STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, record review, and interview, the facility failed to preserve the dignity of one Resident (#107) out of a total sample of 26 residents. Specifically, the facility failed to ensure that Resident #107's wheelchair was maintained in a clean manner for use by the Resident. Findings include: Resident #107 was admitted to the facility in September 2022 with diagnoses including Dementia, generalized muscle weakness and unsteadiness on feet. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #107: -was severely cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of one out of a possible total score of 15 -used a wheelchair for mobility. Review of Resident #107's clinical medical record indicated the following: -An Activated Health Care Proxy (HCP- a legally appointed person that has authority to make health care decisions for someone that is unable to do so themselves), effective 3/3/21. -A comprehensive, person-centered care plan indicating a focus of impaired mobility with intervention of wheelchair use for mobility, effective 10/1/22. On 12/12/24 at 1:14 P.M., the surveyor observed Resident #107 seated in his/her wheelchair during the lunch meal. The surveyor observed dried yellow and brown debris on the left arm rest and both sides of the seat cushion of the wheelchair. The surveyor also observed a thick coating of dried debris and dust on the seat platform and lower frame of the wheelchair. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 1:33 P.M., the surveyor observed Resident #107 seated in his/her wheelchair during a group activity and the wheelchair remained with the same dried yellow and brown debris on the left arm rest and both sides of the seat cushion. The surveyor further noted the thick coating of dried debris and dust remained on the seat platform and lower frame of the wheelchair. On 12/16/24 at 2:39 P.M., the surveyor observed Resident #107 lying in bed with his/her wheelchair along the side of the bed. The surveyor observed that the wheelchair seat cushion surface had a smeared white substance, and dried yellow and brown debris on the left arm rest and both sides of the seat cushion. The surveyor further observed the thick coating of dried debris and dust on the seat platform and lower frame of the wheelchair was still present. On 12/17/24 at 1:00 P.M., the surveyor observed Resident #107 seated in his/her wheelchair and being assisted with the lunch meal by MDS Nurse #1. During an interview at the time MDS Nurse #1 said that Resident #107's wheelchair was very dirty and needed to be cleaned. MDS Nurse #1 further said that the housekeeping department is responsible for cleaning wheelchairs in the facility. On 12/17/24 at 1:51 P.M., the surveyor and the Director of Housekeeping (DOH) observed the Resident's wheelchair. During an interview at the time, the DOH said that Resident #107's wheelchair was very dirty and needed to be cleaned immediately. The DOH said he could not provide evidence of when Resident #107's wheelchair was last cleaned but cleaning should have been done on 12/5/24 when the total room cleaning had occurred but did not appear that the wheelchair had been cleaned at the time. The DOH said Resident #107's dirty wheelchair was concerning because the wheelchair was a high contact surface and could spread germs. The DOH further said that the dirty wheelchair could also be a dignity concern because it did not look good. On 12/17/24 at 1:57 P.M., the surveyor and the Infection Preventionist (IP) observed Resident #107's wheelchair. During an interview at the time, the IP said the wheelchair was dirty. The IP further said that she was concerned about the dirtiness of the Resident's wheelchair and the wheelchair needed to be cleaned. The IP said that even for residents that are unable to speak for themselves a dirty wheelchair was concern for a resident dignity. The facility did not provide evidence of policy or procedure for wheelchair cleaning to the survey team prior to the end of the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on observation, interview, and record review, the facility failed to provide a comfortable and homelike environment for two Residents (#55 and #37) and on three units (Second Floor, Third Floor and Forth Floor) out of three total units observed. Specifically, the facility failed to: 1. maintain comfortable water temperatures for bathing in resident rooms and unit shower rooms, resulting in Resident #55 and #37 not receiving showers as desired and requested due to cold water temperatures. 2. maintain comfortable water temperatures in resident rooms and for three of three unit shower rooms as needed. Findings include: Review of the facility policy titled Showers, dated April 2015, indicated the following procedure: -Resident/patient will receive a shower, assisted/and given by the nursing staff as desired. -Procedure: >Prepare shower room and equipment >Run water for the shower, checking to ensure that temperature is not greater than 100-102 degrees (*) Fahrenheit (F) -Documentation: >Document the procedure Review of the facility policy titled Bathing Assisted/Partial/Personal Hygiene, dated April 2015, indicated: -Residents who need assistance to perform bathing/personal hygiene will be provided assistance. -Procedure: >Place wash basin, cleaning product, washcloth, towels, and lotion over bed table in front of resident/patient within reach. >Water temperature should be tested on inner wrist. -Documentation: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>Chart bathing and personal care on designated forms. 1a. Resident #55 was admitted to the facility in February 2017 with diagnoses including Congestive Heart Failure. Review of Resident #55's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible 15. -was dependent on staff assistance for bathing and showering, personal hygiene, and both upper and lower body bathing and dressing. During an observation and interview on 12/12/24 at 10:33 A.M., Resident #55 was observed in bed and dressed for the day with a shirt and pants on, with the head of the bed elevated and bilateral side rails in place. Resident #55 said that he/she was scheduled for showers on Mondays on the 7:00 A.M. to 3:00 P.M (7-3) shift and Thursdays on the 3:00 P.M. to 11:00 P.M. (3-11) shift and that he/she anticipated receiving a shower that evening. During an observation and interview on 12/13/24 at 8:49 A.M., Resident #55 said he/she had not received his/her scheduled shower on 12/12/24 at approximately 9:30 P.M., as there was no hot water available. Resident #55 said that he/she notified Unit Manager (UM) #1 that morning. Review of Resident #55's December 2024 Certified Nursing Assistant (CNA) Flow Sheet indicated that showers were scheduled for Thursdays on the 3-11 shift and Mondays on the 7-3 shift. Further review of the CNA Flow Sheet documentation indicated that Resident #55 refused a shower on 12/12/24. 1b. Resident #37 was admitted to the facility in May 2023 with diagnoses including Chronic Obstructive Pulmonary Disease. Review of Resident #37's MDS assessment dated [DATE], indicated the Resident: -was cognitively intact as evidenced by BIMS score of 15 out of a total possible 15. -required partial to moderate assistance by staff for personal hygiene, showering and bathing, and upper and lower body dressing and bathing. During an observation and interview on 12/12/24 at 1:05 P.M., Resident #37 was observed dressed for the day and seated in a chair at his/her bedside with oxygen in use via a nasal cannula. Resident #37 said that the facility did not have hot water for showers. Resident #37 said that he/she has chronic respiratory issues and therefore could not take cold showers. Resident #37 said he/she was scheduled to take a shower today, but refused because the water was cold. The surveyor observed the water in Resident #37's bathroom sink at the time of the interview, was hot to touch and warmed quickly. Resident #37 said the water temperatures were inconsistent, and that staff would often come to his/her room to obtain hot water for other residents at times. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/13/24 at 7:36 A.M., UM #1 said there have been challenges with the hot water which was discussed with the maintenance team. UM #1 said residents receive showers weekly and if there was no hot water available on the 7-3 shift, then the 3-11 shift would assist with showers. UM #1 said there were times during the day when hot water was less available and that the CNAs know the times during the day when hot water was available for residents' showers and bed baths, and in what areas of the building. During an interview on 12/13/24 at 9:08 A.M., with CNA #2 who said she regularly worked with Resident #37 and that he/she received showers on Thursdays. CNA #2 said Resident #37 had respiratory issues, required the assistance of staff with showers, and that cold water for showers could make his/her symptoms worse. CNA #2 said the facility water for resident showers could be either hot or cold, and often start hot, but do not remain hot. CNA #2 said sometimes she and other staff must go to other resident bathrooms to obtain hot water for the residents' bed baths. CNA #2 said she knew Resident #37's bathroom had a good supply of hot water and that if a resident refused a shower on her shift, she would report it to the next shift for follow-up so that they can offer the resident another opportunity to shower, and that this would be communicated on the resident shower list. 2. During an interview on 12/13/24 at 7:43 A.M., Maintenance Staff #1 said the facility administration was aware of the hot water usage. At this time, Maintenance Staff #1 demonstrated checking the water temperature in a resident bathroom near the Nurses' station on the Second Floor Unit, and the surveyor observed the water was hot to touch and warmed quickly. During an interview on 12/13/24 at 7:47 A.M., the Maintenance Director (MD) said the facility had two boilers and one mixing valve for the whole facility, and that the hot water was in use for the facility all day long by the kitchen and the nursing departments. The MD said when the kitchen was not serving meals, the dish machine was running and using hot water. The MD further said the best times for hot water availability for resident showers/bathing were in the early morning and late evening hours. During a subsequent interview on 12/13/24 at 8:06 A.M., the MD said there were areas of the building where water ran a bit colder due to the distance of those areas from the mixing valve. The MD said that he typically took temperatures in the morning several times a week, in different resident bathrooms, and in the three unit shower rooms, in addition to other areas of the facility. The MD said the water temperatures obtained in the resident bathrooms and shower rooms were between 100*F and 120*F, and should ideally be around 110*F. On 12/13/24, the following water temperature observations were made by the surveyor with temperatures taken by the Maintenance Director after running the water for two minutes: >Second Floor Unit: -1:22 P.M- Shower Room, Shower A: 111.7*F, warm -1:26 P.M.- Shower Room, Shower B: 90.0*F, lukewarm -1:31 P.M.- room [ROOM NUMBER]: 109.6*F, warm -1:35 P.M.- room [ROOM NUMBER]: 95.2*F, lukewarm (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1:39 P.M.- room [ROOM NUMBER]: 82.9*F, cool -2:00 P.M.- room [ROOM NUMBER]: 80.8*F, cool >Third Floor Unit: -1:45 P.M.- Shower Room: 75.6*F, cold >Fourth Floor Unit: -1:49 P.M.- Shower Room: 77.4*F, cold -1:55 P.M.- room [ROOM NUMBER]: 82.6*F, cool During an interview on 12/13/24 at 1:49 P.M., while performing temperature checks in the Fourth Floor Unit shower room, the Maintenance Director said the 77.4*F temperature obtained was not even lukewarm. During an interview on 12/13/24 at 2:32 P.M., the Administrator said that in her time in the role of Administrator during the past month, she was not aware of any water temperature issues, resident complaints of cold showers, or cold water temperatures. During a follow-up interview on 12/17/24 at 11:12 A.M., CNA #2 said the issues with the availability of hot water remained and when she provided a bed bath to a resident in room [ROOM NUMBER] that morning, the water was barely lukewarm.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on record review and interview, the facility failed to resolve a grievance timely for one Resident (#40), out of a total sample of 26 residents. Specifically, the facility staff failed to reimburse Resident #40 timely when money was reported missing, an investigation was completed, and the grievance was resolved 80 days after the initial grievance was filed. Findings include: Review of the Grievance Policy, undated, indicated: -Upon receipt of a grievance, the staff person receiving the grievance shall immediately notify the grievance officer. -The grievance officer shall begin the grievance process by logging a summary of the grievance (if oral), the date the grievance was received and by initiating an investigation. -Review of any grievances filed should be completed within seven days. If the review cannot be completed within this timeframe, the grievance officer should communicate the status of the review and an updated time in which it is expected the review will be completed. -Upon completion of the review, the grievance officer should document the following: >A summary of the pertinent findings or conclusions regarding the grievance, >A statement as to whether the grievance was confirmed or not; and >Any corrective action taken or to be taken in response. Resident #40 was admitted to the facility in August 2021 with diagnoses including Seizure Disorder, Hypertension and Hyperlipidemia (an excess of fatty substances called lipids, largely cholesterol and triglycerides, in the blood). Review of Resident #40's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible 15. During an interview on 12/12/24 at 12:29 P.M., Resident #40 said that he/she was missing $54.00 a few months ago and had noticed it when he/she returned to his/her room. The Resident further said the lock to his/her drawer was broken and he/she was missing money out of a wallet. Resident #40 said he/she had been told that the money would be replaced and that an investigation had occurred, but he/she had not received any reimbursement. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Missing Item Report dated 9/30/24, indicated: -Resident #40 reported he/she was missing $54.00 which was last seen on 9/28/24. -Resident stated that the money was in a wallet and the wallet was behind a box of tissues in a locked drawer and that the drawer had been locked. -Reported to the nurse on the unit on 9/28/24. -Action taken to locate the missing item: >Checked and have been unable to find. >Stated lock was broken and maintenance fixed the broken lock on 10/1/24. -Submitted for reimbursement. During an interview on 12/18/24 at 9:11 A.M., the Administrator said that they were resolving the grievance by reimbursing the Resident and provided evidence of a Check Request Form dated 10/14/24 for $54.00. The Administrator said that she was unsure of the status of the check request as it would be processed by the corporate office and would get back to the surveyor. During a subsequent interview on 12/18/24 at 2:43 P.M., the Administrator provided an Invoice #101424 for a reimbursement check for $54.00 to Resident #40. The Administrator said that the check would be delivered to Resident #40 on 12/19/24. Review of the documentation provided to the survey team indicated that Resident #40 would receive reimbursement 80 days after the initial grievance was filed.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment was accurately coded for one Resident (#84) out of a total sample of 26 residents. Specifically, the facility staff incorrectly coded Clopidogrel (an antiplatelet [prevents platelets from sticking together] medication) as an anticoagulant on the MDS. Findings include: Resident #84 was admitted to the facility in February 2021 with diagnoses including Atrial Fibrillation (an irregular heart rate which can result in poor blood flow and blood clots forming). Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #84 was currently prescribed an anticoagulant (blood-thinning medication which disrupts blood clot formation). Review of Resident #84's December 2024 Physician's orders indicated: -Clopidogrel 75 mg (milligrams) PO (by mouth) in the morning. -No Physician order for an anticoagulant medication. During an interview on 12/18/24 at 12:19 P.M., the surveyor and MDS Nurse #1 reviewed the MDS dated [DATE], and MDS Nurse #1 said she had coded that the Resident was taking an anticoagulant medication. MDS Nurse #1 said she followed the Resident Assessment Instrument (RAI) Manual guidelines for coding. MDS Nurse #1 said Resident #84 was not prescribed an anticoagulant and in fact was prescribed an antiplatelet medication. MDS Nurse #1 further said she had coded the MDS incorrectly and it would need to be changed. MDS Nurse #1 said that accurate assessments were important for resident care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50138 Based on observation, record review, and interview, the facility failed to implement the comprehensive person-centered plan of care for two Residents (#88, #104) out of a total sample of 26 residents. Specifically, the facility failed to: 1. For Resident #88, implement the fall risk intervention for non-skid strips to the Resident's bedside and bathroom placing the Resident at risk for falls and injury. 2. For Resident #104, implement the nutritional risk intervention for a lip plate with meals placing the Resident at risk for calorie deficit. Findings include: Review of the facility policy titled Comprehensive Care Plans, date with revision date November 2017 indicated: -The facility is committed to providing residents with all the necessary care and services to enable them to achieve the highest quality of life. -Recognizing each resident as an individual, we identify and meet those needs in a resident centered environment. -Care plans are oriented toward preventing avoidable decline in clinical and functional levels services and treatment. 1. Resident #88 was admitted to the facility in February 2024 with diagnoses including weakness and Wernicke's Encephalopathy (neurological symptoms caused by low vitamin B1 levels often leading to confusion, impaired balance and weakness of eye muscles). Review of Resident #88's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident: -was severely cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of four out of a possible total score of 15. -required substantial/maximal assist to transfer to and from bed, chair and/or toilet. Review of Resident #88's clinical record indicated: -The Resident was at moderate to high risk for falling as evidenced by the most recent falls risk assessment, dated 12/7/24. -The Resident had been moved into his/her current room since 11/19/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #88's comprehensive person-centered care plan indicated: -The Resident was at risk for falls and related injuries secondary to history of self transferring, loss of balance and landing on buttocks and refusal to ask for help with transferring. -The Resident had fall risk interventions which included non-skid strips (adhesive floor strips with non-skid surface used to prevent slipping of the foot/feet when making contact to the floor) to bedside and bathroom, effective 5/23/24. The surveyor observed Resident #88 lying in his/her bed with no non-skid strips observed at the Resident's bedside or in the bathroom on the following days: -12/12/24 at 11:45 A.M. -12/16/24 at 7:46 A.M. During an interview and observation on 12/16/24 at 11:28 A.M., Certified Nurses Aide (CNA) #1 said that he was assigned to Resident #88. The surveyor and CNA #1 observed Resident #88 lying in bed without any non-skid strips at the bedside or in the bathroom. CNA #1 said that the Resident had a history of falling. CNA #1 said that fall interventions were listed on the CNA Care Kardex (a paper record, kept in a binder that included daily care needs for each individual resident). The surveyor and CNA #1 reviewed the CNA Care Kardex which indicated the need for bilateral (both sides) non-skid strips to bedside and bathroom. CNA #1 said sometimes if a Resident has a room change the non-skid strips don't get put back on. CNA #1 said Resident #88 had a few room changes since being at the facility. During an interview and observation on 12/16/24 at 11:46 A.M., Nurse #1 said she was the Nurse assigned to Resident #88. The surveyor and Nurse #1 observed Resident #88 lying in bed without non-skid strips beside the bed or bathroom. Nurse #1 said that Nurses need to be familiar with care plans to prevent falls for each Resident. Nurse #1 said interventions for non-skid strips are listed on both the Resident's CNA Care Kardex and the Resident's care plan. Nurse #1 said that the non-skid strips should be in place to prevent Resident #88 from falling but the non-skid strips were not in place. During an interview on 12/16/24 at 11:57 A.M., the Director of Nursing (DON) said that Resident #88 had several room changes since being at the facility. The DON said that all room changes are reported during morning report to all departments, including the maintenance department. The DON said that the non-skid strips should have been placed at Resident #88's bedside and bathroom to prevent injury and falls. 2. Resident #104 was admitted to the facility in October 2023 with diagnoses including Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment, weight loss, decreased appetite or poor nutrition and inactivity) and Dementia. Review of Resident #104's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -was severely cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of three out of a possible total score of 15. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-required supervision or touching assist for eating. Review of Resident #104's clinical record indicated: -The Resident had a Physician's order for regular consistency diet with thin liquids, extra sauce/gravy to all meals, Italian sausage and baked hams need to be ground, and a scoop lip plate (often called a lip plate), effective 10/27/23. Review of Resident #104's comprehensive person-centered care plan indicated: -The Resident was at risk for nutritional decline and had interventions including lip plate at all meals, last revised on 12/12/24. -The Resident had a 12-pound weight loss between November 2024 and December 2024. On 12/16/24 at 9:09 A.M., the surveyor observed facility staff setting up the breakfast tray for Resident #104 without a lip plate in place. The surveyor observed Resident #104 attempt to scoop his/her breakfast food with a spoon and then spilled breakfast foods over the edge of the plate and onto the table surface. On 12/17/24 at 9:00 A.M., the surveyor observed Resident #104 seated in the multi-purpose room on the unit eating a breakfast of two fried eggs and toast with his/her hands. The surveyor observed the Resident was not provided with a lip plate or utensils for the duration of the breakfast meal. During an observation and interview on 12/17/24 at 4:42 P.M, the surveyor and the Registered Dietitian (RD) observed Resident #104 to be served his/her evening meal tray by a staff member without a lip plate in place. The RD said the lip plate should be listed on the meal ticket to be sent from the kitchen but was not. During an interview on 12/18/24 at 10:01 A.M., the Speech Therapist (ST) said that Resident #104 was actively being treated by the ST due to his/her identified weight loss, effective 12/10/24. The ST said that Resident #104 had been ordered for a lip plate because he/she was known to knock food off his/her plate during mealtimes. The ST said that Resident #104 had been ordered for lip plate since 10/16/23, to aid in filling the utensils during mealtimes. The ST said a lip plate was ordered so that Resident #104 would not push the food off the plate and would support filling the utensil with a whole bite of food. The ST said that a calorie deficit can occur if food falls off the utensil or over the edge of the plate which could result in weight loss.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, record review, and interview, the facility failed to provide respiratory care and services consistent with professional standards of practice for two Residents (#81 and #70), out of a total sample of 26 residents. Specifically, the facility failed to: 1. For Resident #81, ensure a Physician's order was in place for the use of oxygen (O2) therapy. 2. For Resident #70, ensure that oxygen therapy was administered as ordered by the Physician. Findings include: Review of the facility policy titled Oxygen Administration Nasal Cannula, revised November 2020, indicated the following: -To deliver low flow oxygen, per the physician's order (generally one to six liters per minute and 24% to 45% concentration) via nasal cannula. 1. Resident #81 was admitted to the facility in October 2020 with diagnoses including Acute Respiratory Failure with Hypoxia, morbid obesity, Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Review of the COPD care plan indicated the following in part: -O2 via n/c (nasal cannula) as ordered per MD/PA (Medical Doctor/Physician Assistant), initiated 9/12/24. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident did use oxygen therapy while a Resident at the facility. Review of the Order Summary Report, Active Orders as of 12/17/24, indicated no Physician order in place for the use of oxygen therapy. On 12/12/24 at 12:25 P.M., the surveyor observed Resident #81 had a nasal cannula in place and was receiving O2 at 4 liters per minute (LPM). During an interview and observation on 12/17/24 at 9:22 A.M., the surveyor and UM #1 observed Resident #81 was receiving 4 LPM O2 via nasal cannula. UM #1 said that the Resident had been receiving O2 for about three months, since he/she returned from the hospital after having hypoxia. The surveyor and UM #1 reviewed the current Physician orders and found there was no oxygen order for Resident #81. When the surveyor asked UM #1 how staff knew what liter flow to set the O2 level at, UM #1 said that she was not sure how the staff knew what liter flow to set because there were no orders in place. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 12/17/24 at 9:41 A.M., UM #1 said without an order the Resident should not be receiving O2. UM #1 said after reviewing the Resident's record it appeared that the O2 order had been discontinued in October 2024, but the Resident had continued to use the O2. 37400 2. Resident #70 was admitted to the facility in June 2023 with diagnoses including Acute Respiratory Failure with Hypoxia, shortness of breath, weakness, dependence on supplemental oxygen, COPD and Asthma. Review of the Resident #70's Care Plan, initiated 7/7/23 and revised 4/4/24, indicated the Resident had a diagnosis of COPD and shortness of breath, and included the following interventions: -Administer oxygen and monitor effectiveness by checking saturation as/if indicated, initiated 7/7/23 -Resident was unable to lie flat, causes shortness of breath, elevate the head of the bed and utilize pillows to relieve shortness of breath, initiated 10/7/24 -Resident takes rest periods as exertion causes shortness of breath, initiated 10/7/24 -Oxygen as ordered, initiated 10/7/24 Review of the MDS assessment dated [DATE], indicated Resident #70: -was cognitively intact as evidenced by a Brief Interview of Mental Status score of 15 out of a possible 15. -utilized oxygen while in the facility. Review of the December 2024 Physician's orders indicated the following: -Oxygen continuously via nasal cannula at 2 LPM, check every shift, check pulse oximetry (measures blood oxygen levels and pulse) and liters per minute, initiated 11/1/24. On 12/12/24 at 10:04 A.M., the surveyor observed Resident #70 lying in bed with the head of the bed elevated and oxygen was being administered via a nasal cannula and was set at 1.5 LPM on the oxygen concentrator. During an interview at the time, Resident #70 said he/she had been on oxygen therapy for a long time, that the nursing staff just changed the oxygen tubing, and he/she had no concerns. On 12/18/24 at 1:42 P.M., the surveyor observed the Resident lying in bed with the head of the bed elevated. Oxygen was being administered at 1 LPM via a nasal cannula and was connected to the oxygen concentrator positioned near the bed. During an interview at the time, Resident #70 said he/she was on continuous oxygen therapy and was usually on 2 LPM, but the Nurse put him/her on 1 LPM today and was having no issues (shortness of breath, difficulty breathing). The Resident said the Nurses check the oxygen and change the tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the December 2024 Medication Administration Record (MAR) indicated oxygen was administered at 2 LPM as ordered on all shifts except the following dates/shifts: -12/2/24 on 11:00 P.M. to 7:00 A.M., oxygen was set at 15 [sic] LPM -12/9/24 on 3:00 P.M. to 11:00 P.M., oxygen was set at 3 LPM -12/11/24 on 3:00 P.M. to 11:00 P.M., oxygen was NA -12/14/24 on 7:00 A.M. to 3:00 P.M., oxygen was NA -12/16/24 on 3:00 P.M. to 11:00 P.M., oxygen was set at 3 LPM -12/17/24 on 3:00 P.M. to 11:00 P.M., oxygen was set at 3 LPM Review of the Resident's clinical record indicated no documented evidence as to the reason/rationale for the Resident's liter flow change in oxygen therapy that corresponded with the MAR documented dates/shifts. During an interview on 12/18/24 at 2:58 P.M. and 3:14 P.M., Nurse #3, who was taking care of Resident #70, said the Resident's respiratory status was stable and was monitored every shift. Nurse #3 further said the Resident was on continuous oxygen set at a flow rate of 2 LPM, which the Nurses monitor every shift. Nurse #3 said the Resident does not adjust the liter flow rate for the oxygen settings. On 12/18/24 at 3:16 P.M., the surveyor and Nurse #3 observed Resident #70. The Resident remained lying in bed and the nasal cannula was observed out of his/her nose. Nurse #3 provided verbal education to Resident #70 and was observed to re-apply the Resident's nasal cannula. The oxygen concentrator positioned near the Resident's bed was observed to be set at 1 LPM. During an interview at the time, the Resident said that he/she worked with Physical Therapy (PT) that morning. Nurse #3 said that the Resident had an order for oxygen to be administered at 2 LPM and she would look into who worked with the Resident for PT that morning to see if it was adjusted. Nurse #3 further said that the Respiratory Therapist (RT) also worked with the Resident, had last worked with the Resident on 12/12/24 and indicated he/she was tried on 1 LPM of oxygen and had an oxygen saturation level of 94%. Nurse #3 said if there were recommendations to change the Resident's oxygen liter flow rate, the RT would notify the Nurses and the Physician so that the oxygen orders could be changed. During an interview on 12/18/24 at 3:27 P.M. and 3:41 P.M., Unit Manager (UM) #1 said Resident #70 had a Physician's order to administer continuous oxygen to be set at 2 LPM. UM #1 said there was no order to titrate (adjust the flow rate of supplemental oxygen to achieve a specific target oxygen saturation level) the Resident's oxygen flow rate and that if there was a recommendation by the RT to change or titrate the oxygen flow rate, the Physician would need to be notified, agree to the change, and the oxygen order updated. UM #1 said she would follow up with the Rehabilitation Director to see if the Resident's oxygen was adjusted during PT that morning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 4:13 P.M., the Director of Rehabilitation (DOR) said Resident #70 had therapy that morning and provided the surveyor with the Therapy Encounter Note dated 12/18/24. The DOR said the therapists who worked with Resident #70 indicated in their documentation note that the Resident was on 1 LPM of oxygen during the therapy session on 12/18/24. The DOR said the Physical and Occupational Therapists would not typically adjust a Resident's oxygen liter flow unless there was a Physician's order to titrate the flow rate.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 44337 Based on observation and interview, the facility failed to post required nurse staffing information on a daily basis. Specifically, the facility failed to include daily posting of the following: -the resident census information on the daily posting for the facility nurse staffing. -total number and actual hours worked by Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nurse Aides (CNAs). Findings include: On 12/15/24 at 12:30 P.M., the surveyor observed a paper posting of nurse staffing information for 12/15/24 encased in a plastic sleeve and posted on a wall in the facility lobby area. The nurse staffing information posted contained the following: -the facility name -the current date -the 7:00 A.M. to 3:00 P.M. staff scheduled to work and the shift hours assigned to each staff member. Further review of the nurse staffing information posting did not indicate the facility census number, staff scheduled to work on the 3:00 P.M. to 11:00 P.M. and 11:00 P.M. to 7:00 A.M. shifts, and the total number of hours worked by Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nurse Aides (CNAs) for all shifts. During an observation and interview on 12/16/24 at 2:24 P.M., the surveyor and the Director of Nursing (DON)observed the nurse staff posting encased in a plastic sleeve and posted on a wall in the facility lobby area. The nurse staff posting was observed to contain the facility name, the current date, the 7:00 A.M. to 3:00 P.M. staff, and the shift hours assigned to each staff member. The nurse staff posting did not contain the facility census information or the total number of hours worked by Registered Nurses (RNs), Licensed Practical Nurses (LPN's), and Certified Nurse Aides (CNAs). The DON said that the nurse staff posting was a reference for the staff coming into work so that they knew which nursing unit they were are assigned to for that particular shift. The DON further said that the nurse staff posting did not contain the facility census information or the total hours worked for the staff and he was unaware of all the requirements for the nurse staff posting.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 42741 Based on interview, and record review, the facility failed to ensure that one Resident (#24) was free from the use of unnecessary medications out of a total sample of 26 residents. Specifically, the facility failed to ensure that Resident #24 did not receive extra doses of Insulin (medication used to control elevated blood sugar levels) when his/her blood sugar was under the 150 mg/dL (milligram per deciliter) level specified by the Physician. Findings include: Review of the facility policy titled Medication Administration by Route or Dosage, revised 3/2017, indicated the following: -Subcutaneous Injections: >Verify medication order on the Medication Administration Record (MAR). >Check against Physician order. Resident #24 was admitted to the facility in April 2017 with diagnoses including Type II Diabetes (DM-chronic condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident #24's November 2024 Physician's orders indicated: -Lantus (brand name for insulin glargine) Injection 100/milliliters (ml): Inject 50 units subcutaneously at bedtime for antidiabetic related to Type II Diabetes Mellitus without complications. Hold (do not give) if fasting blood sugar (FSBS) is less than 150 mg/dL or if resident not eating, initiated 5/15/24 and discontinued 11/15/24. -Lantus Injection 100/milliliters ml: Inject 46 units subcutaneously at bedtime for antidiabetic related to Type II Diabetes Mellitus without complications. Hold if fasting blood sugar (FSBS) is less than 150 mg/dL or if resident not eating, initiated 11/15/24. Review of Resident #24's December 2024 Physician's orders indicated: -Lantus 100/ml: Inject 46 units subcutaneously at bedtime for antidiabetic related to Type II Diabetes Mellitus without complications. Hold if fasting blood sugar (FSBS) is less than 150 mg/dL or if resident not eating, initiated 11/15/24. Review of the November 2024 MAR for Resident #24 indicated Lantus was administered on: -11/1/24 with a blood sugar of 135 mg/dL -11/3/24 with a blood sugar of 134 mg/dL (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/4/24 with a blood sugar of 138 mg/dL -11/9/24 with a blood sugar of 123 mg/dL -11/14/24 with a blood sugar of 130 mg/dL -11/15/24 with a blood sugar of 143 mg/dL -11/30/24 with a blood sugar of 107 mg/dL Review of the December 2024 MAR for Resident #24 indicated Lantus was administered on: -12/1/24 with a blood sugar of 116 mg/dL -12/10/24 with a blood sugar of 101 mg/dL -12/15/24 with a blood sugar of 130 mg/dL During an interview on 12/17/24 at 11:32 A.M., Nurse #2 reviewed Resident #24's bedtime Lantus order and said the bedtime Lantus was only to be given if the Resident had a blood sugar level of 150 mg/dL or above, if it was below 150 mg/dL the Lantus should be held. Nurse #2 said if the Resident received extra doses of Insulin, it could put him/her at risk for hypoglycemia (low blood sugar). During an interview on 12/17/24 at 1:13 P.M., Unit Manager (UM) #1 reviewed Resident #24's bedtime Lantus order and said if the Resident's blood sugar is less than 150 mg/dL, the Lantus should be held. During an interview on 12/17/24 at 1:37 P.M., UM #1 said she believed the bedtime Lantus order was written incorrectly. UM #1 said staff should have reached out to the Resident's Medical Provider to clarify the order and this had not been done. During an interview on 12/17/24 at 2:30 P.M., UM #1 said on the dates in question Resident #24 did receive the bedtime dose of Lantus even though the Resident's blood sugar levels were under 150 mg/dL and as the Physician order was written he/she should not have received those doses.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44337 Based on observation, interview, and record review, the facility failed to ensure that medications were stored in a secure and safe manner, and according to professional standards of practice in the second-floor medication storage room. Specifically, the facility failed to store Lorazepam Concentrated Oral Liquid (controlled substance medication [a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction] used to treat anxiety disorders) in a safe manner when the Lorazepam was stored in a black metal box that was not fixed (could be removed) to the inside of the medication refrigerator in the second-floor medication storage room. Findings include: On 12/17/24 at 11:33 A.M., during an observation of the second-floor medication storage room, the surveyor and Unit Manager (UM) #1 observed a black metal box with a padlock located in the medication storage room refrigerator. During an interview at the time, UM #1 said that the black metal box was locked with a padlock because it contained controlled medications that required refrigeration. UM #1 then removed the black metal box from the refrigerator, placed the box on a counter and opened the box to reveal two (2) bottles of Lorazepam Concentrated Oral Liquid. The surveyor did not observe the black metal box to be fixed to the inside of the medication storage refrigerator. UM #1 said that the black box used to have a chain attaching it to the inside of the refrigerator, but there was no chain now, and the box was not attached to the refrigerator. UM #1 said she was unaware that the box containing controlled medications should have been fixed to the inside of the refrigerator. During an interview on 12/18/24 at 2:40 P.M., the Director of Nursing (DON) said that the black metal box in the medication storage refrigerator contained controlled medications and should have been fixed to the inside of the refrigerator as required.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on record review and interview, the facility failed to maintain complete and accurate medical records for two Resident's (#77 and #5) out of a total sample of 26 residents. Specifically, the facility failed to: 1. for Resident #77, maintain documentation relative to behavioral health services that the Resident was receiving from a consulting firm. 2. for Resident #5, document that Physician/NPP was notified when Resident #5 had a significant change in condition relative to: A) blood sugar readings greater than 350 mg/dL (milligrams per deciliter) as indicated by a Physician's order, and B) when a laboratory value for Hemoglobin A1C (test that measures the average blood sugar level over the past three months) was out of normal range and noted as high, putting the resident at risk for complications related to hyperglycemia (high blood sugar levels). Findings include: Review of the facility policy titled Consultant Services dated 4/2015, indicated the following: -A note should be recorded on the consultation form by any health care consultant who sees the resident/patient at the request of the MD or the family. The consultant should document findings and recommendations on this form. -A consultant's report or some form of documentation pertaining to the results will be retained in the clinical record. Review of the Service agreement between the facility and the Mental Health Provider, signed by the Administrator on 1/10/23 indicated the following in part: -Confidential Information: --both parties acknowledge and agree that in the course of performance under this agreement, each may have access to certain confidential information belonging to the other party including but not limited to . Patient information . -Record Keeping and Confidentiality of Medical Information: --To the extent possible both parties shall abide by all applicable federal state and local laws, rules, regulations, and standards with respect to clinical record keeping and maintenance of the confidentiality of medical records . 1. Resident #77 was admitted to the facility in February 2021 with diagnoses including Alcohol dependence, Anxiety and Bipolar Disorder. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #77 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. During an interview on 12/17/24 at 11:59 A.M., Resident #77 said that he/she meets with the Substance Use Disorder counselor monthly and also meets with a Therapist every Friday. Review of Resident #77's medical record indicated no documented evidence that the Resident was meeting with a Therapist weekly every Friday. During an interview on 12/17/24 at 2:12 P.M., Social Worker (SW) #1 said that the Therapist identified by Resident #77, works for the Nurse Practitioner's Consulting Firm that provided talk therapy to the facility residents. SW #1 said that two Therapists come into the facility from this Consulting Firm two times a week. When the surveyor asked where the documentation could be found that Resident #77 received services from the Consulting Firm, SW #1 said that the facility does not have any documentation regarding any of the Therapist visits. SW #1 said that documentation has been an ongoing conversation between the facility and the Consulting Firm. 48206 2. Review of the facility policy titled Hyperglycemia, dated April 2015, indicated: -Hyperglycemia, or high blood sugar, is a condition that causes changes in physiological status. -Procedure if a resident has signs and symptoms of high blood sugar: >Check physician orders for specific acceptable blood glucose (sugar) range for the resident. >Perform a glucose test by finger stick: If over 400 mg/dL, recheck for accuracy. >Notify Physician immediately for further directions if blood sugar is not within the acceptable range for high parameters. -Document relevant evaluations, interventions, and resident's response to interventions in the medical record. Resident #5 was admitted to the facility in July 2022 with diagnoses including Type 2 Diabetes Mellitus (Type 2 DM) with Hyperglycemia. During an observation and interview on 12/12/24 at 3:16 P.M., the surveyor observed Resident #5 was in bed, dressed in a hospital gown, with his/her head of the bed elevated. Resident #5 said he/she had issues with high blood sugars, and he/she usually had values around 320 [mg/dL]. The Resident further said that staff check his/her blood sugars three times a day and he/she received Insulin (a hormone that controls blood sugar) after meals. Review of Resident #5 Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -was severely cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of one out of a total possible 15. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-received Insulin by injection seven out of seven total days during the assessment look-back period. Review of Resident #5's December 2024 Physician's orders indicated: -Insulin Lispro Injection Solution (fast-acting Insulin medication), 100 unit/ml subcutaneously (beneath the skin) before meals for DM, Inject as per sliding scale, if blood sugar is: 0 - 149 mg/dL = 0 units 150 - 199 mg/dL = 2 units 200 - 249 mg/dL = 4 units 250 - 299 mg/dL = 6 units 300 - 349 mg/dL = 8 units Greater than 350 mg/dL = 10 units -If blood sugar is lower than 60 mg/dL or greater that [sic] 350 mg/dL . Call Nurse Practitioner (NP), Physician Assistant (PA), Medical Doctor (MD)., initiated 6/19/24 -Insulin Lispro Injection Solution 100 unit/ml, Inject 30 units subcutaneously with meals for DM, initiated 6/19/24 -Insulin Glargine- Subcutaneous Solution (long-acting Insulin medication) 100 UNIT/ML (Insulin Glargine), Inject 72 units subcutaneously at bedtime for DM, initiated 11/20/24 -Jardiance Oral Tablet (medication that helps control blood sugar levels) 10 milligrams (mg), Give 1 tablet by mouth in the morning for DM, initiated 12/4/24 -Metformin HCl Oral Tablet (medication that lowers blood sugar levels) 500 mg, Give 1000 mg by mouth two times a day for DM, initiated 9/16/24 -Monitor for [signs and symptoms] of hyper/hypoglycemia, every shift, initiated 11/1/24 -Lipids (laboratory test that measures amount of fats within the blood) /Triglycerides (specific fat in the blood) /HemoglobinA1c (HgbA1c: blood test that measures average blood sugar over a two to three month period), every three months. Nursing to put lab on the following lab draw, initiated 12/3/22. Review of Resident #5's Care Plan for Diabetes initiated 6/20/24, and last revised 10/15/24, indicated the goal was for the Resident to remain free of complications from Diabetes and/or signs of hypergylcemia/ hypogylcemia (low blood sugar), and included the following interventions: -perform Accucheck (blood sugar check) per Physician order. Utilize sliding scale [insulin] as ordered, initiated 6/20/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-signs of hyperglycemia may include clammy skin, shallow respirations, mental status or vision changes, restlessness, dizziness, or irritability, initiated 6/20/24. Review of Resident #5's Blood Sugar Summary Report provided to the survey team from 9/23/24 through 12/17/24 indicated the following blood sugar levels greater than 350 mg/dL were obtained: -10/5/24 at 12:22 P.M.: 417.0 mg/dL -10/11/24 at 5:32 P.M.: 386.0 mg/dL -10/12/24 at 5:40 P.M.: 388.0 mg/dL -10/18/24 at 5:30 P.M.: 364.0 mg/dL -10/22/24 at 5:51 P.M: 413.0 mg/dL -10/24/24 at 3:31 P.M.: 354.0 mg/dL -10/25/24 at 8:23 P.M: 422.0 mg/dL -10/26/24 at 9:50 A.M.: 399.0 mg/dL -10/30/24 at 5:10 P.M.: 391.0 mg/dL -11/2/24 at 8:48 A.M.: 366.0 mg/dL -11/3/24 at 4:24 P.M.: 436.0 mg/dL -11/5/24 at 5:48 P.M.: 358.0 mg/dL -12/5/24 at 4:44 P.M.: 360.0 mg/dL Review of the Nursing Progress Notes did not indicate evidence that the Physician/NP/PA were notified of the Resident's elevated blood sugar readings over 350 mg/dL from 10/5/24 - 12/5/24 as required. Review of the Physician's Encounter Visit Note, dated 11/20/24, indicated: -Diagnosis of Uncontrolled Diabetes with Hyperglycemia and Long- term insulin use. -Resident has history of refusing Glargine/Metformin/ regular insulin. -Continues with noncompliance with PO (by mouth) medications. -Discussed with nursing, reports patient refused all medication except insulin, non-compliant with oral DM II (Diabetes Type 2) medications . -Discussed obtaining lab work . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nursing Progress note dated 11/20/24, indicated: -Physician's Assistant in to see Resident -New orders for . HgbA1c level -Increased Lantus to 72 units Review of the Resident #5 laboratory results collected on 11/22/24 indicated the following: -Hemoglobin A1c result was 9.5 %. -Flagged as H (High). -A1c Reference Range of 4.8-5.6 %. -Signature line for ordering Physician was blank. Review of the Nursing Progress Notes did not indicate evidence that the Physician/NP/PA was notified of the Resident's elevated Hgb A1c value obtained on 11/22/24. Review of the Physician's Encounter Note dated 12/3/24, indicated: -Diabetic screening: Assess glycemic status at least quarterly in diabetic patients with A1C not under control. -No Physician documentation of review of the Hemoglobin A1C value obtained on 11/22/24. Review of the Nursing Progress Note dated 12/3/24, indicated: -New order from PA to start Jardiance 10 mg daily. -No PA documentation of review of the Hemoglobin A1C value obtained on 11/22/24. During an interview on 12/17/24 at 11:38 A.M., Nurse #2 said that Resident #5 typically tests high on his/her blood sugars, but levels have improved more recently. Nurse #2 said Resident #5 was non-compliant with taking oral medications but was compliant to have his/her blood sugars tested and accepted injectable insulin. Nurse #2 said if a Resident's blood sugar test were over 400 (mg/dL), she would contact the Physician/NPP (Non-Physician Practitioner) to discuss concerns about hyperglycemia or adjustment to the sliding scale insulin. Nurse #2 said she monitors for signs and symptoms of hyperglycemia which can include sluggishness, increased thirst, and confusion. Nurse #2 also said that when lab reports come in, she would contact the Physician to review the results and obtain any orders for change in treatment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/17/24 at 1:55 P.M., Unit Manager (UM) #1 said that Resident #5 received sliding scale injectable insulin and had a standing order for injectable insulin. UM #1 further said that Resident #5 would often refuse oral medications that manage his/her diabetes, but allowed the staff to check his/her blood sugars as ordered and was accepting of the injectable insulin. When the surveyor requested evidence that the Physician was notified relative to the Resident's high blood sugars over 350 mg/dL or the HgbA1c lab value obtained on 11/22/24, UM #1 said she would follow-up with the surveyor. During an interview on 12/17/24 at 2:46 P.M., the Director of Nursing (DON) said that there was no documentation that the Physician/NPP was notified of Resident #5's high blood sugars from 10/1/24 - 12/5/24. The DON further said there was no documentation that the Physician/NPP was contacted on 11/22/24 to review the Resident's HgbA1c laboratory value, and the Physician review of the lab values should have been documented.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interview, and record review, the facility failed to implement an Antibiotic Stewardship Program for one Resident (#52) out of a total sample of 26 residents. Specifically, for Resident #52, the facility failed to ensure that documentation was reviewed for signs and symptoms of infection prior to requesting an order for antibiotics from the Physician and/or Non-Physician Practitioner (NPP) and administering antibiotics for a suspected urinary tract infection (UTI). Findings include: Review of the facility policy titled Antibiotic Stewardship dated 7/2017, indicated the following: -It is the policy of this facility to treat only symptomatic infection meeting criteria, and to promote antibiotic stewardship to reduce inappropriate antimicrobial use, improve patient care outcomes and reduce possible consequences of antimicrobial use. -When symptoms of an infection are documented . Resident #52 was admitted to the facility in September 2016 with diagnoses including frontotemporal neurocognitive disorder (a form of Dementia that effects the frontal and temporal lobes), Traumatic Brain Injury, major depressive disorder, anxiety disorder, and was receiving Hospice services (care at the end of life). Review of Resident #52's December 2024 Physician's orders indicated: -Macrobid (a type of antibiotic) Oral Capsule 100 milligram (mg), Give one capsule by mouth two times a day for a UTI for five days, with a start date of 12/4/24. -Ativan (an antianxiety medication) Oral Tablet 1 mg, Give 1 mg by mouth every six hours as needed for anxiety, with a start date of 11/22/24. Review of the December 2024 Medication Administration Record (MAR) indicated Resident #52 was administered Macrobid twice daily as ordered from 12/5/24 through 12/9/24. During an interview on 12/17/24 at 8:41 A.M., Nurse #4 said she was unsure why Resident #52 was started on antibiotics and would need to ask Unit Manager (UM) #1. During an interview on 12/17/24 at 8:42 A.M., UM #1 said she was unsure why Resident #52 was on antibiotics and that she would need to go ask the Social Worker. During a follow-up interview on 12/17/24 at 8:59 A.M., UM #1 said the Resident was on Hospice services so no labs could be drawn on him/her to check for a UTI. UM #1 said the Resident had been experiencing increased episodes of behaviors including agitation and needed to be administered his/her as needed (PRN) Ativan to address the increased agitation and this could suggest a possible UTI. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the November 2024 MAR indicated Resident #52 had not been administered his/her PRN Ativan during the month of November. Further review of the November 2024 MAR indicated no documented behaviors. Review of the December 2024 MAR indicated Resident #52 had not been administered his/her PRN Ativan from 12/1/24 through 12/4/24. Further review of the December 2024 MAR indicated no documented behaviors from 12/1/24 through 12/4/24. Review of the Hospice Nursing assessment dated [DATE], indicated the Resident was experiencing an increase in agitation. Review of the Hospice Nursing assessment dated [DATE], indicated: -all of Resident #52's medications were to be stopped except for Ativan and Morphine (a pain medication). -this included stopping two antidepressant medications. During an interview on 12/17/24 at 10:06 A.M., the Infection Preventionist (IP) said staff should be looking for signs and symptoms of a UTI as Resident #52 was unable to verbalize if he/she was exhibiting signs of a UTI. The IP said staff should look for signs and symptoms such as pain, strong odor to the urine, dark urine, increase in urine, fever, and/or hematuria (blood in urine). The IP said she was unsure if the Resident exhibited clinical signs of a UTI and she would need to look at the Resident's chart. The IP said it was also a possibility to see a change in mental status since the Resident recently came off antidepressant medications. Review of the Nursing Progress Notes dated 11/25/24 through 12/4/24, indicated no documentation Resident #52 had increased agitation or signs and symptoms of a UTI. During an interview on 12/17/24 at 1:49 P.M., the Director of Nursing (DON) said he was unable to provide any documentation that would indicate Resident #52 was having signs and symptoms of a UTI. The DON said one Hospice Note dated 12/2/24, indicated the Resident had an increase in his/her agitation but there was no additional documentation to support the Resident had a suspected UTI as the Resident had a history of increased periods of agitation at baseline.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on record review, and interview, the facility failed to offer the Pneumococcal Vaccination as recommended to one Resident (#104), for five applicable residents, out of a total sample of 26 residents. Specifically, the facility failed to ensure that Resident #104 was offered the Pneumococcal Conjugate Vaccine (PCV- a vaccine that helps protect against diseases caused by pneumococcal bacteria) at the time of admission or shortly thereafter, putting the Resident at risk for developing facility acquired Pneumonia. Findings include: Review of the facility document titled Procedure for Pneumococcal Vaccination of Residents indicated the following: -Each resident or their representative will be asked on admission if they have previously had any pneumococcal vaccinations and their age at the time of vaccination. The records that accompany the resident will also be used to determine immunization status. -The pneumococcal conjugate vaccine will be offered to all eligible residents . -Adults aged [AGE] years and older who have not previously received a pneumococcal conjugate vaccine or whose vaccination history is unknown should receive a pneumococcal conjugate vaccine . Resident #104 was admitted to the facility in October 2023 with diagnoses including Adult Failure to Thrive. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #104 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of a total possible score of 15. Review of Resident #104's clinical record indicated no evidence that Resident #104 had received the PCV vaccine. Review of Resident #104's Resident Admission Vaccination Education Form did not indicate Resident #104 and/or the Resident Representative had been provided education for or offered the PCV vaccine. (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 12/17/24 at 10:14 A.M., the Infection Preventionist (IP) said when Residents are admitted to the facility a Resident Admission Vaccination Education Form is filled out with the Resident or their Representative to evaluate the Resident's immunization status. The IP said that the form indicated whether the Resident had the vaccine previously, refused the vaccine, or consented to administration of the vaccine. During a review of Resident #104's Resident Admission Vaccination Education Form, the IP said that there was no evidence that Resident #104 had been administered the Pneumococcal vaccine. The IP further said that there was no evidence that Resident #104 or their Representative had been educated or offered the Pneumococcal vaccine, but they should have been offered the vaccine.

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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. 42741 Based on observation, interview, and record review, the facility failed to develop a system to conduct regular maintenance and inspections of all bed frames, mattresses, and bed rails (side rails) as part of a regular maintenance program to identify areas of possible entrapment for two Residents (#5 and #70) out of three applicable residents for bed rail use, out of a total sample of 26 residents. Specifically, the facility failed to: 1. For Resident #5, provide inspection documentation for the Resident's bed frame, mattress, and side rails. 2. For Resident #70, provide documentation that the Resident's bed frame, mattress, and side rails were regularly inspected. Findings include: Review of the facility policy titled Restraints: Bed Rail Safety Check, undated, indicated the following: -Regularly inspect each of the seven areas (areas between the mattress and side rails, head board, and foot board) on each bed with restraints. -Maintenance and monitoring of the bed, mattress, and accessories (such as resident/caregiver assist items) should be ongoing. 1. Resident #5 was admitted to the facility in July 2022, with diagnoses including difficulty in walking, weakness, and Osteoarthritis (degenerative joint disease). On 12/12/24 at 3:16 P.M., the surveyor observed Resident #5 lying in bed with bilateral (both sides) side rails in place on his/her bed. Review of the most recent side rail evaluation dated 9/26/24, indicated Resident #5 used quarter (1/4) side rails for positioning or support bilaterally on his/her bed. 2. Resident #70 was admitted to the facility in June 2023 with diagnoses including chronic obstructive pulmonary disease (COPD), Acute Respiratory Failure with hypoxia, dependence on oxygen, and weakness. On 12/12/24 at 10:04 A.M., the surveyor observed Resident #70 lying in bed with bilateral side rails in place on his/her bed. Review of the most recent side rail evaluation dated 9/6/24, indicated Resident #70 used 1/4 side rails for positioning or support bilaterally on his/her bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 9:40 A.M., the Maintenance Director said bed frames, mattresses, and side rails are only inspected if a new mattress is placed on a bed or if staff lets him know there is a problem with the bed. Review of the Bed System Measurement Device Test Results Worksheet Binder (Binder where the Maintenance Department documents when beds were last inspected), provided by the Maintenance Director indicated the following: -No documentation was available for when Resident #5's bed frame, mattress, and side rails were last inspected. -Documentation that Resident #70's bed frame, mattress, and side rails were last inspected on 9/4/18. During a follow-up interview on 12/18/24 at 1:11 P.M., the Maintenance Director said currently there was no program in place to regularly inspect the bed frames, mattresses, or side rails. He further said he was unable to provide any additional documentation that would show Resident #5 and Resident #70 had their bed frame, mattress, or side rails inspected recently. He said a procedure should be in place to regularly inspect the Resident's beds to ensure they are in safe working order.