STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225300	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation & Nursing Center at Everett (the)	289 Elm Street Everett, MA 02149

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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** 43846 Based on record review and interviews, the facility failed to obtain informed consents for psychotropic medications explaining the risks and benefits of treatment, prior to administering psychotropic medication for one Resident (#141) out of a sample of 31 residents. Findings include: Resident #141 was admitted to the facility in July 2024 with diagnoses that included foot drop, chronic non-pressure wounds, peripheral vascular disease. Review of Resident #141's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had severe cognitive impairment. Further review on the MDS indicated he/she received antidepressant medications. Review of Resident #141's physician order, dated 7/19/24, indicated Mirtazapine (antidepressant) 7.5 mg (milligrams). Give 1 tablet by mouth at bedtime related to depression. Review of Resident #141's physician order, dated 7/23/24, indicated Fluoxetine (antidepressant) 10 mg. Give 1 capsule by mouth one time a day for depression. Review of Resident #141's August 2024 Medication Administration Record (MAR), indicated the Resident received Mirtazapine 7.5 mg and Fluoxetine 10 mg daily as ordered. During an interview on 8/28/24 at 7:27 A.M., Unit Manager #1 reviewed Resident #141's medical record with the surveyor. Unit Manager #1 said Resident #141 should have psychotropic consents in place for both Mirtazapine and Fluoxetine but does not. During an interview on 8/28/24 at 8:45 A.M., the Director of Nurses (DON) said the expectation is that nursing obtains consents for psychotropic medications on admission and yearly.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview the facility failed to ensure the Physician/Nurse Practitioner were notified of recommendations made by a Wound Physician for two Residents (#141 and #53) out of a total sample of 31 residents. Specifically, 1. For Resident #141, the facility failed to ensure the Physician or Nurse Practitioner were notified of recommendations made by the Wound Physician on 8/19/24 and 8/26/24. 2. For Resident #53, the facility failed to ensure the Physician or Nurse Practitioner were notified of recommendations made by Psychiatric Nurse Practitioner. Findings include: 1. Resident #141 was admitted to the facility in July 2024 with diagnoses that included foot drop, chronic non-pressure wounds, peripheral vascular disease. Review of Resident #141's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had severe cognitive impairment. The MDS further indicated the Resident has unhealed pressure ulcers and is at risk for developing pressure ulcers. Review of Resident #141's Wound Physician notes, dated 8/19/24 and 8/26/24, indicated left heel full thickness stage 3 pressure wound dressing treatment plan: - Apply Alginate calcium to wound, cover with ABD pad (large pad dressing) apply once daily. Review of Resident #141's active physician order, dated 7/25/24, indicated wash left heel with NS (normal saline), pat dry apply skin prep apply once daily. Review of Resident #141's Wound Physician notes, dated 8/19/24 and 8/26/24, indicated diabetic right heel wound dressing treatment plan: - Apply Santyl (helps debride the wound) to wound and cover ABD pad apply once daily. Review of Resident #141's active physician's order, dated 7/25/24, indicated wash right heel with NS, pat dry apply Betadine apply once daily. Review of Resident #141's August 2024 Treatment Administration Record (TAR), indicated on 8/20/24, 8/21/24, 8/22/24, 8/24/24, 8/25/24, 8/26/24, and 8/27/24 wash left heel with NS, pat dry apply skin prep apply once daily and wash right heel with NS, pat dry apply Betadine apply once daily were signed off as administered. Review of Resident #141's Nurse Practitioner (NP) Note, dated 8/26/24, indicated the Resident was evaluated by the NP. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 7:17 A.M., Unit Manager #1 said the Wound Physician rounds weekly with nursing staff, if the Wound Physician makes recommendations they tell the nursing staff then nursing staff relays the information to the provider in the facility. Unit Manager #1 said the recommendations should have been verbalized to the physician and/or NP here but were not. During an interview on 8/28/24 at 8:54 A.M., Nurse Practitioner #1 said she was unaware that Resident #141 was being seen by the Wound Physician and said she was unaware of the Wound Physician's treatment plans for his/her wounds. 2. Resident #53 was readmitted to the facility in April 2024 with diagnoses that included bipolar disorder, dysphagia and sleep apnea. Review of Resident #53's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. During an interview on 8/26/24 at 8:16 A.M., Resident #53 said he/she has been feeling more depressed lately. Review of Resident #53's psych medication management Nurse Practitioner (NP) note, dated 8/8/24, indicated the Resident reported that his/her mood was labile. Recommended increasing Lamictal to 100 mg daily. Review of Resident #53's physician order, dated 11/28/23, indicated Lamictal (anti-epileptic medication also used for mood stabilization) tablet 25 mg (milligrams) give three tabs (75 mg) daily. Review of Resident #53's NP progress note, dated 8/26/24, indicated Lamictal 25 mg tablet. Take 3 tablets (75 mg) by mouth in the morning. Review of Resident #53's August 2024 Medication Administration Record (MAR), indicated the Resident received Lamictal 75 mg daily as ordered. On 8/28/24 at 7:15 A.M., Unit Manager #1 said nursing will update the Nurse Practitioner that follows the Resident in house of the new psych medication recommendations. Unit Manager #1 said she was unaware that Resident #53 had new medication recommendations made on 8/8/24. On 8/28/24 at 8:52 A.M., Nurse Practitioner #1 said she was unaware of the medication recommendations made by the psych NP on 8/8/24 and said she would expect nursing staff to relay her this information but they did not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure the Minimum Data Set assessment (MDS) was accurately coded to reflect the status of two Residents (#71, #21) out of a total sample of 31 residents. Specifically: 1) For Resident #71, the MDS did not accurately assess Resident #71's functional ablities for self-care, specifically for eating and 2) For Resident #21, the facility failed to complete a discharge MDS Assessment when the Resident was discharged from the facility to the hospital. Findings include: 1) Resident #71 was admitted to the facility in February with diagnoses that include but are not limited to cerebral vascular accident, anemia, and malnutrition. Review of the most recent Minimum Data Set assessment dated [DATE] indicated Resident #71 scored a 7 out of 15 on the Brief Interview of Mental Status exam indicating he/she as having a severe cognitive impairment. Further review of the MDS indicated Resident #71 had the following nutritional approaches: feeding tube, mechanically altered diet, and therapeutic diet. Review of Resident #71's physician's orders indicated the following: - Regular diet, Pureed texture, Thin Liquids consistency Diet Active date [DATE]. On [DATE] at 8:52 A.M. Resident #71 was observed in bed with a breakfast tray in front of him/her. On [DATE] at 8:51 A.M., Resident #71 was observed in bed with a breakfast tray in front of him/her holding a bowl of hot cereal and spooning the cereal into his/her mouth. A Certified Nursing Assistant (CNA) was next to Resident #71. During an interview on [DATE] at 12:04 P.M., CNA #3 said the Resident eats his/her meals with someone with him/her due to aspiration. CNA #3 said the Resident does not eat too much but needs supervision to eat. During an interview on [DATE] at 12:08 P.M. Nurse #6 said the Resident takes his/her medication whole with apple sauce. Review of Resident #71's MDS dated [DATE] indicated nutritional approaches as feeding tube, mechanically altered diet and therapeutic diet. The MDS document under functional abilities for eating was documented as 'not applicable' The MDS dated [DATE] indicated under functional abilities for eating was documented as 'not applicable.' Two MDSs failed to accurately assess Resident #71's functional abilities for eating. During an interview on [DATE] at 1:57 P.M., the MDS nurse said she did not know why the MDS was documented as 'not applicable for eating and that Resident #71 is dependent on staff for eating. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45984 2) Review of Resident #21's medical record indicated that the Resident went on hospital leave on [DATE] and did not return to the facility. Review of Resident #21's most recent Minimum Data assessment dated [DATE] indicated a quarterly MDS Assessment was the last completed MDS assessment. The medical record failed to indicate a discharge MDS assessment was completed. Review of Resident #21's nursing progress note dated [DATE] at 10:52 P.M. indicated that the Resident was sent out to the hospital. Review of Resident #21's nursing progress note dated [DATE] at 10:36 A.M. indicated that the Resident had expired in the hospital. During an interview on [DATE] at 1:57 P.M., the MDS Nurse said she is in charge of completing MDS assessments and when a Resident gets discharged from the facility a discharge MDS assessment gets completed. The MDS Coordinator and the surveyor reviewed Resident #21's medical record and she said she did not assess Resident #21 leaving the facility and it must have been forgotten.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46339 Based on observation, policy review and interviews, the facility failed to ensure professional standards of practice were followed for one Resident (#131) out of a total sample of 31 residents. Specifically, the facility failed to ensure nursing staff did not leave medications with Resident #131 while unattended. Findings include: Review of the facility policy titled 'Administration of Medications -General' dated November 2023, indicated the following but not limited to: -Medication may not be left unattended. Keep medications secured in a locked area or in visible control at all times. -Medications are never to be left at resident bedside if a situation occurs which necessitates that nurse must step away from resident prior to administration of all medications, medications must be removed from room and secured in locked medication cart until medications can be administered to resident. -Administers medications to residents via correct route. Offers residents a full glass of beverage. Observes residents to ensure medication consumption. During a medication pass on 8/27/24 at 9:28 A.M., the surveyor observed Nurse #2 prepare and administer medication to Resident #131 including the following medication, MiraLAX 17 grams (medication for constipation) mixed in water. Nurse #2 administered medications and left the cup of MiraLAX mixed in water with the resident. Nurse #2 did not wait to see if the Resident consumed the entire amount. During an interview on 8/27/24 at 1:37 P.M., Nurse #2 said she should have waited until the Resident took all the medications. During an interview on 8/28/24 at 8:43 A.M., the Director of Nursing said nurses are to stay with the residents until all medications are taken and no medications should be left with the residents.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, record review and interview, the facility failed to provide activities of daily living for dependent residents for one Resident (#2) out of a total sample of 31 Residents. Specifically, for Resident #2, the facility failed to provide supervision with meals. Findings include: Review of the facility policy titled Activities of Daily Living, dated November 2023, indicated the following: - It is the facility's policy that based on the comprehensive assessment of a resident consistent with the resident's needs and choices, care and services will be provided to maintain their current ADL status. - Care and services for the following ADL's include: Dining - eating, including meals and snacks - Referrals to therapy can be made based on the interdisciplinary team's review of resident's status during scheduled Comprehensive Care Plan Meetings. - Care Plans - All Resident care plans MUST match the Resident Profile care, CNA assignment, Pocket Sheet and DC POC and CNA Accountability sheets with regards to ADLs. Resident #2 was admitted to the facility in July 2007 with diagnoses including dementia, bipolar disorder and Barrett's esophagus. Review of Resident #2's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 5 out of a possible 15 indicating the Resident has severe cognitive impairment. Further review of the MDS indicated the Resident only requires setup assistance with eating. The surveyor made the following observations: - On 8/26/24 at 8:44 A.M., Resident #2 was observed sitting in a wheelchair in his/her room. A staff member entered his/her room with a breakfast tray, set it up and exited the room. Resident #2 was then observed eating a large cut piece of French Toast with no staff present in the room. - On 8/27/24 at 8:33 A.M., Resident #2 was observed sitting in his/her wheelchair in his/her room. A staff member delivered his/her breakfast tray, set up the tray and left the room. No staff were present in the room for supervision or cueing while Resident #2 was eating his/her breakfast. At 8:35 A.M., a staff member delivered Resident #2's roommate's tray and left the room at 8:36 A.M. At 8:39 A.M., a staff member entered Resident #2's room to cut up his/her pancakes and left the room. Resident #2 was observed eating his/her hot cereal with no supervision in his/her room. At 8:50 A.M., Resident #2 was observed to continuously eat his/her breakfast in his/her room without supervision or cueing assistance as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/28/24 at 8:10 A.M., Resident #2 received his/her breakfast tray while laying in his/her bed. At 8:16 A.M. , a staff member left the Resident's room, Resident #2 was observed eating his/her breakfast without supervision. At 8:27 A.M., a staff member entered Resident #2's room to take away the Resident's breakfast tray and left the room. Resident #2 was observed drinking from his/her coffee cup with no supervision from staff. Review of Resident #2's self-care deficit: feeding & dysphagia care plan, revised and dated 11/20/23, indicated the following interventions: - Provide meal support per Resident's need. He/she needs supervision for meals & verbal cueing to initiate or continue to intake food due to cognitive impairment/dementia. Review of Resident #2's swallowing care plan related to esophagus impaction reviewed and dated 8/16/24 indicated the following interventions: - All staff to be informed of Resident #2's special dietary and safety needs. - Resident #2 is to eat only with supervision. Monitor for aspiration. Review of Resident #2's nutritional risk care plan revised and dated 4/3/24 indicated the following intervention: - Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Review of Resident #2's Kardex on the electronic medical record indicated the following under the Eating/Nutrition section indicated the following: - Resident #2 is to eat only with supervision. Monitor for aspiration. - Provide meal support per Resident's need. He/she needs supervision for meals & verbal cueing to initiate or continue to intake food due to cognitive impairment/dementia. Review of Resident #2's Kardex with a review date of December 2020 in Certified Nursing Assistant (CNA) assignment binder on the unit indicated the following under the Eating section: - Set-up or clean up assistance Review of Resident #2's CNA ADL assignment sheet for August 2024 indicated that the Resident was documented as receiving setup or clean-up assistance with meals for every day of the month and not supervision with meals. Review of Resident #2's Nurse Practitioner progress note written on 8/9/24 at 2:25 P.M., indicated the following: - Pt. underwent EDG with RFA on 8/8/24: findings showed two esophageal nodules as well as hiatal hernia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Patient Active Problem List: Esophageal obstruction due to food impaction, aspirations into airway Review of Resident #2's document titled Speech Therapy Discharge Summary dated from 7/26/24 through 8/22/24 indicated the following under the Intake Protocol section: Supervision for Oral Intake = close supervision (recommend set up and close supervision). During an interview on 8/28/24 at 9:25 A.M., CNA #2 said she asks residents what level of assistance they need each day she provides care, CNA #2 also said she uses the kardex to know what level of care each resident need. CNA #2 continued to say when a resident requires supervision with meals they need to be watched at all times while eating. CNA #2 said Resident #2 is able to feed him/herself without supervision, he/she only needs his/her meal tray setup. During an interview on 8/28/24 at 9:38 A.M., Nurse #5 said she speaks with the CNAs about what level of care each resident requires and she refers to the care plans and kardex. Nurse #5 said Resident #2 requires supervision with meals and that supervision means that a staff member needs to be within sight of Resident #2 while he/she is eating. Nurse #5 and the surveyor reviewed Resident #2's care plan and kardex and Nurse #5 said Resident #2 should be supervised at all meals. During an interview on 8/28/24 at 10:58 A.M., the Director of Rehabilitation (DOR) and the surveyor reviewed Resident #2's Speech Therapy Discharge Summary dated from 7/26/24 through 8/22/24. The DOR said given Resident #2's cognitive level of function and swallowing history, he/she needs to be closely supervised while eating. The DOR said close supervision means a staff member needs to be in the room with Resident #2 due to cueing needs and to monitor for aspiration risk. The surveyor shared the observations and the DOR agreed that Resident #2 was not receiving the appropriate supervision during meal times.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure standards of quality of care were implemented for one Resident (#2), out of a total sample of 31 residents. Specifically, the facility failed to identify a skin injury on the Resident's right forearm. Findings include: Review of the facility's policy subject: Managing Skin Integrity with an effective date of 1/3/2024, indicated the following: It is the policy of the facility to ensure that all residents receive the highest practicable level of quality of care. Nursing, in collaboration with the health care team, will assess and manage skin integrity for all residents throughout their residence in the facility. Focus is on a 'gentle hands' approach when providing care to all residents. Any deterioration in or development of an alteration in skin integrity will be promptly addressed and individualized approaches in accordance with the resident's needs and goals will be implemented. Resident #2 was admitted to the facility in July 2007 with diagnoses including dementia, bipolar disorder and Barrett's esophagus. Review of Resident #2's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status exam score of 5 out of 15 indicating the Resident as having severe cognitive impairment. During the survey the following observations were made: - On 8/26/24 8:44 A.M., Resident #2 was sitting up in a wheelchair in his/her room with a round approximately quarter sized discoloration with yellowed edges on his/her right forearm. - On 8/26/24 at 3:29 P.M., Resident #2 was in the activity room on another floor and had a round fading discoloration on his/her right forearm. - On 8/27/24 at 8:13 A.M., Resident #2 was up, dressed and in his/her wheelchair. Resident #2's right forearm had a fading round discoloration with yellowing edges. Resident #2 said it was a bruise. Review of Resident #2's medical record indicated the following: - Progress notes dated 7/30/24 through 8/26/24 did not indicate any entry regarding the identification of the skin discoloration consistent with a bruise on Resident #2's right forearm. - A Physician's order dated active 11/8/2021 weekly skin check Monday 3-11 every evening shift every Monday. On 8/27/24 at 7:06 A.M., review of the weekly skin assessment dated [DATE] indicated Resident #2's skin as intact. This assessment conflicts with the observations made on 8/26/24 of Resident #2's discoloration on Resident #2's right forearm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 2:24 P.M., Certified Nursing Assistant #2 (CNA) said Resident #2 requires care for everything and that she provided bathing dressing this morning. CNA #2 said if skin changes or injuries are seen during care they are reported to the nurse. CNA #2 said Resident #2 moves around in his/her wheelchair and can easily bang his/her arms. During an interview and observation on 8/27/24 at 2:26 P.M., Nurse #6 said the CNA staff report any skin concerns to the nurses. Nurse #6 said residents have weekly skin assessments and anything identified should be on the assessment. Nurse #6 walked into Resident #2's room with the surveyor and saw the circular discolored area on his/her right forearm. Nurse #6 said the area looked old due to the yellow fading edges, was a bruise and a couple days old. Nurse #6 said any skin change/injury on a resident needs an incident report. Nurse #6 said the Resident's bruise should have been noted or reported by staff. During an interview on 8/27/24 at 3:19 P.M., the Assistant Director of Nursing (ADON) said the Nurse on Resident #2's unit just brought the skin injury to her attention. The ADON said it was a bruise on the right forearm, looks to be old, round smaller than quarter, and that Resident #2 had a history of banging his/her arms when he/she moves around the facility. The ADON said staff are to report any skin changes or injuries on a resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to a) develop a care plan for the assessed risk for developing a pressure ulcer/injury and b) failed to implement the physician's order for prevalon boots (a heel protector) for one Resident (#79) out of a total sample of 31 residents. Findings include: Review of the facility's policy titled Subject: Pressure Ulcer Preventions and Management, with an effective date 1/3/2024 indicated the following: It is the policy of the facility to assess all resident for the risk of pressure injuries and to have an appropriate interdisciplinary preventive care plan implemented when indicated. Procedure: 3. When a resident is identified as at risk for development of a pressure injury, the licensed nurse/unit manager will initiate a care plan that recognizes the resident's needs and goals and addresses the same with individualized interventions that are consistent with recognized standards of practice. Resident #79 was admitted to the facility in November 2023 with diagnoses that include but are not limited to chronic obstructive pulmonary disease, type 2 diabetes mellitus, mild protein-calorie malnutrition, and partial traumatic amputation on right foot. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #79 scored a 13 out of 15 on the Brief Interview for Mental Status exam indicating he/she is cognitively intact, requires partial/moderate assistance from staff on bathing, dressing and transfers, and is at risk for developing pressure ulcers. Review of the Norton Scale for Predicting Pressure Ulcer conducted for Resident #79 on 11/27/23 score of 9, 2/26/24 score of 8, and 5/28/24 score of 10, all indicated Resident #79 as being at high risk for developing a pressure ulcer/injury. A score of 10 or below places the resident at risk for developing a pressure ulcer. a) Review of the comprehensive MDS dated [DATE] indicated a Care Area Assessment note: Care Plan considerations: (Resident #79) Dependent to Extensive assist with ADLs/Mobility. Skin intact. Always incontinent; Prompt incontinent care needed. Weekly skin assessments. Pressure relief devices. Pressure Ulcer/Injury will be addressed in the care plan. Review of the documented care plans failed to indicate a person-centered care plan with an individualized goal and interventions for the risk of developing pressure ulcers was developed. During an interview on 8/27/24 at 2:05 P.M., the Minimum Data Set nurse said if an area for care triggers with the decision to proceed with a care plan, the care plan with the specific focus the focus should be developed. The MDS nurse said Resident #79 should have a care plan for the risk of developing pressure ulcer/injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) On 8/26/24 8:46 A.M., Resident #79 was observed in bed, wearing a nasal cannula in his/her nose administering oxygen, and eating his/her breakfast. Resident #79 said he/she needs help with bathing and dressing. Review of Resident #79's medical record indicated the following: *A physician's order: Prevalon boots while in bed at bedtime, dated 12/28/24 *A physician's order dated 12/28/24 skin prep to dry eschar on right heal (sic). Apply BID (two times a day) and prn (as needed). During an interview on 8/26/24 at 12:12 P.M., Resident #79 said he/she did not have any boots that he/she wears to bed and that he/she did not have any issues with his/her heels. On 8/27/24 at 7:49 A.M., Resident #79 was observed in bed. Resident #79's heels were directly on the mattress and he/she was not wearing prevalon boots. There were no prevalon boots observed in the Resident's room. During an interview on 8/27/24 at 2:41 P.M., Certified Nursing Assistant (CNA) #3 said she works days, and that Resident #79 is in bed when she starts her shift and does not have or use boots or any pillows for his/her heels. During an interview on 8/27/24 at 2:50 P.M., Nurse #6 said Resident #79 has a pink dryness on his/her right heel which is treated with skin prep. Nurse #6 reviewed the MAR and said there is an order for the prevalon boots which he/she is supposed to be wearing at night. Nurse #6 went with the surveyor to Resident #79's room and was unable to locate the prevalon boots. On 8/27/24 at 3:30 P.M., the Assistant Director of Nursing said her recollection is that Resident #79 had broken skin at one point and the prevalon boots were for preventative measures. The ADON said typically the use of the prevelon boots is documented on the Treatment Administration Record (TAR) and not the MAR, but she would expect that they are implemented per the physician's order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, interviews, policy review, and record review, the facility failed to provide respiratory care services in accordance with professional standards of practice for one Resident (#48) out of a total sample of 31 residents. Specifically for Resident #48, the facility failed to ensure his/her oxygen concentrator air filter was in place. Findings include: Review of the facility policy titles Oxygen Therapy, dated 1/3/24, indicated Maintenance of Concentrator: - Filters will be washed in warm soapy water weekly. - Filters should be dried thoroughly before being reinstalled. Resident #48 was admitted to the facility in July 2024 with diagnoses that included sepsis, pneumonia, acute respiratory failure with hypoxia and chronic obstructive pulmonary disease. Review of Resident #48's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. Further review of the MDS indicated he/she is receiving oxygen therapy. Review of Resident #48's physician orders, dated 7/26/24, indicated change 02 (oxygen) tubing and clean filter every week. On 8/26/24 at 8:06 A.M., the surveyor observed Resident #48 in bed receiving oxygen via nasal cannula, the oxygen concentrator did not have an air filter in place. On 8/27/24 at 7:43 A.M., the surveyor observed Resident #48 in bed receiving oxygen via nasal cannula, the oxygen concentrator did not have an air filter in place. During an interview on 8/28/24 at 7:28 A.M., Unit Manager #1 said the oxygen concentrator should have an air filter in place because if the air filter is not in place it puts the resident at risk for an infection. During an interview on 8/28/24 at 11:28 A.M., the Director of Nurses (DON) said she expects air filters to be in place at all times on the oxygen concentrator machines.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46339 Based on observations, record reviews, policy reviews and interviews, the facility failed to ensure it was free from a medication error rate of five percent or greater. One out of four nurses observed made two errors in 40 opportunities on one unit resulting in a medication error rate of 5%. These errors impacted one Resident (#53), out of four residents observed. Findings include: Review of the facility policy titled 'Administering of Medications-General' dated, November 2023, indicated the following but not limited to: -It is the facility's policy that medications will be administered to residents in a timely and accurate manner by a licensed nurse or physician. -Nurse compares the medication names, strength, and dosage schedule on the medication administration record against the prescription label. Always check three times prior to administration. -Review physician's orders and compares against medication administration record. 1. During a medication pass on 8/27/24 at 9:44 A.M., the surveyor observed Nurse #1 prepare and administer including the following medications for Resident #53: -Vitamin D3 5000 units one cap by mouth. -Calcium 600 milligram with 400 units of vitamin D. Review of the Resident #53's current physician orders indicated the following medication orders: -Cholecalciferol tablet 1000 unit. Give one tablet by mouth one time a day for osteoporosis. -Calcium carbonate 600 milligrams. Give one tablet by mouth one time a day for osteoporosis. During an interview on 8/27/24 at 1:38 P.M., Nurse #1 said she substitutes medication with whatever she has on hand which the Resident ended up receiving 4400 units extra of vitamin D. She further said she administered the wrong dosages. During an interview on 8/28/24 at 8:38 A.M., the Director of Nursing said if medication is not available the nurse would call the physician and get a substitute for what is on hand. Nurses should not substitute medications without a physician order.

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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** 43846 Based on observation, policy review and interview, the facility failed to ensure nursing staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically, 1. The facility failed to properly secure the medication cart on one of four units 2. The facility failed to properly secure the medication room on one of four units Findings include: Review of the facility policy titled Maintenance of Medications, dated 11/8/23, indicated Only authorized licensed personnel are to have access to the keys and the medications. Medication carts must be locked at all times when not in use, including during medication passes when the nurse steps away from the cart. 1. On 8/26/24 at 7:48 A.M. and 12:38 P.M., the surveyor observed the medication cart on the [NAME] 1 Unit unlocked and unsupervised. No staff were at the medication cart. During an interview on 8/28/24 at 7:30 A.M., Unit Manager #1 said the medication cart should be locked if a nurse is not present at it. During an interview on 8/28/24 at 8:44 A.M., the Director of Nurses (DON) said she expects nursing to keep their medication carts locked unless they are present at the cart. 2. On 8/26/24 from 8:02 A.M. to 8:32 A.M., the medication room on the Main 1 Unit was unlocked and unsupervised. No staff were present in the medication room or at the nurses station. On 8/27/24 from 8:18 A.M. to 8:55 A.M., the medication room on the Main 1 Unit was unlocked and unsupervised. No staff were present in the medication room or at the nurses station. During an interview and observation on 8/27/24 at 8:56 A.M., Nurse #2 said the medication room is unlocked at the present time and should not be. Nurse #2 said the medication room should always be locked unless a nurse is present in the room. During an interview on 8/28/24 at 7:30 A.M., Unit Manager #1 said the medication room should be locked at all times unless a nurse is in the room obtaining supplies. During an interview on 8/28/24 at 8:44 A.M., the Director of Nurses (DON) said she expects nursing to keep their medication rooms locked unless they are present in the in the medication room.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, record reviews and interviews, the facility failed to obtain dental services for one Resident (#87) out of a total sample of 31 Residents. Findings include: Review of the facility policy titled Dental Services/Dentures, dated November 2023, indicated the following: -Routine and emergency dental services are available to meet the resident's oral health services in accordance with the residents' assessment and plan of care. -Social services representatives with assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. -If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting dental services, and the reason for the delay. Resident #87 was admitted to the facility in March 2024 with diagnoses including dementia, dysphagia (difficulty swallowing), adult failure to thrive, hyperlipidemia, diabetes mellitus, and anxiety. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #87 has a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicating he/she has intact cognition. The MDS also indicated Resident #87 requires extensive assistance from staff for all functional tasks. Review of the Nutritional Comprehensive Assessment, dated 3/18/24, indicated that Resident #87 is a nutritional risk related to advanced age, FTT (failure to thrive), dysphagia, HLD (hyperlipidemia), T2DM (Type 2 Diabetes Mellitus), Dementia with potential for changes in appetite and weight. Review of the Activities of Daily Living care plan dated 3/14/24, indicated the following: -Set up for oral care; Resident #87 has upper/lower dentures refer to dental services if needed. Review of physician order dated 3/14/24, indicated the following: -Dental evaluation and treat as indicated. Review of the clinical record failed to indicate that Resident #87 was offered dental services with the facility's contracted dental service on admission and there was no signed consent or declination form on file. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record does not indicate that Resident #87 was seen by a contract or outside service for oral evaluation since admission. Review of the Activities of Daily Living care plan dated 3/14/24, indicated the following: -Set up for oral care; [NAME] has upper/lower dentures refer to dental services if needed. During an interview on 8/26/23 at 9:26 A.M., Resident #87 said he/she had dentures but lost them prior to admission and has been asking to see a dentist to obtain new dentures since admission. Resident #87 said he/she told multiple staff that he/she needs new dentures but has not been to the dentist. Resident #87 was observed to have no teeth and no dentures in his/her mouth. During an interview on 8/28/23 at 7:58 P.M., the Unit Manager said appointments are made for residents and residents are added to the list if they need or request to be seen by the dentist and residents or families will notify staff if they want to be seen. The Unit Manager said Resident #87 has not received an oral evaluation and does not have a signed consent for dental services on file but should have been offered dental services on admission and should have been seen by the dentist. The Unit Manager said physician orders and nutritional recommendations should be followed within 48 hours and that Resident #87 should have been added to the list for dental evaluation to replace his/her dentures. During an interview on 8/28/24 at 8:44 A.M., the Director of Nurses (DON) said Resident #87 should have been offered dental services for dental evaluation and should have been seen by the dentist to follow up with new dentures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48671 Based on observation, record review and interview the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Findings include: Review of the facility policy titled Infection Prevention and Control undated, indicated the following: -The Infection Prevention and Control Program includes a comprehensive, total surveillance protocol which is based on the principles of epidemiology. -To provide a systematic method of collecting, consolidating and analyzing data concerning the distribution and determinants of a given disease or event followed by dissemination of that information to those who can improve the outcomes. A. Data Sources. Sources of data for infection surveillance include but are not limited to the following: Clinical record, Microbiology reports, Antibiotic Reports, Radiographic report, Activity logs / 24 hour report, Clinical rounds/staff reports. B. Data Collection and Tabulation: A line listing form is maintained for each unit it is a concise summation of information gathered on the above forms. Potential as well as actual infections are listed on this form. Statistics are kept on a monthly basis; therefore, a new line listing is begun each month. Infections are tabulated according to body site geographic location and type of pathogen. C. Analysis and Interpretation of Data: Infection rates are calculated per unit per body site. Analysis and interpretation includes comparison to previous rates within the facility. E. Procedure Related Process Surveillance: In addition to providing data, procedure related surveillance serves as an educational and training tool for infection control practices. H. Calculation of Nosocomial Rates: Numerator =the number of nosocomial infections that occurred. Denominator the number of patient care days in a specific period of time(month). Review of the facility form titled QAPI Antibiotics for May dated, 5/1/24 to 5/30/24, indicated one diagnosis of C. diff (also known as Clostridium difficile or C. difficile) is a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon) and started on antibiotic therapy. The form failed to indicate any additional details regarding the infection or any control measures taken. Review of the infection control program line listings failed to indicate the monitoring, tracking, and analyzing of infections in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/24 at 9:28 AM., the surveyor asked the Infection Preventionist (IP) to provide her with the facility's line listing. The IP said she has line listings that she reviews at the end of the month, and she will review the clinical dashboard for new antibiotics, but she does not track clinical signs, symptoms or trending of infections because if there were infections present residents would be prescribed antibiotics. The IP said she counts the number antibiotics prescribed but does not evaluate the infections. The IP said she does not obtain reports from the lab on antibiotic use in the facility because if residents are symptomatic the provider will order antibiotics, and the facility does not obtain cultures. The IP said she does not know the monthly infection control rates and said she knows there are a lot of infections in the building if the number of antibiotics prescribed is high at the end of the month. The IP was unable to provide documentation of infection control surveillance, including a system for recording incidents and the corrective actions taken by the facility. During an interview on 8/28/24 at 11:20 A.M. the Director of Nurses (DON) said she expects the facility to follow infection control guidelines for tracking and evaluating infections as well as document surveillance of signs and symptoms of communicable diseases. The DON said the facility should be aware the infection control rates in the facility and should be identifying clusters and monitoring for increases in infections. Refer to F881

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48671 Based on record review, policy review and interview, the facility failed to implement an Antibiotic Stewardship Program to promote and monitor the appropriate use of antibiotics which are used to guide decisions for evaluating antibiotic prescribing patterns in accordance with the Antibiotic Stewardship Program. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled: The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following: - The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance. - Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. - The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. - Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting. Review of the facility policy titled, Antibiotic Stewardship Program, dated as revised January 2024, indicated the following: -It is the facility's policy to ensure that the use of antibiotics within the facility is done so in a way that optimizes the treatment of infections while striving to reduce adverse events. -Infection preventionist (IP) - will play an elemental role in supporting antibiotic stewardship by utilizing several strategies such as tracking antibiotic use, monitoring adherence to established prescribing standards, and reviewing antibiotic resistance patterns within the facility: -Antibiotic use within the facility including trends of resistance. -Monitoring antibiotic resistance patterns (MRSA (Methicillin-Resistant Staphylococcus Aureus), VRE (Vancomycin-Resistant Enterococci), ESBL (Extended -Spectrum, Beta-Lactamases), CRE (Carbapenem-Resistant Enterobacteriaciae), etc.) -Gather data on the amount of antibiotics prescribed (including number of days prescribed), and the number of residents treated each month. -Monitor the number of residents on antibiotics that did not meet criteria for active infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Action Plan: *Assisting in developing and improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection. -Assisting and developing an antibiotic use process (algorithm) for all antibiotics prescribed in the facility promptly clinicians/direct care providers to stop and release the need for, and choice of, an antibiotic when the clinical picture is clearer and more information is available: for example, an antibiotic time out after 48 hrs to review and assess for appropriateness. -Tracking: The IP will be responsible for infection surveillance and MDRO (Multidrug- Resistant Organisms) tracking -See Antibiotic Use Monthly Tracking Form. -The IP will collect and review data such as: -Type of antibiotic ordered, route of administration, antibiotic costs. -Whether appropriate tests such as cultures were obtained before ordering antibiotic(s). -Whether the antibiotic was changed during the course of treatment including testing and documentation explaining the reasons for the change. -Reporting: -The IP will be responsible for the regular reporting of information on antibiotic use and resistance to doctors, nurses, and relevant staff to assist in keeping track and assuring appropriate antibiotic therapy is being utilized, and unnecessary antibiotic use can be decreased. Review of the facility's Antibiotic Use Monthly Tracking Forms failed to contain detailed information as indicate on the form and was missing criteria necessary to monitor the appropriate use of antibiotics. During an interview on 8/28/24 at 9:25 A.M., the surveyor asked the Infection Preventionist (IP) to provide her with the facility's line listing and antibiotic usage audit tool. The IP said she has line listings that she reviews at the end of the month, and she will review the clinical dashboard for new antibiotics, but she does not track clinical signs, symptoms or trending of infections because if there were infections present residents would be prescribed antibiotics. The IP said she counts the number antibiotics prescribed but does not evaluate the infections. The IP said she does not obtain reports from the lab on antibiotic use in the facility because if residents are symptomatic the provider will order antibiotics, and the facility does not obtain cultures. The IP said she does not know the monthly infection control rates and said she knows there are a lot of infections in the building if the number of antibiotics prescribed is high at the end of the month. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/24 at 11:13 A.M., the Director of Nurses (DON) said she expects the facility to document and implement the antibiotic stewardship program and follow the requirements for tracking, evaluating and reporting the use of antibiotics and infections. The DON said she expects cultures and labs to be reviewed along with the type and duration of antibiotics prescribed and evaluations should be discussed regarding stopping or continued antibiotics. The DON said the facility should be aware the usage and infection control rates in the facility.