Therapy (OT) since 2018. The PT and OT discharge summaries from 2018 did not indicate that Resident #18 had any limited range of motion in his/her hands. Review of Resident #18's clinical progress notes, diagnoses and care plans did not indicate Resident #18 had limited range of motion in his/her hands, nor did the record indicate that staff were performing range of motion exercises with Resident #18 to prevent contractures or decreased range of motion. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #18's most recent Nurse Practitioner and Physician notes did not indicate Resident #18 had a limited range of motion in his/her hands. Review of the Activities note dated 5/28/24 indicated: Resident #18 has a tough time feeding himself/herself or picking things up by hand without assistance as his/her hands don't work like they did. During an interview on 5/28/24 at 2:28 P.M., Certified Nursing Assistant (CNA) #1 said that Resident #18 had been closing his/her hands in a fisted position for a while. CNA #1 said that Resident #18 cannot open his/her hands completely and the CNA's do not place a hand towel in his/her palms and Resident #18 does not utilize hand splints. During an interview on 5/29/24 at 10:56 A.M., CNA #2 and CNA #3 said that Resident #18 cannot open one of his/her hands completely. CNA #3 said that he/she had been unable to open his/her hand for a few weeks. During interviews on 5/29/24 at 10:59 A.M., and 5/30/24 at 9:50 A.M., Unit Manager (UM) #1 said that Resident #18 has arthritis in his/her hands and he/she had been holding his/her hands in fists since she became the Unit Manager in the fall of 2023. UM #1 said that the expectation would be for CNAs to alert nursing staff regarding any changes in range of motion and a referral to would be placed to rehab (rehabilitation) services. UM#1 said she would alert the rehab department to screen Resident #18's range of motion. When asked if Resident #18 had a stroke or any other neurological issue which could be related to his/her limited range of motion, UM #1 said no. On 5/29/24 at 11:08 A.M., the surveyor entered the [NAME] unit and observed UM #1 speaking with the Rehab Director. UM #1 introduced the surveyor to the Rehab Director and then told the Rehab Director that Resident #18 needed to be screened by rehab because CNAs had reported his/her hand was contracted. During an interview on 5/29/24 at 11:22 A.M., Family Member #1 said that Resident #18 had been holding his/her hands in a closed fist position for approximately six to eight months. During an interview on 5/30/24 at 9:37 A.M., the Rehab Director said that the rehab department does not do routine screens of residents and that referrals and screens are based on nursing requests. On 5/30/24 at 10:02 A.M., the surveyor observed Occupational Therapist (OT) #1 assess Resident #18's hand for limited range of motion. OT #1 was able to provide passive range of motion (PROM) but could not fully open Resident #18's hand. While moving Resident #18's fingers into an open position, OT #1 said, that's a little tight, I can feel it. There was a buildup of an unknown substance on Resident #18's left palm and OT#1 offered to use a face cloth for hygiene. OT #1 said that she could not say if Resident #18 had developed a new contracture. OT #1 said that Resident #18's fingers remained in a fixed, flexed position and could not be fully ranged on his/her left hand. Review of OT #1's evaluation note dated 5/30/24 indicated: (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Reason for referral: Referral to OT to assess LUE (left upper extremity)/hand ROM d/t concern for [question] contracture/decreased ROM. Pain Assessment: c/o (complaints of) increased pain with attempts to perform PROM to 3rd/4th/5th digits past approx [sic] 90 degrees flexion and when performing hand hygiene to L (left) hand. UE (upper extremity) ROM: LUE = impaired. Clinical Impressions: Pt (patient) was agreeable in hand hygiene and trialing face cloth for gentle stretching to L hand digits to maintain skin integrity and prevent further contracture. Max A (maximum assistance) hand hygiene to L hand with use of warm cloth and soap. C/O occas [sic] pain with hand hygiene, subsiding with rest. [Question] if pt would benefit from possible splint d/t (due to) arthritic pain vs. positioning strategies to L hand in order to increase ROM vs prevent further decrease of ROM, maintain skin integrity, improve pt comfort and decrease risk for/prevent further contracture. During a follow up interview on 5/30/24 at 1:25 P.M., the Rehab Director said that Resident #18's limited ROM in his/her left hand was not a contracture and could be related to tone (the muscles becoming resistant to passive stretching.) The Rehab Director said that Resident #18's hands had been like that for a while. The Rehab Director was not aware that there was no information in the clinical record to indicate the onset of Resident #18's limited range of motion, and staff statements to the surveyor ranged between months and weeks since Resident #18 could fully open his/her hand. During an interview on 5/30/24 at 11:35 A.M., the Director of Nursing (DON) and Staff Development Coordinator (SDC) said that when residents demonstrate limited range of motion, it is expected for staff to involve the rehab department, alert the physician and the health care proxy (HCP). During an interview on 5/30/24 at 12:50 P.M., Nurse Practitioner (NP) #1 said that staff are expected to notify her or the physician for any onset of limited range of motion or contracture. NP #1 said that she had seen Resident #18 a couple weeks ago and spoke with his/her HCP. NP #1 said that she did not recall being told about any changes in Resident #18's range of motion. When asked if residents with arthritis could develop contractures or limited range of motion, NP #1 said that anyone who is not moving their bodies regularly could develop contractures or limited range of motion.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure the use of an indwelling urinary catheter had a clinical indication for its use for one Resident (#105) out of seven applicable residents in a total sample of 23 sampled residents. Findings include: Review of the facility's policy titled 'Indwelling Catheter Management' dated as revised 4/2018 indicted the following: Standard: Indwelling catheters may be used for residents whose bladder problem is caused by medical reasons that cannot otherwise be treated and for which alternative therapy is not feasible: i.e. obstruction, terminally ill or severely impaired residents, and residents with pressure ulcers as short-term treatment. 1. Admission: A. When a resident is admitted to the facility with an indwelling catheter, identify 1. Insertion type, 2. Type of catheter, 3. Catheter size, and 4. Balloon size. B. Review the resident's medical history to determine an indication for continued use: 1. Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by: a) documented post void residual (PVR) volumes in a range over 200 milliliters (ml); b) Inability to manage retention/incontinence with intermittent catheterization; and c) persistent overflow incontinence, symptomatic infections, and/or renal dysfunction 2. Contamination of Stage III or IV pressure ulcers with urine which has impeded healing, despite appropriate personal care for incontinence. 3. Terminal illness or severe impairment which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain. 4. Acute illness requiring close monitoring of fluid balance. C. Consult with the physician when reasons for continued usage of the indwelling catheter are not clearly identified and develop a plan to remove the catheter. D. If continued usage of the catheter is indicated, obtain complete physician's orders, E. Review the clinical necessity for continued catheter usage at least quarterly. F. Address catheter usage on the Interdisciplinary Care Plan. Resident #105 was admitted to the facility in April 2024 with diagnoses that include but not limited to hypertension, anemia, chronic kidney disease stage 3, hyperlipidemia, history of non-displaced fracture of the greater trochanter left femur, pneumonia, and deep vein thrombosis. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #105 scored an 11 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment and was dependent for bathing and had an indwelling catheter. Further review of the MDS indicated that Resident #105 was not coded as having any unhealed pressure ulcers or a life expectancy of less than six months. On 5/29/24 at 7:33 A.M., the surveyor observed Resident #105 resting in bed with his/her eyes closed. A urinary drainage bag was hooked on to the bed and contained yellow urine. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hannah Duston Healthcare Center	126 Monument Street Haverhill, MA 01832

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the observation report conducted by nursing dated 4/30/24 indicated the following: genitourinary: Indwelling catheter. Review of the care plan dated 5/7/24 indicated Resident (#105) requires an indwelling urinary catheter R/T (related to) hospital report of urinary retention. Review of Resident #105's physician orders indicated the following: Change Foley catheter monthly with a #16 French with a 10-cc balloon 5/7/2024. Review of the hospital discharge summary and additional paperwork from the referring hospital for Resident #105 indicated the following: nephrology consult recommendation: dated 4/23/24 obtain bladder scan to exclude retention. Further, review of the hospital discharge paperwork failed to indicate results or documentation related to a bladder scan performed for Resident #105. The hospital discharge summary and additional documentation did not indicate a clinical indication for the use of an indwelling urinary catheter, a plan for continued use, or if Resident #105 had urinary retention. During an interview on 5/29/24 at 4:50 P.M., Nurse #2 said Resident #105 was admitted to the facility with the indwelling urinary catheter and she did not recall if there was a voiding trial. During an interview on 5/29/24 at 4:54 P.M., Unit Manager (UM) #3 said Resident #105 was admitted to the facility with the indwelling urinary catheter and since admission Resident #105 has been declining, staying in bed and could be uncomfortable with movement and this could be one reason why the indwelling catheter was in use. UM #3 said Resident #105 had a consult for palliative care earlier in the month. UM #3 said she would review the hospital paperwork and get more information about the clinical use of the urinary indwelling catheter. During an interview on 5/30/24 at 12:23 P.M., UM #3 said she had reviewed Resident #105's hospital paperwork and was unable to determine the clinical reason for the use of the indwelling Foley catheter. UM #3 said the care plan indicated urinary retention from the hospital, but she did not see that information in the hospital paperwork and has asked the unit secretary to obtain further information from the hospital. During an interview on 5/30/24 at 12:39 P.M. Nurse Practitioner (NP) #1 said she reviewed Resident #105's chart and did not see a clinical indication for the indwelling urinary catheter. NP #1 said she was aware that Resident #105 was admitted to the facility with an indwelling urinary catheter. NP #1 said an indication for continued use is assessed by determining if it is used for a chronic condition, and if not, typical practice would be to do a voiding trial. NP #1 said she is hesitant now to pull the indwelling catheter because the Resident is moving towards comfort care. NP#1 said she read the discharge summary from the hospital and did not follow up on the need for the continuation of the urinary indwelling catheter.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 49880 Based on observation, record review and interview the facility failed to adhere to professional standards for the administration of enteral feeding (nutrition taken through a tube directly to the stomach or small intestine) for one Resident (#91) out of a total sample of 23 residents. Specifically, the facility failed to implement the enteral feeding in accordance with the physician's order to receive the enteral feeding for 20 hours per day. Findings Include: Resident #91 was admitted to the facility in September 2022 with diagnoses that include dysphagia following cerebral infarction, gastrostomy tube and dementia. Review of Resident #91's Minimum Data Set (MDS) Assessment, dated 3/5/24, indicated he/she was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff has having severe cognitive impairment. The MDS Assessment further indicated that Resident #91 utilizes a feeding tube. On 5/28/23 at 12:23 P.M., the surveyor observed staff bring Resident #91 out of his/her room in a wheelchair. Resident #91 was not connected to his/her enteral feeding. Resident #91 was then assisted into the hallway near the nurses station. On 5/28/23 at 1:29 P.M., the surveyor observed Resident #91 in his/her wheelchair at the nurses station. Resident #91 was not connected to his/her enteral feeding. Review of Resident #91's physician's orders, dated 1/26/24, indicated Jevity 1.2 Cal (a type of enteral feeding) to be hung at 85 ml/hr (milliliters per hour) for 20 hours per day, up at 6:00 P.M., and take down at 2:00 P.M. Review of Resident #91's progress notes failed to indicate that the enteral feeding was taken down early on 5/28/24 and that a physician was notified that the Resident did not receive the enteral feeding in accordance with physician orders. During an interview on 5/29/24 at 12:57 P.M., Unit Manager #1 said she would expect that the enteral feeding would be connected to Resident #91 until 2:00 P.M. in accordance with physician's orders. She then said that even if the Resident is out of his/her room in the hallway, the enteral feeding should remain connected until 2:00 P.M. During an interview on 5/30/24 at 11:44 A.M., the Director of Nurses (DON) said that she would expect Resident #91 to get his/her enteral feeding for 20 hours per day in accordance with physician's orders.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 49880 Based on observation, record review, policy review, and interview, the facility failed to provide care and maintenance of a peripherally inserted central catheter (PICC), consistent with professional standards of practice for one Resident (#39), out of a total sample of 23 residents. Specifically, for Resident #39 the facility failed to ensure nursing completed a PICC line dressing change as ordered by the physician. Findings Include: Review of facility policy titled Central Venous Access Device Catheter Dressing Change, dated January 2022, indicated the following: -Policy: 4. dressing changes will occur according to the IV (intravenous) order and when the dressing is compromised (Drainage/ moisture observed, loose, soiled). -Procedure: 16. document site assessment and procedure (dressing change) in resident's medical record. Resident #39 was admitted to the facility in May 2024 with diagnoses that include osteomyelitis left ankle and foot, pathological fracture left foot and cellulitis right and left lower limb. Review of Resident #39's most recent Minimum Data Set (MDS) Assessment, dated 5/22/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #39 is cognitively intact. The MDS further indicated that Resident #39 is on IV antibiotics and has a central line/ IV access. On 5/28/24 at 9:30 A.M., the surveyor observed a peripherally inserted central catheter (PICC) line in Resident #39's right arm. There was a red substance consistent with blood under the dressing at the insertion site and the dressing was dated as 5/16/24. On 5/28/24 at 2:00 P.M., the surveyor observed the PICC line in Resident #39's right arm. There was a red substance consistent with blood under the dressing at the insertion site and the dressing was dated 5/16/24. Review of Resident #39's physician orders, dated 5/17/24 indicated, PICC dressing change transparent dressing weekly. Review of Resident #39's IV therapy care plan, dated 5/17/24, indicated to complete IV site dressing change as ordered. Review of Resident #39's progress notes failed to indicate that a PICC line dressing change had been completed since admission to the facility. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/24 at 11:04 A.M., the Director of Nurses (DON) observed the PICC line dressing dated 5/16/24 and said that she would expect that the dressing is changed weekly in accordance to physician orders or as needed if the dressing is soiled and peeling.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure for one Resident (#162) out of two applicable residents out of a total sample 23 residents that professional standards of care were developed and implemented for the care of a hemodialysis access site. Specifically, the care and treatment of an internal jugular (IJ) catheter, (a type of central venous catheter that is inserted in the internal jugular vein for hemodialysis). Findings include: Resident #162 was admitted to the facility in May 2024 with diagnoses that include, but are not limited to, chronic obstructive pulmonary disease, end stage renal disease, and dependence on renal dialysis. (Hemodialysis is a treatment for advanced kidney failure that filters wastes, salts and fluid from your blood). Review of the Minimum Data Set assessment dated [DATE] indicated Resident #162 had intact cognition with a score of 13 out of 15 on the Brief Interview for Mental Status exam, required partial to moderate assistance with most activities of daily living and is on dialysis. During an interview and observation on 5/28/24 at 8:39 A.M., Resident #162 was sitting on the side of his/her bed. Resident #162 said he/she goes out three times a week for dialysis. Resident #162 pulled at his/her clothing, revealing a catheter on his/her right chest, the end of the catheter was wrapped in gauze. Resident #162 said the staff at the dialysis center take care of the catheter and dressing. Review of Resident #162's acute care hospital discharge summary dated as created 5/21/24, indicated a past medical history of ESRD (end stage renal disease) on HD (hemodialysis) via right chest dialysis cath (catheter) MWF (Monday, Wednesday, Friday). Further, under imaging findings: lines/tubes: Tunneled right IJ (internal jugular) dialysis catheter present, tip in the right atrium. Further review of Resident #162's medical record indicated the following: -A nursing observation document dated 5/21/24, skin comments: right chest port-a-cath. -A care plan dated 5/23/24, hemodialysis related to renal failure. Goal: Maintain vascular access. Interventions dated 5/23/24 included: Assess and document vital signs, including blood pressure in the arm where the access site is not located, avoid constrictive clothing, jewelry or excessive pressure on affected extremity, avoid vital signs and blood draws in access extremity (specify site) left blank, maintain integrity of dressing if present monitor for any reports of pain, numbness, tingling in extremity with access site, monitor for extremity swelling distal to the access site, monitor patency of shunt by palpating for thrill and bruit, shunt fistula location: right chest. Review of the interventions on the hemodialysis care plan indicated interventions regarding an extremity fistula (a shunt placed in an arm for dialysis access) and failed to be specific and individualized for Resident #162's IJ catheter for hemodialysis access. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Progress notes for Resident #162 entered by nursing indicated the following: -5/21/24 Res has a right sided port-a-cath. Review of nursing progress notes dated 5/21/24 at 2:32 P.M., 5/22/24 at 11:30 A.M., 5/22/24 at 4:43 P.M., 5/28/24 at 11:55 P.M., failed to address the presence of the right IJ catheter, or a plan of care for the care, and monitoring of the IJ catheter. Review of the current physician's orders history failed to indicate an order or medical plan of care for the IJ catheter located on Resident #162's right chest. On 5/29/24 at 8:44 A.M., Resident #162 was observed with a right chest catheter with the end wrapped in gauze and gauze at the insertion site. During an interview on 5/29/24 at 3:17 P.M., Nurse #3 said she was the nurse who admitted Resident #162 and did the assessments and paperwork with the Resident. Nurse #3 said another nurse reviewed and obtained the orders. Nurse #3 said vital signs are done before and after Resident #162's dialysis days, they update the communication book that the Resident brings to dialysis. Nurse #3 said the Resident has a right port-a-cath and there are supposed to be orders for monitoring of the catheter. Nurse #3 reviewed the orders and said that there was no order for the monitoring of the right port-a-cath. During an interview on 5/29/24 3:25 P.M., Charge Nurse #1 said Resident #162 should have physician's orders for the monitoring of the chest catheter. During an interview on 5/29/24 at 4:44 P.M., Nurse #2 said Resident #162 was back from dialysis. Nurse #2 said she checks in with the Resident upon return and checks his/her vital signs. Nurse #2 said she would check the catheter for patency, bruit and thrill, (patency assessed by feeling the 'thrill' or vibration of blood through the access or using a stethoscope to listen to the 'bruit' or 'whoosh' of blood through the access). The presence of an external catheter on Resident #162's right chest is not an arterial/venous graft site and therefore cannot be checked for bruit and thrill. During an interview on 5/30/24 at .7:43 A.M., Unit Manager #3 said the IJ dialysis catheter should be monitored for bleeding, drainage and that the dressing is intact and should have physician orders. Unit Manager #3 said this is the first dialysis patient she has seen since starting at the facility a few months ago. Unit Manager #3 said no recent education was provided for residents requiring dialysis or residents requiring IJ catheters. During an interview on 5/30/24 at 11:19 A.M. the Director of Nursing said referrals to the facility are reviewed before accepting a resident, to ensure the facility can provide for their care. The DON said she is cautious about IJ catheters, and the plan of care should have physician's orders to monitor the catheter access site. See F726

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36431 Based on observation, record review and interview the facility failed to ensure licensed nursing staff possessed the appropriate competency and skills to care for one Resident (#162) out of two applicable residents, requiring dialysis, out of a total sample of 23 residents, and 2. the facility failed to ensure nursing staff had been provided with education or demonstrated necessary competencies to care for residents in the facility with specialized needs, inclusive of dialysis care and treatment. Findings include: Review of the Facility assessment dated [DATE] indicated that for specialized services, on average, the facility has an average of three residents receiving IV medications, two residents receiving dialysis, and 38 residents receiving injections. The Facility Assessment also indicated: Staff training/education and competencies: Staff that are hired all go through facility orientation. On day two, new employees receive 8 hours of dementia training inclusive of abuse, neglect, non-pharmacological interventions then four hours of partially interactive training annually thereafter. Length of orientation is based on experience; new grads receive additional training on the units. We have preceptors and senior aides to guide new staff as well as charge nurses on the units. All new hires are signed off on an orientation check list before working independently on the unit. If an issue is identified and additional education is needed, that will be provided to the individual as well as to others in the department. The Facility Assessment did not indicate methods or means for ongoing competency evaluation or training for licensed nurses related to specialized treatments. 1. Resident #162 was admitted to the facility in May 2024 with diagnoses that include, but are not limited to, chronic obstructive pulmonary disease, end stage renal disease, and dependence on renal dialysis. (Hemodialysis is a treatment for advanced kidney failure that filters wastes, salts and fluid from your blood). Review of the Minimum Data Set assessment dated [DATE] indicated Resident #162 had intact cognition with a score of 13 out of 15 on the Brief Interview for Mental Status exam, required partial to moderate assistance with most activities of daily living and is on dialysis. During an interview and observation on 5/28/24 at 8:39 A.M., Resident #162 was sitting on the side of his/her bed. Resident #162 said he/she goes out three times a week for dialysis. Resident #162 pulled at his/her clothing, revealing a catheter on his/her right chest, the end of the catheter was wrapped in gauze. Resident #162 said the staff at the dialysis center take care of the catheter and dressing and the facility staff do not provide any care to the catheter. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #162's acute care hospital discharge summary dated as created 5/21/24, indicated a past medical history of ESRD (end stage renal disease) on HD (hemodialysis) via right chest dialysis cath MWF (Monday, Wednesday, Friday). Further, under imaging findings: lines/tubes: Tunneled right IJ (internal jugular) dialysis catheter present, tip in the right atrium. (An IJ dialysis catheter is a type of central venous catheter that is inserted in the internal jugular vein for hemodialysis). Further review of Resident #162's medical record indicated the following: -A nursing observation document dated 5/21/24, skin comments: right chest port-a-cath. -A care plan dated 5/23/24, hemodialysis related to renal failure. Goal Maintain vascular access. Interventions dated 5/23/24 included: Assess and document vital signs, including blood pressure in the arm where the access site is not located, avoid constrictive clothing, jewelry or excessive pressure on affected extremity, avoid vital signs and blood draws in access extremity (specify site) left blank, maintain integrity of dressing if present monitor for any reports of pain, numbness, tingling in extremity with access site, monitor for extremity swelling distal to the access site, monitor patency of shunt by palpating for thrill and bruit, shunt fistula location: right chest. Review of the interventions on the hemodialysis care plan indicated interventions regarding an extremity fistula (a shunt placed in an arm for dialysis access) which is not what Resident #162 has for dialysis access and failed to be specific and individualized for Resident #162's IJ catheter for hemodialysis access. Review of the current physician's orders history failed to indicate an order or medical plan of care for the IJ catheter located on Resident #162's right chest. On 5/29/24 at 8:44 A.M., Resident #162 was observed with a right chest catheter with the end wrapped in gauze and gauze at the insertion site. During an interview on 5/29/24 at 4:44 P.M., Nurse #2 said Resident #162 was back from dialysis. Nurse #2 said she checks in with the Resident upon return and checks his/her vital signs. Nurse #2 said she would check the catheter for patency, bruit and thrill, (patency is assessed by feeling the 'thrill' or vibration of blood through the access or using a stethoscope to listen to the 'bruit' or 'whoosh' of blood through the access). The presence of an external catheter on Resident #162's right chest is not an arterial/venous graft site and therefore cannot be checked for bruit and thrill. During an interview on 5/29/24 3:25 P.M., Charge Nurse #1 said Resident #162 should have physician's orders for the monitoring of the chest catheter. Charge Nurse #1 said she was not aware what an IJ catheter would require for emergency preparedness and that they have not had many residents on the unit who require dialysis or have an IJ catheter. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/30/24 at 7:43 A.M., Unit Manager (UM) #3 said the IJ dialysis catheter should be monitored for bleeding, drainage and that the dressing is intact and should have physician orders. UM #3 said this is the first dialysis patient she has seen since starting at the facility a few months ago. UM #3 said no recent education was provided for residents requiring dialysis or residents requiring IJ catheters. During an interview on 5/30/24 at 11:19 A.M. the Director of Nursing said referrals to the facility are reviewed before accepting a resident, to ensure the facility can provide for their care. The DON said she is cautious about IJ catheters. 36876 2. Review of employee records indicated that three of four licensed nursing staff had no evidence that nursing competencies had been evaluated upon hire or annually. During an interview on 5/30/24 at 10:32 A.M., the Staff Development Coordinator (SDC) said that the expectation is upon hire, nursing staff have their competencies evaluated. The SDC had only been working in the facility for a few months and was unable to locate evidence that three of the four selected nursing staff reviewed had nursing competencies evaluated. The SDC agreed that one of the four who had received competency training and evaluation, was not inclusive of dialysis training.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, interview, document review, and policy review, the facility failed to ensure an accurate account of a controlled medication was maintained. Specifically, the facility failed to ensure an accurate account of an Opioid; a Fentanyl patch (schedule II -controlled drug with a high potential for abuse, treats pain) was accurately maintained in the controlled substance accountability record book, as required, and failed to implement their policy for the potential discrepancy, loss and/or diversion of a controlled medication. Findings include: Review of the facility policy titled Discrepancies, Loss and/or Diversion of Medications, dated December 2019, indicated that immediately upon the discovery or suspicion of a discrepancy, suspected loss of diversion, the Administrator, Director of Nursing and the Consultant Pharmacist are notified and an investigation conducted. Further review indicated that if the loss is a controlled substance, the loss is documented. Resident #212 was admitted to the facility in April 2024 with diagnoses including quadriplegia (paralysis of all extremities) and stroke. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated that Resident #212 experienced frequent pain that interfered in daily life. Further review indicated that Resident #212 is treated for pain with a scheduled Opioid. Review of the doctor's order indicated an order for Fentanyl - schedule II patch 72 hour; 75 mcg (micrograms)/hr (hour); amount to administer: 1 patch; transdermal (on skin) every three days. Review of the Medication Administration Record (MAR) dated 5/25/24 indicated that the nurse applied the Fentanyl patch as ordered. Review of the nurse's note dated 5/25/24, indicated that the Fentanyl patch (narcotic patch used to treat pain) applied previously was missing. Further review failed to indicate that the nurse notified administration of the missing Fentanyl patch. Review of the narcotic recording book indicated that a Fentanyl 75 mcg. patch was applied at 7 A.M., on 5/25/24. Further review failed to indicate that the old patch was removed and destroyed or that it was missing. During an interview on 5/29/24 at 10:26 A.M., the Director of Nursing (DON) said that the process for a missing Fentanyl patch would be to notify her and she would then complete an investigation and report to the state Health Care Reporting System (HCFRS). The DON then said that she had not been informed of the missing Fentanyl patch and no investigation had been completed. The DON the said that the narcotic recording book should have indicated that the old patch was unable to be located.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49880 Based on observation, policy review and interview the facility failed to ensure staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically: 1. The facility failed to properly secure medications and medication carts on two of three units. 2. The facility failed to ensure medication carts were kept clean and orderly on one out of three medication carts reviewed. Findings Include: Review of facility policy titled Medication Storage in the Facility, December 2019, indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The facility policy further indicated Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity. 1. During an observation on 5/28/24 at 6:59 A.M., the surveyor observed a medication cart unlocked and unattended in the hallway accessible to visitors and residents on the Pentucket Unit. During observation of a medication pass on 5/29/24 at 7:32 A.M. on the Pentucket Unit, Nurse #4 walked away from her unlocked medication cart to get gloves from the storage room. Nurse #4 left the surveyor at her unlocked medication cart with medications out on top of the cart. At 7:33 A.M., Nurse #4 then left the medication cart again to retrieve insulin syringes from the nurse at the second medication cart on the unit. Nurse #4 again left the surveyor at her unlocked medication cart with medications out on top of the cart. At 7:42 A.M., Nurse #4 retrieved the vital signs tower and went into a resident's room to check their blood pressure prior to medication administration. Nurse #4 left a cup of Miralax (a medication used to treat constipation) on top of her medication cart unattended and within reach of other residents. During an observation on 5/29/24 at 5:05 P.M., the surveyor observed a medication cart parked in the hallway outside of a resident's room on the [NAME] Unit unlocked and unattended. Charge Nurse #1 came by saw the unlocked medication cart and locked it. Nurse #2 exited a resident room and said the medication cart should have been locked when she left the cart. During an interview on 5/29/24 at 11:04 A.M., the Director of Nurses said that medication carts should be locked when unattended. She further said nurses should not walk away from the medication cart with medications on top of the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a medication storage observation on 5/29/24 at 12:07 P.M., the low end medication cart on the [NAME] Unit had approximately 11 loose pills in the second drawer. In the third draw of the medication cart there was a pink sticky substance on the bottom of the draw. During an interview on 5/29/24 at 12:08 P.M., Nurse #1 said there should not be loose pills in the medication cart and that the cart should be clean without substances in the drawers. During an interview on 5/30/24 at 11:44 A.M., the Director of Nurses said that medication carts should be clean and free from loose pills and spills.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, interviews, the resident group meeting and test tray results, the facility failed to ensure foods provided to residents were prepared by methods that conserve nutritional value, flavor, were palatable and at appetizing temperatures on 3 out of 3 units. Findings include: Review of the facility Food Temperature policy, undated, indicated: Keep the temperature of potentially hazardous cold foods no greater than 41 degrees F. During the screening portion of the survey, numerous residents expressed concerns about poor food quality, palatability, and temperature. During the Resident Group Meeting conducted on 5/29/24 at 2:05 P.M., the Residents said the following: -The food is yuck -The food is institutional All 17 residents participating in the meeting said that hot food is not served hot and that cold food items are not served cold. The residents said this occurs for all three meals. The residents also said they have brought up their concerns around their meals during meetings and are told they are working on it. On 5/29/24 at 11:15 A.M. the surveyor observed temperatures taken in the kitchen prior to distributing to the units. The surveyor observed the temperatures of all the liquids being served, including but not limited to, milk, juice, and soda to have temperatures between 50 F (degrees Fahrenheit) and 70 F. During an interview on 5/29/24 at 11:30 A.M. The Food Service Director (FSD) said that the liquids are pre-poured and placed on the trays in all the 6 food trucks before the food plating begins, which can take more than an hour. The FSD then said that the temperature of the liquids was too warm. The FSD also said that hot food was to be maintained at least 140 F or above. On 5/30/24 at 8:08 A.M., the surveyor observed the 2nd food truck arrive on the Pentucket Unit. While staff were delivering the meals, they left the doors to the truck open allowing the food to cool. At 8:38 A.M., the residents were served, and the surveyor conducted a test tray: Waffles with strawberry topping: 110 F. Tasted mushy, lukewarm and bland. Milk: 59 F. Tasted lukewarm. There were no other items such as coffee, tea or hot cereal on the test tray. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/24 at 8:11 A.M., the surveyor observed the food truck arrive on the [NAME] unit. While staff were delivering meals, they left the truck doors open allowing food to cool. At 8:30 A.M., the residents were served, and the surveyor conducted a test tray: Waffles with strawberry topping: 123.9 F. Tasted bland, lukewarm and mushy. Milk: 55.3 F. Tasted lukewarm. There were no other items such as coffee, tea or hot cereal on the test tray. On 5/30/24 at 8:30 A.M., the meal truck arrived at the [NAME] Unit. At 8:40 A.M., the residents were served, and the surveyor received the test tray and recorded the following: Waffles with strawberry topping: Tasted lukewarm, dry, with minimal strawberry syrup, which was absorbed in the waffle. Tea, served in a Styrofoam cup was 110.4 F. Tasted warm, not hot. Coffee, served in a Styrofoam cup was 115.8 F. Tasted warm, not hot. Milk was 52.5 F. Tasted cool, not cold. There was no sugar, cream or hot cereal served on the test tray. The facility failed to ensure that meals were served at temperatures that were palatable and appetizing to the residents.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on observation, record review, policy review and interviews, the facility failed to provide special eating equipment and utensils for one resident (#101) out of a total sample of 23 residents. Specifically, for Resident #101, the facility failed to provide built-up utensils with foam during meal service. Findings Include: Review of facility policy titled Adaptive Eating Equipment, dated 2/12/24, indicated adaptive eating devices are pieces of equipment used by residents to enable them to achieve or maintain their highest practicable level of eating independence. The policy further indicated the Culinary Department sanitizes the utensils after each use and places the devices on the resident's tray as needed. Resident #101 was admitted to the facility in March 2024 with diagnoses that include rheumatoid arthritis, moderate protein calorie malnutrition and abnormalities of gait and mobility. Review of Resident #101's most recent Minimum Data Set Assessment (MDS), dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. On 5/28/24 at 8:15 A.M., the surveyor observed Resident #101 eating his/her breakfast in bed. The meal ticket on the tray indicated the use of built-up utensils with foam. The Resident's tray did not have built-up utensils. On 5/28/24 at 12:28 P.M., Resident #101's lunch tray was served and did not include built-up utensils. The Resident was observed eating without the built-up utensils. On 5/29/24 from 12:43 P.M. to 12:49 P.M., the surveyor observed Resident #101 eating lunch. The utensils sent on the Resident's meal tray were not built-up with foam. The surveyor observed the Resident drop the fork twice and continually need to re-grip and reposition the fork while eating. Resident #101 said that it is hard to hold utensils that are not built-up because of his/her hands. Review of Resident #101's active nutrition care plan dated 3/16/24 indicated to serve his/her meals with built-up utensils. Review of Resident #101's nutrition note, dated 5/22/24, indicated that his/her meals should be serviced with built-up utensils. During an interview on 5/29/24 at 12:53 P.M., Unit Manager #1 said that utensils built-up with foam should be sent from the kitchen for every meal. She said she would expect that the staff who are checking the trays for accuracy would verify that the utensils are on the tray. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 8:30 A.M., the Director of Nurses (DON) said that she would expect the Resident to have built-up utensils as per the Resident's plan of care. The DON said that she would expect that staff are ensuring the built-up utensils are provided.

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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. 36797 Based on observation and interview, the facility failed to store and prepare food under sanitary conditions in the facility's main kitchen. Findings include: During a kitchen walk through on 5/28/24 at 7:05 A.M., the following was observed: - nine cases of food directly on the floor of the food storage room. - one tray of cinnamon buns unlabeled and not dated. - a container of opened whole milk that was undated and unlabeled. - a container of opened Lactaid milk that was undated and unlabeled. - a container of opened orange juice that was undated and unlabeled. - two containers of opened Half & Half that were undated and unlabeled. - two containers of opened cranberry juice that were undated and unlabeled. - one plastic to go cup of Boba tea open and without a date. - two gallons of applesauce open and not dated. - one quart container of pureed orange colored fruit open and not dated. - one quart container of pineapple chunks open and not dated. - a tray of Jello and fruit cups open and dated 5/21/24. - a tray of pasta tortellini open and not dated. - one pound of ham open, unlabeled and without a date. - five trays of cups of drinks including but not limited to, milk, juice and soda unlabeled and not dated. The tray on top had a number of half empty cups and a brown liquid substance on the paper tray protector. - one half used angel food cake open without a date. - a container of ham salad dated 5/19/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- one jar of ketchup dated opened 1/27/24. During an interview on 5/28/24 at 7:30 A.M. the Food Service Director (FSD) said that all open food should be labeled and dated and discarded three days after opening. On 5/29/24 at 11:37 A.M., the surveyor observed a bearded staff member plating food in the kitchen during the lunch service without wearing a protective cover for his facial hair. During an interview on 5/29/24 at 11:37 A.M. the FSD said that all staff members with beards should wear a net covering the facial hair to prevent contamination of the food.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49880 Based on observation, record review and interview, the facility failed to maintain accurate medical records in accordance with professional standards and practices for one Resident (#39) out of a total sample of 23 residents. Specifically, for Resident #39 the facility inaccurately documented the changing of a peripherally inserted central catheter (PICC) dressing. Findings include: Resident #39 was admitted to the facility in May 2024 with diagnoses that include osteomyelitis left ankle and foot, pathological fracture left foot and cellulitis right and left lower limb. Review of Resident #39's most recent Minimum Data Set (MDS) Assessment, dated 5/22/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #39 is cognitively intact. The MDS further indicated that Resident #39 is on IV antibiotics and has a central line/ IV access. On 5/28/24 at 9:30 A.M., the surveyor observed a peripherally inserted central catheter (PICC) line in Resident #39's right arm. There was a red substance consistent with blood under the dressing at the insertion site and the dressing was dated as 5/16/24. On 5/28/24 at 2:00 P.M., the surveyor observed the PICC line in Resident #39's right arm. There was a red substance consistent with blood under the dressing at the insertion site and the dressing was dated 5/16/24. Review of Resident #39's physician orders, dated 5/17/24 indicated, PICC dressing change transparent dressing weekly. Review of Resident #39's IV therapy care plan, dated 5/17/24, indicated to complete IV site dressing change as ordered. Review of Resident #39's May 2024 Medication Administration Record indicated that the PICC line dressing change was signed off as completed on 5/20/24 and 5/27/24. Review of Resident #39's progress notes failed to indicate that a PICC line dressing change was completed on 5/20/24 or 5/27/24. During an interview on 5/29/24 at 11:04 A.M., the Director of Nurses (DON) said that she would expect that if an order is signed off on the Medication Administration Record that it has been completed as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49880 Based on observations and interviews, the facility failed to ensure that staff transported linens to prevent the spread of infection on one out of three units. Findings Include: On 5/29/24 at 7:15 A.M., the surveyor observed Certified Nursing Assistant (CNA) #5 exit a resident room on the Pentucket Unit with gloved hands carrying dirty, un-bagged linens and bring them into the dirty laundry room. On 5/29/24 at 7:17 A.M., the surveyor observed CNA #1 exit a resident room on the Pentucket Unit carrying dirty, un-bagged linen through the hallway and bring them into the dirty laundry room. On 5/29/24 at 7:37 A.M., the surveyor observed CNA #7 exit a resident room on the Pentucket Unit carrying dirty un-bagged linen through the hallway and bring them into the dirty laundry room. On 5/29/24 at 7:40 A.M., the surveyor observed CNA #5 exit a resident room on the Pentucket Unit with gloved hands carrying dirty, un-bagged linens and bring them into the dirty laundry room. On 5/29/24 at 7:44 A.M., the surveyor observed CNA #8 exit a resident room on the Pentucket Unit with gloved hands carrying dirty, un-bagged linens and being them into the dirty laundry room. On 5/29/24 the surveyor requested a policy for transporting linen, and the Administrator said that they did not have one. During an interview on 5/29/24 at 8:24 A.M., Unit Manager #1 said that staff should not be entering the hallways with gloved hands or un-bagged dirty linens. She said that staff should be bringing linen baskets to the doorway of the resident room or placing dirty linens in a bag to transport them to the dirty laundry room. During an interview on 5/29/24 at 11:01 A.M., the Director of Nurses said that staff should be placing dirty linen in a bag for transport and that staff should not be wearing gloves in the hallway.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49880 Based on record review, policy review and interview the facility failed to provide pneumococcal vaccination to two Residents (#101 and #93) who consented to receive the vaccine out of a five sampled residents. Specifically: 1. For Resident #93, the facility failed to administer the pneumococcal vaccine after the Resident/ Resident Representative signed the consent for the vaccine on 8/17/23. 2. For Resident #101, the facility failed to administer the pneumococcal vaccine after the Resident/ Resident Representative signed the consent for the vaccine on an undated form. Findings Include: Review of facility policy titled Immunization & Vaccination of Residents, dated as revised January 2024, indicated It is the policy of this facility that all residents are offered immunizations and vaccinations that help in preventing infectious disease, unless medically contraindicated or otherwise ordered by the resident's attending physician or the facilities Medical Director. The policy further indicated 1. All residents will be offered influenza, Prevnar 13, pneumovax 23, Covid-19 vaccines upon admission. 1. Resident #93 was admitted to the facility in August 2023 with diagnoses that include dementia. Review of Resident #93's medical record indicated a consent to receive the pneumococcal vaccine, signed and dated 8/17/23. Further review of the medical record failed to indicate that Resident #93 received the pneumococcal vaccine. 2. Resident #101 was admitted to the facility in March 2024 with diagnoses that include rheumatoid arthritis, moderate protein calorie malnutrition and abnormalities of gait and mobility. Review of Resident #101's medical record indicated a consent to receive the pneumococcal vaccine, signed and undated. Further review of the medical record failed to indicate that Resident #101 received the pneumococcal vaccine. During an interview on 5/30/24 at 12:35 P.M., the Infection Control Nurse said that the facility process for vaccinations is that the nurses offer the vaccines on admission and follow up with the physician for orders to administer the vaccines. She reviewed Resident #101 and Resident #93's medical records and said she did not see any physician's orders for the pneumococcal vaccination. She also reviewed the Massachusetts Immunization Information System (MIIS) to determine if either Resident had previously received a pneumococcal vaccine, she said neither resident had a recorded history of receiving the vaccine. The Infection Control Nurse said that both Residents should have received the pneumococcal vaccine. During an interview on 5/30/24 at 12:45 P.M., Nurse #3 said if a resident consents for any vaccines, they notify the Infection Control Nurse (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 12:26 P.M., Unit Manager #3 said that if a resident consents to any vaccines on admission the nurse should let the physician and the Infection Control Nurse know so that it can be ordered from the pharmacy.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on observation and interview, the facility failed to ensure a gap in the bed was filled to prevent possible entrapment for one Resident (#79) out of a total sample of 23 residents. Findings include: Resident #79 was admitted to the facility in December 2023 with diagnoses that include hemiplegia and hemiparesis, dysarthria, visuospatial deficit, and spatial neglect following cerebral infarction. Review of Resident #79's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #79 is cognitively intact. The MDS further indicated that Resident #79 is dependent for Activities of daily Living and rolling side to side in bed. On 5/28/24 at 7:51 A.M., the surveyor observed Resident #79 laying in bed. There was a gap between the footboard and the end of the mattress. Resident #79 said his/her bed is uncomfortable and his/her feet hit the footboard. On 5/29/24 at 8:15 A.M., the surveyor observed Resident #79 laying in bed with his/her feet touching the footboard. There was a gap between the mattress and the footboard. Resident #79 said that someone from maintenance extended his/her bed due to his/her height. On 5/30/24 at 7:18 A.M., the Maintenance Director and the surveyor observed Resident #79's bed. The Maintenance Director said there is a gap that is approximately four inches from the end of the mattress to the foot board of Resident #79's bed. He said that there should be a gap filler in the space after the bed is extended. During an interview on 5/30/24 at 7:21 A.M., Unit Manager #1 said that there should not be a gap between the mattress and the footboard of the bed. She said that usually maintenance or central supply would fill it with a gap filler and they should have been notified to fill it. During an interview on 5/30/24 at 8:32 A.M., the Director of Nurses said that there should be no gaps between the mattress and the footboard due to risk of entrapment.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation and interview, the facility failed to ensure call lights were functional for one Resident (#38) out of a total of 23 sampled residents. Findings include: On 5/30/24, the surveyor was informed there was no facility policy regarding functioning call lights. Resident #38 was admitted to the facility in March 2024 with diagnoses including Parkinsons disease and asthma. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #38 scored 15 out of a possible 15 on the Brief Interview for Mental Status Exam indicating he/she is cognitively intact. During an interview on 5/28/24 at 9:49 A.M., the surveyor observed Resident #38's call light panel hanging off the wall. Resident #38 said that his/her call light had not been working all weekend (Saturday, Sunday and the Monday holiday), and he/she would yell out of help. Resident #38 said his/her roommate's call light was also not working so he/she would have to yell for his/her roommate too. Resident #38 said that staff were aware it was not working but he/she was told that he/she would have to wait until the holiday weekend was over for someone to fix it. The surveyor then pressed Resident #38's call light and his/her roommate's call light. The light over the door did not luminate and there was no sound at the nurse's station to alert staff that the call lights had been activated. Resident #38 said not having a functioning call light made him/her feel nervous. On 5/29/24 at 11:04 A.M. the surveyor observed Resident #38's call light panel had been re-attached to the wall and both call lights in the room were functional. During an interview on 5/29/24 at 11:32 A.M., Unit Manager (UM) #2 said that she was made aware that Resident #38's call light was non-functional yesterday (5/28/24) and it had since been fixed. UM #2 said that Resident #38's family member had brought in a handbell for him/her to use, but his/her roommate did not have one. UM #2 said she did not know that during the surveyor's observations on 5/28/24 there had been no handbell in the room. UM #2 said staff should have provided a handbell to Resident #38 and his/her roommate until the call light system was fixed. During an interview on 5/29/24 at 12:26 P.M., the Maintenance Director said he was told on 5/28/24 in the afternoon that the call lights were not working for Resident #38 and his/her roommate, and he immediately fixed it. The Maintenance Director said that he did not know that the call lights were not working over the weekend, staff should have notified him sooner and it could have been fixed at that time. The Maintenance Director said that there are handbells available to give to residents if call lights are not working. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225290	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hannah Duston Healthcare Center	126 Monument Street Haverhill, MA 01832

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/24 at 12:29 P.M., Family Member #2 said he had been in to visit Resident #38 over the weekend and that his/her call light was not working. Family Member #2 said that when he alerted staff on the weekend that the call light was not working. Family Member #2 said that staff told him that there was no one available to fix it and did not provide handbells or another means for Resident #38 or his/her roommate to call for help. Family Member #2 said he brought in a small dinner bell for Resident #38 to use, but it was not loud enough for staff to hear at the nurse's station since the room was far, and Resident #38 told him to bring it home as he/she was afraid it would break. Family Member #2 said when he came to visit in the afternoon on 5/28/24 the call bell was still broken and he went and spoke with Unit Manager #2 who then had maintenance come up and fix it. During an interview on 5/30/24 at 11:35 A.M., the Director of Nursing (DON) said that the facility does have handbells available to residents if the call light systems stop working. The DON said that even over the weekend, staff could have alerted her or the Maintenance Director that Resident #38's call light was not functioning and should have provided him/her with a handbell.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225290	A. Building B. Wing	05/30/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that paid feeding assistants have the training they need. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, interview and record review, the facility failed to ensure staff assisting residents with meals completed required training. Specifically, on 5/30/24, Unit Secretary #1 assisted Resident #18, who has a diagnosis of dysphagia, with his/her breakfast meal without having training. Findings include: During the entrance conference interview on 5/28/24 at 8:30 A.M., the Administrator and Director of Nursing (DON) said that the facility does not utilize paid feeding assistants. Resident #18 was admitted to the facility in October 2018 with diagnoses including dementia and arthritis. A diagnosis of dysphagia was added to his/her clinical record in January 2024. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #18 scored two out of a possible 15 on the Brief Interview for Mental Status exam indicating severe cognitive impairment. The MDS indicated Resident #18 is dependent on staff for eating, transfers and dressing. Review of Resident #18's SLP (speech therapy) discharge summary dated 2/8/24 indicated: Analysis and monitoring of oral and pharyngeal phases of the swallow and diet texture tolerance as well as staff/caregiver training in recommended consistencies, need for assist with feeding and swallow safe strategies. Dependent - max assist feed. On 5/30/24 at 8:20 A.M., Unit Secretary #1 was observed assisting Resident #18 take bites of his/her breakfast meal. During an interview on 5/30/24 at 8:23 A.M., Unit Manager #1 said that Unit Secretary #1 should not be assisting Resident #18 with his/her breakfast and proceeded to ask a Certified Nursing Assistant (CNA) to assist Resident #18 with his/her breakfast. During an interview on 5/30/24 at approximately 8:25 A.M., Unit Secretary #1 said that she was only trying to help because Resident #18 requires assistance with meals and there were no staff in the dining room. Unit Secretary #1 said she previously worked as a CNA [AGE] years ago. Unit Secretary #1 said that she had not kept up with her CNA license or relevant trainings. During an interview on 5/30/24 at 11:34 A.M., the Director of Nursing and Staff Development Coordinator said that it is the expectation of certified or trained staff to assist with meals and Unit Secretary #1 should not have assisted Resident #18 with his/her breakfast meal. The facility did not provide a policy regarding staff assistance with meals.