STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225299	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Redstone	135 Benton Drive East Longmeadow, MA 01028

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on interview and record review, the facility failed to ensure that one Resident (#24) out of a total sample of 29 residents, was afforded the ability to review/sign documents pertaining to his/her medical care. Specifically, the facility failed to ensure that Resident #24, who was identified as his/her own person and was able to make his/her own decisions, was able to review and sign documentation relative to Advanced Directives (life sustaining measures that can be taken when a person's heart stops or they fail to breathe on their own) and ancillary services that could be provided while at the facility. Findings include: Resident #24 was admitted to the facility in August 2022 with a diagnosis including Cerebral Infarction (Stroke: occurs when the blood flow to the brain is disrupted causing tissue damage) without residual effects. Review of the Resident's clinical record included the following: -Request for Services Form for consent or declination for audiology (hearing services), eye care, podiatry (foot care services), dental, and behavioral health, which was completed, all services were declined and was signed by the Resident's Representative on 8/17/22. -Advanced Directive Care Plan, initiated on 8/18/22, which included the intervention to discuss Advanced Directives with the patient, family or legal representative, and to honor the Medical Orders for Life-Sustaining Treatment (MOLST: indicates preferences for life sustaining measures) form. -MOLST form completed and signed by the Resident's Representative on 10/20/22. Further review of Resident #24's clinical record indicated that Resident #24 was not invoked (put into effect, was not dependent on a designated person to make medical and health care decisions) by the Physician/Medical Provider since his/her admission. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #24 was cognitively intact as evidenced a Brief Interview of Mental Status (BIMS) score of 15 out of 15. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 3:55 P.M., the surveyor and Unit Manager (UM) #3 reviewed the Resident's clinical record. During an interview at the time, UM #3 said Resident #24 was not invoked relative to decision making. After review of the Resident's MOLST form, which was signed by the Resident's Representative, UM #3 said that she would have a new MOLST form completed because the Resident did not sign the MOLST form and was able to make his/her own decisions. During an interview on 6/4/24 at 4:02 P.M., Resident #24 said that he/she would like to sign his/her own paperwork. The Resident further said that because of visual deficits, the paperwork would need to be reviewed with him/her but that he/she was capable and able to sign it once reviewed. During a follow-up interview on 6/5/24 at 5:32 P.M., Resident #24 said he/she could not recall if ancillary services like dental, eye/vision care and foot care were discussed/offered to him/her and was not aware if his/her Representative had previously signed paperwork for this. The Resident said that he/she would like someone from the facility to review the options for services with him/her, and possibly look into receiving new eyeglasses and dental care. The Resident further said that if this information was discussed on admission and he/she was out of it, it was possible that his/her Representative signed for him/her but did not recall anyone from the facility reviewing the services with him/her.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 50563 Based on observation, interview, record and policy review, the facility failed to notify the Physician of a need to alter treatment for two Residents (#130 and #73), out of a total sample of 29 residents. Specifically: 1) For Resident #130, the facility failed to notify the Physician/ Provider timely for an emergency order and/or alternative pain medication when the ordered pain medication was unavailable from the pharmacy to address the Resident's pain. 2) For Resident #73, the facility failed to notify the Provider when the ordered pain medication regimen was determined to be ineffective in managing the Resident's pain. Findings include: Review of facility policy titled Pain Assessment and Management, with an edit date of 11/10/22, indicated but was not limited to the following: -Pain management is a multidisciplinary care process that includes the following: >monitoring for the effectiveness of interventions >and modifying approaches as necessary. -The medication regime is implemented as ordered. -Results of the interventions are documented and communicated directly to the provider when appropriate. -Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medication. -Contact the prescriber immediately if the resident's pain or medications side effects are not adequately controlled. -Report the following information to the physician or practitioner: .prolonged, unrelieved pain despite care plan interventions. 1) Resident #130 was admitted to the facility in April 2024 with diagnoses including Fracture of the Right Patella with surgical repair (broken bone in the knee that required surgery to fix) and Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) Assessment, dated 4/10/24, indicated Resident #130 was cognitively intact based on a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15. Review of the Resident's Physician's orders for April 2024 indicated: -Morphine Sulfate (opiate medication that works by changing the way the brain and nervous system respond to pain) oral tablet, 22.5 milligrams (mg) every 6 hours for pain (on a scale of 7-10), initiated 4/6/24 at 11:30 P.M. Review of Resident #130's Nursing Evaluation Note dated 4/6/24 at 8:25 P.M., indicated the Resident had a pain assessment score of 8 out of 10 (severe pain on a scale where 0 is no pain and 10 is the worst pain). Review of Resident #130's Nursing Note dated 4/7/24 at 7:28 A.M., indicated that Nurse #5 contacted the pharmacy several times regarding the pending delivery of the Resident's Morphine Sulfate immediate release medication with no answer from the pharmacy. Further review of the clinical record indicated no documented evidence that the Physician and/or covering Provider was notified of Resident #130's complaint of severe pain (8 out of 10) on 4/6/24 and that the Morphine Sulfate ordered for the Resident was not available to be administered. During an interview on 6/4/24 at 3:01 P.M., Nurse #5 said if a resident was admitted to the facility with pain, and was awaiting delivery of their own supply of pain medication from the pharmacy, she would contact the on-call Provider (a Physician, Nurse Practitioner[NP], or Physician Assistant[PA]) to obtain an order for narcotic medication (strong pain medication such as morphine) from the emergency kit (supply the facility maintains on site to minimize gaps in medication administration of essential medications). During an interview on 6/4/24 at 3:15 P.M., the surveyor and Unit Manager (UM) #2 reviewed the Resident's Evaluation Note dated 4/7/24 at 8:25 P.M. UM #2 said the pain scale indicated the Resident's pain was an 8 out of 10 at the time of evaluation and a strong pain medication should have been offered. UM #2 said if the appropriate pain medication was not immediately available, the Nurse should have contacted the on-call Provider to get an order to administer a pain medication that was available in the facility emergency kit. During an interview on 6/5/24 at 9:22 A.M., NP #1 said with the Resident's pain scale being an 8 out of 10, the on-call Provider should have been called for an order to administer the same or similar pain medication from the facility emergency kit to manage the Resident's pain until his/her supply of pain medication arrived from the pharmacy. During an interview on 6/5/24 at 4:19 P.M. the Director of Nursing (DON) said the expectation relative to pain medication administration for Resident #130 was that the Nurse should have contacted the on-call Provider to obtain a one-time dose of pain medication from the emergency kit. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #73 was admitted to the facility in April 2024 with diagnoses including Osteomyelitis of Vertebra, Sacral Region (infection of the bone(s) in the lower spine in the area of the lower back and buttocks), Stage 4 Pressure Ulcer (a wound caused by pressure extending down into the muscle, tendon or to the bone) of the Sacral Region (in the area of the buttocks), Stage 3 Pressure Ulcer of the Right Buttock (a wound caused by pressure extending past the surface skin into fat tissues but not to the muscle), and a Stage 4 Pressure Ulcer of the Right Hip. Review of the MDS Assessment for Resident #73 dated 4/27/24, indicated the Resident: -was cognitively intact as evidenced by a BIMS score of 14 out of 15. -his/her pain assessment indicated pain was almost constant with the worst pain rating at 9 out of 10 on the pain scale (severe) and had an almost constant effect on his/her sleep and activities of daily living (ADLs: dressing, bathing, getting in out of bed, mobility). Review of Resident #73's Physician's orders, from April 2024 through May 2024 included the following medications for pain: -Morphine Sulfate extended release 15 mg (a type of Morphine Sulfate that works over a longer period of time than traditional Morphine Sulfate tablets for a more controlled effect on pain) scheduled twice a day at 8:00 A.M. and 8:00 P.M., initiated 4/21/24 -Dilaudid (Hydromorphone: opioid analgesic medication prescribed for pain) 2 mg every 4 hours as needed (PRN), initiated 4/21/24 and hold dates (dates the medication could not/should not be administered) from 5/15/24 through 5/22/24 -Morphine Sulfate oral tablet 15 mg every 6 hours as needed (PRN) for pain before dressing change, initiated 5/11/24 and discontinued 5/16/24 -Morphine Sulfate oral solution (liquid version of Morphine pain medication) 5 mg every 4 hours as needed (PRN) for pain, initiated 5/17/24 and discontinued 5/17/24 -Morphine Sulfate oral tablet 7.5 mg every 4 hours as needed for pain, initiated 5/15/24 -No order for Tylenol medication Review of the Resident#73's clinical record indicated the PRN medications were used to treat pain and were documented as ineffective after administration on the follow-up pain assessment on the following dates/times: >Dilaudid 2 mg on: -4/22/24 at 8:43 A.M. with a 10 out of 10 pain, follow-up pain assessment -4/24/24 at 11:27 A.M. with a 10 out of 10 pain, follow-up pain assessment -4/25/24 at 10:28 A.M. 10 out of 10 pain, follow-up pain assessment (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/29/24 at 10:52 A.M. with an 8 out of 10 pain, follow-up pain assessment -5/1/24 at 11:46 A.M. with a 10 out of 10 pain, follow-up pain assessment -5/2/24 at 10:48 A.M. with a 10 out of 10 pain, follow-up pain assessment >Morphine Sulfate 15 mg on: -5/12/24 at 4:53 A.M. with a 10 out of 10 pain, follow-up pain assessment -5/15/24 at 4:00 A.M. with a 10 out of 10 pain, follow-up pain assessment >Morphine Sulfate 7.5 mg on: -5/29/24 at 3:15 P.M. with no documented follow-up pain assessment Further review of the clinical record for Resident #73 indicated no documented evidence that the on-call Provider was contacted and notified that the Resident's pain medication regimen was not managing his/her pain effectively. During an interview on 5/31/24 at 8:34 A.M., the Resident said he/she has had issues with constant pain, that the pain medication helps some, but he/she still had to deal with a lot of pain. During an interview on 6/4/24 at 11:22 A.M., Nurse #4 said that if pain medication was ineffective in managing pain, the Provider should be notified for additional orders and/or to have the Provider reassess the Resident. During an interview on 6/4/24 at 3:22 P.M., the surveyor and UM #2 reviewed the clinical record for Resident #73. UM #2 said if the follow-up pain assessment indicated the Resident's medication to treat pain was ineffective, she would expect the Nurse to contact the Provider for additional orders. When the surveyor asked UM #2 if there was evidence that the Provider was contacted relative to Resident #73's pain documentation, UM #2 was unable to provide any documented evidence that the ineffectiveness of the Resident's pain medication was communicated to the Provider. During an interview on 6/5/24 at 9:13 A.M., NP #1 said her expectation would be for staff to contact her or the on-call Provider relative to a resident who was experiencing unrelieved pain so that an order for an additional dose of medication could be obtained. NP #1 said she was not notified that Resident #73 was experiencing unrelieved pain. During an interview on 6/5/24 at 4:13 P.M., the DON said if a follow-up assessment indicated a resident's pain relief was ineffective, the staff would be expected to contact the Provider to obtain additional orders. Please Refer to F697

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 42690 Based on record review, policy review, and interview, the facility failed to accurately complete a Level I Preadmission Screening and Resident Review (PASARR- screen to determine if a resident had an intellectual or developmental disability (ID or DD) and/or serious mental illness (SMI) and needed further evaluation) for one Resident (#112), out of a total sample of 29 total residents. Specifically, for Resident #112 the facility failed to accurately complete a Level I PASRR indicating that the Resident had a diagnosis of Bipolar Disorder, and received Behavioral Health Services within the last two years in the community, resulting in a Level II PASRR Evaluation (an evaluation conducted to determine if an individual who screened positive for an SMI or ID/DD requires specialized services) not being completed as required. Findings include: Resident #112 was admitted to the facility in February 2023 with the following diagnoses: Bipolar Disorder (a mental illness that causes extreme mood swings, from high to low, that affect your energy, thinking and behavior) and Adjustment Disorder (excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior) with mixed anxiety and depressed mood. Review of the facility policy titled Admission Criteria, edited on 6/23/22, indicated the following: -If the Level I screen indicates that the individual may meet the criteria for a MD, ID (or RD [related disorders], he or she is referred to the state PASARR [SIC] representative for the Level II (evaluation and determination) screening process. Review of the Hospital Admission Information referral dated 2/11/24, indicated Resident #112 had a history of Bipolar Disorder. Review of the Social Service Admission Evaluation dated 2/21/24, indicated the Resident had a history of Bipolar Depression and utilized outside Behavioral Health Services. Review of the PASRR Level I Screening, dated 2/20/23 indicated No to the following questions: -Does the applicant have a documented diagnosis of a mental illness or disorder (MI/D) or substance use disorder (SUD) that may lead to chronic disability? -Within the past two years, is the applicant known to have required one of the treatments or interventions listed below, that is, or may be due to a mental illness or disorder (MI/D) .Association with mental health agency. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 12:12 P.M., the surveyor and Social Worker (SW) #2 reviewed Resident #112's Social Service Admission Evaluation dated 2/21/24 and the PASRR that was completed upon admission. SW#2 said that the PASRR was not completed correctly upon admission. SW #2 said that the PASRR should have indicated the Resident had a diagnosis of Bipolar Disorder, and that the Resident received Behavioral Health Services within the last two years in the community. SW #2 said that if the information had been completed accurately the Resident would have been reviewed and prompted a Level II PASRR evaluation to be completed. SW #2 further said that a Level II PASRR had not been completed as required.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on interview, record and policy review, the facility failed to ensure that the Resident and/or Resident Representative was provided the right to participate in the care plan process for two Residents (#2 and #122), out of a total sample of 29 residents. Specifically, the facility failed to: 1) For Resident #2, ensure that quarterly care plan meetings were conducted as required. 2) For Resident #122, ensure that an admission and subsequent care plan meetings were conducted as required. Findings include: Review of the facility policy titled Comprehensive Person-Centered Care Plans, revised 4/25/22, included the following: -Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -IDT includes: the Attending Physician, a Registered Nurse who was responsible for the resident, a nurse aide who is responsible for the resident, a member of food and nutrition services staff, the resident and the resident's legal representative (to the extent practicable), and other appropriate staff or professionals as determined by the resident's needs or as requested by the resident -Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: >participate in the planning process, >identify individuals or roles to be included, >request meetings, >request revisions to the plan of care, >participate in establishing the expected goals and outcomes of care, >participate in determining the type, amount, frequency and duration of care, >receive the services and/or items included in the plan of care, and >see the care plan and sign it after significant changes are made (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident will be informed of his or her right to participate in his or her treatment -An explanation will be included in a resident's medical record if the participation of the resident and his/her resident representative for developing the resident's care plan is determined to not be practicable. -The IDT must review and update the care plan: >when there has been a significant change in the resident's condition, >when the desired outcome is not met, >when the resident has been readmitted to the facility from a hospital stay, and >at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment -The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatment. Such refusals will be documented in the resident's clinical record in accordance with established policies. 1. Resident #2 was admitted to the facility in January 2012, with diagnoses including Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and Type 2 Diabetes Mellitus (DM II - condition in which the body does not produce enough insulin and has trouble controlling blood sugar levels). Review of the MDS assessment dated [DATE], indicated that Resident #2 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of 15. Review of Resident #2's clinical record indicated no documented evidence that the Resident/Resident Representative were invited to/participated in the care planning process or that the IDT meet quarterly to review the plan of care, as required. Further review of the clinical record indicated no meetings or refusal to participate in the meetings by the Resident/Resident Representative were documented: -between 11/29/22 and 5/16/23 -between 5/16/23 and 11/7/23 -after 1/30/24 During an interview on 6/4/24 at 11:39 A.M., Social Worker (SW) #1 said the MDS Nurses arrange the resident care plan meetings and the notifications to the meetings go through reception. SW #1 said that notices of the scheduled care plan meetings are sent to the residents or their representative about the date and time of the meeting. SW #1 said the Social Services Department was responsible for coordinating the resident care plan meetings and documenting that the care plan meetings occurred in the resident's clinical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 6/4/24 at 1:56 P.M., SW #1 said Resident #2 should have had a care plan meeting on 4/23/24, but there was no documented evidence that a care plan meeting occurred. SW #1 further said that he was unable to find evidence that the required care plan meetings occurred between 11/29/22 and 5/16/23 and between 5/16/23 and 11/7/23 as required. SW #1 said the care plan meeting notes should include who was present at the meeting, topics that were discussed and the Resident/Resident Representative would be provided with a copy of the care plan. SW #1 said even if the Resident/Resident Representative was unable or declined to attend the scheduled meetings, the care plan meeting would still occur. During an interview on 6/4/24 at 3:02 P.M., MDS Nurse #2 said she creates the care plan meeting schedule after the scheduled MDS assessments, typically 14-21 days after the assessment reference date (ARD: the last date of the observation period that the assessment covers), or when residents are transferred to a new unit or are new to Hospice Care. MDS Nurse #2 said she sends notifications via email to the IDT team to remind them of the scheduled care plan meetings and reminds them to document the meeting in the required note within the resident's clinical record. MDS Nurse #2 said she was made aware that the required meetings for Resident #2 did not occur as scheduled. MDS Nurse #2 said that there should have been care plan meetings scheduled in February 2023 and in August 2023 but these meetings did not occur. 2. Resident #122 was admitted to the facility in January 2024 with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), Depression and Type 2 Diabetes Mellitus. Review of the MDS assessment dated [DATE], indicated that Resident #122 was moderately cognitive impaired as evidenced by a BIMS score of 9 out of 15. Review of the clinical record indicated no documented evidence that care plan meetings were held for Resident #122 since January 2024, as required. On 6/4/24 at 11:39 A.M., the surveyor requested evidence of the Resident's care plan meetings from SW #1 since admission to the facility. During an interview on 6/4/24 at 2:54 P.M., SW #1 said there were no care plan meetings held for Resident #122, as required and that the care plan meetings must have been overlooked. During an interview on 6/4/24 at 3:18 P.M., MDS Nurse #3 said Resident #122 should have had a care plan meeting on admission and another care plan meeting after the 4/16/24 MDS Assessment, but there was no evidence that the meetings occurred as required.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation, interview, record and policy review, the facility failed to provide care in accordance with professional standards of practice for two Residents (#66 and #71), out of a total sample of 29 residents. Specifically, 1. For Resident #66, the facility failed to: a)complete PICC device dressing changes as ordered by the Physician, b)complete external catheter length measurements as ordered, c)notify the Provider timely when changes in external catheter length and arm circumference measurements were identified for a Resident with a Peripherally Inserted Central Catheter (PICC: a thin, soft tube that is inserted into a vein in the arm, for long-term antibiotics, nutrition, medications, and blood draws. The PICC is a type of CVAD [Central Vascular Access Device] catheter) placing Resident #66 at risk for undiagnosed infiltration (when fluid or medication given by an intravenous [IV] device exits the vein and enters the soft tissues) and/or deep vein thrombosis (DVT: a blood clot in a deep vein). 2. For Resident #71, the facility failed to ensure that: a) required steps were taken when scheduled medication was unavailable from the pharmacy for 24 days, including notifying the Physician of the continued medication non-availability b) administer medication via the right route as prescribed by the Physician. Findings include: 1. Review of the facility policy titled Central Venous Catheter Care and Dressing Changes, undated, indicated the following: -Perform site care and dressing change at established intervals . -Change the dressing if it becomes damp, loosened, or visibly soiled and: -at least every seven days . -Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion. -Report any signs and symptoms of complications to Physician, supervisor, and oncoming shift. (continued on next page)

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	225299	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Redstone	135 Benton Drive East Longmeadow, MA 01028

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Lippincott Nursing Procedures-9th Edition (2023), to ensure to ensure the PICC line has not migrated (moved out of the appropriate location for safe use): -the Nurse should measure the external length of the catheter during dressing changes. Resident #66 was admitted to the facility in May 2024, with diagnoses of Pneumonia with Lung Abscess (an infection of the lungs that may be caused by bacteria, viruses, fungi or aspiration [when food or liquid is accidentally inhaled into airways and lungs] with abscesses resulting from necrosis [death of body tissue] of the pulmonary tissue and formation of cavities) and Sepsis (a life-threatening medical emergency that occurs when an infection triggers the body's immune system to damage its own organs and tissues). Review of the June 2024 Physician's orders indicated the following: -Dressing-PICC .24 hours after insertion, then weekly and PRN. >Change needless connector with weekly dressing change and after blood draw. >If securement device is used, change at time of dressing change, every day shift, every seven days, > measure external catheter length in centimeters (cm), with a start date of 5/20/24. -PICC Baseline Assessment Total Catheter Length 43 cm, External Length 0 centimeters (cm). >Document changes in external length in nurses notes. >Baseline arm circumference 38 cm, no routine interval, check PRN only, with a start date of 5/21/24. -Ceftriaxone Sodium Injection Solution Reconstituted (antibiotic) 2 grams (gm), use two gram intravenously one time a day for Sepsis until 6/12/24, with start date of 5/17/24. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of 15. During an interview on 5/30/24 at 1:52 P.M., Resident #66 said he/she had to ask for his/her PICC dressing to be changed as it had not been done since it was originally changed at the time of his/her admission to the facility. Resident #66 said the staff at the facility were not regularly changing the dressing, and were not measuring the catheter length. The Resident further said that a Nurse came in very early this morning and changed the dressing for him/her because the dressing was falling off and he/she asked for it to be changed. During an observation of the Resident's PICC line dressing on his/her right upper arm, the surveyor observed that the dressing was changed at 12:15 A.M., but there was no date documented on the bandage. Review of the IV Insertion Company Record for IV Placement dated 5/7/24, indicated the external catheter length was 0 cm. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the May 2024 Treatment Administration Record (TAR) indicated the Resident's PICC dressing was changed on 5/21/24, but no measurement of the external catheter length was recorded. Further review of the TAR indicated on 5/28/24 the Resident was supposed to have the PICC dressing changed and external catheter length measured, but the documentation was left blank on the TAR. Review of the Nursing Progress Note dated 5/30/24, indicated the Resident's PICC dressing was changed and the external catheter length measured at 2 cm (which was a change from the 5/7/24 external catheter length of 0 cm). Review of the June 2024 TAR indicated that on 6/4/24 the Resident's PICC dressing was changed and the external catheter length measured at 11 cm (which was a change from the 5/30/24 external catheter length of 2 cm). During an interview and observation on 6/4/24 at 2:45 P.M., two surveyors observed Nurse #1 demonstrate how she would measure the external catheter length of Resident #66's PICC line. Nurse #1 demonstrated and measured from the PICC line insertion site (the site at which the catheter tubing enters under the skin) down to the top of the clamp (device used to keep the catheter tubing closed when not in use). Nurse #1 stated she had no recent facility specific training on PICC line measurements and had only been working at the facility for a couple months. Nurse #1 further said she had not compared her external catheter length measurement to the previously documented external catheter length measurements and she was unsure if there had been changes since the external catheter length was last measured. During an interview on 6/4/24 at 2:55 P.M., Unit Manager (UM) #1 said the facility used the initial external catheter measurements obtained from the hospital as a baseline, then would measure the external catheter length every seven days following admission. UM #1 said the order for measuring the external length should be obtained at the time of admission. UM #1 said the order for Resident #66 was not obtained until 5/20/24, several days after the Resident had been admitted to the facility. The surveyor and UM #1 reviewed the Resident's TAR and UM #1 said the PICC line dressing was changed on 5/21/24 but there was no documentation to indicate if the external catheter length was measured, per the Physician's order. UM #1 also said on 5/28/24 there was no documentation to indicate the PICC line dressing change was performed or the external catheter length was measured as ordered. UM #1 further said she was unable to find any documentation that on 5/30/24 and 6/4/24 the Physician had been notified that there were changes in the external catheter length. UM #1 said it was important to update the Physician regarding changes in external catheter length because the changes could indicate that the catheter may have moved out of place and the Resident could be ask risk for the medication not being delivered correctly and the Physician would need to give orders on how the facility should proceed. 37400 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #71 was admitted to the facility in October 2021, with diagnoses including Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Delirium (disturbed state of mind or consciousness, characterized by symptoms of confusion, disorientation, agitation, and hallucinations), Psychotic Disturbance (mental disorder characterized by a disconnection from reality), Mood Disturbance (disorder where long periods of extreme happiness, sadness, anger and/or irritability are experienced), Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment) and Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), and Insomnia (sleep disorder with persistent problems falling and/or staying asleep). Review of the Resident's clinical record included specific care plans to address the following: -Verbal/physical agitation/aggression due to diagnoses of Dementia and Depression, initiated 10/25/21 -Episodes of combativeness with staff, throwing things, and refusals of care and medications, initiated 10/25/21 -Behavior management, initiated 10/25/21 -Cognition/communication loss related to dementia with behavioral disturbance, initiated 10/25/21 and revised 10/28/21 -At risk for adverse effects related to use of .antipsychotic medications (medications that treat symptoms of psychosis), initiated 10/25/21 and revised 8/15/22 Review of the Minimum Data Set (MDS) Assessment, dated 1/1/24, indicated Resident #71: -was severely cognitively impaired as obtained by staff interview, -was dependent on staff for activities of daily living (eating, bathing, dressing, toileting activities), -had physical behaviors and rejection of care that occurred 4-6 days of the assessment period. 2a.) Review of the facility policy titled Unavailable Medications, effective February 2019, indicated medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion and included the following: -The facility must make every effort to ensure that medications are available to meet the needs of each resident: a. The pharmacy staff shall: >Call or notify nursing staff that the ordered product(s) is/are unavailable. >Notify nursing when it is anticipated that the drug(s) will be available (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available, which is covered by the resident's insurance. b. The nursing staff shall: > Notify the attending Physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. >If the facility Nurse is unable to obtain a response from the attending Physician, the Nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction. >Obtain a new order and cancel/discontinue the order for the non-available medication. >Notify the pharmacy of the replacement order. Review of the Physician's orders for Resident #71 dated January 2024, included the following orders: -ABH gel (combination of Ativan (antianxiety medication), Benadryl (antihistamine used to treat pain, itchiness and also used to aid in sleep) and Haldol (antipsychotic medication used to treat mental disorders), 1/25/1 milligram (mg)/milliliter (ml), apply to inner wrist topically twice daily for anxiety related to major depressive order, initiated 8/23/23. Review of the January 2024 Medication Administration Record (MAR) indicated the ABH gel was documented as administered to Resident #71 twice daily from 1/1/24 through 1/7/24. Further review of the January 2024 MAR indicated 9 was documented from 1/8/24 through 1/31/24, with the exception of 1/29/24 at 5:00 P.M. where there was no documentation (left blank). Review of Resident #71's Medication Administration Notes from 1/8/24 through 1/31/24 indicated the following relative to the ABH gel administration: -1/8/24 at 9:07 A.M. medication was unavailable, Physician was notified for the script (prescription) to be sent and call out to the pharmacy to verify -medication not available, awaiting delivery from the pharmacy on: >1/8/24 at 4:07 P.M., >1/12/24 at 5:34 P.M., >1/15/24 at 4:09 P.M., (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>1/16/24 at 4:25 P.M., >1/17/24 at 4:22 P.M., >1/20/24 at 4:38 P.M., >1/21/24 at 4:29 P.M., >1/22/24 at 4:26 P.M., >1/25/24 at 4:27 P.M., >1/26/24 at 4:26 P.M., >1/30/24 at 4:33 P.M., >1/31/24 at 4:35 P.M. -medication not available: >1/9/24 at 7:30 A.M., >1/11/24 at 7:51 A.M., >1/11/24 at 4:06 P.M., >1/11/24 at 10:11 P.M., >1/18/24 at 8:13 A.M., >1/22/24 at 9:51 A.M., >1/23/24 at 7:43 A.M., >1/24/24 at 7:44 A.M., >1/25/24 at 9:06 A.M., >1/26/24 at 8:00 A.M., >1/29/24 at 8:04 A.M., >1/30/24 at 8:03 A.M. -not available from the pharmacy: >1/9/24 at 4:08 P.M. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-not available: >1/10/24 at 9:39 A.M.,>1/13/24 at 10:53 A.M., >1/14/24 at 9:06 A.M., -waiting for pharmacy to deliver: >1/10/24 at 5:26 P.M. -awaiting delivery: >1/12/24 at 10:17 A.M. -on order: >1/13/24 at 4:52 P.M., >1/14/24 at 5:57 P.M., >1/18/24 at 6:55 P.M., >1/19/24 at 4:32 P.M., >1/23/24 at 5:32 P.M., >1/24/24 at 5:26 P.M., >1/27/24 at 7:13 P.M., >1/28/24 at 6:20 P.M. -awaiting pharmacy: >1/15/24 at 8:17 A.M. -awaiting medications: >1/16/24 at 9:15 A.M. -unavailable: >1/17/24 at 9:10 A.M., >1/28/24 at 9:39 A.M. -no documentation noted: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>1/19/24 at 8:42 A.M., >1/20/24 at 8:11 A.M., >1/21/24 at 9:43 A.M., >1/27/24 at 10:05 A.M., >1/31/24 at 8:13 A.M. Review of the clinical record indicated no documented evidence that the Physician and/or other Medical Provider (Nurse Practitioner/Physician Assistant) was notified that the ABH gel was not available to administer to the Resident, so that additional orders could be obtained after the request for the prescription was sent to the pharmacy on 1/8/24. During an interview on 6/5/24 at 10:33 A.M., the surveyor asked Unit Manager (UM) #3 about the January 2024 MAR documentation for the ABH gel which indicated 9 from 1/8/24 through 1/31/24. UM #3 said that she could recall a period of time when the medication needed to be made at the pharmacy and the facility was unable to obtain the medication. When the surveyor asked what happened when a medication was not available as ordered by the Physician for administration, UM #3 said the Physician would be notified and additional orders would be obtained for alternate medications. During an interview on 6/5/24 at 12:00 P.M., the Director of Nursing (DON) said there have been issues with the pharmacy that the facility utilized. The DON said if a medication was not available, the Physician would be notified and additional orders for medication change would be obtained. The DON said there should be documentation in the Resident's clinical record that this communication occurred, that she would look into the documentation, and get back to the surveyor. During a follow-up interview on 6/5/24 at 1:12 P.M., the DON said she was unable to find evidence that the Physician was notified of the ABH gel not being available from the pharmacy from 1/8/24 through 1/31/24. 2b) Review of the Journal of the American Medical Directors Associations Article titled ABH Gel ., dated January 2021, indicated the following areas for administration: -Application of ABH gel is typically to the volar (pertaining to the palm or sole) or palmar (inner) surface of the wrists, rubbed behind the ears or the bottoms of the feet. Review of the Lippincott Nursing Procedures 9th Edition (2023) manual for safe medication administration included but was not limited to the following: -Follow the five rights of medication administration: >the right patient, >the right medication, >the right dose, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>the right time >and the right route. -Some literature indicates use of nine rights which adds the right documentation, the right action, the right form and the right response. -Identify high alert medications, examples of these include opioid medications and precautions may include having a second Nurse independently verify the medication and dose before administration Review of the Physician's orders from December 2023 through June 2024 included the following order: -ABH gel: 1/25/1 mg/ml, apply to inner wrist topically (application to body surfaces such as skin or mucous membranes) twice daily for anxiety related to major depressive order, initiated 8/23/23. Review of the December 2023 through June 2024 MARs indicated the ABH gel was administered to the following locations (other than the inner wrist as ordered by the Physician): -left or right inner ankle: on 51 occurrences -left or right outer ankle: on six occurrences -right or left forearm: on two occurrences -top of left foot: on two occurrences -right or left arm: on one occurrences -front of thigh: on one occurrence -right leg: on one occurrence During an interview on 6/5/24 at 10:13 A.M., UM #3 said Resident #71's Physician's orders indicate to apply the ABH gel to his/her inner wrist, if the nurses were applying the gel elsewhere, they would need to contact the Physician and have the order clarified. Nurse #6, who was present during the interview, said that she applies the ABH gel to the Resident's inner ankle. During an interview on 6/5/24 at 12:00 P.M., the DON said that she had only ever seen ABH gel applied to patients' inner wrists. The DON further said she would follow-up with the Provider about the application of the ABH gel to other locations on Resident #71's body. During a follow-up interview on 6/5/24 at 12:39 P.M., the DON said the Provider was contacted and indicated that the ABH gel could be applied to other specified locations, but it was usually ordered to be applied to the inner wrist because the medication was better absorbed. The DON said if the nurses had concerns about applying the medication to the Resident's inner wrist as ordered, the Physician/Provider should have been notified to request to change the Resident's administration order for the ABH gel to allow application to other areas.

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45435 Based on observation, interview, record and policy review, the facility failed to ensure that an audiology (hearing services) appointment was arranged for one Resident (#10), out of a total sample of 29 residents. Specifically, the facility staff failed to ensure that Resident #10 was provided with audiology services as required, when the Resident voiced a concern about being able to hear adequately. Findings include: Review of the facility policy titled Physician Orders for Consultation dated 9/30/15, indicated the following: -To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- 1. In making appointments, and 2. By arranging for transportation to and from the office of a Practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Resident #10 was admitted to the facility in December 2021. Review of the Request for Services Form, signed by the Resident on 12/4/21, indicated audiology as a requested service to be provided by the facility mobile contracted agency. Review of the Care Plan indicated the following: -Potential difficulty communicating related to hearing loss . Date created 12/10/21. Review of the Nursing Progress Note dated 4/8/24, indicated the following: -patient and family concerned with the patient not able to hear the television clearly. -New order: Debrox (a medication used to soften and loosen ear wax) 5 drops each ear for four days, flush with warm water on day five, document results. Review of the April 2024 Medication Administration Record, indicated the Resident was administered Debrox Otic Solution 6.5%, 5 drops in both ears on 4/8/24 through 4/12/24. Further review of the Medication Administration notes indicated the results after the flush was - no cerumen (ear wax). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15, -had minimal difficulty hearing, -and did not have a hearing aid. During an observation and interview on 5/30/24 at 2:50 P.M., the surveyor observed that the Resident could only hear questions when asked with a raised voice. Resident #10 said he/she had not had his/her hearing checked while at the facility but that he/she would like to have his/her hearing checked. During an interview on 5/31/24 at 1:30 P.M., Unit Manager (UM) #3 said Resident #10 had not been seen by an Audiologist. UM #3 further said the Medical Records Clerk was responsible for scheduling appointments with the mobile contracted provider. During an interview on 5/31/24 at 1:41 P.M., the Medical Records Clerk said that she receives the schedule of audiology visits from the mobile contracted provider prior to each visit. The Medical Records Clerk reviewed the list of residents scheduled for the next audiology visit scheduled on 7/23/24 and said that Resident #10 was not scheduled to be seen. The Medical Records Clerk further said that according to the contracted providers census sheet, the Resident should have been seen on 3/23/24 but she did not have any notes from that visit. During a follow-up interview on 6/4/24 at 8:28 A.M., the Medical Records Clerk said that she had spoken to the mobile contracted provider service representative and was told that Resident #10 was not enrolled for audiology services. The Medical Records Clerk said she then re-called the mobile contracted provider and spoke with the Regional Account Manager and was told the Resident had been enrolled since 2021 but had never been seen by the Audiologist. The Medical Records Clerk said she did not know why the mobile contracted provider census sheet was not correct as it was provided to her from the contracted provider. The Medical Records Clerk further said that sometimes the mobile contracted provider sends her visit dates but then the provider did not always come to the facility when scheduled. The Medical Records Clerk said that sometimes she receives calls from family members asking what was happening with the appointments. During an interview on 6/5/24 at 12:04 P.M., the Administrator said that he was not aware that Resident #10 was not provided audiology services as requested.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview, record and policy review, the facility failed to provide pain management consistent with professional standards of practice for two Residents (#130 and #72), of two applicable Residents reviewed for pain, out of a total sample of 29 residents. Specifically: 1) For Resident #130, the facility failed to provide pain medication as ordered for severe pain reported by the Resident. The facility also failed to contact the Physician/ Provider for an emergency order and/or alternative pain medication to aid in managing the Resident's pain when the ordered pain medication was unavailable from the pharmacy to be administered. 2) For Resident #73, the facility failed to appropriately monitor the Resident for effectiveness of prescribed pain medication, and notify the Physician/ Provider for evaluation and modification of the pain medication regimen as needed. Findings include: Review of facility policy titled Pain Assessment and Management, with an edit date of 11/10/22, indicated but was not limited to the following: -Pain management is a multidisciplinary care process that includes the following: monitoring for the effectiveness of interventions; and modifying approaches as necessary. -The medication regime is implemented as ordered. -Results of the interventions are documented and communicated directly to the provider when appropriate. -Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medication. -Contact the prescriber immediately if the resident's pain or medications side effects are not adequately controlled. -Report the following information to the physician or practitioner: .prolonged, unrelieved pain despite care plan interventions. 1) Resident #130 was admitted to the facility in April 2024 with diagnoses including Fracture of the Right Patella with surgical repair (broken bone in the knee that required surgery to fix), and Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities). (continued on next page)

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	225299	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Redstone	135 Benton Drive East Longmeadow, MA 01028

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #130 was cognitively intact as indicated by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15. Review of the April 2024 Physician's orders, included the following: -Morphine Sulfate (opioid medication used to reduce moderate to severe pain) oral tablet, 22.5 milligrams (mg) every 6 hours for pain (on a scale of 7-10 out of 10), with an order date of 4/6/24. -Scheduled Tylenol (medication used for mild/minor pain) 650 mg every 6 hours (at 12:00 A.M., 6:00 A.M., 12:00 P.M. and 6:00 P.M.) with an order date of 4/6/24. -Ativan (medication to treat anxiety), 0.5 mg every 12 hours as needed (PRN) for anxiety with an order date of 4/7/24 Review of Resident #130's Nursing Evaluation Note dated 4/6/24 at 8:25 P.M., indicated a pain assessment score of 8 out of 10 (severe pain on a scale where 0 is no pain and 10 is the worst pain). Review of the Medication Administration Note dated 4/7/24 at 3:00 A.M., indicated that Nurse #5 administered Ativan to the Resident for right knee pain per the Resident's request. Review of the Nursing Clinical Note dated 4/7/24 at 7:28 A.M., indicated that Nurse #5 contacted the pharmacy several times about the pending delivery of the Resident's Morphine Sulfate immediate release medication (a strong medication used to relieve pain) with no answer. Further review of the Nursing Clinical Note indicated that the Resident was offered and accepted ice applied to the knee which helped the pain a little and he/she was able to sleep after the administration of Ativan from 3:50 A.M. until 6:00 A.M. on 4/7/24. Review of Resident #130's April 2023 Medication Administration Records (MAR) indicated: -Tylenol was documented as administered to Resident #130 on 4/7/24 at 12:00 A.M. (3.5 hours after the Resident expressed an 8 out of 10 pain scale). -Morphine Sulfate oral tablet was documented as administered to the Resident on 4/7/24 at 11:26 A.M. (approximately 15 hours after the Resident expressed a severe 8 out of 10 pain scale) Further review of the clinical record indicated no documented evidence that the Physician/ Provider was notified that the Resident had expressed severe pain and that the ordered Morphine Sulfate pain medication was not available to be administered for pain management. During an interview on 5/31/24 at 11:57 A.M., Resident #130 said he/she went a long time without any pain medications upon admission to the facility. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/24 at 3:01 P.M., Nurse #5 said that Ativan was not a medication used to treat pain. Nurse #5 further said that if a resident was admitted to the facility with pain, and was awaiting delivery of their own supply of pain medication from the pharmacy, that she would contact the on-call Provider (Physician, Nurse Practitioner [NP], or Physician Assistant [PA]) to obtain an order for narcotic medication (strong pain medication such as morphine) from the emergency kit (supply the facility maintains on site to minimize gaps in medication administration of essential medications). During an interview on 6/4/24 at 3:15 P.M., the surveyor and UM #2 reviewed the Resident Evaluation Note dated 4/7/24 at 8:25 P.M. UM #2 said the pain scale indicated that the Resident's pain was an 8 out of 10 at the time of assessment, and a strong pain medication should have been offered. The surveyor and UM #2 also reviewed the Nursing Clinical Notes dated 4/7/24 at 3:00 A.M., and 4/7/24 at 7:28 A.M. UM #2 said that Ativan was not a pain medication and should not have been administered for pain. UM #2 said if the appropriate pain medication was not immediately available, the Nurse should have contacted the on-call Provider to get an order to administer a pain medication that was available in the facility emergency kit. During an interview on 6/5/24 at 9:22 A.M. Nurse Practitioner (NP) #1 said with the Resident's pain scale being an 8 out of 10, the on-call Provider should have been called for an order to administer the same or similar pain medication from the facility emergency kit to manage the Resident's pain until his/her supply of pain medication arrived from the pharmacy. NP #1 said Ativan medication was not used for pain management. During an interview on 6/5/24 at 4:19 P.M., the Director of Nursing (DON) said the Nurse should have contacted the on-call Provider to obtain a one-time dose from the emergency kit when Resident #130 had severe pain and the prescribed medication was not available to be administered. The DON further said that because Resident #130 regularly took narcotic pain medication prior to admission, there would be concern for both withdrawal from the pain medication as well as pain becoming harder to manage effectively due to the lapse in administering the medication. 2) Resident #73 was admitted to the facility in April 2024, with diagnoses including Osteomyelitis of Vertebra, Sacral Region (infection of the bone(s) in the lower spine in the area of the low back and buttocks), Stage 4 Pressure Ulcer (a wound caused by pressure extending down into the muscle, tendon or to the bone) of the Sacral Region (in the area of the buttocks), Stage 3 Pressure Ulcer of the Right Buttock (a wound caused by pressure extending past the surface skin into fat tissues but not to the muscle), and a Stage 4 Pressure Ulcer of the Right Hip. Review of Resident #73's MDS assessment dated [DATE], indicated that the Resident: -was cognitively intact as evidenced by a BIMS score of 14 out of 15. -His/her pain assessment indicated pain was almost constant with the worst pain rating at 9 out of 10 on the pain scale (severe) and had an almost constant effect on his/her sleep and activities of daily living (ADLs: dressing, bathing, getting in out of bed, mobility). Review of the Resident's Pain Care Plan, revised 4/29/24, indicated the following goal: -Resident will express pain management was within acceptable limits. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #73's Physician's orders, from April 2024 through May 2024 included the following medications for pain: -Morphine Sulfate extended release (ER: a type of Morphine Sulfate that works over a longer period of time than traditional Morphine Sulfate tablets for a more controlled effect on pain) 15 mg scheduled twice a day at 8:00 A.M. and 8:00 P.M., initiated 4/21/24 -Dilaudid (opioid analgesics used to manage pain) 2 mg every 4 hours as needed (PRN), initiated 4/21/24 and hold dates (dates the medication could not/should not be administered) from 5/15/24 through 5/22/24 -Morphine Sulfate oral tablet 15 mg every 6 hours as needed (PRN) for pain before dressing change, initiated 5/11/24 and discontinued on 5/16/24 -Morphine Sulfate oral solution (liquid version of morphine pain medication) 5 mg every 4 hours as needed (PRN) for pain, initiated 5/17/24 and discontinued on 5/17/24 -Morphine Sulfate oral tablet 7.5 mg every 4 hours as needed (PRN) for pain, initiated 5/15/24 Review of the April 2024 and May 2024 Medication Administration Records (MARs) indicated that the Resident received his/her scheduled Morphine Sulfate ER 15 mg twice daily as ordered. Review of Resident #73's clinical record indicated the following PRN pain medications were administered and the follow-up pain assessments conducted by the Nurse indicated the medication was ineffective on the following dates/times: > Dilaudid 2 mg: -4/22/24 at 8:43 A.M.: initial pain scale was 6 out of 10, follow-up pain scale was 10 out of 10 -4/24/24 at 11:27 A.M.: initial pain scale was 6 out of 10, follow-up pain scale was 10 out of 10 -4/25/24 at 10:28 A.M.: initial pain scale was 8 out of 10, follow-up pain scale was 10 out of 10 -4/29/24 at 10:52 A.M.: initial pain scale was 10 out of 10, follow-up pain scale was 8 out of 10 -5/1/24 at 11:46 A.M.: initial pain scale was 10 out of 10, follow-up pain scale was 10 out of 10 -5/2/24 at 10:48 A.M.: initial pain scale was 9 out of 10, follow-up pain scale was 10 out of 10 >Morphine Sulfate 15 mg: -5/12/24 at 4:53 A.M.: initial pain scale of 8 out of 10, follow-up pain scale was 10 out of 10 -5/15/24 at 4:00 A.M.: initial pain scale of 8 out of 10, follow-up pain scale was 10 out of 10 >Morphine Sulfate 7.5 mg: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/29/24 at 3:15 P.M.: there was no documentation that pain was assessed using the pain scale at the time of medication administration and the follow-up pain assessment. Review of the clinical record indicated no documented evidence that additional interventions were offered to Resident #73 to manage and relieve pain, or that the on-call Provider was contacted and notified that the pain medication was ineffective in managing the Resident's pain. During an interview on 5/31/24 at 8:34 A.M., Resident #73 said he/she has issues with constant pain, that the pain medication helps some, but he/she still had to deal with a lot of pain. During a follow-up interview on 6/4/24 at 10:10 A.M., Resident #73 said when his/her pain medication had been ineffective, neither medication or non-medication interventions were offered to help with his/her unrelieved pain. The Resident said that he/she had asked for Tylenol at times but was not given or offered anything to assist with the unrelieved pain. Review of the clinical record indicated no documented evidence that Tylenol medication was ordered or had been administered for Resident #73. During an interview on 6/4/24 at 11:22 A.M., with Nurse #4, who said she was a regular staff member and familiar with providing care for Resident #73. Nurse #4 said if she assessed the Resident after pain medication was administered and it was not effective, she would offer him/her another dose if he/she was due, but she had not documented offering another dose and should have. Nurse #4 said that if pain medication was ineffective in managing pain, the Provider should be notified for additional orders and/or to reassess the Resident. During an interview on 6/4/24 at 3:22 P.M., the surveyor and UM #2 reviewed the clinical record. UM #2 said the Medication Administration Note dated 5/2/24 at 10:48 A.M., indicated that the Resident's follow-up pain scale after the Dilaudid administration was 10 out of 10 (severe pain). UM #2 said the Nurse should have contacted the Provider after completing the follow-up assessment for Resident #73 to obtain additional pain medication orders. When the surveyor asked UM #2 if there was documented evidence that the Provider was contacted relative to Resident #73's pain documented on 5/2/24, UM #2 said she was unable to provide any evidence the 5/2/24 occurrence had been communicated to the Provider or that additional pain control measures had been offered to the Resident. During an interview on 6/5/24 at 9:13 A.M., NP #1 said her expectation would be for staff to contact her or the on-call Provider relative to a resident who was experiencing unrelieved pain so an order for an additional dose of medication could be obtained. NP #1 further said that if notified, the Provider would know to review whether the pain medication regimen needed to be changed for improved pain management. NP #1 said she was not notified that Resident #73 was having unrelieved pain. During an interview on 6/5/24 at 4:13 P.M., the DON said if a follow-up assessment indicated a resident's pain medication was ineffective, the staff would be expected to contact the Provider to obtain additional orders. The DON further said that unrelieved pain would be concern that could indicate a larger issue and that the Provider would need to determine if a medical workup could be managed in-house or if it would have required the Resident to be transferred to the hospital for further evaluation.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interview and record review, the facility failed to ensure that one Resident (#106) out of a total sample of 29 residents received trauma-informed care in accordance with professional standards of practice. Specifically, for Resident #106 who had a history of Post Traumatic Stress Disorder (PTSD: a mental and behavioral disorder that developed from having experienced a traumatic event, causing flashbacks, nightmares and severe anxiety), the facility failed to complete an assessment and develop a care plan that included the Resident's identified PTSD triggers (certain stimuli that bring back strong memories from a traumatic event, these can include but are not limited to sounds, smells, physical actions, and thoughts, that can cause an adverse reaction). Findings include: Review of the facility policy titled Trauma-Informed and Culturally Competent Care, edited 12/29/22, indicated the following: *Resident Screening: -Perform universal screening of residents, which includes a brief, nonspecialized identification of possible exposure to traumatic events. -Utilize initial screening to identify the need for further assessment and care. *Resident Assessment: -Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. *Resident Care Planning -Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. -Identify and decrease exposure to triggers that may re-traumatize the resident. Resident #106 was admitted to the facility in May 2024, with a diagnosis of PTSD. Review of the most recent comprehensive Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #106 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 13 out of 15. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 9:13 A.M., Resident #106 said he/she had recently been involved in a motor vehicle accident, had a history of PTSD, and utilized medication for Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of the Resident's medical record indicated no documentation that the Resident had been assessed for his/her triggers related to PTSD and that a care plan had been developed related to his/her diagnosis of PTSD. During an interview on 6/3/24 at 4:00 P.M., the Director of Social Services (DSS) said upon admission all residents should be assessed for trauma and if the resident have a history of PTSD. The DSS said he had reviewed Resident #106's medical record and was not able to locate a trauma informed care assessment that should have been completed at the time of admission. During an interview on 6/3/24 at 4:48 P.M., Social Worker (SW) #1 said upon admission the trauma informed care assessment should be completed for each resident. SW #1 further said Resident #106 had a diagnosis of PTSD and a care plan should have been developed on admission to address the Resident's history of trauma and if he/she had any triggers related to his/her past trauma that staff should be aware of. SW#1 said no care plan had been developed until the surveyor brought it to the facility's attention today.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37400 Based on interview, record and policy review, the facility failed to ensure the Consultant Pharmacist recommendations were responded to timely for two Residents (#71 and #58), of five applicable residents reviewed, out of a total sample of 29 residents. Specifically, the facility failed to: 1. For Resident #71, implement two Consultant Pharmacist recommendations directed to Nursing staff when the Resident was prescribed an antipsychotic medication (used to manage psychosis or severe mental condition when thought and emotions are affected and some contact with reality is lost). 2. For Resident #58, implement the Consultant Pharmacist recommendation to clarify the administration orders of a prescribed inhaler. Findings include: Review of the facility policy titled Medication Regimen Review (MRR), effective February 2019, indicated the Consultant Pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least month. The policy also included the following: -The MRR involves a thorough review of the resident records, and may include collaboration with other members of the interdisciplinary team (IDT) . -Involves reporting of findings with recommendations for improvement -All findings and recommendations are reported to the Director of Nurses (DON), Attending Physician, the Medical Director, and the Administrator. -the Prescriber is notified of the Consultant findings applicable to the Prescriber by the facility in a timely manner to allow the Prescriber sufficient time to respond prior to the next monthly Consultant visit. 1. Resident #71 was admitted to the facility in October 2021 with diagnoses including Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Delirium (disturbed state of mind or consciousness, characterized by symptoms of confusion, disorientation, agitation, and hallucinations), Psychotic Disturbance (mental disorder characterized by a disconnection from reality), Mood Disturbance (disorder where long periods of extreme happiness, sadness, anger and/or irritability are experienced), Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment) and Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), and Insomnia (sleep disorder with problems falling and/or staying asleep). Review of the Minimum Data Set (MDS) Assessment, dated 7/13/23, indicated Resident #71: (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 0 out of 15, -had physical behaviors daily which impacted the Resident's care and participation in social interactions, -and received antipsychotic medications on a routine basis. Review of the June 2023 Physician's orders included the following: -ABH gel (combination of Ativan (antianxiety medication), Benadryl (antihistamine used to treat pain and itchiness and also used to aide in sleep) and Haldol (antipsychotic medication used to treat mental disorders), 1/25/1 milligram (mg)/milliliter (ml), apply to inner wrist topically twice daily for anxiety related to major depressive disorder, initiated 8/23/23. Review of Resident #71's clinical record indicated the Consultant Pharmacist had recommendations on 12/29/23 and 2/28/24. Further review of the clinical record indicated no documented evidence of what the Consultant Pharmacist recommendations were. On 6/4/24 at 10:57 A.M., the surveyor requested from the DON the Consultant Pharmacist recommendations made for Resident #71 on 12/29/23 and 2/28/24. During an interview on 6/4/24 at 4:48 P.M., the DON provided the surveyor with the requested Consultant Pharmacist recommendations. The DON said when the Consultant Pharmacist conducts the MRR's monthly for the residents, any recommendations for nursing or the Attending Physician are given to the Unit Managers (UM) to follow-up on and then placed in the pharmacy book once completed and/or responded to. Review of the Consultant Pharmacist recommendations dated 12/29/23 and 2/28/24 indicated the following: -12/29/23 was addressed to nursing: please note this new resident is on antipsychotic medication therapy and will need: 1. AIMS (abnormal involuntary movement - Clinician rated scale to assess severity of dyskinesias [specifically orofacial movements]) test, 2. Orthostatic (measurements obtained when lying, sitting and standing) Blood Pressures (BPs), and 3. Psychiatric Evaluation -2/28/24 was addressed to the DON due to no response on 12/29/23 recommendations, and included the same recommendations as 12/29/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview on 6/4/24 at 4:48 P.M., the DON said the Consultant Pharmacist recommendation dated 2/28/24 was a duplicate recommendation from the 12/29/23 MRR completed. The DON further said that she would look into these recommendations to see if they were addressed. Review of the Resident's Clinical record indicated the following: -A Psychiatric Evaluation and AIMS testing was completed on 2/19/23 (approximately 1.5 months after the recommendations made by the Consultant Pharmacist. -The Physician's order to obtain orthostatic BPs was initiated on 4/12/24 to be completed monthly (approximately 3.5 months after the recommendation was made by the Consultant Pharmacist). On 6/5/24 at 10:13 A.M., the surveyor and Unit Manager (UM) #3 reviewed Resident #71's clinical record. During an interview at the time, UM #3 she was not aware of the 12/29/23 Consultant Pharmacist recommendations. UM #3 further said there was no documented evidence that orthostatic BPs were entered into the Resident's clinical record to be monitored until April 2024 and that a Psychiatric evaluation was completed on 2/19/23. 42741 2. Resident #58 was admitted to the facility in February 2024 with a diagnosis of Asthma (condition where the airways narrow and swell [inflammation] making it difficult to breathe). Review of the Resident's April 2024 and May 2024 Physician's orders indicated the following: -Symbicort Inhalation Aerosol, two puff inhale orally two times a day, with a start date of 3/5/24. Review of the April and May 2024 Medication Administration Record (MAR) indicated the Resident utilized the Symbicort as directed daily when in the facility. Review of the Pharmacy Interim Medication Regimen Review (IMRR), dated 4/15/24, indicated the following recommendation: -Symbicort - add rinse parameter to order. Review of the Symbicort website www.mysymbicort.com, last updated April 2024, indicated the following: -Rinse your mouth with water without swallowing after using Symbicort to help reduce your chance of getting thrush (a fungal infection that can occur due to use of oral steroids). During an interview on 6/4/24 at 7:49 A.M., the DON said the Unit Managers (UMs) review the Pharmacist's MRRs and address the nursing concerns or provide the MRRs to the Physician if appropriate. The DON said she had reviewed the MRR with the UM #1 and UM #1 had not updated the Physician's order to indicate nursing should have the Resident rinse his/her mouth after being administered the Symbicort inhaler per the Pharmacist's recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 4:45 P.M., the DON said the MRRs should be reviewed, and the recommendations implemented within a month.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on interview and record review, the facility failed to ensure that one Resident (#73) out of a total sample of 29 residents was free of significant medication errors. Specifically, for Resident #73, the facility failed to ensure two nurses (Nurse #10 and Nurse #9) administered the correct opioid pain medication (a drug class of strong pain medications) as ordered by the Physician on two separate occasions, placing the Resident at risk for sedation (medication induced calm and/or sleepiness) and respiratory depression (slowing of breathing that can include stopping breathing all together). Findings include: Review of the Professional Standards of Practice in the Lippincott Nursing Procedures 9th Edition (2023) manual, safe medication administration is included but was not limited to the following: -Follow the five rights of medication administration: the right patient, the right medication, the right dose, the right time and the right route. -Some literature indicates use of nine rights which adds the right documentation, the right action, the right form and the right response. -Identify high alert medications, examples of these include opioid medications and precautions may include having a second Nurse independently verify the medication and dose before administration. Resident #73 was admitted to the facility in April 2024 with the following diagnoses: Osteomyelitis of Vertebra, Sacral Region (infection of the bone(s) in the lower spine in the area of the low back and buttocks), Stage 4 Pressure Ulcer (a wound caused by pressure extending down into the muscle, tendon or to the bone) of the Sacral Region (in the area of the buttocks), Stage 3 Pressure Ulcer of the Right Buttock (a wound caused by pressure extending past the surface skin into fat tissues but not to the muscle), and a Stage 4 Pressure Ulcer of the Right Hip. Review of Resident #73's Minimum Data Set (MDS) assessment dated [DATE], indicated: -that the Resident was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of 15. -His/her pain assessment indicated pain was almost constant with the worst pain rating at 9 out of 10 on the pain scale (severe) and had an almost constant effect on his/her sleep and activities of daily living (ADLs: dressing, bathing, getting in out of bed, mobility). Review of Resident #73's April 2024 through May 2024 Physician's orders included the following relative to Morphine Sulfate (a opioid pain medication): (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Morphine Sulfate extended release (ER - a type of Morphine Sulfate that works over a longer period than traditional Morphine Sulfate tablets for a more controlled effect on pain) 15 milligram (mg) scheduled twice a day at 8:00 A.M. and 8:00 P.M., with a start date of 4/21/24 -Morphine Sulfate oral tablet (a short acting type of morphine that takes effect quicker but does not last as long as the ER) 15 mg every 6 hours as needed (PRN) for pain before dressing change, with an order date of 5/11/24 and discontinued date of 5/16/24, -Morphine Sulfate oral solution (liquid version of the short acting Morphine pain medication) 5 mg every 4 hours as needed (PRN) for pain, with an order date of 5/12/24 and a discontinued date of 5/17/24, -Morphine Sulfate oral tablet 7.5 mg every 4 hours as needed (PRN) for pain, with a start date of 5/15/24 Review of Resident #73's clinical record indicated the following: -Medication Administration Note, dated 5/12/24 at 9:54 A.M., indicated the Morphine Sulfate ER tablet was held for the 8:00 A.M. scheduled dose due to the 11:00 P.M. to 7:00 A.M. (night shift) Nurse administering the scheduled medication at 4:53 A.M. on 5/12/24. -Nursing Clinical Note, dated 5/16/24 at 3:37 P.M., indicated that the Resident was given his/her scheduled Morphine Sulfate ER tablet at 2:00 A.M. on 5/16/24, and this was reported to the medical staff, the Resident was being monitored, and was stable. Review of the facility Medication Error Report for Resident #73, dated 5/12/24, indicated that Nurse #10 administered Morphine Sulfate ER 15 mg tablet at 5:00 A.M. instead of the ordered as needed (PRN) Morphine Sulfate oral tablet 15 mg that he intended to administer. Further review of the Medication Error Report indicated that Nurse #10 was educated on the rights of medication administration. Review of the facility Medication Error Report for Resident #73, dated 5/16/24, indicated that Nurse #9 administered Morphine Sulfate ER 15 mg tablet at 2:00 A.M. instead of the ordered as needed (PRN) Morphine Sulfate oral solution 5 mg that she intended to administer. Further review of the Medication Error Report indicated that Nurse #9 was educated on the rights of medication administration. During an interview on 6/5/24 at 3:44 P.M., Nurse #10 said he was not thinking when the medication error occurred on 5/12/24, and just popped out the wrong pill from the medication card and not noticing that it was the ER medication. Nurse #10 said he did not know if there was a way to prevent the medication error from occurring again in the future. When the surveyor asked if there was something Nurse #10 should have done to ensure that the correct medication was administered, Nurse #10 said he did not know. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 4:04 P.M., Nurse #9 said when she went to administer the medication on 5/16/24, she made an error and administered the incorrect pain medication for the as needed (PRN) dose. Nurse #9 said that after the medication administration, the error was identified, it was reported to the Provider and the Resident was monitored with no adverse outcomes observed from the error. When the surveyor asked if there were ways to prevent the error in the future, Nurse #9 said that she had received education on the rights of medication administration and listed the rights to the surveyor. During an interview on 6/5/24 at 4:13 P.M., the Director of Nursing (DON) said that both Nurse #9 and Nurse #10 received education on the rights of medication administration from the Staff Development Coordinator (SDC). The surveyor discussed with the DON the interview with Nurse #10 and his response to how to prevent re-occurrence of the medication error in the future. The DON said there would be concern that Nurse #10 could make another medication error and that Nurse #10 may have needed some further education.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observation and interview, the facility failed to ensure that medications were stored in a sanitary manner on two units (Kensington and [NAME]) out of five units observed. Specifically, the facility failed to ensure that the medication refrigerators on the Kensington Unit and the [NAME] Unit were maintained in a clean and sanitary manner. Findings include: Review of the facility policy Medication Labeling and Storage, undated, indicated but was not limited to: -The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. On 6/5/24 at 9:20 A.M., the surveyor and Unit Manager (UM) #1 conducted an inspection of the Kensington Unit medication room refrigerator. The surveyor and UM #1 observed a wet, reddish brown substance dripping down the interior back wall of the refrigerator onto a shelf where medications were stored. UM #1 said the refrigerator was dirty and definitely needed to be cleaned. On 6/5/24 at 10:30 A.M., the surveyor and Nurse #2 conducted an inspection of the [NAME] Unit medication room refrigerator. The surveyor and Nurse #2 observed that the interior back wall of the refrigerator was dripping water, and a reddish brown wet substance was pooling along the back interior edge as well as on the interior floor of the refrigerator where medications were stored. Nurse #2 said the refrigerator needed to be cleaned because there would be a risk of contaminating the medications that are stored in the refrigerator.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 37400 Based on interview and record review, the facility failed to ensure Physician Ordered lab work and diagnostic testing was obtained for one Resident (#2), of five applicable residents reviewed for unnecessary medication review, out of a total sample of 29 residents. Specifically, the facility failed to obtain yearly lab work and diagnostic testing for Resident #2 who was prescribed an antipsychotic medication (used to treat mental disorders) and had a history of breast cancer. Findings include: Resident #2 was admitted to the facility in January 2012 with diagnoses including Schizoaffective Disorder-Bipolar Type (condition that includes hallucinations or delusions as well as Depression or periods of excitement/euphoria), Morbid Obesity (disorder of having too much body fat), and history of Breast Cancer. Review of the June 2024 Physician's orders included the following: -Abilify (antipsychotic medication) 20 milligrams (mg) daily, initiated 10/28/22 -Electrocardiogram or EKG (a test to record the electrical signals in the heart) annually due to Abilify use, ordered 1/24/19 -Annual mammogram (X-Ray of the breast) screening ., ordered 1/24/19 -Yearly lab work: Complete Blood Count (CBC), Basic Metabolic Panel (BMP), HgbA1c, Liver Function Tests (LTFs), Thyroid Stimulating Hormone (TSH), Free T4 and Lipid Profile, starting on 2/1/23 Review of Resident #2's clinical record indicated no documented evidence that the following lab work and diagnostic tests were completed as ordered: -EKG since ordered on 1/24/19 -Annual Mammogram screening since ordered on 1/24/19 -TSH and Free T4 level since 2/1/23 On 6/4/24 at 12:56 P.M., the surveyor requested evidence that the scheduled lab work and diagnostic testing were completed for Resident #2. During an interview on 6/4/24 at 3:47 P.M., Unit Manager (UM) #3 said the Resident's TSH and Free T4 were not obtained and there was no annual mammogram or EKG scheduled this year as ordered by the Physician. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 6/5/24 at 9:34 A.M., UM #3 said she was unable to find evidence that the Resident has had a mammogram or an EKG since the testing was ordered by the Physician on 1/24/19.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37400 Based on observation, interview and policy review, the facility failed to properly follow sanitation and food handling practices to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Specifically, the facility failed to: 1. Ensure resident food was prepared and distributed to prevent potential for cross contamination. 2. Ensure beard nets were worn in the food preparation area. Findings include: Review of the facility policy titled Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, revised December 2008, indicated Food Service employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. The policy also included the following: -Employees must wash their hands: >after handling soiled equipment or utensils >during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks >after engaging in other activities that contaminate the hands -Gloves are considered single-use items and must be discarded after completing the task for which they were used. -Food service employees will be trained in the proper use of utensils as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness -Hair restraints or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens On 6/5/24 at 4:46 P.M., the surveyor observed the following during dinner service in the facility kitchen: -three Dietary Aides (#1, #2 and #3) with facial hair that was not covered with a beard restraint during dinner preparation. During an interview with Dietary Aide #3 at the time, Dietary Aide #3 said that beard restraints are not required if the facial hair was less than 1/2 inch in length. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/5/24 at 4:50 P.M., the Food Service Director (FSD) said he thought that beard restraints were only required for facial hair that is longer than 1/4 inch in length. The surveyor requested to review the facility policy relative to hair restraints at this time. From 4:58 P.M. through 5:17 P.M., the surveyor observed the dinner service and observed the following: -Dietary Aide #3, without a beard restraint, preparing grilled cheese sandwiches. -Dietary Aide #1 serving the food, using gloved hands, to scoop tuna tortellini salad onto plates that had cut up lettuce on them. Dietary Aide #1 used his gloved hands to arrange the tuna tortellini salad and then used the same gloved hands to pick up unwrapped dinner rolls and place them on the plate without changing his gloves and performing hand hygiene. -At 5:08 P.M., Dietary Aide #1 left the serving line, walked through the kitchen, and into the dry storage room, got a box containing bags of chips, exited the storage room, put the open box of chips on a utility cart placed by the serving line, moved the utility cart using the handle and then resumed serving dinner with the same gloved hands used previously. The surveyor stopped Dietary Aide #1 prior to him plating the food and instructed him to remove the gloves and perform hand hygiene, which he did. -At 5:13 P.M., the FSD provided tongs to serve the dinner rolls. During an interview on 6/5/24 at 5:17 P.M., the FSD said that Dietary Staff should be using serving utensils for food items to prevent potential cross contamination. The FSD said this could occur when touching handles and other items and then touching ready to eat foods. During a follow-up interview on 6/6/24 at 7:47 A.M., the FSD said that hair and beard restraints should be worn in the kitchen and serving utensils should be utilized when serving food to prevent potential for food contamination.

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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. 42690 Based on record review and interview, the facility failed to maintain complete and accurate medical records for one Resident (#30) out of a total sample 29 total residents. Specifically, for Resident #30, the facility failed to maintain accurate and consistent medical records relative to Advanced Directives (written instructions that are provided for medical care and the individual's health care wishes i.e: MOLST [Massachusetts Medical Orders for Life Sustaining Treatments]). Findings include: 1. Resident #30 was admitted to the facility in March 2024 with a diagnosis of Dementia. Review of the facility policy titled Advanced Directives, undated, indicated the following: -The Director of Nursing Services (DNS) or designee notifies the Attending Physician of Advance Directives (or changes in the Advanced Directives) so that appropriate orders can be documented in the resident's medical record and plan of care. Review of a MOLST form signed by the Resident on 3/18/24, indicated the following: -Do Not Resuscitate (DNR - a legally recognized order signed by the Physician at the Resident/Resident Representative's request to withhold resuscitation in the event of cardiac arrest or respiratory failure). -Do Not Intubate and Ventilate (Intubate- to place a breathing tube down the throat and into the trachea to assist with breathing]/[Ventilate - the use of a ventilator to assist with breathing when someone is unable to breathe on their own]). Review of the June 2024 Physician's orders indicated no order relative to the Resident's wishes of being resuscitated or not resuscitated. Review of the Advance Directive Care Plan initiated on 3/20/24 and revised on 3/25/24, indicated the Resident wished to be a full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive) and had a MOLST in place. During an interview on 6/4/24 at 8:27 A.M., the surveyor and Unit Manager (UM) #4 reviewed the June 2024 Physician orders, the signed MOLST form and the Advanced Directives Care Plan. UM #4 said that the MOLST form reflected the Resident's wishes however the Advanced Directives Care Plan was inaccurate and should read DNR/DNI to match the MOLST form. UM #4 also said that the Physician orders should reflect the Resident's MOLST form specifically because the Resident's wishes are DNR/DNI.