STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225304	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlene Manor Extended Care Facility	130 Colrain Road Greenfield, MA 01301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview, and record review, the facility failed to ensure that dignity and privacy was maintained for one Resident (#26), out of a total sample of 25 residents and on one unit (Unit 2) out of three units observed. Specifically, the facility failed to: 1) ensure staff provided privacy for Resident #26 while assessing and providing care to the Resident's buttocks. 2) ensure staff were seated while assisting residents during meals in the Unit 2 dining room. Findings include: Review of the facility policy titled Residents' Rights Policy, revised October 2023, indicated the following: -A resident has the right to a dignified existence -The resident has a right to be treated with respect and dignity -The resident has a right to personal privacy 1) Resident #26 was admitted to the facility in April 2013, with diagnoses including Multiple Sclerosis (MS: a chronic autoimmune disorder of the central nervous system marked by numbness, weakness, loss of muscle coordination, and problems with vision, speech, and bladder control) and Cerebral Palsy (a group of neurological disorders that affect the ability to move, balance and maintain posture caused by brain damage to the developing brain before birth). Review of Resident #26's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a possible score of 15. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the Resident was dependent of staff for personal hygiene and for rolling (repositioning) left and right in bed. On 11/6/24 at 2:40 P.M., the surveyor and Nurse #5 observed Resident #26's bilateral buttocks during an assessment procedure. Nurse #5 entered the Resident's room and pulled the privacy curtain closed between Resident #26's bed and his/her roommate's bed but did not pull the privacy curtain closed between Resident #26's bed and the bedroom window that faced a public walkway. Nurse #5 then rolled the Resident in bed with him/her facing towards his/her roommate's bed, and leaving the Resident's exposed buttocks facing the window where a walkway and another resident seated in a wheelchair were visible to the surveyor from the Resident's bedside. During an interview on 11/6/24 at 2:50 P.M., Nurse #5 said that there was concern for Resident #26's privacy as the window was not covered during the assessment and care of the Resident's buttocks. 2) On 11/3/24 at 8:45 A.M., in the Unit 2 dining room, the surveyor observed Certified Nurses Aide (CNA) #3 and CNA #4 assisting residents with their breakfast meals while standing over the residents. On 11/5/24 at 8:42 A.M., the surveyor observed CNA #1 in the Unit 2 dining room assisting a resident with their breakfast meal while standing over the resident. The surveyor observed the Director of Nursing (DON) telling CNA #1 to sit but CNA #1 remained standing while assisting the resident. During an interview on 11/5/24 at 8:44 A.M., CNA #1 said she should have been sitting while assisting the resident during their breakfast but she did not. CNA #1 further said sitting while assisting the resident was important so she would be at the resident's level and not make the resident feel uncomfortable. During an interview on 11/5/24 at 9:59 A.M., the DON said that standing over a resident while assisting them with a meal is a concern for dignity and Resident Rights.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 51466 Based on observation, interview, record and policy review, the facility failed to ensure that an appropriate Hoyer pad (seating device used to assist in transferring a resident using a mechanical lift) was available to assist in transferring one Resident (#26), out of a total sample of 25 residents. Specifically, the facility failed to provide an appropriate sized Hoyer Pad to assist in transferring Resident #26 out of bed based on his/her preferences and Rehabilitation recommendations to get out of bed resulting in the Resident remaining bedbound and increasing the risk for discomfort and skin breakdown. Findings include: Review of the facility Policy titled Activities of Daily Living, effective date 11/14/16, indicated: -Each resident will receive the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing, consistent with resident's comprehensive assessment and plan of care. -The facility will provide care and services for the following activities of daily living: Mobility- Transfer and ambulation. The care and services will be based on the resident's ability as identified in MDS assessment, Rehab evaluation, nursing assessment and person-centered care plan. -Assistive Devices and Adaptive Equipment are provided as needed. -Resident abilities, personal choices and self-image are accounted for during ADLS. Resident # 26 was admitted to the facility in April 2013, and has diagnoses including Multiple Sclerosis (MS: a chronic autoimmune disorder of the central nervous system marked by numbness, weakness, loss of muscle coordination, and problems with vision, speech, and bladder control), Type 2 Diabetes (chronic condition that occurs when your body cannot regulate blood sugar levels), Cerebral Palsy (a group of disorders that affects a person's ability to move, maintain balance and posture caused by brain damage to the developing brain before birth), Chronic Obstructive Pulmonary Disease (a chronic lung disease that blocks airflow and makes it hard to breathe), Heart Failure (HF: when the heart is unable to pump blood as it should resulting in fluid buildup in the feet, arms, lungs and other organs), and Morbid Obesity (when the weight is found to be more than 80 - 100 pounds above the individual's ideal body weight). Review of the Comfort Care Plan, effective 8/15/17, indicated the Resident has potential for alteration in comfort and pain and indicated the following interventions initiated on 8/15/17: -Identify, assess and document presence of pain or discomfort. -Identify activities that can exacerbate pain and medicate prior to activity as indicated. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Encourage the Resident to report occurrences of pain at onset and monitor for changes in sign and symptoms of pain. Review of the ADL (Activities of Daily Living) Care plan, effective 8/15/17, indicated the resident has an alteration in ability to provide self-care and had the following interventions: -Encourage resident to make decisions and choices during care if able, initiated 8/15/17 -Follow daily schedule as much as possible, initiated 8/15/17 -Transfers require two staff assist with a Hoyer Lift, initiated 7/4/22 Review of the High Risk for Skin Breakdown Care Plan, initiated 8/15/17, indicated Resident #26 was at high risk for pressure ulcer development and indicated the following: -Resident should be encouraged to get out of bed daily, initiated 8/15/17 -Encourage activity and mobility, initiated 8/15/17 -Observation of skin condition during care- report pink, red or open areas to Nurse, initiated 8/15/17 -Apply Periguard (barrier cream that helps moisture and protect the skin) with each incontinent episode, initiated 11/24/17 -Gel pressure relieving cushion while in wheelchair, initiated 9/28/23 Review of the Resident's Profile Care Plan effective 8/24/18, indicated the following: -Behaviors exhibited by Resident- none at present, initiated 8/24/18 -Resident prefers to get up later in the morning before lunch and goes to bed before supper, initiated 8/24/18 -Transfers with Hoyer Lift (mechanical device used to transfer individuals with limited mobility) - Large Hoyer Sling (GREEN), initiated 7/21/21 -Decubitus Ulcer (bed sore or open area) Prevention- barrier cream to coccyx (tailbone), buttocks each shift, initiated 7/24/21 Review of the Occupational Therapy (OT) Discharge Summary, dated 2/11/24, indicated the following discharge recommendation: -Staff to assist the Resident with Hoyer transfer into the gerichair (specialized wheelchair) daily for at least one meal per day Review of Resident #26's MDS Assessment, dated 8/15/24, indicated: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Resident was able to make themselves understood and understands others -He/she was cognitively intact as evidenced by a BIMS score of 13 out of a total possible 15. -Had range of motion impairment affecting bilateral (both) lower extremities. -Required total assistance from staff for transfers out of bed, toileting, showering, dressing, personal hygiene, and rolling side to side -Was frequently incontinent of bladder and bowel function. -Was at risk for pressure ulcer development. -Had no rejections of care, refusals or change in behaviors. Review of the Resident's clinical record from 9/6/24 -11/6/24, indicated that he/she did not exhibit any behaviors including refusal of care. During an interview on 11/3/24 at 9:55 A.M., Resident #26 said that he/she has not been out of bed in at least a week because the staff had not been able to find a Hoyer pad that lifts him/her out of the bed and that he/she would like to get out of the bed. The surveyor observed Resident #26 lying in bed on: -11/4/24 at 8:11 A.M. -11/4/24 at 9:58 A.M. -11/4/24 at 4:15 P.M. On 11/4/24 at 8:43 A.M., the surveyor observed Resident #26 lying in bed. The surveyor observed the Nurse Practitioner (NP) entering Resident #26's room, and the Resident said that he/she had buttocks pain. The NP asked the Resident if he/she was getting out of bed daily, and the Resident said that he/she had not been out of bed because the staff did not have the Hoyer pad and that he/she would like to get out of the bed. On 11/4/24 at 12:55 P.M., the surveyor observed Resident #26 lying on his/her back in bed with the head of the bed elevated. During an interview at the time, Resident #26 said that he/she was not getting out of bed today because the CNA said a Hoyer pad was not available. The Resident said the Hoyer pad he/she needed was being used by another resident, and that he/she would like to get out of bed if the facility staff were able to locate a Hoyer pad. Resident #26 said a staff member had taken the Hoyer pad out of his/her room a while ago. Resident #26 described the Hoyer pad as gray with a yellow stripe down the back. Resident #26 further said that Hoyer pad color was the only one that could be used for him/her, and he/she had not been out of bed for about one and a half weeks because there had not been the appropriate Hoyer pad available. The surveyor observed a sign on the Resident's wall, beside the bed, from OT which indicated the following: Resident was to be out of bed three to five times (3-5) per week for two to three (2-3) hours to get stronger and prevent sacral ulcers (skin injury that occurs near base of the spine from extended pressure on the area). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 7:42 A.M., the surveyor observed Resident #26 lying in bed. During an interview at the time, the Resident said he/she would like to get out of bed but there was no Hoyer pad in his/her room. On 11/5/24 at 2:32 P.M., the Resident was observed lying in bed. During an interview with CNA #9 at the time, she said the Resident did not get out of bed today because there were not enough Hoyer pads for all the residents and that it was difficult to find the correct size Hoyer pad for Resident #26. CNA #9 said the Resident needed a yellow striped Hoyer pad. CNA #9 said the Resident wanted to get out of bed, but had not been able to get up for about a week and a half because his/her Hoyer pad was not available. CNA #9 said if the appropriate size Hoyer pad was found, it was often taken out of the Resident's room and used for other residents. CNA #9 said she would look in the laundry every day for the Resident's size Hoyer pad, but there were none in the laundry. CNA #9 said if there were not enough Hoyer pads, then a resident might not receive a scheduled shower or in the case of Resident #26, did not get out of bed. CNA #9 said if a Hoyer pad cannot be found, then Resident #26 cannot get out of bed, and she would notify the Nurse or the Unit Manager (UM). On 11/6/24 at 7:56 A.M., the surveyor observed the Resident lying in bed. During an interview at the time, the Resident said his/her buttocks was sore this morning. CNA #9 entered the room at the time and said that they were able to find a yellow striped Hoyer pad and would be able to get Resident #26 out of bed today. During an interview on 11/6/24 at 8:43 A.M., UM #1 said there have been issues with Hoyer pads, that they often go missing and staff need to search laundry and/or other units to find them for the residents. UM #1 said facility management was aware of the issue, had ordered additional Hoyer pads, but there were still not enough. UM #1 said she did not recall being told about missing Hoyer pads for Resident #26, that he/she was supposed to get out of bed every other day but sometimes refused and needed encouragement. UM #1 further said that if the Resident refused care, it would be documented. UM #1 said she was aware that the Resident had not been out of bed for a week and a half and thought it was due to the refusals and did not know it was because there was a lack of Hoyer pads. During an interview on 11/6/24 at 9:42 A.M., CNA #6 said there has been an issue with not having enough Hoyer pads for all the residents that required them. CNA #6 said it was a real problem when the residents have showers and need two Hoyer pads per resident (one wet/one dry). CNA #6 said that the staff must either wait until they have the right size Hoyer pads and leave people in bed, or they use the incorrect size Hoyer pads if it was safe. CNA #6 said this has been a problem for a long time and that the facility administration was aware. During an interview on 11/6/24 at 10:06 A.M., UM #1 said the issue with not having enough Hoyer pads had been a problem for a while and administration was aware. UM #1 said that her unit had 18 residents that required a mechanical lift and many of them used the same size (yellow stripe) Hoyer pad. UM #1 said there were not enough of these sized Hoyer pads, had made administration aware, and they were now looking to order more. On 11/6/24 at 12:06 P.M., the surveyor observed Resident #26 dressed and seated in a recliner chair next to his/her bed prior to lunch. During an interview at the time, the Resident said he/she was happy to be up and out of bed but was starting to feel sore on his/her buttocks again. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 12:14 P.M., CNA #5 said if the staff need a Hoyer pad for a resident, then they needed to go to the laundry room because all the Hoyer pads were shared between the three units, and it was a hit or miss on whether or not they could find the appropriate Hoyer pad. CNA #5 further said that the yellow and white Hoyer pads were the most popular size used by the residents. During an interview on 11/6/24 at 12:34 P.M., CNA #9 said the staff used red and yellow Hoyer pads more frequently than others and the unit had previously received more Hoyer pads, but that they got absorbed into the rest of the building. During an interview on 11/6/24 at 12:48 P.M., Nurse #2 said the CNAs have informed her that Hoyer pads could not be found for residents, and have had the CNAs search the laundry department, call or go from unit to unit to search for the needed Hoyer pads. Nurse #2 said the unavailability of certain sized Hoyer pads occurs on average two days a week and that she had reported this concern to administration in the past. On 11/6/24 at 2:48 P.M., the Environmental Services Director (ESD) said he had just gone out to a sister facility to get more Hoyer pads because they had one that was torn. The ESD said the Hoyer pads are inspected and replaced if torn and that staff will come to laundry and get them, or the staff will call with what they need. The ESD said he had not been made aware of the facility not having enough Hoyer pads for residents and was not aware of a certain amount of Hoyer pads needed on each unit. The ESD said that they complete rounds and audits to determine if a Hoyer pad was torn, and then they will be replaced if needed. During an interview on 11/6/24 at 2:53 P.M., Maintenance Staff Member #1 said that a Hoyer pad audit was completed every three months and that nursing would notify them if they there were not enough Hoyer pads. Maintenance Staff Member #1 was unsure of the amount of Hoyer pads in the building or how many Hoyer pads were needed. Maintenance Staff Member #1 said if a staff member had mentioned more Hoyer pads were needed, they would order them or get some from a sister facility. During an interview on 11/6/24 at 3:20 P.M., Central Supply Staff #1 said she did not routinely order Hoyer pads but if they were needed, she would be able to order them. Central Supply Staff #1 said some Hoyer pads were ordered in June 2024 and September 2024 (one of each size), and they were distributed to each unit. During an interview on 11/6/24 at 3:45 P.M., with the Administrator and Director of Nursing (DON), the Administrator said nursing staff would communicate the need for Hoyer pads to administration. The DON said there was an audit for Hoyer pads that was supposed to be completed quarterly, but the audit has not been completed. Both the Administrator and DON said they had not been made aware of a Hoyer pad shortage until 11/5/24 and had not been notified of any residents having to stay in bed because there were not enough Hoyer pads to assist the residents out of bed. The DON provided the surveyor with a blank audit tool titled Mechanical Lift Clinical Audit- Quarterly and said that the audit tool provided was supposed to be in use for the Hoyer pads but it had not been completed. Please Refer to F686

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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. 42761 Based on observation, interview, and record review, the facility failed to notify the Physician and/or responsible party of a change in condition for three Residents (#2, #88, and #43) out of a total sample of 25 residents. Specifically, the facility failed to: 1. Notify Resident #2's Physician, in a timely manner, of a change in the Resident's condition when the Resident experienced complications with his/her indwelling (inside one's body) urinary catheter (tube used to drain urine from the bladder into a bag outside of one's body), resulting in a delay in treatment. 2. Notify the Physician and the Resident's Representative timely about a blister that was identified on Resident #88's inner leg. 3. Notify Resident #43"s Resident Representative of multiple dental infections which required medical intervention of several courses of treatment with antibiotics. Findings include: Review of the facility's policy titled Physician Notification, dated 11/11/09 and revised September 2011, indicated the following: -Upon identification of a resident who has clinical changes, change in condition, ., a Licensed Nurse will perform appropriate clinical observations and data collection and report to the Physician as indicated. -The purpose was to communicate a change in resident's condition to the Physician and initiate intervention as needed/ordered. - If clinical findings indicate urgent notification: >notify the Physician >report all pertinent data >obtain and implement specific orders for intervention >notify supervisor/charge nurse >notify family of change in condition and ordered interventions -if clinical findings indicate routine notification, notify the physician as soon as possible during normal business hours (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-document: >findings related to change of condition on SBAR (Situation, Background, Assessment and Recommendation- structured communication framework that shares information about a patient's condition) >Physician notification and response >on 24-Hour Change of Status Report >family notification >interventions >resident's deposition 1. Resident #2 was admitted to the facility in September 2024, with diagnoses including Urinary Retention (condition where the bladder does not empty all the way, or at all), Obstructive Uropathy (blockage in the urinary system) and chronic Foley (type of indwelling urinary catheter) Catheter. Review of Resident #2's clinical record indicated the following active Physician orders: -Provide Foley catheter care, dated 9/1/24. -Foley privacy bag in place for bedside Foley drainage, dated 9/1/24. -Foley catheter output every shift, dated 9/1/24. -May change Foley catheter PRN (as needed) for occlusion or leakage. Change urinary catheter and drainage bag as a complete system. -Foley catheter continuous/site care/privacy bag. Site care QS (every shift). Privacy bag in place for bedside Foley drainage, dated 9/1/24. Further review of the active Physician's order indicated a blank space to enter the Foley catheter size and retention bulb (also known as retention balloon- a tiny balloon at the end of the indwelling urinary catheter that is inflated with water to prevent the indwelling urinary catheter from sliding out of the body) size, but both the Foley catheter size and retention bulb size were left bank. Review of Resident #2's Urinary Catheter Care Plan, initiated 9/2/24, indicated: -Change catheter if closed system is interrupted and as needed to maintain patency (degree of openness to allow flow of urine). -Notify MD (Medical Doctor/Physician) of suspected catheter complications, as needed. Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 9/4/24, indicated the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points. -The Resident had an indwelling urinary catheter. Review of Resident #2's Nursing Progress Note, dated 10/20/24 at 2:20 P.M. and completed by Nurse #5, indicated the following: -The Resident was observed to have urine in his/her incontinence brief after lunch. -Urine in the incontinence brief was abnormal since the Resident had a Foley catheter. -There were no Physician orders for what type of Foley catheter the Resident had or needed if the catheter needed to be replaced. Review of Resident #2's Nursing Progress Note, dated 10/20/24 at 2:45 P.M., indicated the following: -The Weekend Supervisor observed Resident #2's Foley catheter. -The Weekend Supervisor said the Foley catheter looked fine and to enter a note into the Physician Communication Book about the Resident's catheter leaking for the Physician to review the next day. -There were 200 milliliters (mL) of urine in the Foley catheter drainage bag as well as whatever was in the incontinence brief. Review of Resident #2's Nursing Progress Note, dated 10/21/24 at 6:17 A.M., indicated the following: -Certified Nurses Aide (CNA) alerted Nurse to lack of urine in the Resident's Foley bag. -The Resident's Foley catheter was still leaking. -The Resident's incontinence brief was full of urine. -A note was left in the Physician Communication Book. -The Resident appeared to have some discomfort in his/her genital area. Review of Resident #2's Nursing Progress Note, dated 10/21/24 at 8:47 A.M. and written by Nurse #2, indicated the Resident's Foley catheter was not draining. Further review of the Nursing Progress Note indicated Nurse #2 contacted the Physician and completed the following relative to the Physician's instructions: -Nurse #2 deflated the catheter balloon, advanced the catheter, then reinflated the balloon. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #2 flushed the catheter with 60 mL (milliliters) of normal saline (NS: sterile fluid solution). -An order was obtained to change the catheter with a size 16 French (Fr: unit corresponding to the outer circumference of a catheter) and 30 mL balloon if the catheter continued with no flow after flushing. Review of Resident #2's Nursing Progress Note, dated 10/21/24 at 12:04 P.M. and written by Nurse #2, indicated the following: -The Resident had roughly 200 mL of tea colored urine in his/her Foley catheter bag prior to Nurse #2 deflating the balloon and flushing the Foley catheter. -The Resident had urine in his/her incontinence brief. -Nurse #2 changed the Resident's Foley catheter to a 16 Fr/30 mL balloon urinary catheter. -When the new Foley catheter was advanced, some urine leakage was observed. -Nurse #2 advanced the Foley catheter further, got yellow urine return through the catheter with some sediment (particles in urine, visible to the naked eye, that can be a sign of various medical conditions including infection, kidney problems, and dehydration) and minor clotting (blood). -The Resident now had a new Foley catheter. On 11/6/24 at 8:12 A.M., the surveyor observed Resident #2 in his/her room lying in bed. The surveyor observed clear urinary catheter tubing, extending out from under the Resident's bed covers, that connected to a covered drainage bag. The surveyor observed that the tubing was draining clear light yellow urine. During an interview on 11/6/24 at 11:15 A.M., Nurse #5 said she worked at the facility and provided care to Resident #2 on 10/20/24. Nurse #5 said that Resident #2 experienced urinary leakage outside of his/her catheter on 10/20/24 and when she reviewed the Resident's Physician orders, there were no orders to flush the catheter and there were no orders with what size catheter to replace the Resident's catheter with if the catheter leaked. Nurse #5 said that at that time, she entered a note into the Physician Communication Book relative to the Resident's catheter leaking. Nurse #5 said that she entered a note into the Physician Communication Book because 10/20/24 was a weekend day and there were no Physicians in the facility on the weekends. Nurse #5 said that she could not do anything about the Resident's urinary catheter leaking because there were no orders in place. Nurse #5 said she did not call the Physician. (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 11/6/24 at 11:20 A.M., Nurse #2 said that she worked at the facility and provided care to Resident #2 on 10/21/24. Nurse #2 said she observed the Resident with urine leakage from his/her Foley catheter. Nurse #2 said she reviewed the Resident's Physician orders and there were no orders to flush the catheter and no ordered size for replacing the urinary catheter. Nurse #2 said she then contacted the Physician regarding Resident #2's catheter leaking and obtained orders to flush the catheter and to replace the catheter with a size 16 Fr with a 30 mL balloon if flushing the catheter did not correct the problem of urine leakage. Nurse #2 said that she flushed Resident #2's Foley catheter and it continued to leak, so she replaced the catheter, per the order she obtained from the Physician on 10/21/24. During an interview on 11/6/24 at 12:51 P.M., the Director of Nursing (DON) said that the facility has Physician coverage 24-hours daily, seven days per week, and that a Physician can always be contacted by phone. The DON said Nurse #5 should have contacted the Physician on 10/20/24 when she observed that Resident #2's Foley catheter was leaking and found that Resident #2's Physician orders did not include the required information for what to do when Resident #2's Foley catheter leaked. The DON said that the Resident should not have had to wait until the following day for orders to be obtained from the Physician so that his/her Foley catheter could be changed. The DON further said that the delay in notifying Resident #2's Physician of the leaking Foley catheter resulted in a delay in care. Please refer to F690, F726 and F880. 37400 2. Resident #88 was admitted to the facility in August 2022, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), and abnormal posture. Review of the Minimum Data Set (MDS) Assessment, dated 8/1/24, indicated Resident #88: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 4 out of 15. -was dependent on staff for activities of daily living (ADLs: basic skills needed in regular daily life including ambulating, dressing, bathing, eating), positioning and transfers. -was at risk for pressure ulcers. -did not have pressure ulcers during the assessment period. Review of a Nursing Progress Note, dated 10/31/24 (Thursday) at approximately 9:00 P.M., indicated the Certified Nurses Aide (CNA) notified the Nurse about a blister on Resident #88's leg. The Nurse indicated that the area was assessed to be a fluid filled intact blister about inch in diameter, on the Resident's right, lower inner leg. Review of the Resident's clinical record on 11/4/24 indicated no documented evidence that the Physician and/or Resident Representative were notified of the blister identified on the Resident's lower leg on 10/31/24. (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 11/4/24 at 3:00 P.M., Nurse #1 said she was not aware of the blister on Resident #88's right lower leg until today. Nurse #1 said she was not sure if the Physician and Resident's Representative were notified of the area. During an interview on 11/4/24 at 3:07 P.M., Unit Manager (UM) #1 said she was just notified of the blister on Resident #88's lower leg. UM #1 said when the Nurse was initially notified of the Resident's blister (on 10/31/24), an incident report should have been completed and the Physician, the Resident's Representative and the Wound Nurse should have been notified. UM #1 said she was unable to find evidence that this notification occurred, and would be notifying all parties today and obtaining orders for treatment. Please Refer to F684 3. Resident #43 was admitted to the facility in September 2020, with diagnoses including Dementia. Review of Resident #43's Nursing Progress Notes indicated the following: -6/12/24: complained of mouth and tooth pain, Nurse Practitioner (NP) evaluated the Resident and gave a new order to start Amoxicillin (antibiotic) 500 milligrams (mg), three times daily for 5 days. -6/19/24: recently completed antibiotics, complained of mouth, throat still hurting. The Resident's right sided gland was noted to be swollen. The NP was updated and a new order was given for Amoxicillin 500 mg three times daily for 10 days. Review of the MDS Assessment, dated 6/20/24, indicated Resident #43: -had severe cognitive impairment as evidenced by a BIMS score of 3 out of 15. -had received an antibiotic during the assessment period. Review of the June 2024 Medication Administration Record (MAR) indicated Resident #43 was administered the following: -Amoxicillin: 500 milligrams (mg) three times daily for five days for an infected tooth, initiated 6/12/24 through 6/17/24 -Amoxicillin: 500 mg three times daily for 10 days for infection, initiated 6/19/24 through 6/29/24 -Kelfex (antibiotic): 500 mg twice daily for prophylaxis . initiated 6/21/24 through 6/30/24 Review of clinical record indicated no documented evidence that the Resident Representative was notified about the multiple courses of antibiotics administered to the Resident for suspected mouth/throat/tooth infection. During an interview on 11/5/24 at 11:30 A.M., Resident #43's Representative said he/she was not made aware of any dental problems, pain or infections that had occurred with Resident #43 over the last year. (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 11/5/24 at 2:16 P.M., UM #1 said she reviewed Resident #43's clinical record and was unable to find documented evidence that the Resident's Representative was notified of his/her mouth pain and multiple treatments with antibiotics. UM #1 said when the Resident had a change in condition, his/her Representative should have been notified.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48206 Based on interview, and record review, the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC: notice issued to a resident who is receiving benefits under Medicare Part A when all covered services end) and/or Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN: notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) were issued for one Resident (#107), out of three residents reviewed. Specifically, the facility failed to issue: A. The NOMNC to Resident #107's Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) when the Resident was determined to lack the capacity to make medical decisions. B. The SNF ABN notice to Resident #107's HCP so the HCP could decide if they wished to continue receiving skilled services that may not be paid for by Medicare, and were aware of the financial responsibility they may have to assume. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) website for SNF ABN last modified 9/10/24, <https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-snf-abn> indicated: -Skilled Nursing Facilities (SNFs) must issue a notice to Original Medicare (fee for service - FFS) beneficiaries in order to transfer potential financial liability before the SNF provides: >an item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or >custodial care (non-medical assistance with daily tasks and basic living needs for those who are not sick or disabled). Resident #107 was admitted to the facility May 2024, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment). Review of the Physician Determination Concerning Massachusetts Health Care Proxy, dated 6/11/24, indicated: -Resident #107 lacked the capacity to make and/or communicate health care decisions. -The cause and nature of the incapacity was due to Dementia. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Duration of the incapacity was expected to be permanent. Review of the medical record indicated that Resident #107 came off (Medicare benefits ended) his/her Medicare benefit on 6/27/24. Review of the NOMNC, dated 6/25/24, indicated Resident #107 had signed the document. The facility was unable to provide any SNF ABN notice corresponding with the Resident ending his/her Medicare benefit on 6/27/24, for review. During an interview on 11/4/24 at 11:41 A.M., the surveyor and MDS Nurse #1 reviewed Resident #107's record. MDS Nurse #1 said that the NOMNC on 6/25/24 was signed by the Resident but should have been issued to the HCP based on the documentation of resident incapacity and had not been issued to the HCP. MDS Nurse #1 said that a SNF ABN had not been issued to the Resident or his/her HCP and should have been issued.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 37400 Based on observation, interview, record and policy review, the facility failed to ensure that two Residents (#99 and #43) out of a total sample of 25 residents, were free of physical restraints, putting the Residents at potential risk of accidental falls and injury. Specifically, the facility failed to: 1. For Resident #99, assess for the use of bilateral half middle (placement in the middle of the bed) side rails (side rails: adjustable position, rigid bars that attach to the sides of a bed, ranging in sizes from full to one-half, one-quarter, or one-eighth lengths) while in bed which prevented the Resident from exiting the bed, and were not the quarter side rails as ordered by the Physician. 2. For Resident #43, assess the use of wedge cushions (a triangular shaped cushion used to aid in positioning for health issues or comfort) placement on the bed and one side of the Resident's bed positioned against the wall being used as potential restraints. Findings include: Review of the facility policy titled Restraint Management, revised 12/16/16, indicated the interdisciplinary team will determine the necessity to use a physical restraint on a resident as part of a person-centered approach to treat a medical symptom and at the same time promote a safe environment for the resident and the highest practicable level of physical functioning and psychosocial well-being. The policy also included the following: -when a resident's condition necessitates consideration for a restraint, alternative interventions must be attempted and fully documented in the Nursing Notes and in the Care Plan -when the appropriate alternatives outlined in the Care Plan are unsuccessful, the Restraint Assessment will be completed by the Licensed Nurse, prior to initiating the use of a restraint -The resident or resident representative will be included in the decision process. They will be fully informed of: >how the use of the restraint will treat the resident's medical symptoms and assist in attaining the highest practicable level of physical and psychological well-being >potential negative outcomes of restraint usage >alternatives to restraint use -if the resident or resident representative agrees to the use of the restraints, written authorization of Physical Restraint Consent is placed in the clinical record . (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-all restraints will have a specific Physician's order to include: >type of device >medical diagnosis/symptom (physical or physiological need) >how often the device is to be used >frequency of checking and removing (minimum of every 2 hours) -no restraint will be applied . unless there is a Physician's order -medical symptoms that would warrant the use of restraints are reflected in comprehensive assessment and care planning Review of the facility policy titled Side Rails, revised 10/17/17, indicated the facility provided an optimum safe sleeping environment for the resident while taking into individual residents' needs for side rails. The policy also included the following: -side rails may be an enabler, a restraint, or both, and require an assessment of the resident's mobility and cognitive functioning to determine the category of use and determine need. -side rails, even quarter rails, can be considered a restraint if side rails are raised and their use meets the criteria for the restraint as outlined in the practice guidelines. 1. Resident #99 was admitted to the facility in May 2024, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), muscle weakness and abnormal gait and mobility. Review of the Minimum Data Set (MDS) Assessment, dated 8/8/24, indicated Resident #99: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 6 out of 15. -had no range of motion deficits and did not utilize physical restraints. Review of the Side Rail Informed Consent form, dated and signed by the Resident's Representative on 5/14/24, indicated consent was given for the use of bilateral (both left and right) upper (placement at the top of the bed) quarter side rails. Review of the Nursing Quarterly Assessment, dated 8/8/24, indicated Resident #99: -was able to use to side rail to position when in bed and for balance stability when getting in/out of bed or coming to a seated position -had slightly limited mobility (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was chair bound -had a low bed in place -requested or required side rails -had severe cognitive impairment -was able to request staff assistance and utilize the call bell -is assisted by staff in/out of bed (did not indicate he/she was dependent) -the side rails did not prevent ingress (entering)/egress (exiting) out of bed and were not considered a restraint -the assessment indicated the use of quarter upper right and left side rails. Review of the Falls Care Plan, initiated 5/16/24, indicated the following interventions: -educate resident/family on fall prevention strategies, initiated 5/16/24 -gait belt for all transfers, initiated 5/16/24 -keep call bell within reach, initiated 5/16/24 -mat at bedside, initiated 9/21/24 Review of the Activities of Daily Living (ADL) Care Plan, initiated 5/16/24, indicated the following intervention: -assist of one staff with transfers, initiated 11/13/24 (provided to the surveyor after survey exit) Review of the November 2024 Physician's orders included the following: -quarter side rails on both sides of the bed, initiated 5/14/24 -HCP invoked on 10/15/24 On 11/4/24 at 10:32 A.M., the surveyor observed Resident #99 lying in bed on his/her left side facing the door to enter the room. The surveyor observed that middle half side rails were in place on both sides of the Resident's bed and a mat was observed on the floor on the right side of the bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 11:23 A.M., the surveyor heard Resident #99 yelling for help from his/her room. The surveyor knocked and entered the room and observed the Resident was lying on his/her side in bed facing the doorway, the bilateral half middle side rails were up and a mat was on the right side of the bed on the floor. The Resident said he/she wanted to get out of bed but could not because of these things indicating the middle side rail positioned in front of his/her body. The surveyor initiated the call bell and Nurse #2 entered the room shortly after. Resident #99 repeated with Nurse #2 present, that he/she wanted to get out of bed and was unable to do so due to the middle side rail. During an interview at the time, Nurse #2 said the Unit Manager (UM) assesses Residents for the use of side rails, that the side rails would be assessed routinely and care planned. Nurse #2 further said that if Resident #99 was in bed, unless the side rails were assessed and ordered to be up, they should be in the down position. On 11/4/24 at 2:09 P.M., the surveyor observed the Resident lying upright in bed with eyes closed, and with bilateral half middle side rails in the up position. The surveyor observed a floor mat on the right side of the Resident's bed. On 11/4/24 at 2:42 P.M., the Resident was observed seated at the edge of the bed with a visitor. The surveyor observed that the side rail on the right side was in the down position at the time. On 11/5/24 at 5:48 A.M., the surveyor observed Resident #99 lying in bed his/her eyes closed, and the bed in a low position. The surveyor observed that the head of the bed was slightly elevated, the bilateral half middle side rails were in the up position and a floor mat was on the right side of the bed. On 11/5/24 at 5:49 A.M., the surveyor and Certified Nurses Aide (CNA) #13 observed Resident #99 in bed in his/her room. During an interview at the time, CNA #13 said Resident #99 required assistance of one staff with transfers on most occasions. CNA #13 said the Resident used the side rails to assist him/her with repositioning in bed and when transferring out of bed. CNA #13 said the half middle side rails and the floor mat were in place to keep the Resident safe and that the half middle side rails were up to keep him/her in bed. CNA #13 said the Resident would not be able to get out of bed with the half middle side rails in place. On 11/5/24 at 7:44 A.M., the surveyor and UM #1 observed Resident #99 in bed in his/her room. Resident #99 remained lying in a low positioned bed with his/her eyes closed with a floor mat on the right side of the bed and bilateral half middle side rails in the up position. During an interview at the time, UM #1 said Resident #99 currently had half middle side rails in place on both sides and should have quarter side rails up which would be positioned at the top of the bed as ordered by the Physician. UM #1 said she was not sure why the side rails are positioned in the middle part of the bed, that she was not familiar with these types of side rails and that the ones she was familiar with were positioned up near the head of the bed. UM #1 said the Resident had a fall out of bed a few months ago, that if side rails were to be used, the use would be routinely assessed, a consent would be obtained, a Physicians' order in place for their use and the side rail use would be care planned. The surveyor relayed the previous observation from 11/4/24 when Resident #99 was yelling out for help to get out of bed and he/she had the bilateral half middle side rails in place. UM #1 said the side rails should not be used to keep the Resident in bed, that he/she should not have had the half middle side rails in place, and that this could be considered a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #43 was admitted to the facility in September 2020, with diagnoses including Dementia and falls history. Review of the MDS Assessment, dated 9/12/24, indicated Resident #43: -had severe cognitive impairment as evidenced by a BIMS score of 3 out of 15. -had no range of motion deficits. -did not utilize restraints during the assessment reference period. Review of the Falls Care Plan, initiated 9/21/20, indicated the Resident was at risk for falls related to change in mobility, unsafe behaviors, cognition and tendency to crawl out of lower bed and onto the floor mattress. The Care Plan included the following interventions: -call bell within reach, initiated 9/21/20 -frequently used items within reach to prevent bending or reaching, initiated 3/22/22 -concave mattress (scoop mattress) on bed for spatial boundaries, initiated 11/3/22 -left side of bed against the wall with the floor mat to the right side of the bed, initiated 11/3/23 -encourage Resident to remain in common area when not in bed, initiated 11/28/23 -Resident to be out of bed before 8:00 A.M., initiated 3/6/24 -11:00 P.M. to 7:00 A.M. shift to get the Resident up in the morning, initiated 3/21/24 Review of the Resident's clinical record indicated that he/she experienced falls out of bed or wheelchair in his/her room on: -2/24/24 -2/29/24 -3/21/24 -6/8/24 Review of the Activities of Daily Living (ADL: basic skills needed in regular daily life including ambulating, dressing, bathing, eating) Care Plan, initiated 10/23/20, indicated the Resident required assistance of one staff with bed mobility, transfers and positioning. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/3/24 at 1:44 P.M., the surveyor observed that the Resident's bed was positioned with the left side against the wall. The surveyor observed two triangular wedges on top of the Resident's bureau and that the Resident was not in the room at the time. During an interview on 11/4/24 at 1:11 P.M., CNA #10 said Resident #43 required assistance of one staff with transfers and has his/her left side of the bed positioned against the wall because the Resident was at risk for falls. During an interview on 11/4/24 at 1:19 P.M., CNA #8 said that the Resident required assistance of one staff with transfers and toileting. CNA #8 further said that the Resident's left side of the bed was positioned against the wall and a mattress was placed on the floor on the right side of the bed because he/she was a fall risk. CNA #8 said the Resident also had wedge cushions that were placed underneath the fitted sheet on the right side of the bed (the side not positioned against the wall) so that he/she stayed in bed. On 11/5/24 at 5:50 A.M., the surveyor and CNA #13 observed Resident #43 in bed in his/her room. Resident #43 was lying in a low positioned bed with eyes closed. The surveyor observed that the left side of the bed was against the wall and there was a mat on the floor on the right side of the bed. The surveyor observed two triangular shaped wedge cushions were under the fitted sheet of the bed on the right side of the bed (opposite the bedroom wall). During an interview at the time, CNA #13 said Resident #43 has had some falls out of bed and the wedge cushions were in place to keep him/her in bed. CNA #13 further said the Resident was unable to get out of the bed with the wedge cushions in place. During an interview on 11/5/24 at 11:30 A.M., Resident #43's Representative said the Resident has had some falls and he/she knew there was an intervention added for his/her bed to be against the wall so that he/she can only get out of bed on the open side. During an inteview on 11/5/24 at 2:18 P.M., UM #1 said that Resident #43 has had previous falls and has his/her bed against the wall and a mat on the floor. UM #1 said the bed against the wall could be viewed as a potential restraint and that it had not been assessed as a potential restraint because the Resident could exit the bed from the right side (the side not against the wall). UM #1 further said the bed should be in the low position and a mat should be placed on the floor on the right side of the bed while the Resident was in the bed. UM #1 said the Resident was assisted out of bed early in the morning. The surveyor and UM #1 assessed Resident #43's room at this time, and observed the left side of the Resident's bed positioned against the wall and two wedge cushions located on the bureau. The surveyor relayed observations from 5:50 A.M. that morning, and UM #1 said the two wedge cushions should not be placed under the fitted sheet on the right side of the Resident's bed because it would impede the Resident's movement out of bed. UM #1 further said she did not know who put the wedge cushions in place or how long they have been used. UM #1 said that they would be considered a restraint, that a restraint assessment would need to be completed and consent obtained for the use of the devices. UM #1 further said she was not aware that staff were utilizing the wedge cushions and that no Residents on the unit should be using restraints as it could lead to harm if used without proper assessment.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 42761 Based on record review and interview, the facility failed to provide required documentation to the receiving hospital for one Resident (#73) of one applicable closed record, out of a sample of three closed records, when Resident #73's medical needs could not be met at the facility, and he/she required transfer to the hospital. Specifically, the facility failed to provide evidence that the required transfer documentation to ensure a safe and effective transition of care was provided to the receiving hospital when Resident #73 was transferred to the hospital from the facility. Findings include: Resident #73 was admitted to the facility in May 2024. Review of Resident #73's Nursing Progress Note, dated 5/29/24, indicated the following: -The Resident complained of discomfort and multiple episodes of non-productive coughing. -A new order for Mucinex was obtained and scheduled Acetaminophen had been administered as ordered. -The Resident's temperature was 103.1 degrees axillary (under the arm). -The on-call Physician was notified and gave an order to transfer the Resident to the hospital. Review of Resident #73's clinical record did not include any evidence that the following information was provided to the receiving hospital when the Resident was transferred on 5/29/24: -Contact information of the Practitioner (Physician) responsible for the care of the Resident. -Resident Representative information including contact information. -Advanced Directive information. -All special instructions or precautions for ongoing care, as appropriate. -Comprehensive care plan goals. -All other necessary information, . as applicable, to ensure a safe and effective transition of care. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 8:16 A.M., the Social Worker (SW) said that when a Resident was transferred to the hospital, facility staff were required to complete a SBAR (situation, background, assessment, recommendation) assessment which included all of the information required to be provided to the receiving hospital. The SW said that she reviewed Resident #73's clinical record and that facility staff did not complete an SBAR for Resident #73 when he/she was transferred to the hospital on 5/29/24. The SW further said there was no evidence the facility provided the required information to the receiving hospital when Resident #73 was transferred from the facility on 5/29/24. Please refer to F655.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interview, and record review, the facility failed to ensure that Significant Change in Status Minimum Data Set [MDS] Assessments (SCSA) were completed for three Residents (#104, #84, and #88) out of a total sample of 25 residents. Specifically, the facility failed to: 1. For Resident #104, ensure a SCSA was completed when the Resident had a decline in his/her memory, activities of daily living (ADLs), and bowel and bladder. 2. For Resident's #84 and #88, ensure SCSAs were completed when both Residents signed onto Hospice (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) services. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, dated October 2023 indicated the following: -The SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either a major improvement or decline. -A significant change is a major decline or improvement in a resident's status that: >Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting. >Impacts more than one area of the resident's health status. >Requires interdisciplinary review and/or revision of the care plan. -An SCSA is appropriate when: >There is determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent quarterly assessments. >If the resident is admitted on the Hospice benefit. 1. Resident #104 was admitted to the facility in January 2024. Review of Resident #104 most recent comprehensive MDS assessment dated [DATE], indicated the following: (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	-Resident #104 was partial to standby assist for ADLs. -Resident #104 scored a 15 out of 15 on the Brief Interview of Mental Status (BIMS-cognitive assessment used in nursing facilities) exam indicating the Resident was cognitively intact. -Resident #104 was occasionally incontinent of bladder and continent of bowel. Review of Resident #104 most recent quarterly MDS assessment dated [DATE], indicated the following: -Resident #104 was now dependent for ADLs. -Resident #104 scored a 9 out of 15 on the BIMS exam indicating the Resident was now moderately cognitively impaired. -Resident #104 now had an indwelling urinary catheter (tubing inserted through the urethra into the bladder to allow urine to drain) and had a colostomy (a surgical procedure that reroutes a portion of the colon through an opening in the abdominal wall to divert waste outside the body). During an interview on 11/5/24 at 2:02 P.M., the MDS Nurse said she reviewed Resident #104's most recent comprehensive MDS assessment dated [DATE], and Resident #104's most recent quarterly MDS assessment dated [DATE], and said Resident #104 had multiple declines in his/her status and his/her last quarterly MDS Assessment should have been completed as a SCSA, and this was not done. 2. Resident #84 was admitted to the facility in August 2024. Review of the Hospice Certification of Terminal Illness, signed 9/5/24 by the Hospice Medical Director indicated Resident #84 was admitted to Hospice services on 9/6/24. Review of Resident #84's MDS Assessments indicated no documentation that a SCSA was completed within 14 days of Resident #84 signing onto Hospice services. During an interview on 11/4/24 at 3:37 P.M., the MDS Nurse said a SCSA for Resident #84 should have been completed within 14 days of the Resident signing onto Hospice services, and this was not done. 37400 3. Resident #88 was admitted to the facility in August 2022. Review of the MDS assessment dated [DATE], indicated Resident #88 had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 4 out of 15, and was not on Hospice services. Review of the Resident's clinical record indicated the following: -Nursing Progress Note dated 8/12/24: Hospice referral due to 10 pound (lbs) weight loss. (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	-Social Service Note dated 8/21/24: Resident's family met with Hospice Services on 8/20/24, and has elected Hospice services which will occur on 8/21/24. -No documented evidence that a SCSA was completed after Hospice services were elected. Review of the Hospice Certification of Terminal Illness Form, indicated Resident #88 was started on Hospice care services on 8/21/24. Review of the End of Life Care Plan initiated 8/21/24, indicated Resident #88 had signed onto Hospice care on 8/21/24. During an interview on 11/4/24 at 3:38 P.M., the MDS Nurse said she did not know that Resident #88 was on Hospice services and a SCSA should have been completed, but one was not.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on record review and interview, the facility failed to accurately complete Minimum Data Set (MDS) Assessments for one Resident (#17), out of a total sample of 25 residents. Specifically, for Resident #17, the facility failed to accurately code the indication for use of an antipsychotic (medication that alters brain chemistry to reduce psychotic symptoms) medication and an antidepressant (medication that treat Depression and other conditions) medication on one MDS Assessment. Findings include: 1. Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, Chapter 3, Section N: Medications, dated October 2024, indicated the following: -The intent of the items in this Section is to record the number of days, during the last seven days (lookback period) . that . select medications were received by the resident. -High risk drug classes included antipsychotic and antidepressant medications. -If the resident is taking medications in high risk drug classes, check the column one (is taking). -If column one is checked, check if there is an indication noted for all medications in the drug class. Resident #17 was admitted to the facility in December 2023, with diagnoses including Dementia (group of symptoms that affects memory, thinking, and interferes with daily life) with Psychotic Disturbance (serious mental illness that affects a person's ability to think clearly, make good judgments, respond emotionally, communicate effectively, understand reality, and behave appropriately) and Anxiety (intense, excessive and persistent worry and fear about everyday situations). Review of Resident #17's Physician orders, dated 1/31/24, indicated: -Lexapro (antidepressant medication that can be used to treat Anxiety Disorders) 10 milligram (mg) tablet (tab), one tab, TD (total dose) = 10 mg, oral once daily for Anxiety. Review of Resident #17's Physician orders, dated 9/21/24, indicated: -Seroquel (antipsychotic medication) 25 mg tablet, give with 25 mg 1/2 tab (TD = 37.5 mg), oral three times daily for Unspecified Dementia, Unspecified Severity, with Psychotic Disturbance. Review of Resident #17's October 2024 Medication Administration Record (MAR) indicated the following: -The Resident received Lexapro as ordered, on six out of seven days between 10/4/24 and 10/10/24. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-The Resident received Seroquel as ordered, on six out of seven days between 10/4/24 and 10/10/24. Review of Resident #17's MDS assessment dated [DATE], indicated the following: -The Resident received antipsychotic medication during the lookback period for the Assessment. -The Resident received antidepressant medication during the lookback period for the Assessment. -The box titled Indication Noted, relative to the antipsychotic medication use was not selected. -The box titled Indication Noted, relative to the antidepressant medication use was not selected. During an interview on 11/5/24 at 2:14 P.M., the Regional MDS Nurse said she reviewed Resident #17's clinical record and the MDS assessment dated [DATE]. The Regional MDS Nurse said the Resident had diagnoses of Dementia with Psychosis and Anxiety which were the conditions the Lexapro and Seroquel were ordered to treat. The Regional MDS Nurse said that the MDS was coded inaccurately and that the box titled Indication Noted should have been selected for antidepressant and antipsychotic medication use for Resident #17.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 42761 Based on record review and interview, the facility failed to develop a baseline care plan for one Resident (#73) out of a sample of three closed resident records reviewed. Specifically, the facility failed to develop a baseline care plan for Resident #73 within 48 hours of admission to the facility, when a comprehensive care plan was not developed in place of a baseline care plan, to provide effective and person-centered care of the Resident. Findings include: Resident #73 was admitted to the facility in May 2024, with diagnoses including Unspecified Fall and Displaced (out of alignment or in several pieces) Intertrochanteric (top of the thigh bone, where the hip and thigh meet) Fracture (cracking or breaking) of Right Femur (thigh bone). Review of Resident #73's Baseline Admission Care Plan, dated 5/26/24, indicated the following: -The Resident's date of birth. -The Resident's date of admission to the facility. -The Resident's medical history. -The Resident's Physician's name and contact information. Further review of the Baseline Care Plan indicated that no other sections of the Baseline Care Plan had been completed and included no initial goals for the Resident. Review of Resident #73's clinical record did not include any evidence that a Comprehensive Care Plan had been developed in place of a Baseline Care Plan. Further review of Resident #73's clinical record included a Nursing Progress Note that indicated the Resident was transferred to the hospital on 5/29/24 (more than 48 hours following the Resident's admission to the facility). During an interview on 11/6/24 at 8:02 A.M., the Social Worker (SW) said that nursing staff were responsible to complete Baseline Care Plans when Residents were admitted to the facility, and the SW was responsible to set up a Baseline Care Plan meeting for the Resident within 72 hours of admission. The SW said that she would review Resident #73's record, and that the Baseline Care Plan probably did not get completed because the Resident was at the facility for a short time. During a follow-up interview on 11/6/24 at 8:16 A.M., the SW said that the required Baseline Care Plan was not completed for Resident #73 following the Resident's admission to the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on record review and interview, the facility failed to ensure that care plans were reviewed and revised by the interdisciplinary team (IDT), and included the Resident and/or Resident's Representative for three Residents (#17, #92, and #88) out of a total sample of 25 residents. Specifically, facility failed to provide evidence that: 1. Resident #17 and/or his/her Representative were invited and attended/did not attend two separate care plan meetings held for the Resident. 2. Resident #92's care plan was reviewed and revised by the IDT following one Resident Assessment completed. 3. Resident #88's care plan was reviewed and revised by the IDT following two separate Resident Assessments completed. Findings include: Review of the facility's policy titled Care Planning, dated 10/1/10 and revised 10/28/22, indicated the following: -A letter will be sent to each resident or resident representative inviting them to the care plan meeting. -Each discipline reviews the overall plan and any concerns prior to the care plan meeting and completes their section of the Care Plan UDA (user defined assessment). -The Care Plan Coordinator (Social Worker) oversees the meeting. -Unit managers, Activities Staff, Dietary, Certified Nurses Aides (CNAs), Rehabilitation Staff as indicated. -The Care Plan Coordinator will review the Care Plan Meeting UDA for completion and document participation of IDT and resident/resident representative within the UDA. -The Care Plan Coordinator will document a summary of the meeting in the Care Conference Note section of the Care Plan Meeting UDA. 1. Resident #17 was admitted to the facility in December 2023, with diagnoses including Cerebrovascular Accident (CVA: when blood flow to a part of the brain is stopped either by a blockage or a rupture of a blood vessel). Review of Resident #17's clinical record indicated the facility held Care Plan Meetings on the following dates: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/18/24 -4/16/24 Review of Resident #17's Care Plan Meeting Notes, dated 1/18/24 and 4/16/24, included no information relative to: -Whether the Resident and/or his/her Representative were invited to attend the meetings. -Whether the Resident and/or his/her Representative attended or did not attend the meetings. -Which members of the facility staff attended the meetings. 2. Resident #92 was admitted to the facility in May 2023, with diagnoses including Dementia (group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident #92's clinical record indicated facility staff completed a Minimum Data Set (MDS) Assessment for Resident # 92, dated 4/25/24. Further review of Resident #92's clinical record did not indicate any evidence that the Resident's care plan was reviewed and revised by the IDT following completion of the MDS Assessment. During an interview on 11/5/24 at 1:44 P.M., the Social Worker (SW) said that the Care Plan Meeting Notes for Resident #17 dated 1/18/24 and 4/16/24 were incomplete. The SW said that there was no evidence to indicate whether the Resident and/or his/her Representative were invited to attend the meetings, and whether the Resident and/or his/her Representative did or did not attend the meetings. The SW also said there was no evidence to indicate which facility staff attended the meetings to review the care plan. The SW said that participation of the Resident/Representative and facility staff in the care plan meetings was required to be documented in the Resident's clinical record, but was not documented for Resident #17. The SW also said that the IDT did not meet to review and revise Resident #92's care plan following completion of the MDS assessment dated [DATE]. The SW said that the meeting for Resident #92 did not occur and was missed due to human error. 37400 3. Resident #88 was admitted to the facility in August 2022 with diagnoses including Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and Chronic Kidney Disease Stage 3 (considered the middle stage kidney disease where there is mild to moderate damage to the kidneys, and the kidneys do not filter waste and fluid as well as they should). Review of the Resident's clinical record indicated MDS Assessments were scheduled on the following dates: -11/16/23 -2/15/24 -5/7/24 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/1/24 Review of the Resident's Care Plan Meeting Notes indicated no documented evidence of what was discussed and/or who attended the meetings on the following dates: -11/30/23 -3/1/24 Further review of the Resident's clinical record indicated no documented evidence that any care plan meetings were held after the 5/7/24 MDS Assessment. During an interview on 11/5/24 at 1:02 P.M., the SW said once an MDS Assessment is completed, the care plan meeting would be scheduled 1-2 weeks after the completion of the MDS Assessment. The SW said the MDS Nurse would schedule the care plan meetings, the SW would assign the care plan meeting times, and the Receptionist would send the care plan meeting dates/times to the Resident/Resident responsible party. The SW said the care plan meetings are held with the interdisciplinary team regardless of whether the family/Resident attends and that each discipline would discuss changes relative to the Resident over the last quarter and then the meeting would be open discussion about other concerns. The SW said Social Services, Activities, Nursing and Dietary staff are to be present at the Resident care plan meetings. The SW said she would include a synopsis of the meeting in the care plan meeting notes and also indicate who attended the meeting. The SW further said the care plan meeting for Resident #88 was missed after the 5/7/24 MDS Assessment. The surveyor and the SW reviewed Resident #88's Care Plan Meeting Forms and the SW said there did not appear to be any care plan meeting synopsis notes or any indication of who participated in the Resident's meetings on 11/30/23 and 3/1/24.

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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. 37400 Based on observation, interview and record review, the facility failed to provide assistance with personal hygiene for two Residents (#88 and #43) out of a total sample of 25 residents. Specifically, the facility failed to ensure Resident #88 and #43 were offered and/or provided with grooming assistance when both Residents required the assistance of staff for grooming activities. Findings include: 1. Resident #88 was admitted to the facility in August 2022, with diagnoses including Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and Parkinson's Disease (a progressive degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination) with Dyskinesia (uncontrolled, involuntary movements of the face, arms or legs). Review of the Activities of Daily Living (ADL: basic skills needed in daily life and include eating, bathing, toileting and grooming/personal hygiene) Care Plan, initiated 8/25/22, indicated Resident #88 had decreased ability to perform ADLs due to decreased cognition and mobility. The ADL care plan included the following intervention: -Assist to dependent of one staff for grooming (includes brushing teeth, shaving, hair and nail care), initiated 1/1/23 Review of the Minimum Data Set (MDS) Assessment, dated 8/1/24, indicated Resident #88: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 4 out of 15 -was dependent on staff for personal hygiene, including grooming tasks Review of the October 2024 and November 2024 Medication Administration Records (MARs) indicated the following Resident Behavior Monitoring which was documented every shift (7:00 A.M. to 3:00 P.M., 3:00 P.M. to 11:00 P.M. and 11:00 P.M. to 7:00 A.M.) -No behaviors were documented from 10/1/24 through 10/31/24 -No behaviors were documented from 11/1/24 through 11/4/24 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/3/24 at 9:29 A.M., the surveyor observed Resident #88 dressed with shoes on and seated in a specialized wheelchair. The surveyor observed that the Resident had facial hair on his/her cheeks, chin and upper lip. During an interview with Resident #88's Representative, who was present at the time, he/she said Resident #88 was dependent on the staff for care including grooming needs and preferred to have the hair removed from his/her face. The Resident Representative said the Resident was very particular about how he/she looked prior to admission and would always have neat matching clothes and remove facial hair daily. On 11/4/24 at 8:49 A.M., the surveyor observed the Resident was seated in a specialized wheelchair in the unit dining room during breakfast. The surveyor observed Resident #88 was dressed, but facial hair remained on his/her cheeks, upper lip and chin. On 11/4/24 at 2:13 P.M., the surveyor observed that Resident #88 was awake, dressed and lying slightly upright in bed. The surveyor observed that hair remained on the Resident's cheeks, upper lip and chin. During an interview on 11/4/24 at 2:31 P.M., Certified Nurses Aide (CNA) #8 said she took care of Resident #88 today and was very familiar with his/her care. CNA #8 said the Resident was dependent on staff for ADL care. On 11/5/24 at 9:01 A.M., the surveyor observed the Resident dressed and seated in a specialized wheelchair during breakfast. The surveyor observed that the Resident remained with facial hair on his/her cheeks, upper lip and chin. During an interview on 11/5/24 at 9:17 A.M., Resident #88's Representative approached the surveyor and said the facility staff on the day shift (7:00 A.M. to 3:00 P.M.) are really good but there were not enough of them to care for the Residents on the unit. The Resident Representative further said there did not seem to be enough time for the staff to provide the care that the Residents needed. During an interview on 11/5/24 at 9:58 A.M. and 10:15 A.M., CNA #8 said she had worked with Resident #88 since 11/4/24. CNA #8 said facial hair removal should be offered daily and that Resident #88 preferred to have no facial hair. CNA #8 said said the Resident required total assistance from staff with all personal care including grooming/personal hygiene needs and does not refuse care. CNA #8 said she was able to partially remove the Resident's hair from under his/her chin but was unable to finish because the breakfast meal arrived and then she had other Residents to take care of so she did not have time to finish assisting Resident #88. During an interview on 11/5/24 at 10:15 A.M., Unit Manager (UM) #1 said Resident #88 should be provided facial hair removal daily as per his/her preference. UM #1 said she was aware that the Resident's family requested to have facial hair removed daily and and that this would be completed today. 2. Resident #43 was admitted to the facility in September 2020 with diagnoses including Dementia. Review of the ADL Care Plan, initiated 10/23/20, indicated Resident #43 had decreased ability to perform ADLs due to cognitive deficits, decreased activity tolerance and decreased mobility. The plan of care included the following intervention: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-assistance to dependent of one staff for grooming, initiated 11/4/24 Review of the MDS Assessment, dated 9/12/24, indicated Resident #43 had: -severe cognitive impairment as evidenced by Brief Interview of Mental Status (BIMS) score of 3 out of 15 -was dependent on staff for personal hygiene Review of the October 2024 and November 2024 MARs indicated the following Resident Behavior Monitoring which was documented every shift: -No refusals of care behaviors were documented from 10/1/24 through 10/31/24 -No refusals of care behaviors were documented from 11/1/24 through 11/4/24 On 11/3/24 at 1:47 P.M., the surveyor observed Resident #43 dressed and seated in a specialized wheelchair. The surveyor observed the Resident had long facial hair on his/her chin and cheeks. On 11/4/24 at 8:04 A.M., the surveyor observed the Resident was dressed and seated in a specialized wheelchair. The surveyor observed that long facial hair remained on the Resident's chin and cheeks. During an interview on 11/4/24 at 1:11 P.M., CNA #10 said Resident #43 was able to do some of his/her facial hair removal with an electric razor, and then staff assist him/her to finish. CNA #10 said the Resident was receptive to staff assisting him/her with facial hair removal. CNA #10 said he tried to remove the Resident's facial hair everyday or every other day. During an interview on 11/4/24 at 1:19 P.M., CNA #8 said she regularly assisted with Resident #43's care. CNA #8 said the staff set the Resident up with the electric razor and he/she was able to use it to remove some of his/her facial hair but the staff had to assist with finishing. CNA #8 said Resident #43 was receptive to staff assistance with care and did have days when he/she required more assistance from staff with the task. On 11/5/24 at 7:34 A.M., the surveyor observed Resident #43 dressed and seated in a wheelchair in the dining room. The surveyor observed that long facial hair remained on the Resident's chin and cheeks. During an interview on 11/5/24 at 11:30 A.M., the Resident's Representative said Resident #43 preferred to have no facial hair and used to remove his/her facial hair daily prior to admission to the facility. During an interview on 11/5/24 at 10:10 A.M., UM #1 said Residents should have their facial hair removed daily or at least every other day. UM #1 said Resident #43 was receptive to care and liked to have his/her facial hair removed. UM #1 said it appeared that Resident#43 had not had his/her facial hair removed for a few days.

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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** 37400 Based on observation, interview, record and policy review, the facility failed to ensure one Resident (#88) out of a total sample of 25 sampled residents, received care and services consistent with professional standards of practice relative to completing a timely assessment and obtaining treatment orders for an identified skin issue. Specifically, the facility identified Resident #88 had a quarter sized fluid filled blister on his/her right lower leg and failed to assess the cause of the blister, notify the Physician and Responsible Party timely and obtain treatment orders to assist in healing, increasing the risk of potential further skin decline and infection. Findings include: Review of the facility policy titled Skin Integrity Management, revised November 2023, indicated based on the comprehensive assessment of the resident, the facility must ensure that the resident receives care, consistent with professional standards of practice to prevent pressure ulcer or injury and does not develop pressure ulcer or injury unless the individual's clinical condition demonstrates that they were unavoidable. The policy also included the following: -Purpose: > maintain the integrity of the resident's skin, the largest organ in the body which plays a significant factor in overall health, >minimize the risks and prevent the occurrence of skin breakdown through initial comprehensive and regular skin assessments >develop and implement a comprehensive, person-centered plan of care aimed at maintaining skin integrity, prompt identification, intervention and management of any skin breakdown on accepted clinical standards of practice -Procedure: >when skin breakdown is identified, report this timely to Medical Practitioner and resident representative as required by policy. Complete an Incident Report for newly developed pressure ulcer/injury. >obtain wound treatment order, document in Physician's Order and ETAR (electronic treatment administration record) >obtain a referral to Wound Consultant who will partner with facility Nurse in conducting weekly wound assessment and treatment review. Resident, if by their choice can be seen by outside wound, vascular, or surgical consultant for treatment (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>every treatment recommendation will be reviewed timely with the resident's primary Medical Practitioner and an order will be entered in the resident's electronic medical record >referral to Registered Dietician for nutritional interventions to promote wound healing >referral to Rehabilitation Services for treatment modalities that they can provide to aid wound healing >monitor all medical conditions that may affect wound healing . >conduct weekly wound rounds- complete measurements of each wound: L x W x D (length of wound by width of wound by depth of wound), description of wound med, description of wound edges and surrounding skin, type and amount of exudates (wound drainage), type of wound dressing, signs of infection and presence or absence of pain >document findings of the weekly wound assessments in the resident's electronic medical record: Weekly Skin Condition Report >develop a comprehensive plan of care addressing the management and treatment of the resident's wound, towards the goal of healing the wound, managing pain from the presence and treatment of the wound and preventing infection >use wound care and treatment products consistent with the company's protocol. Document each prescribed wound treatment in the resident's electronic health record- ETAR >ensure resident/family participation by providing education related to prevention and treatment while a resident >ensure that resident or resident representative is made aware of the progress or non-progress of wound healing, changes to treatment and management of wound as it occurs Resident #88 was admitted to the facility in August 2022, with diagnoses including Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and Chronic Kidney Disease Stage 3 (considered the middle stage kidney disease where there is mild to moderate damage to the kidneys, and the kidneys do not filter waste and fluid as well as they should), Anemia (condition that develops when the blood produces a lower than normal amount of red blood cells and/or hemoglobin [protein in red blood cells that carries oxygen from the lungs to other organs/tissues] to carry oxygen to the body's tissues), and abnormal posture. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the following for Resident #88: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 4 out of 15 -had no range of motion deficits -utilized a wheelchair (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was dependent on the assistance of staff with toileting, personal hygiene, bathing, dressing, turning, repositioning and transfers -was at risk for pressure ulcers and did not have pressure ulcers Review of the Activities of Daily Living (ADLs: basic skills needed in regular daily life including ambulating, dressing, bathing, eating) Care Plan, initiated 8/25/22, indicated Resident #88 had an alteration in ability to provide self-care due to cognitive deficits, decreased activity tolerance/endurance and decreased mobility. The plan of care included the following interventions: -be alert to non-verbal cues or problems, initiated 8/25/22 -check skin during care and report any abnormalities/issues to nursing/Medical Doctor (MD), initiated 8/25/22 -assistance to dependent of 1 staff with bathing, dressing, grooming, initiated 1/1/23 -assistance to dependent on 2 staff with transfers, initiated 1/1/23 -assistance of 1-2 staff with bed mobility and positioning, initiated 1/1/23 Review of the Nursing Progress Note dated 10/31/24, indicated the Certified Nurses Aide (CNA) notified the Nurse at approximately 9:00 P.M. that Resident #88 had a blister on his/her leg. The Nurse assessed the area and indicated it was located on the Resident's right lower inner leg and was an intact fluid filled blister that measured 1 inch in diameter. Nursing Progress Note indicated a protective dressing was applied to the area. On 11/4/24 at 2:13 P.M., the surveyor observed Resident #88 was awake, dressed, and lying in a low positioned bed. The surveyor observed the Resident was wearing regular socks on his/her feet which were resting on the mattress. During an interview on 11/4/24 at 2:31 P.M., CNA #8 said she was very familiar with Resident #88. CNA #8 said the Resident currently had a blister on his/her inner leg, was not sure how the blister appeared and that it was raised and fluid filled. CNA #8 said she notified the Nurse about the Resident's blister and was not aware of any treatments/interventions that were currently in place. On 11/4/24 at 3:00 P.M., the surveyor, CNA #8 and Nurse #1 observed the Resident's right lower leg. Resident #88 was observed lying in bed and was awake. Nurse #1 put on gloves, instructed Resident #88 that she was going to observe his/her right leg and proceeded to lift the Resident's right pant leg and exposed a raised fluid filled blister located on his/her inner right calf approximately the size of quarter. The surveyor did not observe any redness around the fluid filled blister. During an interview at the time, Nurse #1 said the Resident's blister was previously identified by another Nurse and that she was just made aware of it today. Nurse #1 said she notified Unit Manger (UM) #1, an incident report was being completed and that the Physician and Resident's Representative were going to be notified. Nurse #1 said there were currently no treatment orders for the blister. (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 11/4/24 at 3:07 P.M., UM #1 said she was completing an incident report about the Resident's blister today because she was just notified of the area. UM #1 said when a skin area was identified, the Nurse would complete an incident report, update the wound provider, and the Physician and the Resident Representative would also be notified. UM #1 said when staff notified her about the Resident's blister today, she assessed the area. UM #1 said it was a fluid filled blister about the size of a quarter which she thought could be from friction. UM #1 said the Physician was going to be notified and treatment orders for the area requested. Review of the Resident's clinical record indicated no documented evidence that the Physician and Resident Representative were notified prior to 11/4/24 about the blister on the Resident's leg. Further review of the clinical record indicated there were no treatment orders for the area until 11/4/24 (4 days after the 10/31/24 notification) when the Physician was notified, and a treatment order was obtained. Review of the November 2024 Physician's orders included the following that was initiated on 11/4/24: -Skin Prep twice daily, apply skin prep to the Resident's blister on right lower inner calf twice daily. -Do not apply if the blister opens. Change order. During an interview on 11/6/24 at 3:30 P.M., UM #2, who was also the facility Wound Nurse, said she evaluated Resident #88's blister on 11/5/24. UM #2 said the blister was located on the Resident's right calf, was quarter size and was in an odd location for a blister because the Resident had no edema (swelling). UM #2 said an order was obtained from the Physician to apply Skin Prep. UM #2 said she was not notified of the Resident's blister until 11/5/24, which was unfortunate because had she been notified, she would have assessed the area and implemented interventions.

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F 0686 Level of Harm - 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** 51466 Based on observation, interview, and record review, the facility failed to provide necessary care and services to prevent and treat pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) and prevent further skin and pressure injury for two Residents (#26 and #53), of four applicable residents reviewed for pressure ulcers, out of a total sample of 25 residents. Specifically, the facility failed to: 1. For Resident #26: -offload (minimizing or removing any weight or force to help prevent and heal pressure ulcers) pressure on his/her buttocks and provide repositioning and assistance out of bed daily per Resident's plan of care to reduce the risk of developing pressure ulcers per the comprehensive plan of care and Resident preference/request. -assess the Resident's skin when he/she complained of buttocks discomfort. -implement interventions per professional standards of care and practice when a pressure ulcer was identified, including having hoyer pads available to transfer the Resident out of bed daily. -ensure the low loss air mattress was at the appropriate setting per the Resident's weight and comfort. 2. For Resident #53: -complete skin screening and assessment as required for the Resident who was at risk for pressure ulcers. -identify and implement treatment for a pressure ulcer that developed from the use of a nasal cannula (a thin flexible tube that provides supplemental oxygen through the nose via nasal prongs) resulting in a Stage Two pressure ulcer (partial-thickness skin loss with exposed dermis) of the philtrum (the vertical groove between the base of the nose and the border of the upper lip) and the base of the nostrils. Findings include: Review of the facility Policy titled Skin Integrity Management, revised November 15, 2024, indicated the following: -The facility must ensure the resident receives care, consistent with professional standards of practice to prevent pressure ulcer or injury and does not develop pressure ulcer or injury unless the individual's clinical condition demonstrates they were unavoidable. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Any resident with pressure ulcer or injury receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. -Skin assessment can and should be included in the normal workflow such as: >during provision of care, when turning, lifting, or transferring a resident. >each time you apply oxygen, check the resident's ears for any pressure areas. -When a resident has a device [sic], obtain Medical Doctor (MD) order to remove device and monitor skin integrity every shift unless it is medically contraindicated. Secure the device properly and regularly monitor and adjust if needed, the degree of tension to reduce pressure at the skin device interface. -When a skin breakdown is identified, report this timely to the Medical Practitioner. Obtain a wound treatment and document in Physician order and ETAR (electronic treatment administration record). -Use wound care and treatment products consistent with the company's protocol. Document each prescribed wound treatment in the resident's electronic health record 1. Resident #26 was admitted to the facility in April 2013, with diagnoses including Multiple Sclerosis (MS: a chronic autoimmune disorder of the central nervous system marked by numbness, weakness, loss of muscle coordination, and problems with vision, speech, and bladder control), Type 2 Diabetes (DM II - condition in which the body does not produce enough insulin hormone and has trouble controlling blood sugar levels), Cerebral Palsy (a group of conditions that affect movement and posture caused by brain damage to the developing brain before birth), and Morbid Obesity (when the body weight is found to be more than 80 - 100 pounds above the individual's ideal body weight). Review of the High Risk for Skin Breakdown Care Plan, initiated 8/15/17, indicated Resident #26 was at high risk for pressure ulcer development and indicated the following: -Resident should be encouraged to get out of bed daily, initiated 8/15/17 -Encourage activity and mobility, initiated 8/15/17 -Observation of skin condition during care - report pink, red or open areas to Nurse, initiated 8/15/17 -Apply Periguard (barrier cream that helps moisture and protect the skin) with each incontinent episode, initiated 11/24/17 -Gel pressure relieving cushion while in wheelchair, initiated 9/28/23 Review of the Activities of Daily Living Care Plan initiated 8/15/17, with an effective date of 10/11/23 indicated Resident #26 had decreased mobility and should be Out of Bed to wheelchair daily. Review of the Resident's Profile Care Plan effective 8/24/18, indicated the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Behaviors exhibited by Resident- none at present, initiated 8/24/18 -Resident prefers to get up later in the morning before lunch and goes to bed before supper, initiated 8/24/18 -Transfers with Hoyer Lift (mechanical device used to transfer individuals with limited mobility) - Large Hoyer pad (GREEN), initiated 7/21/21 -Decubitus Ulcer (bedsores that develop when an individual was unable to change positions for extended periods of time) Prevention- barrier cream to coccyx (tailbone), buttocks each shift, initiated 7/24/21 Review of the Occupational Therapy (OT) Discharge Summary, dated 2/11/24, indicated the following discharge recommendation: -Staff to assist the Resident with Hoyer transfer into the gerichair (specialized wheelchair) daily for at least one meal per day. Review of the Resident#26's MDS Assessment, dated 8/15/24 indicated: -he/she was cognitively intact as evidenced by a BIMS score of 13 out of a total possible 15. -had range of motion impairment affecting bilateral (both) lower extremities. -required total assistance from staff for toileting, showering, dressing, personal hygiene, rolling side to side, and transfers out of bed. -was frequently incontinent of bladder and bowel function. -was at risk for pressure ulcer development with a history of Moisture Associated Skin Damage (MASD - erosion of skin caused by prolonged moisture such as urine, stool or sweat). -utilized a Pressure Reducing Bed -weighed 190 pounds -had no rejections of care, refusals or change in behaviors. Review of Resident #26's October 2024 Physician orders indicated the following: -Alternating pressure mattress overlay. Every shift ensures inflation and correct setting every shift. Setting at 260 [sic] based on weight and manufacturers guidelines. Set at 260 for pain management based on resident assessment and preferences, initiated 6/26/24. -Weekly Skin screening for new areas of concern on Monday day shift, initiated 6/17/22 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/3/24 at 9:55 A.M., the surveyor observed Resident #26 lying in bed on his/her back with the head of the bed slightly elevated. The surveyor observed the Resident's legs were elevated on pillows and an air mattress was on the bed and set at 250 pounds. During an interview at the time, Resident #26 said that the air mattress was not always comfortable, and he/she needed to sleep with a pillow under his/her buttocks because if he/she was in the wrong position it hurt because there was a sore on his/her buttocks. Resident #26 said that he/she has not been out of bed in at least a week because the staff had not been able to find a Hoyer pad for the lift that assists with transferring him/her out of the bed and that he/she would like to get out of the bed. On 11/4/24 at 8:11 A.M., 8:43 A.M., 9:58 A.M., and 4:15 P.M., the surveyor observed the Resident lying in bed. At 8:43 A.M., the surveyor observed the Nurse Practitioner (NP) enter Resident #26's room and the Resident reported that he/she had buttocks pain. The NP asked the Resident if he/she was getting out of bed daily, and the Resident said that he/she had not been out of bed because the staff did not have the Hoyer pad and that he/she would like to get out of the bed. On 11/4/24 at 12:55 P.M., the surveyor observed Resident #26 lying on his/her back in bed with the head of the bed elevated. The Resident said that he/she was not getting out of bed today because the CNA said a Hoyer pad was not available. The surveyor observed a sign on the Resident's wall beside the bed, from OT which indicated the following: Resident was to be out of bed three to five (3-5) times per week for two to three (2-3) hours to get stronger and prevent sacral (skin injury near the base of the spine from extended pressure on the area) ulcers. On 11/5/24 at 7:42 A.M., and 2:32 P.M., the surveyor observed the Resident lying in bed. During an interview with CNA #9 at 2:32 P.M., she said the Resident did not get out of bed today because there were not enough Hoyer pads for all the residents and that it was difficult to find the correct size Hoyer pad for Resident #26. CNA #9 said if a Hoyer pad cannot be found, then Resident #26 cannot get out of bed, and she would notify the Nurse or the Unit Manager (UM). CNA #9 further said that if Resident #26 stayed in the bed, this would put him/her at risk for skin breakdown and that the Resident recently had an area that healed on his/her buttocks. CNA #9 said Resident #26 currently had redness and pain on his/her buttocks, and that she applied a cream and repositioned her. CNA #9 said if she noticed a skin issue, she would alert the Nurse. At this time, the surveyor requested to evaluate Resident #26's buttocks redness with CNA #9 and Nurse #9 and observed the following: -the Resident's right and left buttocks were deep red in color. -the left buttocks were painful upon touch and appeared deep red in color and was intact. -the right buttocks had two small round superficial (outer layer of the skin is open and damaged) open areas, each about 1.0 centimeter (cm) in diameter. During an interview at the time, Nurse #9 said the Resident had a Stage Two pressure area on his/her right buttock and a possible Stage Two on his/her left buttock but wanted to have the Wound Nurse evaluate the Resident's skin. Nurse #9 said they would make the NP/MD aware of his/her areas. Review of the medical record failed to indicate interventions were implemented for the two stage 2 pressure injuries observed on 11/5/24 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/6/24 at 7:56 A.M., the Resident was observed lying in bed with the air mattress set at 250 pounds. During an interview at the time, the Resident said his/her buttocks was sore this morning. During an interview on 11/6/24 at 8:24 A.M., CNA #9 said Resident #26 had complaints of discomfort in his/her buttocks. CNA #9 said she notified the Resident's Nurse (#5), who gave CNA #9 a cream to apply to the Resident's buttocks area. During an interview on 11/6/24 at 8:30 A.M., Nurse #5 said she had administered the scheduled pain medication to Resident #26 for complaints of buttocks pain and was aware there was an open area on his/her buttocks. During an interview on 11/6/24 at 8:43 A.M., UM #1 said she did not recall being told about missing Hoyer pads for Resident #26, that he/she was supposed to get out of bed every other day but sometimes refused and needed encouragement. UM #1 further said that if the Resident refused care, it would be documented. UM #1 said she was aware that the Resident had not been out of bed for a week and a half and thought it was due to the refusals and did not know it was because there was a lack of Hoyer pads. On 11/6/24 at 12:06 P.M., the surveyor observed Resident #26 dressed and seated in a recliner chair next to his/her bed prior to lunch. During an interview at the time, the Resident said he/she was happy to be up and out of bed but was starting to get a sore on his/her buttocks again. Resident #26 said the facility staff applied a cream to his/her buttocks early that morning and that he/she was scheduled to see the Wound Nurse. During an interview on 11/6/24 at 1:43 P.M., Nurse #5 said she provided CNA #9 Zinc Oxide (medicated cream to treat or prevent skin irritation) ointment, to be applied to Resident #26's painful buttocks. Nurse #5 said she had not assessed the Resident's buttocks yet today. The surveyor and Nurse #5 reviewed the current Physician's orders for Resident #26, and Nurse #5 said there were currently no treatment orders for the Resident's buttock areas. Nurse #5 said the Resident had two open areas on his/her buttocks that were identified on 10/23/24 (14 days prior) and she thought the current areas the Resident had were the same areas that were previously identified. Nurse #5 said when an alteration in a Resident's skin integrity was identified, the Nurse would assess the area, notify UM #1, complete an incident report and notify the Physician by utilizing the Provider Communication Book. The surveyor and Nurse #5 reviewed the Provider Communication Book and were unable to locate where there was notification about the Resident's identified buttocks areas on 11/5/24. Further review of the Provider Communication Book indicated an entry from Nurse #5, dated 10/23/24, notifying the Provider of two open areas to Resident #26's buttocks, that Zinc Oxide ointment had been applied, and a request for a treatment to the areas. An additional notation next to the written communication from Nurse #5 indicated a handwritten ? Triad (cream applied to promote wound healing and protect skin). Nurse #5 said she thought this notation for Triad was a response from the Provider and that she was not aware that this notation was made. Nurse #5 further said that if there was a Provider response in the Provider Communication Book, then the Nurse should have clarified with the Physician about the response and should have transcribed treatment orders if that was what was intended. Nurse #5 said she should not have provided CNA #9 with the Zinc Oxide ointment to apply to Resident #26 because it was not ordered by the Physician for use. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record failed to indicate an assessment was completed for the two open areas identified on 10/23/24 or additional interventions were implemented. On 11/6/24 at 2:45 P.M., the surveyor observed Resident #26's buttocks with Nurse #5 and observed the following: -A layer of white cream was covering the Resident's left and right buttocks. -The right buttocks had two small circular superficial (on the surface or shallow) areas about 1.0 cm in diameter, due to the white cream covering the buttocks, the wound beds (open areas) were unable to be thoroughly visualized by the surveyor. -Redness was observed on both the right and left buttocks. During an interview immediately following the observation, Nurse #5 said the Resident's left buttocks was impaired, but it was difficult to assess as the areas were covered in a thick white cream. Nurse #5 further said she thought the Resident's current areas were in the same spots as the areas identified on 10/23/24 but was unable to verify this. The surveyor observed the Resident's air mattress was set at 260 pounds and Nurse #5 also said the Resident's air mattress was set to 260 pounds and that air mattresses were supposed to be set according to the Resident's weight. The surveyor and Nurse #5 reviewed the current weight for Resident #26 which was 174 pounds on 10/15/24. Nurse #5 said that the current setting on the Resident's air mattress did not match what the Resident's current weight was and if the air mattress was set too high (increased pressure/firmness), that would put the Resident at a higher risk for skin breakdown. Nurse #5 said she did not feel comfortable adjusting Resident #26's air mattress because she had never been taught how to do that (adjust the settings). During an interview on 11/6/24 at 3:37 P.M., UM #2, who was identified as the Wound Nurse, said she had not been notified of any new alterations in skin or areas of concerns for Resident #26 over the past month. UM #2 said if an alteration in a Resident's skin is identified, the Nurse completes a notification form which is put in her mailbox. UM #2 said she completes weekly wound rounds on Tuesdays and had not been notified therefore was not following Resident #26. UM #2 said the Nurse who identified the Resident's areas should have followed the facility's wound protocol, completed an assessment of the wound including the measurements and description, and notified the Physician to obtain treatment orders. UM #2 said the Provider should have been contacted immediately to obtain an appropriate treatment order for Resident #26 and the Nurse should not have written the request in the Provider Communication Book. UM #2 said Zinc Oxide ointment was a prescription medication, and only the Licensed Nurses should be applying the medication, and it should only be applied when there was a Physician's order. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/6/24 at 3:58 P.M., UM #1 said Resident #26 had re-occurring moisture associated skin damage on the buttocks and would be followed by the Wound Nurse until resolved. UM #1 said when the Resident's areas were identified, an incident report should have been promptly completed, the Physician called to notify of the areas and obtain treatment orders, and the facility Wound Nurse also notified so that the Resident would be assessed on weekly wound rounds. UM #1 said the Nurses should be checking in the Provider Communication Book to review any new orders. The surveyor and UM #1 reviewed Resident #26's current Physician orders, and UM #1 said there were no current treatments in place for Resident #26's buttocks areas and orders would need to be obtained prior to applying any treatments. UM #1 said that a Licensed Nurse should be assessing the Resident's skin condition when applying Physician ordered treatments, not the CNAs. UM #1 said once a wound was identified, it would be monitored daily on the Resident's treatment record, and the Nurse would complete assessments which include any pain, condition/status of the wound, the skin condition surrounding the wound, the condition of the wound bed, drainage, odor and if the area was worsening to call the Physician. UM #1 said the Resident wounds were to be measured weekly. UM #1 said the Resident's air mattress should be set to the Resident's weight and comfort. UM #1 said the Resident's weight obtained today was about 190 pounds, so the air mattress should be set at about 200 pounds but was set to 260 pounds. UM #1 said if an air mattress was set higher than it should be, it could affect the Resident's skin negatively and cause increased pressure because the air mattress was firmer. UM #1 said the air mattresses were monitored every shift by the Nurses to ensure that they are set appropriately. UM #1 said if a Resident on an air mattress developed a wound or complained of pain, the Nurse should assess the air mattress setting to determine if it was an appropriate setting based on the Resident's weight and comfort. UM #1 said Resident #26 was alert, oriented and able to communicate his/her needs. 2. Resident #53 was admitted to the facility in December 2022 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes obstructed airflow from the lungs that leads to respiratory problems including difficulty breathing, shortness of breath and wheezing), Hypoxemia (low levels of oxygen in the blood), and Non-ST Elevation Myocardial Infarction (NSTEMI: type of heart attack that occurs when an artery is partially blocked, reducing blood flow and oxygen to the heart muscle). Review of the Activities of Daily Living Care Plan, initiated 12/22/22, indicated Resident #53 had an alteration in his/her ability to provide self care and included the following interventions: -Check skin during care and report any abnormalities/issues to nursing/Medical Doctor (MD), initiated 12/22/22 -Assistance of one staff with bathing, dressing, grooming, initiated 1/16/23 Review of the Cardiac Care Plan, initiated 12/22/22, included the following intervention: -Administer oxygen as ordered by the MD . Monitor O2 (oxygen) saturation (SpO2 - measure of oxygen in the blood as a percentage of the maximum oxygen the blood could carry) as ordered and as needed (PRN), initiated 12/22/22 Review of the Minimum Data Set (MDS) Assessment, dated 9/5/24, indicated: -Resident #53 had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of a total possible score of 15. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-required moderate assistance from staff with bathing, grooming and dressing. -was at risk for pressure ulcers. -utilized oxygen therapy during the reference period. Review of Resident #53's Nursing Progress Notes indicated the Resident was using 2 LPM (LPM: amount of oxygen administered per minute) oxygen via nasal cannula on the following dates: -9/11/24 at 10:37 P.M. -9/12/24 at 2:45 P.M., and 9:18 P.M. -10/2/24 at 10:50 P.M. -10/6/24 at 9:48 P.M. -10/7/24 at 10:58 P.M. -10/8/24 at 1:49 P.M., and 3:27 P.M. -10/13/24 at 2:02 P.M. -10/23/24 at 12:37 A.M. Review of the Resident's clinical record indicated the following: -he/she was transferred to the hospital on 9/7/24 for increased fevers and generalized malaise and returned to the facility on [DATE]. -a skin check completed on 9/11/24 (upon return from the hospital) indicated he/she had bruises on both arms and a scratch on the left arm. -weekly skin checks completed for September 2024, October 2024, and November 2024 indicated no new areas of concern. Review of November 2024 Physician's orders indicated: -Oxygen as needed (PRN) to keep pulse oximetry (amount of oxygen in the blood) above 93 percent (%) as needed for shortness of breath, initiated 11/29/23 -Replace oxygen tubing every 7 days, weekly on Wednesdays, initiated 10/23/24 -Weekly Skin Screening for new areas of concern during the day shift on Tuesdays. Complete incident report for any new areas of concern, initiated 2/16/24 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/3/24 at 9:40 A.M., the surveyor observed Resident #53 lying in bed with oxygen being administered via nasal cannula from an oxygen concentrator which was set at 2 LPM and included a humidifier bottle. The surveyor observed a reddened open area at the base of the Resident's nose (below the nostrils) underneath the nasal cannula tubing/prongs. During an interview at the time, Resident #53 said that he/she had been having pain to the open area and he/she did not think the staff were aware of the open area. The surveyor observed Resident #53 utilizing 2 LPM humidified oxygen and visible open area at the base of the nostrils on the following: -11/4/24 at 9:56 A.M., and 12:53 P.M. -11/5/24 at 7:47 A.M. During an interview on 11/4/24 at 2:59 P.M., Certified Nurses Aide (CNA) #8 said she had given Resident #53 a shower earlier in the day. CNA #8 said she had removed the Resident's oxygen/ nasal cannula during the shower, and re-applied the oxygen, and had not noticed anything abnormal about the Resident's skin condition. CNA #8 further said if a new skin condition had been noticed, a Stop and Watch Form would be filled out, in addition to alerting the Nurse. On 11/5/24 at 7:47 A.M., the surveyor observed Resident #53 with humidified oxygen being administered via nasal cannula at 2 LPM. The Resident said his/her nasal area was sore and lifted the nasal cannula from under the nose to show the surveyor a round, open wound, approximately 1 centimeter (cm) which was red/yellow in color. The surveyor observed scabbed tissue surrounding the wound and that the nasal cannula tubing/prongs was in direct contact with the Resident's nasal wound. On 11/5/24 at 7:54 A.M., the surveyor and CNA #8 observed the area where Resident #53 said he/she was experiencing pain when the Resident lifted the nasal cannula from under his/her nostrils to show the area. CNA #8 said she did not see the area prior to now. During an interview on 11/5/24 at 7:56 A.M., Unit Manager (UM) #1 said the open area under Resident #53's nose was not identified from staff prior to today. UM #1 said she assessed the Resident's open area and thought it was irritated and caused from the use of his/her oxygen nasal cannula tubing. The surveyor relayed the previous observations of the Resident's nostril area to UM #1. UM #1 said if a Resident was on oxygen therapy, the nursing staff should be assessing the oxygen flow rate, the tubing, and the condition of the Resident's skin including the ears and nostrils daily. During an interview on 11/5/24 at 9:13 A.M., Nurse #8 said she assessed Resident #53's nose that morning after being alerted by CNA #8, and described the Resident's skin underneath the nostrils to be an open area with a wound yellow/red base and scabbed areas below the open area. Nurse #8 said the area was likely a result of the oxygen nasal cannula tubing rubbing against the Resident's skin. Nurse #8 said she did not see a progress note or treatment orders written relative to the Resident's open area, so she was going to alert the Nurse Practitioner (NP)/MD and the facility Wound Nurse for an evaluation. Nurse #8 said if a Resident utilized oxygen, the Nurse should be assessing the Resident every shift to ensure the oxygen nasal cannula tubing was an appropriate fit in order to avoid rubbing, pressure and skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Incident/ Accident Report Form, dated 11/5/24, and completed by UM #1, indicated that Resident #53 was on continuous oxygen and that his/her nostrils were red, chaffed and have opened. During an interview on 11/5/24 at 9:36 A.M., UM #2 (Wound Nurse) said she assessed the Resident's skin and the nasal wound area was a Stage 2 Pressure Ulcer (open wound with partial thickness skin loss) which resulted from the oxygen nasal cannula tubing.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 42741 Based on observation, interview, and record review, the facility failed to offer assistance in scheduling an appointment to ensure good foot health was maintained for one Resident (#78) out of a total sample of 25 residents. Specifically, for Resident #78, the facility failed to offer podiatry services to maintain good foot health when the Resident was at risk for decline in his/her foot health related to a history of Peripheral Vascular Disease (PVD - a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and below the knee amputation (surgically cutting off a limb). Findings include: Review of the facility policy titled Consulting services, Podiatry/Dental/Optometry/Audiology, approved date 12/22/16, indicated the following: -Resident/Resident Representative are provided information about consulting services upon admission and at any time when need arrives. Resident #78 was admitted to the facility in September 2024, and had diagnoses of PVD, Sepsis (a life-threatening medical emergency that occurs when an infection triggers the body's immune system to damage its own organs and tissues), Osteomyelitis (inflammation of bone or bone marrow due to infection), and had a recent right below knee amputation. During an observation and interview on 11/3/24, at 9:51 A.M., the surveyor observed Resident #78 lying in bed. Resident #78 said he/she was worried about a reddened area on his/her lower left leg. The surveyor observed the Resident's lower left leg which had a small reddened area. The surveyor also observed the Resident's left foot to be dry on the sole, with large patches of skin flaking off, his/her toenails were very long extending beyond the tip of the toe, hardened, and dirty under the nails. Resident #78 said he/she had not been offered podiatry services since his/her admission to the facility. Resident #78 said he/she was concerned about maintaining good foot health because he/she did not want to have his/her left leg amputated like his/her right leg had been. Review of Resident #78's medical record indicated no documentation the Resident had been offered podiatry services at the time of his/her admission. During an observation and interview on 11/5/24 at 10:02 A.M., the surveyor and Nurse #4 observed Resident #78 was lying in bed. Nurse #4 observed Resident #78's foot and said Resident #78's toenails were long and hardened and needed to be trimmed. Nurse #4 said for Residents with a history of PVD, good foot health was important and Resident #78 should have been offered podiatry services. During an interview on 11/5/24 at 12:46 P.M., the Director of Admissions said Resident #78 should have been offered podiatry services at the time of his/her admission to the facility and she could find no documented evidence that podiatry services had been offered to him/her.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interview, record review and policy review, the facility failed to ensure that one Resident (#53) out of a total sample of 25 residents, was free from potential accidental hazards when the Resident was allowed to store an Albuterol Sulfate inhaler (aerosolized bronchodilator medication) on his/her bedside table and use the inhaler without assessment or supervision. Specifically, for Resident #53, the facility failed to ensure: -that a prescribed Albuterol Sulfate inhaler was kept in a secured medication cart and not at the Resident's bedside. -the Resident was assessed to self-administer the medication, and was aware of precautions like an increased heart rate and/or difficulty breathing that could result from the medication use or overuse. -that the inhaler was not easily accessible to the Resident and potentially other residents when it was left on Resident #53's bedside table to be administered without Physician approval and without Licensed Staff supervision. Findings include: Review of the facility policy titled Administration Procedures for All Medications, dated 9/20/13, indicated medications would be administered in a safe and effective manner. The policy also included: -check the Medication Administration Record (MAR) for the order Review of the facility policy titled Self Administration of Medications, revised 6/30/21, indicated a resident would be assessed for cognitive, physical, and visual ability to self-administer medications. The policy also included: -if the resident wishes to self administer, the Nurse, the Interdisciplinary Team (IDT) will determine the resident's ability to safely self-administer -the Self-Administration of Medications Informed Consent and Assessment Tool will be completed -ensure a Physician's order is in place -provide safe, locked storage if keeping medications at bedside -the Medication Nurse will monitor the resident's compliance and record on the MAR (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53 was admitted to the facility in December 2022, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD: a chronic lung disease that causes obstructed airflow from the lungs and leads to respiratory problems including difficulty breathing, shortness of breath and wheezing). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #53 had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 5 out of 15. On 11/3/24 at 9:40 A.M., the surveyor observed Resident #53 lying in bed and an Albuterol inhaler was observed on a table positioned next to the Resident's bed and was easily accessible to him/her. During an interview at the time, Resident #53 said he/she self administered the Albuterol medication whenever he/she needed it. On 11/4/24 at 12:53 P.M., the surveyor observed Resident #53 seated on the edge of the bed eating lunch. The surveyor observed that the Albuterol inhaler remained on the Resident's bedside table. On 11/5/24 at 7:47 A.M., the surveyor observed the Resident lying in bed and the Albuterol inhaler remained on the his/her bedside table. On 11/5/24 at 7:54 A.M., the surveyor and Certified Nurses Aide (CNA) #8 observed Resident #53 in his/her bedroom. During an interview at the time, CNA #8 said she was unsure if the Resident was able to have the Albuterol inhaler accessible at his/her bedside. Review of Resident #53's November 2024 Physician's orders indicated the following: -Health Care Proxy (HCP: the person chosen as the healthcare decision maker when the individual is unable to do so for themself) was invoked, initiated 1/16/23 -Albuterol Sulfate 0.09 milligram (mg) per 1 actuation, 2 puffs orally as needed every 4 hours for COPD, initiated 5/27/24 Review of the November 2024 MAR indicated no documented evidence that Resident #53 was administered the Albuterol inhaler nor was there documented evidence in the clinical record that the Resident was able to self- administer the Albuterol inhaler. During an interview on 11/5/24 at 7:56 A.M., Unit Manager (UM) #1 said she did not think Resident #53 had been evaluated for self administration of the Albuterol medication. UM #1 further said leaving medication unattended at the Resident's bedside could be dangerous because the Resident could be administering the medication incorrectly or another resident on the unit could wander into the Resident's room and use the inhaler. UM #1 said if the Resident was assessed to be able to self-administer the Albuterol inhaler, it would need to be stored in a secure place where other residents could not have access to it. UM #1 said it was unclear how often Resident #53 had been taking the Albuterol medication and because he/she had memory impairment, it could put the Resident at risk for self-harm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/24 at 9:13 A.M., the surveyor and Nurse #8 observed Resident #53 in his/her room. Resident #53 was observed lying in bed and the Albuterol inhaler remained on the bedside table. When the surveyor asked about the inhaler, Nurse #8 removed the Albuterol inhaler from the Resident's bedside table and said Resident #53 should not have the inhaler accessible to him/her because he/she would be unable to self-administer the medication safely.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42761 Based on observation, record review, and interview, the facility failed to provide appropriate treatment and services relative to an indwelling urinary catheter, for one Resident (#2) out of a total sample of 25 residents, which increased the Resident's risk for indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body). complications and resulted in a delay in treatment. Specifically, facility staff failed to: -Follow hospital discharge instructions for Resident #2 to attend a scheduled appointment with the Urologist. -Consult the Physician when Resident #2 experienced urinary leakage (complication that can occur when a urinary catheter becomes dislodged or obstructed) outside of his/her indwelling urinary catheter system when the Resident's plan of care did not contain specific instructions to manage indwelling urinary catheter leakage. -Provide timely treatment to correct indwelling urinary catheter complications when the Resident's indwelling urinary catheter was leaking and was not replaced timely by facility staff. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidelines for Proper Techniques for Urinary Catheter Maintenance, reviewed at https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html, indicated the following: -Maintain a closed drainage system. -If . leakage occurs, replace the catheter and collecting system . -Maintain unobstructed urine flow. - . it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. -If obstruction is anticipated, closed continuous irrigation is suggested to prevent obstruction. Review of Resident #2's Hospital Discharge Summary, dated 9/1/24, indicated the following: -The Resident's discharge diagnoses included Dementia and Chronic Indwelling Foley Catheter. -The Resident was to be discharged from the hospital to a skilled nursing facility (SNF). -The Resident was scheduled for a follow-up appointment with the Urologist on 9/4/24 at 1:45 P.M. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was admitted to the facility in September 2024, with diagnoses including Urinary Retention (a condition where the bladder does not empty all the way, or at all), Obstructive Uropathy (blockage in the urinary system) and Chronic Foley (type of indwelling urinary catheter) Catheter. Review of Resident #2's clinical record indicated the following active Physician orders: -Provide Foley catheter care, dated 9/1/24. -Foley privacy bag in place for bedside Foley drainage, dated 9/1/24. -Foley catheter output every shift, dated 9/1/24. -May change Foley catheter PRN (as needed) for occlusion or leakage. Change urinary catheter and drainage bag as a complete system. -Foley catheter continuous/site care/privacy bag. Site care QS (every shift). Privacy bag in place for bedside Foley drainage, dated 9/1/24. Further review of the Physician orders indicated a space to enter the Foley catheter size and retention bulb (or retention balloon - a tiny balloon at the end of the indwelling urinary catheter that is inflated with water to prevent the indwelling urinary catheter from sliding out of the body) size, but both the Foley catheter size and retention bulb size spaces were left bank. Review of Resident #2's Urinary Catheter Care Plan, initiated 9/2/24, indicated: -Change catheter if closed system is interrupted and as needed to maintain patency (degree of openness to allow flow of urine). -Notify MD (Medical Doctor: Physician) of suspected catheter complications, as needed. -Refer to Urologist as needed . Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 9/4/24, indicated the following: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points. -The Resident had an indwelling urinary catheter. -The Resident was dependent on staff for toilet hygiene. Review of Resident #2's clinical record did not indicate any evidence the Resident attended his/her scheduled Urology appointment on 9/4/24. Review of Resident #2's Nursing Progress Note, completed by Nurse #5 and dated 10/20/24 at 2:20 P.M., indicated the following: -The Resident was observed to have urine in his/her incontinence brief. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Urine in the incontinence brief was abnormal since the Resident had a Foley catheter. -There were no Physician orders for what type of Foley catheter the Resident had or needed if the catheter needed to be replaced. -Will ask supervisor for assistance on what to do next. Review of Resident #2's Nursing Progress Note, completed by Nurse #5 and dated 10/20/24 at 2:45 P.M., indicated the following: -The Weekend Supervisor came to the Unit to observe Resident #2's Foley catheter. -The Weekend Supervisor said the Foley catheter looked fine and to enter a note into the Physician Communication Book about the Resident's catheter leaking for the Physician to review the next day. -There were 200 milliliters (mL) of urine in the Foley catheter drainage bag as well as urine in the Resident's incontinence brief that same day. Review of Resident #2's Nursing Progress Note, written by Nurse #10 and dated 10/21/24 at 6:17 A.M., indicated the following: -A Certified Nurses Aide (CNA) alerted Nurse #10 to lack of urine in the Resident's Foley bag. -The Resident's Foley catheter was still leaking, and the Resident's incontinence brief was full of urine. -A note was left in the Physician Communication Book. -The Resident appeared to have discomfort in his/her genital area. Review of Resident #2's Nursing Progress Note, written by Nurse #2 and dated 10/21/24 at 8:47 A.M., indicated the Resident's Foley catheter was not draining. Further review of the Nursing Progress Note indicated Nurse #2 contacted the Physician and obtained instructions to flush the Foley catheter and to replace the Foley catheter if the catheter continued with no flow after flushing. Specific instructions were indicated in the Nursing Progress Note as follows: -Deflate the catheter balloon, advance the catheter, then reinflate the balloon. -Flush the catheter with 60 mL of normal saline (NS: sterile fluid solution). -Change the catheter with a size 16 French (Fr: unit corresponding to the outer circumference of a catheter) and 30 mL balloon if the catheter continued with no flow after flushing. Review of Resident #2's Nursing Progress Note, written by Nurse #2 and dated 10/21/24 at 12:04 P.M., indicated the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident had roughly 200 mL of tea colored urine in his/her Foley catheter bag prior to Nurse #2 flushing the Foley catheter. -There was urine in the Resident's incontinence brief. -Nurse #2 changed the Resident's Foley catheter with a 16 Fr/30 mL balloon. -When the new Foley catheter was advanced, some urine leakage was observed. -Nurse #2 then advanced the Foley catheter further, got yellow urine return through the catheter with some sediment (particles in urine, visible to the naked eye, that can be a sign of various medical conditions including infection, kidney problems, and dehydration) and minor clotting (blood). On 11/6/24 at 8:12 A.M., the surveyor observed Resident #2 lying in bed in his/her room. The surveyor observed clear catheter tubing, extending out from under the bed covers, that connected to a urinary drainage bag. The surveyor observed that the tubing was draining clear light yellow urine. During an interview on 11/6/24 at 11:15 A.M., Nurse #5 said that if a Resident's catheter leaked, the Nurse would need to flush the catheter according to the Physician's order and that if flushing the catheter did not correct the leaking, then the Nurse would need to replace the catheter with the catheter type and size ordered by the Physician. Nurse #5 said when she observed Resident #2's urinary catheter leaking on 10/20/24, she reviewed the Resident's Physician orders, but there were no orders in place to flush the urinary catheter and there were no orders with what size urinary catheter to replace the Resident's catheter with. Nurse #5 said there were no Physicians in the facility on the weekends, so she wrote a note in the Physician Communication Book relative to the Resident's catheter leaking. Nurse #5 said that she could not do anything about the Resident's urinary catheter leaking because there were no orders in place. During an interview on 11/6/24 at 11:20 A.M., Nurse #2 said she observed the Resident with urine leakage around his/her catheter on 10/21/24. Nurse #2 said when she observed the leakage, she reviewed the Resident's Physician orders and there were no orders to flush the catheter and no order for the size of the replacement catheter. Nurse #2 said she then contacted the on-call Physician regarding Resident #2's catheter leaking because 10/21/24 occurred on a weekend. Nurse #2 said there was always a Physician on-call outside of normal weekday hours and on the weekends. Nurse #2 said she obtained orders from the on-call Physician to flush the catheter and to replace the catheter with a size 16 Fr with a 30 mL balloon if flushing the catheter did not correct the problem of urine leakage. Nurse #2 said she flushed Resident #2's Foley catheter and it continued to leak, so she replaced the catheter, per the order she obtained from the Physician. Nurse #2 said that Physician orders should have been obtained for Resident #2 relative to management of indwelling urinary catheter complications when the Resident was admitted to the facility in September 2024 and that the Resident should not have had to wait until 10/21/24 to have his/her indwelling urinary catheter replaced after it began leaking on 10/20/24. Nurse #2 said that she could not answer whether Resident #2 had been seen by a Urologist since being admitted to the facility. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 12:51 P.M., the Director of Nursing (DON) said that the facility has Physician coverage 24-hours per day, every day of the week and that if a Physician is not in the facility, one can always be contacted by phone. The DON said that Residents admitted to the facility with indwelling urinary catheters should have Physician orders with specific instructions to care for catheter associated complications, including urinary leakage, at the time they are admitted to the facility. The DON said that orders to care for urinary catheter complications should have been obtained for Resident #2 when the Resident was admitted to the facility in September 2024. The DON further said Nurse #5 should have contacted the Physician on 10/20/24 when she observed that Resident #2's Foley catheter was leaking and Resident #2's Physician orders did not indicate the process for what to do if the Resident experienced urinary catheter complications, including urinary leakage. The DON said that Nurse #5 should have called the on-call Physician and obtained instructions to replace Resident #2's urinary catheter when she observed urine leaking outside of the Resident's catheter on 10/20/24 and that the Resident should not have had to wait until the following day for orders to be obtained from the Physician by Nurse #5 so that his/her Foley catheter could be changed. The DON said that she was not sure whether Resident #2 attended his/her scheduled appointment with the Urologist on 9/4/24. During a follow-up interview on 11/6/24 at 3:40 P.M., the DON said that she did not locate any evidence in Resident #2's clinical record that the Resident attended his/her scheduled Urology appointment on 9/4/24 and that a facility staff member was in the process of contacting the Urology office to inquire whether the Resident attended the appointment. No evidence was provided to the survey team relative to whether Resident #2 attended his/her scheduled Urology appointment on 9/4/24 prior to the end of the survey period. Please refer to F726 and F880.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42741 Based on interview, and record review, the facility failed to ensure recommendations made by the facility Dietitian were followed for one Resident (#104), out of a total sample of 25 residents, who experienced a significant weight loss and was at risk for further decline. Specifically, for Resident #104, the facility failed to ensure that weekly weights were obtained when recommended by the Dietitian after the Resident experienced a significant weight loss of 13.44% in five months. Findings include: Review of the facility policy titled Nutrition Management, revised 9/30/24, indicated the following: -Review dietitian's recommendations. -Obtain orders per recommendations. -If Medical Doctor (MD) does not want to follow recommendations, document explanation in nursing note. Resident #104 was admitted to the facility in January 2024, with diagnoses of Type 2 Diabetes (DM II - condition in which the body does not produce enough insulin hormone and has trouble controlling blood sugar levels), Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), muscle weakness, Dysphagia (difficulty swallowing), Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment, weight loss, decreased appetite or poor nutrition and inactivity), and muscle wasting and atrophy (deterioration of the muscles). Review of Resident #104's weights indicated the following: -4/8/24: weight - 131 pounds (lbs.) -10/1/24: weight - 113.40 lbs. (13.44% weight loss in five months). Review of the Significant Weight Change Report, dated 10/14/24, indicated the following: -Resident #104 had a significant weight loss of 13.44% and the Dietitian requested the Resident be reweighed. Review of the Dietitian's email correspondence with Unit Manager (UM) #2, dated 10/19/24, indicated the following request: -Resident #104's last weight was obtained on 10/1/24 and was 113 lbs. which was a significant weight loss from his/her previous weight of 131 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Requested a reweigh to clarify current weight. Review of the Significant Weight Change Report, dated 10/21/24, indicated the following: -Resident #104 had a significant weight loss of 13.44% and the Dietitian requested a reweigh. Review of the Dietitian Progress Note, dated 10/24/24, indicated the following: -Resident #104 had a significant loss in weight and met the criteria for malnutrition (lack of nutrients in the body). -Request weekly weights at this time. Review of the Dietitian Recommendation Sheet for Resident #104, dated 10/24/24, indicated the following: -Need current weight and recommend weekly weights at this time. -Dietitian requested a current weight and/or clarification about the significant weight loss. Review of the Dietitian's email correspondence with UM #2 and the Director of Nursing (DON), dated 10/28/24, indicated the following request: -Resident #104 needs to be weighed as he/she had lost a significant amount of weight. -Resident #104 had last been weighed on 10/1/24. -Reweigh was needed to verify weight loss. Review of the November 2024 Physician's orders indicated the following order: -Obtain weight day shift every thirty days with a start date of 10/31/24. Review of the October 2024 Medication Administration Record (MAR) indicated no documentation that a weight had been acquired on 10/31/24 as ordered and no additional documentation to explain why a weight was not acquired. During an interview on 11/5/24 at 1:30 P.M., the Dietitian said she had been asking for Resident #104 to be re-weighed weekly since it was identified Resident #104 had a significant weight loss in October 2024 and reweigh had not been done as she had recommended. The Dietitian said there was no documentation to show why the Resident had not been weighed when requested the Resident be reweighed on 10/14/24, 10/19/24, 10/21/24, 10/24/24, and 10/28/24. The Dietitian said her expectation would be once she makes a recommendation for a reweigh staff would obtain the Resident's weight within a couple of days or provide documentation to her if the Resident refused to be weighted within a couple days of the Dietitian recommendation being made. The Dietitian said she had been waiting on Resident #104's updated, current weight for a couple of weeks. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 2:09 P.M., UM #2 said she had been unable to check her email from the Dietitian for the last couple of weeks because she had to work the medication cart as the facility had Nurses call out. UM #2 said when she is pulled from her Unit Manager position to work on a medication cart there is no one who covers the tasks that need to be completed by the Unit Manager such as reviewing the Dietitian's emails. UM #2 said when the Dietitian makes a recommendation it should be implemented shortly after the Dietitian makes the recommendation. UM #2 said for Resident #104 the recommendation for weekly weights had not been implemented as of 11/5/24.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 42761 Based on observation, interview, and record review, the facility failed to ensure correct use of bed rails (side rails: adjustable position, rigid bars that attach to the sides of a bed, ranging in sizes from full to one-half, one-quarter, or one-eighth lengths) for one Resident (#2) out of a total sample 25 residents. Specifically, facility failed to provide quarter size bed rails for Resident #2, as ordered by the Physician, when facility staff positioned bed rails for Resident #2 in the upward half-rail position at the middle of the bed bilaterally, increasing the Resident's risk for limited mobility and injury. Findings include: Review of the facility's policy titled Side Rails - Assessment and Use of, dated 8/2005 and revised 10/17/17, indicated the following: -The facility provides an optimum safe sleeping environment for the resident. -Individual resident needs for side rails were considered. -Side rails may be an enabler, a restraint, or both. -Use of side rails requires an assessment of the resident's mobility and cognitive functioning to determine the category of use and determine need. Resident #2 was admitted to the facility in September 2024 with diagnoses including Cerebral Palsy (a group of conditions that affect movement and posture caused by brain damage to the developing brain before birth), Wound of Foot, and Memory Deficit. Review of Resident #2's Nursing Admission Assessment, dated 9/1/24, indicated the following: -The Resident was cognitively impaired with poor decision skills. -No physical restraints were in use. -The Resident required or requested side rails. -The Resident was able to move in bed using the side rail to enable turning and minor position changes. -The Resident used the side rail for balance stability when getting in or out of bed or for coming to a sitting position in bed or at the bedside. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident used the side rail to determine bed edge/mattress edge parameters due to vision or other sensory deficits. -The use of side rails were appropriate for the Resident. -The use of the side rails did not prevent ingress/egress ([entering]/egress [exiting]). -The side rails were not considered a restraint for the Resident. -The use of right and left side quarter upper rails were appropriate for Resident #2. Review of Resident #2's Physician orders, dated 9/1/24, indicated: 1/4 (one quarter) side rail on both sides of bed. Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 9/4/24, indicated the following: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points. -The Resident had limitations in functional range of motion. -The Resident required partial/moderate assistance (helper does less than half the effort) to roll left/right. -The Resident required substantial/maximal assistance (helper does more than half the effort) to transition from lying to sitting on the side of the bed. On 11/4/24 at 8:25 A.M., surveyor #1 observed the following: -Resident #2 was lying in his/her bed. -bilateral side rails were in the upward, half-rail position, along the middle of the bed. On 11/6/24 at 8:12 A.M., surveyor #3 observed the following: -Resident #2 was lying in his/her bed. -bilateral side rails were in the upward, half-rail position, placement in the middle of the bed. During an interview on 11/6/24 at 8:32 A.M., between surveyor #3 and Certified Nurses Aide (CNA) #7, CNA #7 said she thought the side rails were positioned in the upward half-rail position in the middle of Resident #2's bed because the Resident had made attempts to get up and the side rails helped to keep the Resident in bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 9:42 A.M., between surveyor #3 and CNA #6, CNA #6 said for as long as the Resident has resided on the Unit, there have been bilateral side rails in the upward half-rail position alongside the Resident when he/she was in bed. CNA #6 said that the Resident used the side rails to roll side to side in the bed and CNA #6 thought the side rails helped the Resident identify where the edges of the bed were and provided the Resident a sense of security. During an observation and interview on 11/6/24 at 10:06 A.M., surveyor #3 and Unit Manager (UM) #1 observed the Resident's bed and the bilateral side rails were in the upward, half-rail position, in the middle of the bed. UM #1 said that Resident #2's side rails were in the upward, half-rail position along the middle of the bed, that the Resident had been assessed for the use of side rails in the upward quarter-rail position to assist the Resident with positioning. UM #1 said that use of the side rails in the half-rail position along the middle of the bed had not been assessed for use with the Resident. UM #1 further said that the use of half rails along the middle of Resident #2's bed could potentially increase the Resident's risk for injury or restricted movement, and UM #1 would not know whether the Resident would actually be at risk for injury or restricted movement because use of the side rails in the upward position along the middle of the Resident's bed had not been assessed. During an interview on 11/6/24 at 3:45 P.M., between surveyor #3 and the Director of Nursing (DON), the DON said Resident #2 had not been assessed for the use of half rails on his/her bed and that the side rail assessment that had been completed for the Resident indicated the use of quarter side rails. The DON said that half rails in the upward position on Resident #2's bed was not how the use of the side rails were assessed to be used and not how the Physician ordered the side rails to be used for the Resident. The DON said if the Resident required use of side rails in a manner other than what was initially assessed, a re-assessment for side rails should have been completed for the Resident.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37400 Based on observation, interview and record review, the facility failed to ensure that one Unit (Homestead) out of three units observed, had sufficient staff members to meet the needs of the unit residents. Specifically, the facility failed to ensure: -sufficient staff were available to assist with Activity of Daily Living (ADL: basic skills needed in daily life and include eating, bathing, toileting and grooming/personal hygiene) for residents residing on the Homestead Unit. Findings include: During the initial pool process on 11/3/24, the following observations/interviews were obtained on the Homestead Unit: 1. On 11/3/24 at 11:36 A.M., a Resident (who requested to be anonymous) said sometimes when he/she rings the call bell to alert staff that he/she needed help, it could take hours for someone to assist him/her. The Resident said he/she required assistance from staff with toileting needs, that this did not occur on all shifts and the occurances vary. The Resident said it bothered him/her when the staff do not answer his/her request for assistance when ringing the call bell. 2. Resident #88 was admitted to the facility in August 2022 with diagnoses including Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and Parkinson's Disease (a movement disorder of the nervous system that worsens over time) with Dyskinesia (uncontrolled, involuntary movements of the face, arms or legs). Review of the Activities of Daily Living (ADL: basic skills needed in daily life and include eating, bathing, toileting and grooming/personal hygiene) Care Plan, initiated 8/25/22, indicated Resident #88 had decreased ability to perform ADLs due to decreased cognition and mobility. The care plan included the following intervention: -Assist to dependent of one staff for grooming (includes brushing teeth, shaving/facial hair removal, hair and nail care), initiated 1/1/23 Review of the Minimum Data Set (MDS) Assessment, dated 8/1/24, indicated Resident #88: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 4 out of 15 -was dependent on staff for personal hygiene, including grooming tasks. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/3/24 at 9:29 A.M., Resident #88's Representative said the Resident required total assistance from staff with ADL care. The Resident Representative said he/she liked to be neatly dressed and without facial hair daily and it appeared that today, Resident #88 was not provided assistance with facial hair removal, and did not have his/her face washed because it looked like there was residue remaining on his/her eyes from sleep. The Resident Representative said the family visits often and have voiced concerns about the Resident's dentures not being cleaned regularly, and that face/head washing did not appear to have been completed by the staff. The Resident Representative said the Resident has very dry skin on his/her head and body, and did not think the staff were applying lotion as needed. The Resident Representative also said the Resident had lost weight and required assistance from staff with meals. The surveyor observed Resident #88 was dressed and seated in a specialized wheelchair, with facial hair observed on his/her cheeks, chin and upper lip. The surveyor observed Resident #88 with facial hair remaining on his/her cheeks, upper lip and chin on the following dates/times: -11/4/24 at 8:49 A.M., -11/4/24 at 2:13 P.M., and -11/5/24 at 9:01 A.M. During an interview on 11/5/24 at 9:17 A.M., Resident #88's Representative approached the surveyor and said the facility staff on the day shift (7:00 A.M. to 3:00 P.M.) were really good but there were not enough of the staff to care for the residents on the unit. The Resident Representative further said there did not seem to be enough time for the staff to provide the care that the residents needed. During an interview on 11/5/24 at 9:58 A.M. and 10:15 A.M., Certified Nurses Aide (CNA) #8 said she was familiar with Resident #88's care. CNA #8 said facial hair removal should be offered daily and that Resident #88 preferred to have no facial hair. CNA #8 said the Resident required total assistance from staff with all personal care including grooming/personal hygiene needs and did not refuse care. CNA #8 said she was able to partially remove the Resident's hair from under his/her chin but was unable to finish because the breakfast meal arrived and she had other residents to take care of so she did not have time to finish assisting Resident #88. 3. On 11/3/24 (Sunday) from 8:18 A.M. through 9:02 A.M., the surveyor observed the following during the breakfast meal pass on the Homestead Unit: -8:18 A.M.: Meal cart arrived to the unit and was positioned at the nursing station. Two Nurses were observed at the medication carts and no staff were observed to assist with passing the meal trays. -8:36 A.M.: (18 minutes after the meal cart arrived on the unit) one CNA began passing the breakfast trays in the Unit Dining room where 17 residents were observed seated at various tables. No other staff were observed to be assisting with meal pass at this itme. -8:45 A.M.: (27 minutes later) A second CNA began assisting with the breakfast meal pass. Serveral Residents were without their breakfast meal and one Resident was observed asking for his/her meal. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8:53 A.M.: (35 minutes later) Several other staff members began to assist with meal pass at this time. -9:02 A.M.: (44 minutes later) the Breakfast meal was served to all residents. On 11/4/24 from 8:15 A.M. through 9:17 A.M., the surveyor observed the following during the breakfast meal tray pass on the Homestead Unit: -Corporate Clinical Staff, the Unit Manager (UM), one CNA and Director of Social Services were observed to assist with the meal pass in the Unit Dining room. During the breakfast meal pass, one Resident asked the surveyor who all the new people on the unit were today assisting with the breakfast meal. During an interview on 11/5/24 at 12:14 P.M., Nurse #11, who was a regular facility staff said the Homestead Unit CNAs, the Unit Manager (UM) and the Activities staff typically assist with resident meal pass. Nurse #11 said the UM worked Monday through Friday and was often on-call during the weekends to cover shifts. Nurse #11 said that she had worked on a Dementia Special Care Unit (DSCU) previously, that there were many residents on the Homestead Unit with high acuity (intensity or severity of resident care needs) and thought there was not enough staff to assist with the care the residents needed. Nurse #11 said the Homestead Unit was supposed to have five CNAs on the 7:00 A.M. to 3:00 P.M. shift and several times when she works, they have four CNAs. Nurse #11 said the 3:00 P.M. to 11:00 P.M. shift should have four CNAs and frequently they have three CNAs. Nurse #11 said she recognized the concerns with the residents meal distributation and that there should be enough staff to assist with meal passing so that residents are served/assisted with the meals at the same time. Nurse #11 said the staff observed assisting with meal pass during the survey do not typically assist with the meal pass.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42761 Based on observation, interview, and record review, the facility failed to ensure all Licensed Nurses had appropriate competencies relative to indwelling urinary catheter care and services for one Resident (#2) out of a total sample of 25 residents. Specifically, facility failed to ensure that Nurse #5 was assessed for competency to care for residents with indwelling urinary catheters when: -The Facility Assessment indicated facility staff had been determined to be clinically competent in caring for residents with genitourinary conditions requiring indwelling catheters. -Resident #2 had an indwelling urinary catheter, experienced an indwelling urinary catheter complication of urinary leakage, and required intervention to correct the urinary catheter leakage. -Nurse #5 was responsible for providing care for Resident #2, assessed that the Resident had urinary catheter leakage, was unfamiliar with the urinary catheter placement and did not obtain Physician orders to address the urinary leakage resulting in delayed treatment and increasing the Resident's risk for further indwelling urinary catheter complications. Findings include: Review of the Facility Assessment Tool, dated 9/6/23 and updated 8/2/24, indicated the following: -The facility's admissions team offered beds to potential patients based on skills that the facility determined its staff to be clinically competent to care for. -Facility staff could care for individuals with genitourinary conditions. -Common genitourinary diagnoses included Obstructive Uropathy (blockage in the urinary system). -Services and care the facility offered, based on the needs of the residents, included indwelling urinary catheter care. Resident #2 was admitted to the facility in September 2024 with diagnoses including Obstructive Uropathy and Chronic Foley (type of indwelling urinary catheter) Catheter. Review of Resident #2's active Urinary Catheter Care Plan, initiated 9/2/24, indicated the following: -The Resident had an indwelling urinary catheter. -Change catheter if closed system is interrupted and as needed to maintain patency (degree of openness to allow urine flow). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notify the Physician of suspected catheter complications, as needed. Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 9/4/24, indicated the following: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points. -The Resident had an indwelling urinary catheter. Review of Resident #2's Nursing Progress Note, dated 10/20/24 and written by Nurse #5 at 2:20 P.M., indicated the Resident had urine in his/her incontinence brief that was abnormal since the Resident had a Foley catheter. The Resident's Foley catheter appeared to be leaking since the Foley catheter was not inserted through the Resident's urethra (tube that connects the urinary bladder for the removal of urine). Nurse #5 could find no Physician orders to indicate the type of Foley catheter the Resident had in place or what type of Foley catheter was needed if the catheter needed to be replaced. Review of Resident #2's Nursing Progress Note, dated 10/20/24 and written by Nurse #5 at 2:45 P.M., indicated the Nurse Supervisor observed the Resident's Foley catheter and said it looked okay to her. There were 200 milliliters (mLs) of urine in the catheter bag as well as urine in the Resident's incontinence brief. Review of Resident #2's Nursing Progress Note, written by Nurse #2 and dated 10/21/24 at 8:47 A.M., (one day after Nurse #5 initially assessed the Resident's urinary catheter) indicated the Resident's Foley catheter was not draining and Nurse #2 contacted the Physician and obtained instructions to flush the Foley catheter and to replace the Foley catheter if the catheter continued with no flow after flushing. Further Review of Resident #2's Nursing Progress Note, written by Nurse #2 and dated 10/21/24 at 12:04 P.M., indicated the Resident had roughly 200 mL of tea colored urine in his/her Foley catheter bag prior to Nurse #2 flushing the Foley catheter, there was urine in the Resident's incontinence brief and Nurse #2 changed the Resident's Foley catheter with a 16 Fr/30 mL balloon. During an interview on 11/6/24 at 11:15 A.M., Nurse #5 said when she observed Resident #2's urinary catheter leaking on 10/20/24, she was unable to identify the catheter size and reviewed the Resident's Physician orders, but there were no orders pertaining to the Resident's urinary catheter size or a replacement size. Nurse #5 also said that she had never seen a Foley catheter inserted through a Resident's urethra the way it was inserted for Resident #2, so she called the Weekend Supervisor (Nurse #12) to observe the Resident's catheter. Nurse #5 said she learned from Nurse #12 that the Resident's Foley catheter was inserted through the Resident's urethra, and that the placement looked abnormal due to a change in the Resident's anatomy related to chronic catheter use. Nurse #5 said there were no Physicians in the facility on the weekends, so she wrote a note in the Physician Communication Book pertaining to the Resident's catheter leaking and that she could not do anything about the urinary catheter leaking because there were no Physician's orders in place. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 12:02 P.M., Nurse #12 said she worked as the Weekend Supervisor on 10/20/24. Nurse #12 said that Nurse #5 contacted her on 10/20/24 and requested that she observe Resident #2's indwelling urinary catheter. Nurse #12 said when she observed the Resident's catheter, the catheter was positioned to the right of where normal insertion would be due to a split in the Resident's genital area. Nurse #12 said this often occurred with chronic indwelling urinary catheter use. Nurse #12 said she made the observation of the Resident with Nurse #5, and showed Nurse #5 how to identify the size of the urinary catheter. Nurse #12 said she instructed Nurse #5 to flush and/or change the Resident's catheter in accordance with the Physician's orders. Nurse #12 said if there were no orders in place, then Nurse #5 would have been required to call the on-call Physician to obtain instructions. Nurse #12 said that she was not sure whether Nurse #5 provided interventions to correct Resident #2's indwelling urinary catheter leaking because she did not hear anything back from Nurse #5 after they observed the Resident together, and she did not follow-up with Nurse #5. During an interview on 11/6/24 at 12:51 P.M., the Director of Nursing (DON) said that the facility has Physician coverage 24-hours per day, every day of the week and that if a Physician is not in the facility, one can always be contacted by phone. The DON said Nurse #5 should have contacted the Physician on 10/20/24 when she observed that Resident #2's Foley catheter was leaking and the Resident's Physician orders did not include the process for what to do if Resident #2 experienced urinary catheter complications, including urinary leakage. The DON said that Nurse #5 should have called the on-call Physician obtained instructions to replace Resident #2's urinary catheter when she observed urine leaking on 10/20/24 and that the Resident should not have to wait until the following day for orders to be obtained from the Physician so that his/her Foley catheter could be changed. During an interview on 11/6/24 at 12:57 P.M., the Staff Development Coordinator (SDC) said that indwelling urinary catheter competency was assessed with Nurses upon hire but was not completed on a routine basis. The SDC said that nursing staff who worked at the facility through their own company's staffing agency received the same orientation and competency assessments as the facility's direct hire nursing staff. The SDC said that Nurse #5 had been working at the facility through the facility's own company staffing agency since June 2024. The SDC also said that the Homestead Unit housed residents with indwelling urinary catheters infrequently, so competency assessments of Nurses working on the Homestead Unit were not assessed relative to indwelling catheter care unless she was made aware of a resident on the Homestead Unit with an indwelling urinary catheter. The SDC said she provided individual education to one Nurse when she became aware that interventions to address Resident #2's indwelling urinary catheter complications were not provided timely, but that she did not realize the complications were initially identified by Nurse #5. The SDC said she would locate Nurse #5's competency assessments and provide them to the surveyor for review. Review of Nurse #5's Licensed Nurse Competency Assessments provided by the facility did not indicate any evidence that Nurse #5 was assessed for competency relative to care and services for indwelling urinary catheters. During a follow-up interview on 11/6/24 at 1:25 P.M., the SDC said Competency Assessments had not been completed relative to indwelling urinary catheter care and services with Nurse #5. Please Refer to F880.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48206 Based on observation and interview, the facility failed to post nursing staff data daily, at the start of each shift, relative to licensed and unlicensed nursing staff directly responsible for resident care per shift. Specifically, the facility failed to post this data, in a prominent place readily accessible to residents and visitors, to include: a) total number and hours for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nurse Aides (CNAs), and b) resident census. Findings include: On 11/4/24 at 8:15 A.M., the surveyor observed the daily staffing report posted on the door of the front office next to the facility lobby. The daily staffing report posted failed to include staffing data including the facility census, the total number and hours for RNs and LPNs, and the total hours for CNAs, as required. The daily staffing report indicated the number of Licensed staff and number of unlicensed staff only. On 11/5/24 at 9:20 A.M., the surveyor observed the daily staffing report posted on the door of the front office next to the facility lobby. The daily staffing report failed to include staffing data including the facility census, the total number and hours for RNs and LPNs, and the total hours for CNAs, as required. The daily staffing report indicated the number of Licensed staff and number of unlicensed staff only. Review of the daily staffing reports provided by the facility for 10/26/24 - 11/3/24 did not include the facility census, the total number and hours for RNs and LPNs, and the total hours for CNAs, as required. The daily staffing reports only indicated the number of Licensed staff and number of Unlicensed staff only. During an interview on 11/5/24 at 11:58 A.M., the facility Scheduler said that she is responsible for updating the staff report and posting it daily. The surveyor reviewed the staffing reports, and the Scheduler indicated that the Licensed Nursing Staff information is combined with the number of RNs and LPNs and the Unlicensed Staff information is the number of CNAs. The Scheduler said that she was not familiar with the posting requirements and that the daily staffing report did not have the facility census or the total number of hours for RNs, LPNs, and CNAs.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 42761 Based on observation, record review and interview, the facility failed to ensure that one Resident (#419) was free from unnecessary drug administration. Specifically, facility failed to administer Oxycodone (highly addictive opioid medication used to treat moderate to severe pain) dosage and pain scale parameters as ordered by the Physician, in accordance with Resident #419's reported pain level, which resulted in the Resident receiving one excessive dose of Oxycodone and increased the Resident's risk for health complications. Findings include: Review of the facility's policy titled Administration Procedures for All Medications, dated 9/20/13, indicated the following: -The purpose was to administer all medications in a safe and effective manner. -Check the Medication Administration Record (MAR) for order. -Read the medication label three times . compare the label to the MAR. -Refer to the MAR for instruction details. Review of the Department of Justice/Drug Enforcement Administration Oxycodone Drug Fact Sheet reviewed at https://www.dea.gov/sites/default/files/2020-06/Oxycodone-2020_0.pdf, dated April 2020, indicated the following: -Oxycodone is a semi-synthetic narcotic analgesic . -Euphoria and feelings of relaxation are the most common effects of Oxycodone on the brain, which explains its high potential for abuse. -Effects of Oxycodone include pain relief, sedation, respiratory depression, constipation, papillary constriction, and cough suppression. -Extended or chronic use of Oxycodone containing acetaminophen may cause severe liver damage. -Overdose effects include extreme drowsiness, muscle weakness, confusion, cold and clammy skin, pinpoint pupils, shallow breathing, slow heart rate, fainting, coma, and possible death. Resident #419 was admitted to the facility in October 2024, with diagnoses including Chronic Pain Syndrome and Opioid Dependence. Review of Resident #419's Nurse Practitioner (NP) Progress Note, dated 11/1/24, indicated the following: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident had good judgment. -The Resident had normal mood and affect, was active and alert. -The Resident was oriented to time, place, and person. -The Resident's recent and remote memory were normal. On 11/4/24 at 1:15 P.M., surveyor #2 observed Resident #419 lying on his/her back, in bed. During an interview at the time, Resident #419 said that he/she had chronic pain, which was present prior to his/her admission to the facility. Resident #419 said the Nurses at the facility administered Oxycodone to him/her and that the Oxycodone was effective. Resident #419 said that he/she was unsure of, and had not kept track of the ordered dose and frequency for Oxycodone administration. Review of Resident #419's Pain Care Plan, dated 11/4/24, indicated the following: -The Resident was at risk for potential alteration in comfort/pain. -Medicate per Physician's orders (see MAR). Review of Resident #419's active Physician Orders indicated the following orders, dated 11/4/24: -Oxycodone HCL (Hydrochloride) five (5) milligram (mg) tablet (tab), one (1) tab TD (total dose) = 5 mg. Do not give at same time as 10 mg dose. Oral, every four hours as needed (PRN) for moderate pain (4-7/[out of]10). -Oxycodone HCL (Hydrochloride) five (5) milligram (mg) tablet (tab), two (2) tabs TD (total dose) = 10 mg. Do not give at same time as 5 mg dose. Oral, every four hours as needed (PRN) for severe pain (8-10/10). Review of Resident #419's November 2024 MAR indicated the following: -Oxycodone HCL 5 mg tablet, 2 tabs TD = 10 mg, oral every four hours as needed for severe pain was administered to the Resident by Nurse #3 on 11/4/24 at 1:34 P.M. -The Resident's pain level report at the time of Oxycodone administration was five (5) out of 10 (moderate pain). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/4/24 at 2:52 P.M., between surveyor #3 and Nurse #3, Nurse #3 said her first interaction with Resident #419 occurred on 11/2/24. Nurse #3 said she was responsible to administer medications to Resident #419 on 11/2/24 and she observed after administering the Resident's scheduled medication and as needed Oxycodone, that the Resident was sleepy, talking, and not making sense, and that she communicated this with the Resident's Physician. Nurse #3 said that the NP adjusted Resident #419's as needed Oxycodone orders on 11/4/24 by reducing the dose per administration and increasing the frequency of availability in order to address the Resident's potential side effects to Oxycodone. Nurse #3 said that Resident #419 reported pain at a level of 5/10 (moderate) on 11/4/24 at 1:34 P.M. and she administered a TD of 10 mg of Oxycodone to the Resident at the time. Nurse #3 further said that the TD of 10 mg of Oxycodone was ordered to be administered for severe (8-10/10) pain. Nurse #3 said she administered 10 mg of Oxycodone when the Resident reported pain at a level of 5/10 because the Resident stated he/she was unhappy with the ordered lower dose and requested 10 mg to be administered. Nurse #3 said she did not obtain instructions from the Physician/NP to administer a dose of Oxycodone outside of the ordered parameters for pain (for the Resident stated pain level of 5/10). On 11/5/24 at 8:25 A.M., surveyor #3 attempted to speak with Resident #419, and Resident #419 declined to speak with the surveyor. During an interview on 11/5/24 at 9:00 A.M., between surveyor #3 and the Regional Quality Improvement (QI) Nurse, the Regional QI Nurse said that Nurses were required to administer medications according to each Resident's Physician orders. The Regional QI Nurse said pain medications ordered on an as needed (PRN) basis were required to be administered according to the dose prescribed and pain level parameters included in the Physician's order, and in alignment with the Resident's report of pain. The Regional QI Nurse said that Nurse #3 should have administered Oxycodone to Resident #419 in accordance with the Physician's order for moderate pain, not severe pain, as the Resident reported pain at a level of 5/10 (moderate) on 11/4/24.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37400 Based on interview, and record review, the facility failed to ensure that one Resident (#99) out of a total sample of 25 residents, was free from a significant medication error when a dose of Vitamin K medication was administered to the Resident and resulted in sub-therapeutic (dose or concentration of a drug lower than that usually prescribed to treat a disease effectively) laboratory levels. Specifically, for Resident #99, the facility failed to ensure that Vitamin K medication was not administered to the Resident when there was no Physician orders for the medication to be administered after a one time dose order was given. Findings include: Review of the facility policy titled Administration Procedures for All Medications, dated 9/20/13, indicated the purpose of the policy was to administer mediations in a safe and effective manner. Review of the facility policy titled Anticoagulant Therapy, revised 7/17/19, indicated anticoagulant therapy is the administration of medications (for example Coumadin or Warfarin) that reduce the tendency of blood to coagulate (become thicker so it does not flow), thus reducing the risk of thrombosis (formation of a blood clot [thrombus] inside a blood vessel, obstructing normal blood flow). The policy also included the following: -Anticoagulation is indicated for a variety of conditions, including treatment of prophylaxis (prevention) of venous thromboembolism (blood clots that form in the vein) and the prevention of systemic embolism (blood vessel blockage that came from elsewhere in the body). -Labs: Prothrombin (PT: test to evaluate blood clotting), International Normalized Ratio (INR: blood test that indicates how long it takes the blood to clot) -If INR level is greater than 4, hold Coumadin until the Prescriber provides further orders. Emergency supply of Vitamin K is located in the Automated Dispensing Machine. Resident #99 was admitted to the facility in May 2024, with diagnoses including Atrial Fibrillation (Afib: disease of the heart characterized by irregular and often faster heartbeat that can lead to blood clots and other heart related complications), Hypertension (high blood pressure), Cardiac Pacemaker (small, battery-powered device that is implanted in the chest to monitor and regulate the heart's rhythm and rate) and Prosthetic Heart Valve (artificial valve surgically implanted into the heart to replace a heart valve that has become damaged). Review of the Anticoagulant Care Plan, initiated 5/16/24, indicated Resident #99 was at risk for bleeding related to anticoagulant therapy and included the following interventions initiated 5/16/24: -monitor blood coagulation levels and labs per Physician orders -anticoagulation medication as ordered (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Assessment, dated 8/8/24, indicated Resident #99: -has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 6 out of 15. -received anticoagulant medication during the assessment period. Review of Resident #99's Laboratory Results indicated the following: -INR levels on 10/4/24: 8.6 (critically high [INR normal range 0.8 - 1.1]) -INR levels on 10/7/24: 7.9 (critically high) Further review of the Laboratory Results, dated 10/7/24, indicated a written order by the Provider to Hold Coum [sic], Vit [sic] 5 milligram (mg). Review of the Physician Telephone Orders for Resident #99, indicated an order dated 10/7/24 to administer Vitamin K 5 mg for one dose now. Review of the Physician's Orders documented in the Electronic Medical Record (EMR), dated 10/7/24, indicated an order to administer Phytonadione (Vitamin K) 5 mg orally for reversal of high INR level, discontinued on 10/9/24. Review of the Certified Physician Assistant (PA-C) Note, dated 10/8/24, indicated: -Resident #99 was being evaluated for recent supratherapeutic (higher than desired) INR level. -Discussion with the Medical Doctor (MD) and decision was made to hold off on any Vitamin K agents as it was difficult to closely monitor the Resident's history of mechanical valves (prosthetic heart valves) and risk for developing (blood) clots. -INR level on 10/8/24 was 3.2. -Plan indicated the following: >on Coumadin for stroke prophylaxis, with mechanical valve, goal INR = (2.5 - 3.5) >recently with supratherapeutic INR- closely monitored Resident for signs of active bleeding or anemia . avoiding Vitamin K due to artificial valve and limited labs at the facility. >continue to allow INR to drift down on its own. Review of the October 2024 Medication Administration Record (MAR) indicated: -Coumadin was held from 10/4/24 through 10/8/24 -Vitamin K 5 mg was administered daily on 10/7/24 and 10/8/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Laboratory Results, indicated the following: -INR levels on 10/8/24: 3.2 (within the Resident's goal range) -INR levels on 10/9/24: 1.4 (low) -INR levels on 10/11/24: 1.3 (low) During an interview on 11/03/24 at 12:14 P.M. and on 11/6/24 at 10:40 A.M., Resident #99's Representative said she had concerns about the management of Resident's Coumadin medication. She said the Resident's INR levels have been all over. She said on 10/4/24, the Resident's INR level was 8.6 and did not receive Coumadin for three days, then was 7.9. She said the Provider gave an order for Vitamin K for one dose but the order was inaccurately put in and Resident #99 received multiple doses of Vitamin K which she was told could have harmed him/her. She said if she had not contacted the facility to inquire about the Vitamin K, the Resident would have continued to receive the medication because there was no date to discontinue it. She said she was worried that something horrible would happen to Resident #99, that she had concerns about how the facility was tracking Resident#99's INR levels to determine Coumadin doses. She said she had asked the Nursing staff about the Resident's coumadin therapy and they have difficulty answering her questions about what the INR ranges and Coumadin doses were on certain days. The Resident's Representative said she had frequently asked to speak with the Resident's Physician about her concerns relative to this and was told that he does not talk with families. During an interview on 11/6/24 at 1:45 P.M., Unit Manager (UM) #1 said she was very aware of the Resident #99 Representative's concerns about the Coumadin therapy. She said there was a binder where Physician Telephone Orders are kept and are entered into the electronic medical record. The surveyor and UM #1 reviewed the Physician Telephone Order Binder and reviewed the order for Resident #99 dated 10/7/24 which indicated to administer Vitamin K 5 mg for one (1) dose now at 5:40 P.M. UM #1 said the Physician's Order from 10/7/24 indicated to give one dose of Vitamin K on 10/7/24. During a subsequent interview on 11/6/24 at 2:42 P.M., UM #1 said Resident #99 was administered two doses of Vitamin K and should have only received one dose. She said this was considered a significant medication error. She said the Nurse entered the order incorrectly on 10/7/24 and did not indicate a stop date of 10/7/24 so it was administered again on 10/8/24. She said Resident #99 could have been harmed from the continued doses of Vitamin K.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 37400 Based on interview, record and policy review, the facility failed to ensure that dental services were provided for two Residents (#88 and #43), out of a total sample of 25 residents. Specifically, the facility failed to: 1. For Resident #88, provide regular bi-annual dental visits as requested by the Resident Representative. 2. For Resident #43, ensure dental services were offered to the Resident's Representative when the Resident had complaints of mouth and dental pain and required antibiotic treatments. Findings include: Review of the facility policy titled Consulting Services, Podiatry/Dental/Optometry/Audiology, dated 12/22/16, indicated the facility has a contract with credentialed providers for in house services of podiatry, dental, optometry, and audiology. The policy also included: -Services will be offered to all residents as a means of providing highest practicable level of functioning and care. -Resident/Resident Representative are provided information about consulting services upon admission and at any time when the need arrives. -Resident/Resident Representative provides written consent to treatment prior to initiation of services. -Appointment is arranged by facility staff. -Resident record is made available to credentialed Consultant for health history/assessment. -Credentialed Consultant documents care and services provided in medical record. 1. Resident #88 was admitted to the facility in August 2022, with diagnoses including Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and Dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) Assessment, dated 8/1/24, indicated Resident #88: -had severe cognitive impairment as evidenced by a Brief Mental Status (BIMS) score of 4 out of 15. -required assistance from staff with eating. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was dependent on staff for oral hygiene. -was on a mechanically altered diet (texture modified consistency to assist with chewing/swallowing). On 11/3/24 at 9:29 A.M., the surveyor observed Resident #88 dressed and seated in a specialized chair in his/her room. During an interview at the time, the Resident's Representative said the Resident had top and bottom dentures and would like him/her to see the Dentist but the Resident Representative had not been asked about these services. Review of the Resident's Clinical Record indicated no documented evidence that consent/declination for dental services had been obtained by the facility. During an interview on 11/5/24 at 10:48 A.M., the Accounts Payable Staff said Resident #88 was currently enrolled in dental services and had not been evaluated since 3/10/23. The Accounts Payable Staff said the Resident should have been seen by the Dental Hygienist in September 2023, and by the Dentist in March 2024, but this did not occur. 2. Resident #43 was admitted to the facility in September 2020, with diagnoses including Dementia. Review of Resident #43's Nursing Progress Notes indicated the following: -6/12/24: complained of mouth and tooth pain, Nurse Practitioner (NP) evaluated the Resident and gave a new order to start Amoxicillin (antibiotic) 500 milligrams (mg) three times daily for 5 days. -6/19/24: recently completed antibiotics, complained of mouth, throat still hurting. The Resident's right sided gland was noted to be swollen. The NP was updated and a new order was given for Amoxicillin 500 mg three times daily for 10 days. Review of the MDS Assessment, dated 9/12/24, indicated Resident #43: -had severe cognitive impairment as evidenced by a BIMS score of 3 out of 15. -was dependent on staff for oral hygiene. During an interview on 11/4/24 at 11:42 A.M., the Accounts Payable Staff said consent for dental services was reviewed by the Nurse during the Resident's admission process. The Accounts Payable Staff said if the Resident/Resident Representative consented to the services, the form would be signed and sent to the Consultant dental services. The Accounts Payable Staff said the Dentist and/or Dental Hygienist provided services in the building approximately every 60-90 days, and copies of these visits along with the consent form should be in the Resident's clinical record. Review of the Resident's clinical record indicated no documented evidence the Resident had a consent and/or had been evaluated for dental services since admission to the facility. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 11:30 A.M., the Resident's Representative said he/she was offered dental services for Resident #43 about a year ago and agreed for him/her to receive those services. The Resident Representative further said she was not aware of Resident #43 having any dental problems. During a subsequent interview on 11/5/24 at 12:07 P.M., the Accounts Payable Staff said she was able to find the Request for Consultant Services form which was completed on Resident #43's admission, but the form did not indicate if dental services was consented to or declined because that section was left blank. The Accounts Payable Staff said Resident #43 had not been receiving dental services since admission and the facility staff had not followed up to reassess if dental services were requested by the Resident Representative. The Accounts Payable Staff further said she left a message with Resident #43's Representative today to inquire if he/she wanted the Resident to receive dental services moving forward.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation, and interview, the facility failed to ensure unit kitchenette cleanliness and safety was maintained on two units (Meadows Unit and [NAME] Unit) out of three unit kitchenettes observed. Specifically, the facility failed to: 1. For the Meadows Unit, ensure the kitchenette refrigerator and toaster were cleaned as required, and broken and/or missing refrigerator equipment were addressed, repaired and replaced. 2. For the [NAME] Unit, ensure the toaster was cleaned as required to maintain the equipment in a clean and safe manner. Findings include: 1. On 11/3/24 at 9:36 A.M., the surveyor observed the following in the Meadows Unit kitchenette: -Refrigerator had one broken and one missing crisper drawer. -Food debris was noted on the inside shelves of the refrigerator door and on the bottom of the inside refrigerator floor. -A dirty plate discarded on the top of the refrigerator. -Toaster was thickly laden with crumbs inside. On 11/4/24 at 2:10 P.M., the surveyor observed the following in the Meadows Unit kitchenette: -Refrigerator had one broken and one missing crisper drawer. -Food debris was noted on the inside shelves of the refrigerator door and on the bottom of the inside refrigerator floor. -A dirty plate discarded on the top of the refrigerator. -Toaster thickly laden with crumbs inside. On 11/5/24 at 9:49 A.M., the surveyor and House Keeping Staff #2 observed the following in the Meadows Unit kitchenette: -Refrigerator had one broken and one missing crisper drawer. -Food debris was noted on the inside shelves of the refrigerator door and on the bottom of the inside refrigerator floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A dirty plate discarded on the top of the refrigerator. -Toaster thickly laden with crumbs inside. During an interview immediately following the observation, House Keeping Staff #2 said it did not appear the toaster had been cleaned recently and it should not be laden with crumbs as it posed a fire risk. House Keeping Staff #2 also said dirty dishes should be removed from the kitchenette every day. House Keeping Staff #2 said it was housekeeping's responsibility to keep surfaces in the kitchenette clean such as the floor and the counter tops, but he was unsure if he was supposed to clean the inside of the refrigerator regularly but would often wipe down if he noticed any spills or debris in the refrigerator. During an interview on 11/5/24 at 12:06 P.M., the Food Services Director (FSD) said it was the Housekeeping Staff's responsibility to keep the kitchenettes clean and this included cleaning the inside of the refrigerators regularly. The FSD said Maintenance Staff should be made aware if refrigerators are broken and in need of repair and any staff member in the facility can report a broken item. On 11/5/24 at 1:07 P.M., the surveyor and the Environmental Services Director observed the following on the Meadows Unit: -Refrigerator had one broken and one missing crisper drawer. -Food debris was noted on the inside shelves of the refrigerator door and on the bottom of the inside refrigerator floor. -A dirty plate discarded on the top of the refrigerator. During an interview directly following the observation, the Environmental Services Director (ESD) said no staff members had made him aware the refrigerator on the Meadows Unit had a broken crisper drawer or that the other crisper drawer was missing. The ESD said it was the responsibility of the Dietary Staff to maintain the cleanliness of the inside of the refrigerator and the refrigerator had debris on the door and the inside bottom of the refrigerator was dirty. The ESD further said dirty dishes should be removed from the kitchenette daily by the Dietary Staff and the dirty plate that was on top of the refrigerator should not have been left there for multiple days. During an interview on 11/6/24 at 11:28 A.M., the Administrator said the facility currently had no written protocol or checklist for who maintains and/or specifically cleans each item in the unit kitchenettes. The Administrator said his expectation is the Dietary Staff maintain the cleanliness of the inside of the unit refrigerator and any time the Dietary Staff come to stock the kitchenette they should be removing any used plates or other utensils. The Administrator further said the toasters are to be cleaned by the Housekeeping Staff and should be cleaned daily. 50563 2. On 11/3/24 at 9:48 A.M., the surveyor observed the toaster in the [NAME] Unit kitchenette to have a buildup of crumbs inside the toaster. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 9:35 A.M., the surveyor and Dietary Staff #1observed a buildup of crumbs in the toaster located in the [NAME] Unit kitchenette. During an interview at the time, Dietary Staff #1 said there was concern for cross contamination and a fire hazard due to the buildup of crumbs in the toaster.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50563 Based on observation, interview, and record review, the facility failed to adhere to infection control standards to prevent the potential transmission of communicable diseases and infections for two Residents (#108 and #2) out of a total sample of 25 Residents. Specifically, the facility failed to: 1) ensure Resident #108's over-bed table was cleaned and disinfected before used to eat and drink off after a used urinal was set on the table. 2) ensure Resident #2's indwelling urinary catheter (a device inserted into the bladder to drain urine) was maintained off the floor. Findings include: 1) Review of the facility policy titled Nutrition and Meals, Assisting Residents with, dated May 2005, indicated the following: -If the resident eats in his/her room: >clean the over-bed table . Resident #108 was admitted to the facility in June 2024, with diagnoses including Cerebral Infarction due to Thrombosis (a condition where a blood clot caused loss of blood flow and damage to the brain). On 11/4/24 at 8:40 A.M., the surveyor observed CNA #2 enter Resident #108's room. The surveyor observed CNA #2 performed hand hygiene, donned (put on) gloves, and picked up a used urinal that was placed on Resident #108's over-bed table and bring it to the bathroom in the room to empty. The surveyor observed CNA #2 return to the Resident's bedside and placed the urinal where the Resident could access it easily, doffed (removed) gloves, performed hand hygiene, and left the Resident's room without cleaning and disinfecting the over-bed table. On 11/4/24 at 8:43 A.M., the surveyor observed Nurse #11 enter Resident #108's room and placed a nutritional supplement drink on the Resident's over-bed table without cleaning and disinfecting the over-bed table. On 11/4/24 at 8:56 A.M., the surveyor observed the Activities Director deliver Resident #108's breakfast tray to the room and placed the breakfast tray on the over-bed table without cleaning and disinfecting the table. During an interview on 11/4/24 at 8:57 A.M., the Activities Director said if a staff member removed a urinal from the over-bed table the staff member should then clean and disinfect the table. The Activities Director further said staff will assume the table is ready for the meal to be served if they do not observe a dirty item, such as the urinal, on the table at the time of meal pass. (continued on next page)

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	225304	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlene Manor Extended Care Facility	130 Colrain Road Greenfield, MA 01301

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/4/24 at 10:58 A.M., CNA #2 said after removing the urinal from the over-bed table she did not clean and disinfect the over-bed table but should have. CNA #2 said there would be concern for a break in infection control when an over-bed table was not cleaned and disinfected before using it for food and beverages when a used urinal had been sitting on the over-bed table. During an interview on 11/4/24 at 11:31 A.M., Unit Manager (UM) #3 said her expectation of staff is that if a CNA removed a urinal from the over-bed table that the table should be cleaned and disinfected at that time. 42761 2. Review of the facility's policy titled Enhanced Barrier Precautions (EBP), dated 1/10/23, indicated the following: -EBPs require gown and glove use for certain residents during specific high-contact resident care activities that are associated with increased risk for MDRO (multi drug resistant organism: germ that is resistant to antibiotic treatment) transmission. -Nursing home residents with . indwelling medical devices are at especially high risk of both acquisition of and colonization (when an individual carries the organism in or on their body, often for very long periods of time, but it is not causing symptoms or making the person ill) with MDROs. -EBPs will be used for all residents with indwelling medical devices e.g., . urinary catheter. Resident #2 was admitted to the facility in September 2024, with diagnoses including Chronic Foley (type of indwelling urinary catheter) Catheter (device inserted into the bladder used to drain urine from the body) and Left Foot Wound. Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 9/4/24, indicated the following: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points. -The Resident had an indwelling urinary catheter. Review of Resident #2's Physician order, dated 10/16/24 with no stop date, indicated the following: -Enhanced Barrier Precautions (EBPs) by policy, . , every shift. -EBP signs posted on Resident's door with proper PPE (personal protective equipment) requirements. -Will be on EBP for the entire stay. -Residents with indwelling devices such as Foley, ., and/or wounds will be on EBP until device removed or wound healed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 at 8:12 A.M., the surveyor observed EBP signage posted outside of the Resident's room on the door frame which indicated providers and staff were required to wear gloves and a gown for the following high-contact care activities: -Dressing -Bathing/Showering -Transferring -Changing Linens -Providing Hygiene -Changing Briefs and Assisting with Toileting -Device Care or Use: . urinary catheter . At the time, the surveyor entered Resident #2's room and observed the following: -The Resident was lying in bed with his/her feet slightly elevated. -Clear catheter tubing was observed extending out from under the Resident's bed sheets and led to a catheter collection drainage bag. -The catheter collection drainage bag was laying on the floor next to the Resident's bed. During an observation and interview on 11/6/24 at 8:32 A.M., Certified Nurses Aide (CNA) #7 said Resident #2's catheter collection drainage bag was laying on the floor and she did not know why. CNA #7 said the catheter collection drainage bag should not have been on the floor. CNA #7 said that she was waiting for CNA #6 to help her assist Resident #2 out of bed for breakfast. CNA #7 then left the Resident's room. The surveyor observed that the Resident's catheter collection drainage bag remained laying on the floor. On 11/6/24 at 8:35 A.M., the surveyor observed the following: -Resident #2's catheter collection drainage bag was laying on the floor next to the bed. -CNA #6 and CNA #7 entered Resident #2's room and closed the door. At the time, the surveyor knocked on the Resident's door and obtained permission to enter the room. Upon room entry, the surveyor observed: -The Resident was positioned on his/her back, on the bed. -The Resident's catheter collection drainage bag was on the bed, next to the Resident's outer left leg. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA #6 and CNA #7 both wore gloves on their hands. -Neither CNA #6 and CNA #7 wore a gown. -CNA #6 and CNA #7 assisted Resident #2 to roll to his/her left and right sides while positioning a mechanical lift pad under the Resident and assisting the Resident with hiking his/her pants over his/her incontinence brief. -CNA #6 and CNA #7 secured Resident #2's mechanical lift pad straps to the mechanical lift. -CNA #7 controlled the mechanical lift while CNA #6 assisted the Resident in the mechanical lift pad to a seated position in the Resident's wheelchair. -CNA #6 then handled the Resident's urinary catheter tubing and catheter collection drainage bag, and secured the drainage bag on the wheelchair frame underneath the Resident's wheelchair seat. -CNA #7 disinfected the mechanical lift and left the room. -CNA #6 assisted Resident #2 out of the room to the Dining Room. During an interview on 11/6/24 at 9:42 A.M., CNA #6 said staff were required to follow EBPs when caring for Resident #2 because the Resident had an indwelling urinary catheter. CNA #6 said that she knew gloves and a gown were required for staff when providing assistance to Resident #2 for bathing, dressing, and emptying the Resident's catheter collection drainage bag. CNA #6 further said she did not think staff were required to wear gowns when providing Resident #2 with assistance for transfers, when completing dressing in the bed, or when handling the Resident's urinary catheter if it was not being emptied. CNA #6 said that catheter collection drainage bags should never be on the floor due to the risk for transmission of infection. During an interview on 11/6/24 at 10:06 A.M., Unit Manager (UM) #1 said Resident #2 had an indwelling urinary catheter and the Resident had been placed on EBPs. UM #1 said catheter collection drainage bags should never be on the floor and that Resident #2's urinary catheter collection drainage bag being on the floor increased the Resident's risk for transmission of infection. UM #1 also said that CNA #6 and CNA #7 should have followed the instructions for EBPs that morning by wearing gowns when they assisted the Resident out of bed.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on record review and interview, the facility failed to provide evidence that updated COVID-19 vaccines were offered to three Residents (#5, #92, and #61) out of five applicable sampled residents, in a total sample of 25 residents, which increased the Residents' risks for illness. Specifically, the facility failed to provide evidence that a second dose of 2023-2024 COVID-19 vaccine was offered to Resident's #5, #92, and #61, according to National Standards, when: -Each Resident received one dose of the 2023-2024 COVID-19 vaccine. -the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommended an additional dose of updated (2023-2024 formula) of COVID-19 vaccine be administered for older adults, aged [AGE] years and older. -Each Resident met criteria for a second dose of the 2023-2024 COVID-19 vaccine. -The COVID-19 vaccine was not medically contraindicated and the residents had not already been immunized with the recommended additional dose. Findings include: Review of the CDC ACIP guidelines titled Use of an Additional Updated 2023/2024 COVID-19 Vaccine Dose for Adults Aged [AGE] years: Recommendations of the Advisory Committee on Immunization Practices - United States, 2024, located at https://www.cdc.gov/mmwr/volumes/73/wr/mm7316a4.htm?s_cid=mm7316a4_w and dated 4/25/24, indicated: -On 2/28/24, ACIP recommended that all persons aged [AGE] years and older receive one additional dose of any updated (2023-2024 Formula) COVID-19 vaccine. -The additional dose should be administered at or after four months following the previous dose of updated COVID-19 vaccine. Review of the facility's policy titled COVID-19 Vaccine Requirements Residents and Staff, effective 5/21/21 and revised 3/21/24, indicated the following: -Residents are strongly encouraged to stay up-to-date with COVID-19 vaccines. -The facility follows the CDC definition of up-to-date. -The facility educates residents about the vaccines, offers and administers the vaccines, and documents vaccination status according to State and Federal guidelines. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #5 was admitted to the facility in November 2019, with diagnoses including Multiple Sclerosis (MS:a chronic autoimmune disorder of the central nervous system marked by numbness, weakness, loss of muscle coordination, and problems with vision, speech, and bladder control) and Dementia (group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident #5's Consent for Influenza and/or Pneumococcal and/or COVID Vaccine Consent form, dated 11/3/23, indicated the following: -Consent for vaccination gave the facility consent to administer vaccines based on the Resident's vaccination history, vaccine guidelines, current and furture updates . -Vaccination consent obtained applied to all current and future vaccines due. -Consent had been obtained for COVID vaccination. Review of Resident #5's clinical record indicated the following: -The Resident was over [AGE] years of age. -The Resident received one dose of the 2023-2024 COVID-19 vaccine on 11/13/23. -The Resident received one dose of the 2024-2025 COVID-19 vaccine on 9/25/24. Further review of the Resident's clinical record did not indicate any evidence that a second dose of the 2023-2024 COVID-19 vaccine was offered to the Resident at, or after four months following the previous dose of COVID-19 vaccine on 11/13/23. 2. Resident #92 was admitted to the facility in May 2023, with diagnoses including Dementia and Stage Four Chronic Kidney Disease (moderately to severely damaged kidneys causing them to no longer work as they should to filter waste from the blood). Review of Resident #92's Consent for Influenza and/or Pneumococcal and/or COVID Vaccine Consent form, dated 10/20/23, indicated the following: -Consent for vaccination gave the facility consent to administer vaccines based on the Resident's vaccination history, vaccine guidelines, current and furture updates . -Vaccination consent obtained applied to all current and future vaccines due. -Consent had been obtained for COVID vaccination. Review of Resident #92's clinical record indicated the following: -The Resident was over [AGE] years of age. -The Resident received one dose of the 2023-2024 COVID-19 vaccine on 10/20/23. -The Resident received one dose of the 2024-2025 COVID-19 vaccine on 9/26/24. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Resident's clinical record did not indicate any evidence that a second dose of the 2023-2024 COVID-19 vaccine was offered to the Resident at or after four months following the previous dose of COVID-19 vaccine on 10/20/23. 3. Resident #61 was admitted to the facility in November 2023 with diagnoses including Dementia and Personal history of Pulmonary (relating to the lungs) Embolism (blockage, usually caused by a blood clot). Review of Resident #61's Consent for Influenza and/or Pneumococcal and/or COVID Vaccine Consent form, dated 11/7/23, indicated the following: - Consent for vaccination gave the facility consent to administer vaccines based on the Resident's vaccination history, vaccine guidelines current and furture updates . - Vaccination consent obatined applied to all current and future vaccines due. - Consent had been obtained for COVID vaccination. Review of Resident #61's clinical record indicated the following: - The Resident was over [AGE] years of age. - The Resident received one dose of the 2023-2024 COVID-19 vaccine on 11/15/23. Further review of the Resident's clinical record did not indicate any evidence that a second dose of the 2023-2024 COVID-19 vaccine was offered for the Resident at, or after four months following the previous dose of COVID-19 vaccine. During an interview on 11/5/24 at 1:30 P.M., the Regional Infection Preventionist (Regional IP) said that the facility had changed their vaccine consent forms recently and that the consent forms were updated to include consent for current and future vaccines due so that a new consent would not need to be obtained each time updated doses of vaccines were due for a Resident. The Regional IP said second doses of the 2023-2024 COVID-19 vaccines were available to the facility for offering and administering to Residents when the CDC recommended an additional dose of the vaccine. The Regional IP said that an additional dose of the 2023-2024 COVID-19 vaccine should have been offered to all eligible Residents. The Regional IP said if a Resident/Resident Representative declined any vaccine offered, a signed declination would be kept on file and if a vaccine was offered and accepted, a signed consent would be kept on file. The Regional IP said he located no evidence that a second dose of the 2023-2024 COVID-19 vaccine was offered to Residents #5 and #92 when the Residents were eligible to receive the additional 2023-2024 COVID-19 vaccine dose, prior to availability of the 2024-2025 COVID-19 vaccine. The Regional IP also said that he located no evidence a second dose of the 2023-2024 COVID-19 vaccine was offered to Resident #61 and that Resident #61 had not yet received the 2024-2025 COVID-19 vaccine.