STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225309	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ledgewood Rehabilitation and Nursing Center	87 Herrick Street Beverly, MA 01915

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on interview, record review and observation, the facility failed to develop individualized, person-centered care plans for two Residents (#1, #104) out of a total sample of 25 residents. Specifically: 1. For Resident #1, the facility failed to develop an individualized, person-centered care plan related to dementia. 2. For Resident #104, the facility failed to develop an individualized person-centered care plan related to nutritional care. Findings include: Review of the facility policy titled Care Plan, revised and dated September 2023, indicated the following: - Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. - A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS). 1. Resident #1 was admitted to the facility in December 2018 with diagnoses including unspecified dementia with agitation and adult failure to thrive. Review of Resident #1's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 13 out of a possible 15 indicating intact cognition. Further review of Resident #1's MDS indicated that he/she has a diagnosis of non-Alzheimer's dementia and requires assistance with all activities of daily living. Review of Resident #1's active care plans failed to indicate an individualized, person-centered care plan relating to dementia care. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 7:40 A.M., Nurse #2 said she would expect all residents with a dementia diagnosis to have an individualized care plan as each resident requires different types of care. During an interview on 8/1/24 at 8:15 A.M., the Director of Nursing (DON) said she would expect Resident #1 to have an individualized dementia care plan. The DON and the surveyor reviewed Resident #1's medical record together and the DON said no dementia care plan had been developed. 2. Resident #104 was admitted to the facility in April 2024 with diagnoses including urinary tract infection, hyperlipidemia, and unspecified dementia. Review of Resident #104's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 7 out of a possible 15 indicating that the Resident has severe cognitive impairment. Review of Resident #104's active care plans failed to indicate an individualized, person-centered care plan relating to nutrition care. During an interview on 7/31/24 at 8:32 A.M., Resident #104 said he/she does not remember speaking with a Registered Dietitian/Nutritionist. During an interview on 8/1/24 at 7:58 A.M., the Registered Dietitian (RD) said she works in the building four days per week. The RD said when there is a new admission, we assess the resident and develop an individualized care plan for their nutritional needs to get their baseline nutrition status. The RD continued to say she missed completing Resident #104's initial nutrition assessment and developing his/her nutritional care plan upon admission to the facility. During an interview on 8/1/24 at 8:21 A.M., the Director of Nursing said an individualized nutritional care plan should be developed when a resident gets admitted to the facility, and she continued to say Resident #104 should have a nutrition care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure staff followed physicians' orders for two Residents (#47 and #23) out of a total of 25 sampled residents. Specifically: 1. For Resident #47, the facility failed to document the external length of a peripherally inserted central catheter (PICC) line (a long thin tube that's inserted into a vein in the arm and passed through to the larger veins near the heart) and failed to document the urine output of his/her Foley catheter, as ordered by the physician. 2. For Resident #23, the facility failed to document the output from his/her negative pressure wound therapy (NWPT; also called a wound vac, is a suction pump and tubing used to remove excess exudate and promote healing in acute or chronic wounds), as ordered by the physician. Findings include: 1. Resident #47 was admitted to the facility in July 2024 with diagnoses including bacteremia, chronic obstructive pulmonary disease, and urinary retention. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #47 scored an 8 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating moderate cognitive impairment. The MDS also indicated he/she requires assistance with bathing and dressing and is receiving IV antibiotics. The MDS also indicated that Resident #47 has a Foley catheter. Review of Resident #47's physician's orders indicated: - 7/15/24: Change dressing of PICC every week and measure and document external length of catheter every day shift. Review of the Medication Administration Record (MAR) for July 2024 indicated that staff did not document Resident #47's external length of the catheter. Additional review of Resident #47's physician's orders indicated: - 7/10/24: Indwelling urinary catheter; measure and record output every shift. Review of the July 2024 MAR indicated that staff did not record Resident #47's output on the following shifts/days: - 7:00 A.M. to 3:00 P.M., on 7/12/24, 7/20/24 and 7/29/24 - 3:00 P.M. to 11:00 P.M., on 7/11/24 and 7/17/24 - 11:00 P.M. to 7:00 A.M. on 7/10/24, 7/14/24, 7/16/24, 7/18/24, 728/24, 7/29/24 and 7/30/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 7/31/24 at 8:50 A.M. and at approximately 9:00 A.M., the Director of Nursing (DON) said that it is expected for external lengths of PICC lines to be measured to ensure the line has not migrated. The DON reviewed Resident #47's July 2024 MAR with the surveyor and was not aware that staff had not completed the measurements for the PICC line or catheter output. 2. Resident #23 was admitted to the facility in June 2024 with diagnoses including encounter for surgical aftercare following surgery on the digestive system, and chronic pulmonary disease with acute exacerbation. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #23 is cognitively intact and requires assistance with bathing, dressing and transfers. Review of Resident #23's physician's orders indicated: - 6/27/24, NPWT (negative-pressure wound therapy) document amount of drainage. Call MD if > (greater than) 100 mls (milliliters) in 8 hours OR if [NAME] red blood is in the canister The order indicated document drainage every shift. Review of the July 2024 Medication Administration Record (MAR) indicated staff did not document the drainage amount per physician's order on the following days/shifts: - 7:00 A.M. to 3:00 P.M. on 7/2/24, 7/5/24, 7/8/24, and 7/25/24 - 3:00 P.M. to 11:00 A.M. on 7/1/24, 7/3/24. 7/4/24, and 7/13/24 - 11:00 P.M. to 7:00 A.M. on 7/14/24, 7/29/24, and 7/30/24. During an interview on 7/31/24 at approximately 9:00 A.M., the Director of Nursing (DON) reviewed Resident #23's July 2024 MAR with the surveyor. The DON said she was not aware that staff had not been documenting the NPWT drainage, as ordered.

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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. 45984 Based on observations and interviews, the facility failed to properly store food items to prevent the risk of foodborne illness and in accordance with professional standards for food service safety. Findings include: The surveyor made the following observations during the initial kitchen walkthrough on 7/30/24 at 7:10 A.M.: - In the walk-in refrigerator, a container of unlabeled, undated sliced meat. - In the walk-in refrigerator, a container labeled as mushrooms with a use by date of 7/29 written on it. The container was partially open. - In the walk-in refrigerator, an opened bottle of Gatorade belonging to a staff member was stored with resident food. - In the walk-in freezer, numerous boxes containing resident food were stored directly on the ground. During the revisit walk-through of the kitchen on 7/31/24 at 11:27 A.M., the surveyor observed the following: - In the walk-in refrigerator, an opened bottle of Gatorade (a different bottle than the day prior) belonging to a staff member was stored with resident food. - In the reach-in refrigerator, an opened bottle of water with a staff member's name written on it was stored with resident food. During an interview on 7/31/24 at 11:50 A.M., the Food Service Director (FSD) said all food needs to be labeled and dated and should be thrown out after three days or as written on the food's label. During an interview on 8/1/24 at 8:30 A.M., the FSD said opened drinks belonging to kitchen employees should not be stored in areas where resident food is stored.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, policy review and interview, the facility failed to ensure nursing staff followed infection control practices during the administration of intravenous (IV) medication for one Resident (#47) out of a total of 25 sampled residents. Findings include: Review of the facility's Enhanced Barrier Precautions policy dated 7/1/24 indicated: Purpose: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: wounds and/or indwelling medical devices. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Device care or use: central line; urinary catheter, feeding tube, tracheostomy/ventilator. Resident #47 was admitted to the facility in July 2024 with diagnoses including bacteremia, chronic obstructive pulmonary disease, and urinary retention. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #47 scored an 8 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS), indicating moderate cognitive impairment. The MDS also indicated he/she requires assistance with bathing dressing and is receiving IV antibiotics. Review of Resident #47's care plans indicated: - Problem: [Resident] is on IV medications ABTX (antibiotic treatment) related to bacteremia. Type of IV: PICC (peripherally inserted central catheter) rt (right) upper arm. Interventions: IV dressing as ordered. Monitor intake and output. Dated 7/21/24. - Problem: [Resident] has catheter. Interventions: EBP (enhanced barrier precautions) as indicated. Monitor and document intake and output as per facility policy. Dated 7/15/24. Review of Resident #47's physician's orders dated 7/9/24 indicated: Penicillin G Potassium Injection Solution Reconstituted (Penicillin G Potassium). Use 3 million units intravenously every 4 hours for bacteremia. On 7/30/24 at 12:40 P.M., the surveyor observed Resident #47's empty IV bag hanging from the IV pole. The physician order's written on the bag indicated: Infuse 50 ML (milliliters) IV every four hours at 100 ml/hr (hour) over 30 minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 8:19 A.M., the surveyor observed Nurse #1 administer Resident #47's ordered intravenous antibiotics. Nurse #1 exited the medication room and walked to the medication cart to gather supplies. Nurse #1 then donned gloves that she obtained from the hallway, without first performing hand hygiene, potentially contaminating the gloves, and then entered Resident #47's room. A sign on the door indicated that Resident #47 was on enhanced barrier precautions and staff were to perform hand hygiene and don gloves and a gown during care. Nurse #1 did not don a gown. Nurse #1 then adjusted the privacy curtain with her gloved hands, set the infusion rate on the IV pump and then removed a bag of IV solution/antibiotic from her pocket, potentially contaminating her gloves. Nurse #1 then proceeded to connect the IV bag to Resident #47's PICC line cite, while still wearing the same gloves, potentially contaminating the IV tubing and PICC line insertion cite. During an interview on 7/31/24 at 8:29 A.M., Nurse #1 said that staff have to wear a gown when providing care to Resident #47. Nurse #1 said she did not have to wear a gown because she was administering medications. During an interview on 7/31/24 at 8:50 A.M., the Director of Nursing said that Nurse #1 should have worn a gown, performed hand hygiene, and not kept the IV solution bag in her pocket.