| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225299 | A. Building<br>B. Wing | 08/20/2025 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0584<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observations, interview, and record review, the facility failed to maintain a homelike environment for one Resident (#15), out of a total sample of 33 residents. Specifically, the facility failed to ensure timely repair of a cracked second floor bedroom window for Resident #15 when it had been reported to the facility 84 days prior.Findings include:Review of the facility's policy titled Homelike Environment, revised February 2021, indicated the following:-Residents are provided with a safe, clean, comfortable, and homelike environment.-The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.Resident #15 was admitted to the facility in August 2024 with diagnoses including Non-Alzheimer's Dementia, Depression, and Post-Traumatic Stress Disorder (PTSD). During a telephone interview on 8/14/25 at 4:16 P.M., Resident Representative (RR) #2 said that Resident #15 had a large crack in their bedroom window on the second floor. RR #2 further said he/she had asked the facility staff in prior care plan meetings to repair the window and had been told a window needed to be ordered, but he/she was unsure if this occurred and the window remained cracked.During an interview on 8/14/25 at 4:36 P.M., the Administrator said she was aware of a cracked window for Resident #15 and that maintenance was in the process of replacing the window. On 8/14/25 at 4:40 P.M., the surveyor observed Resident #15's room which included a large crack in the lower half of the window across four windowpanes.During an interview on 8/14/25 at 4:56 P.M., Nurse #5 said she was not aware of a cracked window in Resident #15's room. The Nurse said any maintenance requests were put in the book on the unit, and the Nurse demonstrated where and how the request book was kept. Further review of the unit Maintenance Request book did not provide evidence of maintenance requests made for Resident #15's room. Review of Resident #15's Care Conference Note, dated 5/27/25, indicated the following attendees: -Social Services,-Nursing,-Recreation, and- RR #2 via telephone call. During an interview on 8/15/25 at 1:35 P.M. Social Worker (SW) #1 said that she participated in Resident #15's care plan meeting on 5/27/25 and recalled that RR #2 had voiced a concern about the Resident's cracked window. SW #1 said that she notified the administrative team about the Resident's window on 5/27/25 during the afternoon wrap-up meeting. During an interview on 8/15/25 at 12:23 P.M. with the Maintenance Director, Administrator, and Maintenance Worker #1, the Maintenance Director stated he was new in the role and was training with Maintenance Worker #1. Maintenance Worker #1 said that he was made aware by the Administrator in July of a cracked window in Resident #15's room. Maintenance Worker #1 said he had initiated the process of obtaining a glass vendor to repair the Resident's window once he was notified, and payment for the repair had been made on 8/15/25, but they do not have an estimated timeframe for the repair to occur.During an interview at the same time on 8/15/25 at 12:23 P.M., the Administrator said the facility had been made aware of RR #2's concern of a cracked window in Resident #15's room earlier than July but she was unable to provide evidence prior to July addressing the cracked window.On 8/19/25 at 9:42 A.M., the surveyor observed that the window in Resident #15's room remained cracked and unrepaired, 84 days after being reported to the facility. |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observations, record reviews, and interviews, the facility failed to ensure one Resident (#157), out of total sample of 33 residents, was free from the use of physical restraints. Specifically, the facility failed to ensure Resident #157's Velcro self-releasing seatbelt was released during supervised activities and failed to evaluate Resident #157's ability to self-release the Velcro seatbelt every shift, restricting his/her ability to move freely when the Resident had a history of attempting to stand up from a seated position. Findings include:Review of the facility's policy titled Use of Restraints, revised April 2017, indicated the following: -Restraints should only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried successfully. -Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. -When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. - Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -Care plans shall also include the measures taken to systemically reduce or eliminate the need for restraint use. Resident #157 was admitted to the facility in February 2025 with diagnoses that included metabolic encephalopathy, repeated falls, and unspecified dementia. Review of the Care Plan for the use of a Velcro alarming seatbelt, initiated on 2/25/25, indicated the following: -Resident #157 had impulsivity, motor restlessness, impaired cognition, poor safety awareness, poor spatial awareness, weakness and unsteady gait. -Restraint Release: FYI- with supervised activities, meals and on rounds, initiated 2/25/25. Review of the active Physician's Orders, initiated 4/23/25, indicated the following: -Velcro alarming seatbelt- prompt for ability to release seatbelt on command. (ensure they document ability in nurse's notes) every shift. Review of the Minimum Data Set (MDS) Assessment, dated 5/12/25, indicated the following for Resident #157: -Brief Interview for Mental Status (BIMS) score of 5 out 15 indicating a severe cognitive impairment. -used a manual wheelchair for mobility. -a history of two or more falls since admission. -does not utilize a restraint. Review of the Nursing Progress notes from 2/23/25 through 8/15/25, did not show evidence of every shift documentation regarding Resident #157's ability to self-release the Velcro Alarmed seatbelt. During a continuous observation on 8/15/25 at 8:04 A.M.- 8:32 A.M., Resident #157 was assisted into the supervised dining room and positioned at a dining room table and remained seated in the wheelchair with the Velcro Seatbelt secured around his/her waist. A breakfast tray was delivered to the Resident and the Velcro seatbelt remained secured at Resident #157's waist throughout the entire breakfast meal while a staff member was supervising the dining room. During a continuous observation on 8/15/25 at 1:46 P.M. - 2:16 P.M., Resident #157 was sitting in a wheelchair with a Velcro Seatbelt secured around his/her waist in the activities room while being supervised by two activities staff members and one Certified Nursing Assistant (CNA). Resident #157 did not attempt to self-rise and did not display any signs of agitation or impulsivity but was smiling and happy while speaking nonsensically to another Resident. Two activity staff members were performing manicures and hand massages to the residents sitting on each side of Resident #157. The Velcro seatbelt remained secured around Resident #157's waist during the supervised activity. During an observation on 8/15/25 at 2:16 P.M., Resident #157 was removed from the activity and brought to the nurse's station where maintenance staff were performing maintenance on the alarmed seatbelt. The seatbelt remained secured at this time. During an interview on 8/19/25 at 12:12 P.M with Unit Manager (UM) #5 and the Director of Nurses (DON)., UM #5 said Resident #157 used a Velcro Alarmed seatbelt due to multiple falls in the facility, agitation, and impulsivity. The DON said that the facility should assess any potential restraint quarterly and that a quarterly restraint assessment should have been completed according to the MDS scheduled for 8/6/25, but that did not happen. The DON said that if the Resident was in a supervised activity or at a supervised meal, then the restraint should have been removed if the Resident was not having impulsive behaviors. The DON further said that nurses should have been documenting Resident #157's ability to self-release the Velcro Seatbelt in the nursing progress notes every shift but could not show evidence this occurred. During an interview on 8/19/25 at 1:35 P.M., the DON said that Resident #157's mental status varied daily and his/her ability to self-release the seat belt was inconsistent, therefore the Self-releasing Velcro Alarmed seatbelt should have been considered a restraint. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview and record review, the facility failed to provide nursing services consistent with professional standards of practice for two Residents (#175 and #4) out of a total sample of 33 residents. Specifically, for Resident #175 and Resident #4, the facility failed to reorder the Residents' medications resulting in the facility staff borrowing other Residents' medications to administer the prescribed dosages. Findings include: Review of the facility's policy titled Medication Ordering and Receiving from Pharmacy, revised January 2018, indicated: -Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. - If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form, by placing a re-order portion of the prescription label in the appropriate area on the order form provided by the pharmacy for that purpose. - The nurse who re-orders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors. - The re-order is called in, faxed, sent electronically or otherwise transmitted to the pharmacy. - Delivery records are retained for one (1) year. Review of the facility's policy titled Pharmacy Services Overview, dated 2001, indicated: -Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. - Medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice. - Pharmacy services are available to residents 24 hours a day, seven days a week. - Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. - Borrowing medications from other residents or from the emergency medication supply because of a failure to order or reorder a medication in time for a resident to receive scheduled medication is not acceptable practice. 1. Resident #175 was admitted to the facility in June 2025 with diagnoses including Adrenocortical Insufficiency (a condition where the hormones do not produce enough cortisol leading to symptoms of fatigue and muscle weakness). Review of Resident #175's August 2025 Physician's Order indicated: - Prednisone Tablet 5 milligram (mg), give 1.5 tablet by mouth one time a day for Adrenocortical Insufficiency total dose=7.5mg. Start date 6/4/25. Review of Resident #175's August 2025 Medication Administration Record (MAR) indicated: -Prednisone 7.5 mg had been administered from 8/1/25 to 8/14/25. On 8/15/25 at 8:41 A.M., the surveyor observed Nurse #1 prepare to administer medications to Resident #175. The surveyor did not observe Nurse #1 administer Prednisone 7.5 mg as ordered by the Physician. During an interview immediately following the observation, Nurse #1 said Resident #175's Prednisone 7.5 mg was not available from the medication cart or the Omnicell (back-up automating and managing medication and supply dispensing in healthcare settings) to be administered as ordered by the physician. Nurse #1 said that it appeared someone attempted to reorder the Prednisone 7.5 mg medication but did not follow through, so the re-order was not transmitted to the pharmacy on 8/5/25. 2. Resident #4 was admitted to the facility in July 2025 with diagnoses including restless leg syndrome. Review of Resident #4's Physician's Orders for August 2025 included but was not limited to: - Ropinirole HCl Oral Tablet 0.5 MG (Ropinirole Hydrochloride) Give 1 tablet by mouth two times a day for restless leg syndrome. Start date 7/9/25. Review of Resident #4's August 2025 MAR indicated: - Ropinirole 0.5 mg by mouth twice a day medication had been administered 22 times from 8/1/25 to 8/15/25. - Ropinirole 0.5 mg by mouth twice a day medication had been documented as not available six times from 8/1/25 to 8/15/25. - Ropinirole 0.5 mg by mouth twice a day medication had been documented as not applicable one time from 8/1/25 to 8/15/25. On 8/15/25 at 9:00 A.M., the surveyor observed Nurse #1 prepare to administer medications to Resident #4. The surveyor did not observe Nurse #1 administer Ropinirole 0.5 mg as ordered by the Physician. During an interview immediately following the observation, Nurse #1 said Resident #4's Ropinirole 0.5 mg medication was not available to be administered. The Resident had run out of the Ropinirole 0.5 mg medication, and the medication was not available in the Omnicell. Nurse #1 said there was no indication that the Ropinirole 0.5 mg medication had been re-ordered. During an interview on 8/15/25 at 9:05 A.M., Unit Manager (UM) #1 said she had no record of Resident #4's Ropinirole medication or Resident #175's Prednisone 7.5 mg medication being ordered and or received from the pharmacy. During an interview on 8/15/25 at 10:15 A.M., the Director of Nursing (DON) said a 10-day supply of the Prednisone medication was last delivered from the pharmacy on 7/28/25 and would have been completed on 8/7/25. There was no evidence that the Prednisone medication was reordered after 8/7/25. The DON further said she was not aware that Resident |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, interview, and record review, the facility failed to ensure that one Resident (#14) received proper treatment and care to maintain mobility and good foot health, out of a total sample of 33 residents. Specifically, the facility failed to ensure Resident #14 received timely foot care and treatment in order to prevent potential and actual complications when Resident #14 was identified as being high risk due to a diagnosis of Diabetes, having elongated toenails that were affecting his/her balance and mobility, experiencing discomfort during physical therapy treatments, and received toenail care on 8/15/25, 73 days after the initial identification of need on 6/3/25.Findings include:Review of the facility's policy titled Nursing Care of the Older Adult with Diabetes, revised November 2020, indicated the following:-Complications associated with Diabetes can be attributed to: (1) uncontrolled hyperglycemia and subsequent damage to vasculature; over treatment of diabetes resulting in hypoglycemia; or (3) common co-morbidities of diabetes. -Hyperglycemia and vascular damage can lead to.<Foot complications- neuropathy, dry skin, calluses, poor circulation, ulcers;<Skin problems- fungal/bacterial infections, itching, diabetic dermopathy.-Skin and Foot Care:<Toenails should only be trimmed by personnel qualified to do so (this can be regular associates, and does not have to be a podiatrist). Resident #14 was admitted to the facility in May 2025 with diagnoses including Vascular Dementia with Agitation and Diabetes Mellitus Type II. Review of the Minimum Data Set (MDS) Assessment, dated 5/28/25, indicated the following relative to Resident #14:-he/she was moderately cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15.-rejected care 1-3 days out of the last 7.-fell in the past month prior to facility admission.-was at risk for developing pressure ulcers/injuries. -did not have dressing or medications to feet. Review of the comprehensive plan of care for Activities of Daily Living (ADLs), last revised 8/7/25, indicated the Resident was at risk for self-care deficits related to physical limitations, incontinence, cognitive loss, and decreased communication. The plan of care included the following:-Goal: Resident to be clean, dressed, and well-groomed daily to promote dignity and psychosocial well-being.-Intervention for Physical Therapy and treatment.-Interventions:>provide assist of one staff with transfers to/from toilit (sic)>Setup to assist of 1 with daily hygiene, grooming, dressing, oral care, and eating.>Supervised to assist of one staff with bed mobility, transfers, and ambulation using front wheeled walker. During a telephone interview on 8/14/25 at 1:37 P.M., Resident Representative (RR) #1 said Resident #14's toenails were very bad, affected the Resident's balance, and that this concern had been discussed with the facility staff previously. RR #1 said he/she had been in touch with the facility and understood that the facility was attempting to get the Resident seen by a Podiatrist, but he/she was unsure of when the next visit would be. During an interview on 8/15/25 at 9:57 A.M., Nurse #6 said Resident #14 was new to her unit, needed to be seen by the Podiatrist, and she was unsure if the Resident was on the list to be seen. During an interview and observation on 8/15/25 at 10:08 A.M., the Surveyor and Nurse #6 observed Resident #14's feet and toenails. All ten toenails were observed to be hard, thick, elongated, yellow, and discolored with ridges. The large toe toenails on both feet were observed to be 2 inches in length beyond the skin, textured, curling at the tips, and overlapping onto the next toenail. Resident #14 verbalized ow when the Nurse manipulated the right great toe to for examination. Resident #14 said that he/she wanted to see the Podiatrist and have his/her toenails cut. Nurse #6 said the Resident's toenails had been elongated like this since the Resident transferred to the unit. Review of the Physical Therapy Treatment Encounter Note, dated 6/3/25, indicated but was not limited to the following:-Care plan meeting was held with the Resident, Therapy staff, Unit Manager, Case manager, Healthcare Proxy (HCP), and RR #1.-Education was provided regarding concerns of the lengths of the Resident's toenails which affected his/her ability to utilize toe muscles effectively.-Resident was a high risk for falls. Review of the Case Management Note, dated 6/3/25, indicated but was not limited to the following:-Physical Therapist reported the Resident's toenails were too long and were affecting his/her ability to walk and his/her balance.-Resident agreed to all services available. Review of Resident #14's medical record indicated a Request for Service form with consent for Podiatry services was signed by the Resident's Representative on 6/26/25. During an interview on 8/15/25 at 11:52 A.M., the Medical Record Staff said the last Podiatry visit occurred on 6/7/25 and Resident #14 had not been seen because a consent had not been signed or submitted until 6/26/25. During an interview on 8/15/25 at 12:59 P.M., the Medical Record staff said the facility was between contracted Podiatrists and that another date and provider had not yet been scheduled since the last visit on 6/7/25. Review of the Physical Therapy Encounter Note, dated 8/9/25 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observation, record review, and interview, the facility failed to provide appropriate treatment and services related to an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body) for three Residents (#1, #2 and #3), out of a total sample of 33 residents. Specifically, the facility failed: 1. For Residents #1 and #3, to ensure staff followed the Physician's orders relative to the Foley (type of indwelling urinary catheter) catheter size, increasing the Resident's risk for indwelling urinary catheter complications; and 2. For Resident #2, to ensure the Resident's Foley catheter was secured with a securement device to reduce friction and movement at the insertion site. Findings include:<br><br>Review of the facility's policy titled Catheter Care, Urinary, dated 2001, indicated:<br><br>-Purpose is to prevent urinary catheter-associated complications including urinary tract infections.<br><br>- Review the resident’s care plan to assess any special needs of the resident.<br><br>- Ensure the catheter remains secured with a securement device to reduce friction and movement at the insertion site.<br><br>- Review and document the clinical indications for catheter use prior to inserting.<br><br>1A. Resident #1 was admitted to the facility in August 2025 with diagnoses of Chronic Kidney Disease, Chronic Respiratory Failure with Hypoxia, and Infection and Inflammatory reaction due to Indwelling Urethral Catheter.<br><br>Review of the Minimum Data Set (MDS) Assessment, dated 8/17/25, indicated that Resident #1:<br><br>- Was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15;<br><br>- Had an indwelling urinary catheter; and<br><br>- Needed assistance for activities of daily living (ADLs- basic skills such as bathing, dressing, eating, etc.).<br><br>Review of Resident #1’s August 2025 Physician’s Orders indicated:<br><br>-Foley catheter, every night shift, every Saturday, Change the catheter secure tube holder<br><br>- as needed for breakage/soilage Change the Foley catheter bag 18 French (Fr) (unit measurement used to indicate the diameter of the catheter) 10 milliliters (ml)<br><br>- as needed Flush the Foley catheter with 10 ml Sterile Saline<br><br>- every shift, provide Foley catheter care<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - every shift Document urinary Output<br><br>- as needed for blockage/leakage change Urinary catheter with French size:18 Fr Balloon size: 10 ccs (cubic centimeters). Start date 8/11/25.<br><br>On 8/18/25 at 8:58 A.M., Unit Manager (UM) #1 observed Resident #1’s Foley catheter with the surveyor. UM #1 said Resident #1’s Foley catheter size was 16 Fr with 10 cc’s balloon. UM #1 reviewed Resident #1’s Physician’s order with surveyor as said the Resident had the wrong Foley catheter size. UM #1 said Resident #1’s Foley catheter size should have been 18 Fr and not 16 Fr.<br><br>B. Resident #3 was admitted to the facility in April 2025 with diagnoses of Sepsis, Heart Failure, Difficulty Walking, Urinary Tract Infection, and Bladder Neck Obstruction.<br><br>Review of the MDS Assessment, dated 7/10/25, indicated that Resident #3:<br><br>- Was cognitively intact as evidenced by a BIMS score of 14 out of 15.<br><br>- Had an indwelling urinary catheter.<br><br>Review of Resident #3’s August 2025 Physician's Orders indicated:<br><br>-Foley catheter as needed for blockage/leakage change Urinary catheter with French size:18 FR and Balloon size:10cc - Start Date 04/15/2025.<br><br>- Foley catheter every night shift, every Saturday, Change the catheter secure tube holder<br><br>- as needed for breakage/soilage Change the Foley catheter bag<br><br>- every 8 hours as needed Flush the Foley catheter with 10 cc Sterile Saline<br><br>- every shift provide Foley catheter care<br><br>- every shift Document urinary Output<br><br>- as needed for blockage/leakage change Urinary catheter with French size: 18 Fr and Balloon size: 10cc<br><br>- Change Foley catheter on 5/16/25 and every 4 weeks. Order start date 05/15/25<br><br>On 8/15/25 at 8:09 A.M., Nurse #2 observed Resident #3’s Foley catheter with the surveyor. Nurse #2 said Resident #3’s Foley catheter size was 16 Fr with 10 cc’s balloon. Nurse #2 said Resident #3’s physician's order indicated the Resident’s catheter size should be 18 Fr and 10 cc’s balloon, and that the Resident did not have the right size as ordered by the Physician.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225299 | A. Building<br>B. Wing | 08/20/2025 |

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

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/15/25 at 8:15 A.M., UM #1 reviewed Resident #3’s physician’s order with surveyor and said the Resident had the wrong Foley catheter size. UM #1 said Resident #3’s Foley catheter size should have been 18 Fr and not 16 Fr.<br><br>2. Resident #2 was admitted to the facility in October 2024 with a diagnosis of retention of urine.<br><br>Resident #2’s MDS Assessment, dated 8/4/25, indicated the following:<br><br>-the Resident was cognitively intact as evidenced by a BIMS score of 15 out of a possible score of 15.<br><br>-the Resident used an indwelling urinary catheter<br><br>Review of Resident #2’s August 2025 Physician's Orders indicated:<br><br>-an active order dated 7/30/25 for Foley Catheter: change the catheter secure tube holder every night shift on Saturday<br><br>During an interview on 8/19/25 at 9:37 A.M., the surveyor observed Resident #2 lying in bed with catheter tubing and lower ¾ of the thigh exposed. There were no catheter securement devices observed in place. The Resident stated he/she had never had a device that secured the catheter tubing in place.<br><br>On 8/20/25 at 8:10 A.M., UM #2 and the surveyor observed Resident #2’s indwelling urinary catheter together. No securement device was observed to be in place on the indwelling urinary catheter.<br><br>During an interview on 8/20/25 at 8:13 A.M., UM #2 said that there was not a securement device in place on Resident #2 but that she would apply one. UM #2 further said that she believed the Resident had a history of removing the device and would look for evidence of this.<br><br>At the time of survey exit, no additional information was provided to the survey team. |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.<br><br>Based on observation, interview, and record review, the facility failed to ensure that one Resident (#95), out of a total sample of 33 residents, had the ability to make choices about their daily preferences. Specifically, for Resident #95, the facility failed to ensure the Resident's preference to receive a peanut butter and jelly sandwich for dinner was honored. Findings include:Review of the Resident's Right Policy and Procedure, dated February 2021, indicated that federal and state law guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: -self-determination. -be informed of, and participate in, his or her care planning and treatment. Resident #95 was admitted to the facility in April 2024 with diagnoses that included Glaucoma and Gastric Esophageal Reflux Disease (GERD). Review of the Minimum Data Set (MDS) Assessment, dated 7/3/25, indicated Resident #95: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. -was able to make him/herself understood -was able to understand others -required set-up assistance from staff for eating. Review of the Dietary slip for Resident #157 indicated he/she had a preference to receive a peanut butter and jelly sandwich with every dinner meal. During an interview on 8/14/25 at 10:41 A.M., Resident #95 said he/she had spoken with the dietitian a few months prior and requested to receive a peanut butter and jelly sandwich with the dinner meal. Resident #95 said that he/she cannot eat a regular dinner meal because it upsets his/her stomach. Resident #95 said the peanut butter and jelly sandwich only comes on the dinner tray once or twice a week and when it does not come on the tray, he/she does not eat. Resident #95 said he/she does not like to bother staff for the sandwich, since the request has already been made for it to arrive on the dinner tray. During an interview on 8/15/25 at 7:45 A.M., Resident #95 said that a peanut butter and jelly sandwich did not come on the dinner tray on 8/14/25, and as a result he/she did not eat dinner. Resident #95 said he/she did not request a sandwich on 8/14/25 and wanted to avoid asking for items repetitively and has asked several times for a peanut butter and jelly sandwich to arrive on the dinner tray. During an interview on 8/15/25 at 11:24 A.M., the Dietitian said that she meets with the residents regarding food preferences/dislikes and passes that information onto the dietary team. The Dietitian showed the surveyor Resident #95's dietary slip that included a preference for him/her to receive a peanut butter and jelly sandwich with dinner. During an interview on 8/15/25 at 11:26 A.M., the Food Service Director (FSD) said that if a resident has food preferences listed on the dietary slip, those preferences should be honored. The FSD said that dietary staff are supposed to refer to the dietary slip when preparing meal trays and Resident #95 should have been receiving a peanut butter and jelly sandwich on every dinner tray. During an interview on 8/15/25 at 11:28 A.M., the Dietitian said it would be important for Resident #95 to receive a peanut butter and jelly sandwich for dinner to avoid nutritional complications such as weight loss and malnutrition. The Dietitian said that Resident #95 was continuously monitored for weight loss and should have been receiving the sandwich as requested. During an interview on 8/15/25 at 1:36 P.M., with the Dietitian and Resident #95, the Resident told the Dietitian that he/she has not been receiving the peanut butter and jelly sandwich and does not eat dinner if it does not come on the tray because he/she cannot eat a heavy meal at dinner. The Dietitian informed Resident #95 that he/she should have been receiving the sandwich as requested. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to maintain infection control practices to provide a safe, sanitary, and comfortable environment and to prevent the potential spread of infection on two Units ([NAME] and [NAME]), out of five Units observed. Specifically, on the [NAME] Unit, the facility failed to ensure:1. Staff wore appropriate personal protective equipment (PPE) when providing incontinence care to a resident who was on contact precautions; [NAME] the [NAME] Unit, the facility failed to ensure:2. Contaminated gloves were disposed of properly and appropriate hand hygiene was performed after removal of contaminated gloves, increasing the potential spread of healthcare-associated infections.Findings include:<br><br>Review of the facility's policy titled Isolation- Categories of Transmission Based Precautions, last revised September 2022, indicated the following:<br><br>-Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection, arrives for admission with symptoms of an infection; or has laboratory confirmed infection; and is at risk for transmitting the infection to other residents.<br><br>- Contact Precautions:<br><br>< Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident’s environment.<br><br>< Contact precautions are also used in situations when a resident is experiencing…incontinence or diarrhea…that cannot be contained and suggest an increased potential for extensive environmental contamination…<br><br>< Staff and visitors wear gloves (clean, non-sterile) when entering the room…<br><br>< Staff and visitors wear a disposable gown upon entering the room and remove gown before leaving the room…<br><br>Review of the Handwashing/Hand Hygiene policy, revised October 2023, indicated the following:-This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.<br><br>-All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.<br><br>-Hand hygiene products and supplies are readily accessible and convenient for staff use to encourage compliance with hand hygiene.<br><br>-Residents, family members and/or visitors are encouraged to practice good hand hygiene.<br><br>-Hand hygiene is indicated:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | >Immediately after glove removal<br><br>-The use of gloves does not replace hand washing/hand hygiene.<br><br>1. Resident #33 was admitted to the facility in August 2022 with a diagnosis of Enterocolitis due to Clostridium difficile (C-diff).<br><br>Review of Resident #33’s August 2025 Physician’s Orders indicated the following:<br><br>-Maintain contact precautions for C-diff, every shift; initiated 7/16/25.<br><br>On 8/14/25 at 9:23 A.M., the surveyor observed signage outside of Resident #33’s room indicating contact precautions and instructions for staff on handwashing, and PPE use of gown and gloves. The surveyor observed Unit Manager (UM) #2 providing the Resident with incontinence care at the bedside. UM #2 was wearing gloves only and was not observed wearing a gown. UM #2 exited the room at 9:31 A.M. and was not observed removing a gown.<br><br>During an interview on 8/14/25 at 9:31 A.M., UM #2 said Resident #33 was on contact precautions due to active C-diff infection. UM #2 said that she provided Resident #33 with incontinence care and that she should have been wearing a gown and had not been. She said that contact precautions are important to prevent the spread of infection to others.<br><br>During an interview on 8/20/25 at 8:56 A.M., the Infection Control Nurse (ICN) said that the expectation for staff when caring for residents on contact precautions is that staff don gowns and gloves prior to entering the room and remove gowns and gloves prior to exiting the room. The ICN said that signage outside of resident rooms will indicate which PPE staff should use. The ICN further said staff should preform hand hygiene prior to donning gloves at any time.<br><br>2. On 8/15/25 at 8:52 A.M., the surveyor observed Hospice Staff Member #1, walk out of a resident room, into the hallway wearing gloves on both hands and holding three plastic bags of soiled material. Hospice Staff Member #1 entered the soiled utility room and disposed of the three plastic bags, while holding the door open with her foot and remaining visible to the surveyor. Hospice Staff Member #1 removed her gloves and put the dirty gloves in her shirt pocket; they fell out of the pocket and Hospice Staff Member #1 picked the gloves off the floor and put the dirty gloves back into her shirt pocket before re-entering the same resident room.<br><br>During an interview on 8/15/25 at 9:01 A.M., Hospice Staff Member #1 said that when she disposed of the bags holding soiled linen and briefs, she should have removed her gloves, thrown them in the trash and washed her hands right away but did not. Hospice Staff Member #1 said she had turned the dirty gloves inside out and put them into her pocket and did not sanitize her hands but should have. Hospice Staff Member #1 said she should have thrown the gloves into a trash can and sanitized her hands to reduce the chances of cross contamination to a resident.<br><br>During an interview on 8/15/25 at 9:11 A.M., UM #5 said staff should not be wearing dirty gloves in the hallway and that Hospice Staff Member #1 should have disposed of the gloves properly then washed her hands.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/15/25 at 12:03 P.M., the Director of Nursing (DON) said it is the facility’s responsibility to educate outside providers on facility infection control policies, such as hospice agencies before they provide care in the building, but this did not happen. The DON said that Hospice Staff Member #1 should have disposed of the dirty gloves into a trash can and should have performed hand hygiene right away. |