STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225312	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blackstone Valley Health and Rehabilitation	447 Hill Street Whitinsville, MA 01588

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure that a Level II [comprehensive evaluation that identifies the specialized services required] Preadmission Screening and Resident Review (PASARR-evaluation done if it was determined by the Level I [initial pre-screening] screen that a resident had an intellectual or developmental disability and/or serious mental illness [SMI] and if a resident was in need of additional support services at the facility) screen was submitted for two Residents (#93) and (#74), out of a total sample of 25 residents. Specifically, for Resident's #93 and #74, the facility failed to request a Level II PASARR evaluation when both Residents demonstrated a change in psychosocial condition requiring emergency mental health intervention. Findings include: 1. Resident #93 was admitted to the facility in May 2024 with diagnoses including Anxiety Disorder, Depression, and Post Traumatic Stress Disorder (PTSD). Review of Resident #93's PASARR Level I screen dated 5/17/24, indicated: -a negative screen -that he/she did not meet criteria for SMI -therefore a Level II PASARR evaluation was not needed Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #93: -was moderately cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 11 out of a possible score of 15. -had expressed feelings of Depression during the look back period. -was prescribed antipsychotic and antidepressant medications. Review of Resident #93's clinical record indicated: (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A Nursing Progress Note dated 7/2/24, that indicated the Physician ordered the Resident to be transferred to the hospital emergency room due to the Resident making a suicidal statement. -A Social Service Progress Note dated 11/12/24, that documented the Resident had expressed feelings of sadness and suicidal ideation to the Consulting Psychiatrist. The facility Physician had been notified and agreed to send the Resident to the Emergency Department for further evaluation. -A Consulting Psychiatrist Note dated 11/12/24, that recommended the Resident be put on one-on-one support and that the Resident agreed to assessment in (hospital) Emergency Department and was sent via medical transport. Further review of the Resident #93's medical record failed to indicate that the Level I PASARR was updated and re-submitted for an additional Resident Review and Level II evaluation following the Resident's change in psychosocial condition requiring emergency mental health interventions in July 2024 and November 2024. During an interview on 4/24/25 at 3:26 P.M., Social Worker (SW) #1 said that an updated Level I should have been submitted to the DMH PASARR office after Resident #93 expressed suicidal ideation (SI) in July 2024 and November 2024, but the Level I screen was not updated and submitted. 2. Resident #74 was admitted in June 2024 with diagnoses including Major Depressive Disorder, Anxiety and Depression. Review of the Resident #74's Level I Preadmission Screening and Resident Review (PASRR) dated 6/12/24, indicated: -he/she had a history of Mood Disorder and Anxiety/Panic Disorder. Review of Resident #74's Level II PASRR determination letter, dated 6/28/24, indicated: -the Resident did not meet criteria for Serious Mental Illness. -no further PASRR involvement was required. Review of Resident #74's Nursing Progress Notes indicated: -On 1/31/25: Resident #74 was agitated and stated to a Certified Nurses Aide (CNA) If I don't get out of here, I will kill myself. When the Resident was approached by the Nurse, the Resident was yelling and agitated and verbalized intentions to kill him/herself. The Nurse Practitioner (NP) was notified, and the Resident was sent out to the hospital for evaluation. -On 2/1/25: a call was placed to the hospital and Resident #74 was admitted for the night for observation. -On 2/1/25: the Resident returned from the hospital with no medication recommendations. Resident #74 started stating to staff he/she wanted to kill him/herself, was yelling and exit seeking. The Physician was notified and ordered Resident #74 be sent out to the hospital for evaluation. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/1/25: Resident #74 returned to facility. Review of the Social Service Progress Notes dated 2/3/25, indicated Resident #74 returned from the hospital and was scheduled to see Behavioral Health Services. The Social Worker followed up with the Resident regarding negative statements that were made by the Resident and indicated that Resident #74 had made no further statements regarding suicidal ideation. Review of the hospital discharge paperwork dated 1/31/25, indicated the Resident was seen for feeling suicidal. Review of Resident #74's Comprehensive Care Plan indicated a focus area initiated on 2/4/25, for a history of suicidal ideation statements. During an interview on 4/24/25 at 3:26 P.M., SW #1 said that the change in status related to the hospitalization for suicidal ideation for Resident #74 should have been reported to the PASRR office, but it had not been.

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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 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** Based on interview, and record review, the facility failed to ensure that the Resident and/or Resident Representative was provided the right to participate in the care plan process for one Resident (#46), out of a total sample of 25 residents. Specifically, the facility failed to ensure that quarterly care plan meetings were conducted as required for Resident #46. Findings include: Review of the facility policy titled Resident Assessment and Care Planning Policies and Procedures, last revised February 2022, included the following: -Residents and their families .are invited to attend and participate in the resident's assessment and care planning conferences (admission, quarterly, annual, and significant change in status). -A timely advance notice of the care planning conference is provided to the resident and interested family members. -Social services maintain a record of such notices. -Attendance will be taken and kept in the resident's record. -All care plans will be reviewed with the attendees for further input, revisions, and approval by the clinical team and the resident/representative. -If the resident or designated representative cannot attend, they will be contacted by the social services staff or designee either in person, by phone, or by mail to be given a review of the information discussed in the meeting. -This event will be documented in the resident's record. Resident #46 was admitted to the facility in February 2020, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and chronic pain syndrome. Review of the MDS (Minimum Data Set) assessment dated [DATE], indicated that Resident #46 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of 15. During an interview on 4/23/24 at 8:16 A.M., Resident #46 said that the facility has not had a care plan meeting with him/her recently. Resident #46 further said that he/she was unaware of what his/her plan of care was. Review of the MDS Schedule for Resident #46 indicated that the Resident had care plan meetings scheduled for August 2024 and February 2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #46's clinical record failed to indicate documented evidence that the Resident/Resident Representative participated in the care planning process or that the interdisciplinary team (IDT) met quarterly to review the plan of care, as required in August 2024 and February 2025. Further review of the clinical record failed to indicate any care plan meetings or refusals to participate in the meetings by the Resident/Resident Representative were documented in August 2024 and February 2025. During an interview on 4/24/24 at 3:23 P.M., Social Worker (SW) #1 said that Resident #46's care plan meeting should have been held in August 2024 and February 2025, but they had not been. SW #1 also said that the meetings should have been added to the MDS care plan meeting schedule but they had not been. During an interview on 4/28/25 at 12:15 P.M., the Assistant Director of Nurses (ADON) said that they were unable to locate evidence or signature pages that the care plan meetings were held for Resident #46 for August 2024 and February 2025.

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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** 2. Resident #113 was admitted to the facility in February 2025 with diagnoses including Unspecified Dementia unspecified severity with other behavioral disturbance and Anxiety Disorder Unspecified. Review of the facility policy titled Wandering/Missing Residents, effective 8/2022, included the following: -Purpose: To provide a safe and secure environment to protect residents from elopement. -Policy: It is the policy of (the facility) that the safety and well-being of all residents with the potential for wandering are ensured. -If it is determined, through assessment, that a resident has a potential for wandering, the Resident Care Plan will reflect this behavior with all disciplines aware of the need for his/her monitoring. -A picture of all elopement risk residents is also located on each unit's nursing station and front desk and updated routinely with any changes. Review of the Resident's clinical record included an Elopement Risk Evaluation completed upon admission to the facility in February 2025 which indicated: -the Resident was cognitively impaired with poor decision-making skills. -the Resident had a pertinent diagnosis of Dementia .Anxiety Disorder. -the Resident ambulates independently without the use of an assistive device. -the Resident verbally expressed a desire to go home, has been observed packing his/her belongings up to go home and/or stays near the exit doors/elevators from the unit. -the Resident wanders aimlessly throughout the building. -the Resident had been recently admitted . -the Resident was considered at risk for elopement. Further Review of the Elopement Risk Evaluation failed to indicate whether or not the Resident's picture had been added to the facility's Elopement Risk Book, and no evidence of any further Elopement Risk Evaluations being completed for the Resident. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #113 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 possible points. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Resident's clinical record indicated: -Physician's order to monitor the Resident for wandering behavior each shift, initiated upon admission to the facility, -Care Plan indicating that the Resident was an elopement risk/wanderer, initiated 2/24/25. Review of the Certified Nursing Assistant (CNA) Behavior/Intervention Monthly Flow Records for the months of February 2025, March 2025, and April 2025, indicated the Resident demonstrated wandering behavior on all days. Further Review of the CNA Behavior/ Intervention Monthly Flow Records indicated there were four days during the three month review period with no CNA documentation noted. Review of the Wandering Resident/Elopement Risk List and Binder with resident pictures located at the facility front desk and unit nurses' station failed to show the Resident's name and photograph to identify Resident #113 for Wandering/Elopement. During an interview on 4/24/25 at 11:44 A.M., Nurse #1 said that the Resident did wander around the unit and that the residents who were evaluated to be at risk for elopement would be included in the Elopement Binder. Nurse #1 said that a resident's risk for elopement was determined by completing an Elopement Risk Evaluation. Nurse #1 said that she had completed the Elopement Risk Evaluation for the Resident on the day the Resident was admitted to the facility. Nurse #1 said that after reviewing the Resident's Elopement Risk Evaluation now, she realized that she should have completed the evaluation to indicate that the Resident would be added to the Red Elopement Risk Binder. Nurse #1 said that she was unsure if the Resident's picture and information were ever added to the Elopement Risk Binder but they should have been. During an interview on 4/24/25 at 12:05 P.M., Receptionist #1 said that the Elopement Binder was located at the front desk. She reviewed the Elopement Binder with the surveyor and confirmed that the Resident was not included in the Elopement Binder. The front page which listed the residents who were considered at risk for elopement did not include the Resident's name, nor was there a photograph of the Resident found in the Elopement Binder. During an interview on 4/24/25 at 3:40 P.M., the Director of Nursing (DON) said that residents were placed in the Elopement Book when they were identified as at risk for elopement per the Elopement Risk Evaluation. She said that Resident #113 was evaluated upon admission to the facility as an elopement risk and his/her name and picture should have been added to the Wandering/Elopement Risk List Red Binder that was located at the front desk and the nurses' stations. Based on record reviews, and interviews, the facility failed to ensure two Residents (#32 and #113) out of a total sample of 25 residents, remained free from accidents and hazards. Specifically, 1. For Resident #32, the facility failed to secure smoking materials at the nurses station after the Resident participated in smoking activities, ensure the Resident disposed of smoking materials safely, and perform one out of three quarterly Safe Smoking Assessments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #113, the facility failed to include the Resident's name and photograph as part of the Wandering Resident Red Binder located at the facility front desk and unit nurses' stations, when the Resident was evaluated as being at risk for elopement. Findings include: 1. Review of the facility policy titled: Facility Smoking, effective date January 2025, indicated the following: -The purpose of this policy is to protect residents' rights while ensuring the highest level of safety for both residents and staff from the serious consequences that may result from fire and/or smoking activities as well as dangers of exposure to secondhand smoke. -All residents who express the desire to smoke have a Safe Smoking Assessment performed at that time, on admission, readmission, quarterly, and with any change in cognitive or physical function. -The Safe Smoking Assessment evaluates the resident's cognitive abilities, judgement, manual dexterity, and mobility. -Residents are to dispose of smoking materials properly in provided non-combustible smoking receptacles, then when the session is ended these smoking materials will be emptied by the staff into a metal self closing container. -All resident smokers are responsible for following the facility policy and procedures for safe smoking. Resident #32 was admitted to the facility in August 2022 with diagnoses including Major Depressive Disorder and Adult Failure to Thrive. Review of the Minimum Data Set (MDS) assessments, dated 10/24/24 and 1/22/25, indicated Resident #32: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a total possible score of 15. -was a smoker. On 4/23/25 at 8:20 A.M., the surveyor observed Resident #32 seated on the edge of the bed in his/her room and a rolling walker with a storage compartment positioned next to the bed. The surveyor also observed smoking materials including a cigarette box, a lighter, and multiple used cigarettes inside the storage compartment of the rolling walker. During an interview at the time, Resident #32 said he/she usually gives the smoking materials to the Nurse to be kept at the nurses station but he/she had been out to smoke earlier that morning and was planning to go to out smoke again, so he/she kept the smoking materials in the storage compartment of the rolling walker. Resident #32 also said that he/she likes to save used cigarettes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/25 at 8:22 A.M., Nurse #6 said that Resident #32 should not have any smoking materials in his/her possession. Nurse #6 was then observed to retrieve the smoking materials from Resident #32. During an interview on 4/24/25 at 9:53 A.M., Unit Manager (UM) #1 said that residents are required to adhere to the facility policy regarding smoking. UM #1 said that all smoking materials should have been kept at the nurses station and when the residents want to go and smoke, they come to the desk and get their smoking materials. UM #1 said Resident #32 should not store his/her smoking materials and used cigarettes in the storage compartment of the rolling walker because it was a fire hazard. Review of the MDS submission schedule for Resident #32 indicated the following: -7/27/25: Quarterly MDS submitted and accepted -10/24/24: Annual MDS submitted and accepted -1/22/25: Quarterly MDS submitted and accepted Review of Resident #32's clinical record indicated a facility smoking safety screen was completed 7/22/24 and identified Resident #32 as safe to smoke with supervision. The clinical record further indicated a facility smoking safety screen completed 1/31/25 that identified Resident #32 as safe to smoke independently. Further review of Resident #32's clinical record failed to indicate that a facility smoking safety screen had been completed between the completion of the 7/27/24 facility smoking safety screen and the 1/22/25 facility safe smoking screen. During an interview on 4/28/25 at 11:35 A.M., the Director of Nursing (DON) said that Resident #32 began to smoke about four or five months ago. The DON said that smoking safety screens were completed initially when a Resident indicates wanting to smoke and then quarterly as part of the MDS assessment. During a follow-up interview on 4/28/25 at 3:58 P.M., the DON said Resident #32 had a smoking safety screen completed on 7/22/24 and 1/31/25, but could not provide evidence that a smoking safety screen had been completed quarterly. During an interview and policy review at the same time, the Assistant Director of Nurses (ADON) said that a smoking safety screen should have been completed in October 2024 with the quarterly MDS assessment, but was not completed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to ensure appropriate care and services were provided for one Resident (#45) out of a total sample of 25 residents, when the Resident was identified as being at risk for altered nutrition status. Specifically, for Resident #45, the facility failed to perform a nutritional assessment when the Resident was admitted to the facility and implement interventions thereafter when the Resident was identified as having experienced a significant weight loss. Findings include: Review of the facility policy titled: Nutrition/Weight Policy, effective 12/1/24, indicated the following: -When weights demonstrate undesired trends, or progressive insidious weight change, or significant weight change (gains or losses) the licensed nurse will document the weight change in the EMR (Electronic Medical Record). -The threshold for significant unplanned and undesired weight change (loss/gain) will be based on the following criteria: a. 1 month -5% weight loss/gain is significant; greater than 5% is severe. b. 3 months -7.5% weight loss/gain is significant; greater than 7.5% is severe. c. 6 months -10% weight loss/gain is significant; greater than 10% is severe. -The Dietician is responsible for monitoring residents, making recommendations and documenting in the medical record, including problems, progress, care plan. Resident #45 was admitted to the facility in February 2025 with diagnoses including Multiple Sclerosis, dysphagia, and Major Depressive Disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #45 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a total possible score of 15. Review of Resident #45's Care Plan for Nutritional Risk, initiated 2/21/25, indicated: -was at nutritional risk due to chronic medical condition significant for MS (Multiple Sclerosis), impaired self-feeding, and increased caloric needs due to uncontrolled spastic movements. -The care plan interventions included the following: >Regular diet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>Monitor and record meal intake. >Obtain and monitor lab work as ordered. >RD (Registered Dietician) to evaluate and make diet change recommendations, PRN (pro-re nata - as needed). Review of the clinical record failed to indicate any Nutritional Assessments had been completed by the Dietician for Resident #45. Review of the facility Weight Record for Resident #45 indicated the following weight measurements: -2/19/2025: 129.0 lbs. (pounds) -2/25/2025: 125.6 lbs. -3/5/2025: 126.2 lbs. -3/12/2025: 122.6 lbs. -3/28/2025: 118.8 lbs. -4/4/2025: 117.4 lbs. Further review of Resident #45's weight record indicated the Resident experienced a 7.5% weight loss (severe) from 3/5/25 to 4/4/25 and a 9.8% weight loss (severe) from 2/19/25 to 4/4/25. Review of Resident #45's Nursing Progress Note, dated 4/6/25, indicated: -the Physician was in to see the Resident -weights were reviewed -a new order for a dietary consult. Review of Resident #45's Physician Progress Note, dated 4/8/25, indicated weight loss, poor PO (per-os-by mouth) intake, and a dietary evaluation was requested to assess malnutrition. Review of the facility documentation titled At Risk Meeting for Resident #45 indicated: -4/3/25 weight: 118.8 lbs., and no intervention documented. -4/10/25 weight: 117.4 lbs., and no intervention documented. Further review of Resident #45's clinical record failed to indicate that any progress notes or nutritional assessments had been entered by the Dietician. (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 4/28/25 at 10:06 A.M., the Dietician said that when a resident was admitted to the facility, a Nutritional Assessment should be completed within a day or two of the admission. The Dietician said when Resident #45 was admitted to the facility she did not complete a Nutritional Assessment and one should have been completed. The Dietician also said that no Nutritional Assessment had been completed at any time for Resident #45 since he/she has been residing in the facility. The Dietician said she could not recall if nursing had made her aware of Resident #45's weight loss. The Dietician further said she had not reviewed Resident #45's weight record and was not aware that the Resident had experienced a significant weight loss, but she should have reviewed Resident #45's record and been aware of the weight loss. During an interview on 4/28/25 at 10:14 A.M., Unit Manager (UM) #1 said that when resident weights are obtained by the Certified Nurses Aide (CNA), they are reported to the Nurse and the Nurse enters the weight directly into the electronic medical record (EMR). UM #1 said if the Nurse identifies an issue with the resident weight, then the Nurse is expected to notify the Dietician and Physician via phone call of the weight issue and document the notification in the progress notes. UM #1 said the Nurses occasionally make her aware of a weight issue but not all the time. UM #1 further said that Resident #45 had been discussed weekly during the At Risk Meeting where his/her appetite and weights were reviewed. UM #1 said that she was not made aware of Resident #45's weight loss and said that Resident #45 was a picky eater.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide respiratory care and services consistent with professional standards of practice for two Residents (#36 and #93) out of a total sample of 25 residents. Specifically, 1. for Resident #36, the facility failed to ensure a clean and sanitary oxygen concentrator (device used to deliver supplemental oxygen) filters in accordance with the manufacturers' guidelines when the air intake gross particle filter was observed with a thick coating of dust, placing the Resident at risk of equipment malfunction and inhaling dust particulate matter. 2. for Resident #93, the facility failed to maintain the Resident's oxygen concentrator filter as required, placing the Resident at risk for impaired oxygen supply delivery and inhaling contaminated oxygen. Findings include: Review of the Invacare Platinum XL II user manual dated, 8/9/06, indicated: -Remove each filter and clean at least once a week depending on environmental conditions. Note: Environmental conditions that may require more frequent cleaning of the filters, include but are not limited to: high dust, air pollutants, etc. -Clean the cabinet filters with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. -Dry the filters thoroughly before installation. Caution do not operate the concentrator without the filters installed. Review of the New Life Elite Airsep user manual, last revised February 2014, indicated: -Clean the air inlet gross particle filter with warm soapy water between each patient's use. -Clean this filter at least once per week, depending on the environment, during normal operation. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Equipment, maintenance and supervision: >All oxygen delivery equipment should be checked at least once daily . >Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. Review of facility policy titled Equipment Change/Disinfection, effective April 2022, indicated: -All respiratory equipment, if not disposable, will be sanitized after a patient's use and before storing. -Oxygen concentrators: rinse and dry the external filter weekly and as needed when visibly dusty. Wipe down the concentrator when visibly dusty or soiled. 1. Resident #36 was admitted to the facility in February 2024, with diagnoses including Encephalopathy and Obstructive Sleep Apnea (OSA). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #36: -was severely cognitively impaired as evidence by a Brief Interview for Mental Status (BIMS) score of 0 out of 15 possible points. -was receiving oxygen therapy. -was dependent on staff for activities of daily living (ADL - washing, bathing, grooming) care. Review of Resident #36's April 2025 Physician's orders indicated: -Change or clean oxygen air exchange grid weekly, every night shift, every Tuesday, initiated 12/17/24. -Change oxygen tubing, humidifier bottle and rinse filter weekly on Tuesday 11-7 shift, every night shift every Tuesday, initiated 11/26/24. -Oxygen at 1-5 Liters continuously via nasal cannula (thin, flexible tube that wraps around the head, with two prongs that fit inside the nostrils to provide a steady flow of oxygen from an oxygen supply) to maintain pulse oximeter above 90% (list Physician parameters). -May use portable oxygen when out of room, initiated 11/24/24. Review of Resident #36's April 2025 Treatment Administration Record (TAR) indicated that the Resident's air exchange grid had been changed/cleaned and that the oxygen filter had been rinsed on: -4/1/25 -4/8/25 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/15/25 -4/22/25 On 4/23/25 at 8:54 A.M., the surveyor observed Resident #36 lying in bed with a nasal cannula in his/her nostrils connected to an oxygen concentrator (New Life Elite Airsep). The surveyor observed a bottle of sterile water on the floor next to the concentrator and the oxygen concentrator was observed to have a thick coating of dark gray dust on the air intake gross particle filter. During an interview at the time, Resident #36 said that he/she was having difficulty breathing. On 4/24/25 at 8:01 A.M., the surveyor observed Resident#36 lying in bed with a nasal cannula in his/her nostrils, that was connected to an oxygen concentrator with a thick coating of dark gray dust on the air intake gross particle filter. During an interview at the time, Resident #36 said that he/she continues to have trouble with his/her breathing. On 4/28/25 at 7:39 A.M., the surveyor and Nurse #4 observed Resident #36's oxygen concentrator. The oxygen concentrator's air intake gross particle filter was observed covered in a thick coating of gray dust. During an interview at the time, Nurse #4 said that the filter on the oxygen concentrator should be cleaned every week, and it had not been. Nurse #4 also said that the bottle of sterile water should not have been on the floor, as the oxygen concentrator has a space for the water bottle to be stored. 2. Resident #93 was admitted to the facility in May 2024, with diagnoses including Chronic Diastolic Heart Failure, unsteadiness on feet and history of falls. Review of the Minimum Data Set (MDS) Assessment, dated 2/18/25, indicated that Resident #93: -was moderately cognitively impaired as indicated by a Brief Interview for Mental Status (BIMS) score of 11 out of a total possible score of 15. -was receiving oxygen therapy. -was receiving partial/moderate assistance from staff for activities of daily living (ADL - washing, bathing, grooming) care. Review of Resident #93's April 2025 Physician's orders indicated: -Oxygen at (1-2) Liters as needed via nasal cannula, maintain pulse oximeter above 90%. May use portable oxygen when out of room, start date 11/1/24 -Change or clean oxygen air exchange grid weekly, every night shift every Tuesday, start date 5/21/24 -Change oxygen tubing and rinse filter weekly on Tuesday during the 11-7 shift, every night shift, start date 5/21/24 Review of Resident #93's April 2025 TAR indicated that the Resident's air exchange grid had been changed/cleaned and that the oxygen filter had been rinsed on: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/1/25 -4/8/25 -4/15/25 -4/22/25 On 4/23/25 at 8:04 A.M., the surveyor observed Resident #93 sitting in a chair next to his/her bed. The surveyor further observed Resident #93's nasal cannula laying on his/her bed, connected to an oxygen concentrator (Invacare Platinum XL II) with a removable filter located on the left side covered with a thick coating of gray dust. During an interview at the time, Resident #93 said that he/she only uses oxygen at night during sleep. On 4/24/25 at 8:41 A.M., the surveyor observed Resident #93 lying in bed with nasal cannula in his/her nostrils and connected to the oxygen concentrator. The surveyor observed the filter on the left side of the oxygen concentrator remained covered in a thick layer of gray dust. During an interview at the time, Resident #93 said while looking at the filter on the concentrator, I don't want to breathe that in. On 4/28/25 at 7:33 A.M., the surveyor and Nurse #4 observed that Resident #93's oxygen concentrator remained with the removable air filter covered in a thick coating of gray dust. During an interview at the time, Nurse #4 said that the filter on the oxygen concentrator should be cleaned weekly, and it appeared to have not been cleaned in a long time as the coating of dust was thick.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, and record review, the facility failed to ensure Medication Regimen Reviews (MRRs) were responded to and/or implemented timely for one Resident (#34), out of five applicable residents reviewed for unnecessary medications, out of a total sample of 25 residents. Specifically, for Resident #34, the facility failed to ensure that duplicate recommendations from the Consultant Pharmacist were reviewed and responded to by the Provider and/or nursing staff, and that orders were implemented timely relative to: -obtaining a Vitamin D level made on 5/3/24, 6/2/24, and 7/2/24. -discontinuation of Loratadine (antihistamine medication) made on 10/2/24, 11/4/24, 12/6/24, and 1/2/25. Findings include: Review of the facility policy titled Drug Regimen Review, dated 4/2022, indicated the following: -Consultant Pharmacist reviews the medication regimen of each active resident at least monthly -Findings and recommendations are reported to the Director of Nurses (DON) and the Medical Director. -The Consultant Pharmacist documents the date each medication regimen review is completed in the residents' medical record .and briefly notes the findings. -The Consultant Pharmacist documents all potential or actual significant nursing documentation problems found relating to medications and communicates them in writing to the DON and the Medical Director. -The facility maintains copies of completed reports on file and according to facility policy . Resident #34 was admitted to the facility in May 2024 with diagnoses including Dementia and Chronic Kidney Disease (CKD). Review of the Consultant Pharmacist Progress Notes indicated the following repeated recommendations: -5/3/24: recommend Vitamin D level -6/2/24: recommend Vitamin D level -7/2/24: recommend Vitamin D level (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's clinical record failed to indicate documented evidence of the Consultant Pharmacist's recommendation dated 5/3/24, or if the recommendation was reviewed and/or responded by the Provider. Further review of the Resident's clinical record indicated the Provider reviewed and consented to the Consultant Pharmacist's recommendation (dated 6/2/24) on 6/11/24. There was no documented evidence that the Consultant Pharmacist's recommendation to check Resident #34's Vitamin D level was implemented until after the MRR dated 7/2/24 (which was reviewed and consented to by the Provider again on 7/3/24) and a Vitamin D level was obtained on 7/5/24. Review of the Consultant Pharmacist Progress Notes indicated the following repeated recommendations: -10/2/24: to the Medial Doctor (MD) - Recommend continued need for Loratadine medication. -11/4/24: to Nursing - Recommend follow through with Consultant Pharmacist's recommendation to discontinue Loratadine. -12/6/24: to Nursing - Recommend follow through with Consultant Pharmacist's recommendation to discontinue Loratadine. -1/2/25: to Nursing - Recommend follow through with Consultant Pharmacist's recommendation to discontinue Loratadine. Review of Resident #34's clinical record indicated the Consultant Pharmacist's MRR dated 10/2/24 was reviewed and the Provider agreed to discontinue the Resident's Loratadine medication on 10/8/24. There was no documented evidence of the MRRs dated 11/4/24, 12/6/24, and 1/2/25. Further review of the clinical record indicated the Loratadine was not discontinued until 2/4/25. During an interview on 4/25/25 at 3:31 P.M., the surveyor requested evidence from the DON of the Consultant Pharmacist MRRs not located in the Resident's record, dated 5/3/24, 11/4/24, 12/6/24, and 1/2/25. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/25 at 4:12 P.M., the surveyor and the DON reviewed Resident #34's clinical record. During an interview at the time, the DON said she was unable to find evidence that the Resident's Vitamin D level was drawn sooner than 7/5/24, when the recommendation to draw the Vitamin D level was agreed to by the Provider on 6/11/24 and 7/3/24. The DON said she was unable to find the corresponding MRR request for the Vitamin D level dated 5/3/24. The DON further said she was unable to find the corresponding MRRs dated 11/4/24, 12/6/24, and 1/2/25, for Resident #34. The DON said the Consultant Pharmacist's Recommendations were emailed directly to the Unit Manager (UM), who was currently on vacation, printed out, and put in the Provider's Communication Book. The DON said once the Provider responds to the MRR, the order is implemented if applicable, and the MRR is scanned into the Resident's electronic medical record. The DON said she would expect that there would not be repeated requests made by the Consultant Pharmacist and that recommendations made would be responded to timely by the facility staff. The DON said nursing staff should be checking the Provider's Communication Book every shift for new orders and communication. The DON further said her expectation was when the Provider agreed with the Consultant Pharmacist's Recommendations, nursing would implement those orders immediately. The DON said if the Consultant Pharmacist makes recommendations for Nursing, those recommendations should also be addressed immediately. During a follow-up interview on 4/25/25 at 4:37 P.M., the DON said she was unable to say why the Loratadine medication was not discontinued on 10/18/24 when the Provider agreed to discontinue the medication. Please refer to F757

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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. Based on interview and record review, the facility failed to ensure one Resident (#34) was not administered unnecessary medications, of five applicable residents reviewed for unnecessary medications, out of a total sample of 25 residents. Specifically, the facility failed to ensure the Consultant Pharmacist Recommendation to discontinue scheduled Loratadine (antihistamine medication), that was approved by the Provider on 10/8/24, was discontinued and Resident #34 continued to receive the scheduled doses of the medication until it was discontinued on 2/4/25 (over three months later). Findings include: Resident #34 was admitted to the facility in May 2024 with diagnoses including Dementia and Chronic Kidney Disease (CKD). Review of the Consultant Pharmacist Progress Notes indicated the following repeated recommendations: -10/2/24: to the Medial Doctor (MD) - Recommend continued need for Loratadine medication -11/4/24: to Nursing - Recommend follow through with Consultant Pharmacist's Recommendation to discontinue Loratadine. -12/6/24: to Nursing - Recommend follow through with Consultant Pharmacist's Recommendation to discontinue Loratadine. -1/2/25: to Nursing- Recommend follow through with Consultant Pharmacist's Recommendation to discontinue Loratadine. Review of Resident #34's clinical record indicated the Consultant Pharmacist's MRR dated 10/2/24 was reviewed and the Provider agreed to discontinue the Resident's Loratadine medication on 10/8/24. Review of a Nurse's Progress Note, dated 10/9/24, indicated the Provider reviewed the Consultant Pharmacist's Recommendation to discontinue Loratadine and was in agreement. Review of October 2024 through February 2025 Medication Administration Records (MARs) indicated Resident #34: -was administered Loratadine 10 milligrams (mg) daily as ordered, with the following exceptions: >10/17/24 >10/21/24 through 10/29/24, due to the Resident being hospitalized . -was discontinued on 2/4/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/25 at 4:12 P.M., the surveyor and the Director of Nursing (DON) reviewed Resident #34's clinical record. During an interview at the time, the DON said the Consultant Pharmacist's Recommendations were emailed directly to the Unit Manager (UM), (who was currently on vacation), printed out, and put in the Provider's Communication Book. The DON said once the Provider responds to the MRR, the order is implemented, if applicable, and the MRR is scanned into the Resident's electronic medical record (EMR). The DON said she would expect that recommendations made by the Consultant Pharmacist would be responded to timely by the facility staff. The DON said nursing staff should be checking the Provider's Communication Book every shift for new orders and communication. The DON further said her expectation was when the Provider agreed with the Consultant Pharmacist's Recommendations, nursing would implement those orders immediately. The DON said if the Consultant Pharmacist makes recommendations for Nursing, those recommendations should also be addressed immediately. During a follow-up interview on 4/25/25 at 4:37 P.M., the DON said she was unable to say why the Loratadine was not discontinued on 10/8/24 when the Provider agreed to discontinue the medication. The DON said she understood the concern relative to unnecessary medication administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to maintain a medication pass error rate of less than five percent (%) for two Residents (#11 and #47), out of five applicable residents, out of 29 medication pass opportunities. The medication error rate was observed to be 6.9%. Specifically, 1. For Resident #11, the Resident was administered the wrong medication dosage form when a Ferrous Sulfate tablet was administered and Ferrous Sulfate Oral Solution was ordered. 2. For Resident #47, the Resident was administered the incorrect dosage of Fish Oil when 2000 mg (milligrams) of Fish Oil was administered and 1000 mg of Fish Oil was ordered. Findings include: Review of the facility policy titled Medication and Treatment Orders, effective June 2022, indicated the following: -Policy: Orders for medications and treatments will be consistent with principles of safe and effective order writing. -Medications shall be administered only upon the written order of physician/NP/PA licensed in MA. Review of the facility policy titled Specific Medication Administration Procedures, effective January 2024, indicated the following: -Policy: To administer medications in a safe and effective manner. -Review the Five (5) Rights of Medication Administration three (3) times: 1) Prior to removing the medication package/container from the cart/drawer. 2) Prior to removing the medication from the container. 3) After the dose has been prepared and before returning the medication to storage. 1. Resident #11 was admitted to the facility in April 2023, with diagnoses including unspecified sequelae of Cerebral Infarction, hemiplegia and hemiparesis following Cerebral Infarction affecting right dominant side, Dysphagia oral phase, and Adult Failure to Thrive. Review of Resident #11's Physician's orders dated 4/24/25, indicated the following: -Ferrous Sulfate Oral Solution 220 ([44 Fe] [Iron]) milligrams (mg)/5 milliliter (ml) (Ferrous Sulfate). Give 7.5 ml via G-Tube (a tube that is placed directly into the stomach through an abdominal wall incision for the enteral [passing through the gastrointestinal tract] administration of food, fluids, and medication) in the morning for supplement. 7.5 ml = 330 mg. Start date 4/10/25. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 9:40 A.M., during a medication administration pass, the surveyor observed Nurse #2 prepare (including crushing) and administer the following medication to Resident #11 via G-Tube: -Ferrous Sulfate 325 mg [65] one tablet. Review of Resident #11's April 2025 Medication Administration Record (MAR), indicated: -Nurse #2 electronically signed that he had administered Ferrous Sulfate Solution 220 (44 Fe) mg/5 ml (Ferrous Sulfate) 7.5 ml via G-Tube at 9:00 A.M. on 4/24/25. During an interview on 4/24/25 at 2:14 P.M., Nurse #2 said that the Physician order indicated to administer Ferrous Sulfate Oral Solution 330 mg, and he administered Ferrous Sulfate in tablet form Resident #11 via G-Tube. Nurse #2 said that he should have administered Ferrous Sulfate Oral Solution but had not done so. 2. Resident #47 was admitted to the facility in November 2023, with diagnoses including normal pressure hydrocephalus, Parkinson's Disease without dyskinesia without mention of fluctuations, Atherosclerotic Heart Disease of native coronary artery without Angina Pectoris, presence of Coronary Angioplasty implant and graft, and unspecified Dementia unspecified severity with other behavioral disturbance. Review of Resident #47's Physician's orders dated 4/28/25, indicated the following: -Fish Oil Oral Capsule 500 mg (Omega-3 Fatty Acids). Give 2 capsules [total = 1000 mg] by mouth one time a day for supplement. Start date 1/25/24. On 4/28/25 at 8:40 A.M., during a medication administration pass, the surveyor observed Nurse #3 prepare and administer Fish Oil 1000 mg Oral Capsule, two capsules [total = 2000 mg] administered to Resident #47 by mouth. Review of Resident #47's April 2025 Medication Administration Record (MAR), indicated the following: -Nurse #3 electronically signed that she administered two capsules of Fish Oil Oral Capsule 500 mg (Omega-3 Fatty Acids) by mouth at 8:00 A.M. on 4/28/25. During an interview on 4/28/25 at 10:50 A.M., Nurse #3 said that the Physician order indicated to administer Fish Oil 500 mg, two capsules, and that she administered Fish Oil 1000 mg, two capsules. Nurse #3 said that she should have administered one -1000 mg capsule of Fish Oil, but had instead administered two -1000 mg capsules of Fish Oil.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, and interview, the facility failed to follow professional standards of practice for food safety and sanitation in the facility's main kitchen to prevent contamination and the potential spread of foodborne illnesses. Specifically, the facility failed to ensure that food items stored in the walk-in refrigerator in the facility main kitchen area were properly labeled and dated as required. Findings include: Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated but was not limited to: -501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when Packaging Food using a Reduced Oxygen Packaging method as specified under §3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours: > shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. >The day of [Food] preparation shall be counted as Day 1. Review of the facility policy titled Dietary - Food Storage effective 2/2022 indicated the following: -Refrigerated Storage: Prepared foods will be kept, covered, labeled with contents and dated. -Leftover poultry, fish, eggs, or meat products must not be stored more than 48 hours at refrigerator temperatures. On 4/23/25 at 7:17 A.M., the surveyor and the Food Service Director (FSD) observed the following in the main kitchen walk in refrigerator: -one large stainless steel mixing bowl containing ham salad, that was unlabeled and undated. -one open clear plastic bag containing cubed chicken, that was unlabeled and undated. -one open clear plastic container containing halved tomatoes, that was unlabeled and undated. -one open clear plastic container containing sliced cucumbers, that was unlabeled and undated. -one open clear plastic container containing diced onions, that was unlabeled and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview immediately following the observation, the FSD said that all food items in the refrigerator were supposed to be labeled and dated with the date the food item was first opened. The FSD further said that the undated food items in the refrigerator should have been discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225312	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blackstone Valley Health and Rehabilitation	447 Hill Street Whitinsville, MA 01588

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on record review, and interview, the facility failed to ensure that specialized rehabilitation services were provided to assist in maintaining the highest practicable level functioning for one Resident (#74) out of a total sample size of 25 residents. Specifically, for Resident #74, the facility failed to ensure that Physical Therapy (PT) Evaluations were completed timely as ordered by the Physician for symptoms of bilateral knee pain and stiffness. Findings include: Resident #74 was admitted to the facility in June 2024 with diagnoses including bilateral primary Osteoarthritis of the knees. Review of the Facility Policy titled Scope of Services, Rehabilitation, revised February 2022 indicated: -Residents are screened and/or evaluated by Physical, Occupational and Speech Therapy according to demonstrated need in a specific area -Such therapy encompasses examination and analysis of patients to maximize functional independence: >A therapy screen to assess the need for skilled service >An initial evaluation and assessment of the patient prior to provision of services >A determination and development of treatment goals and plans in accordance with the residents' stated wishes/choices, diagnosis and prognosis with a treatment plan established to meet both the patient and therapist's goals Review of the most recent Minimum Data Set (MDS) Assessment, dated 3/13/25, indicated Resident #74: -received scheduled pain medication. -participated in the pain interview with responses including: >frequently having pain that interferes with sleep. >occasionally having pain that interferes with day-to-day activities. >a pain level of 4/10 (4 out of 10). Review of Resident #74's clinical record indicated the following: (continued on next page)

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	225312	A. Building B. Wing	04/29/2025

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident had a Consultation on 10/8/24 with an Orthopedic Physician. The Orthopedic Physician gave a referral for PT to evaluate and treat for bilateral knee Osteoarthritis, 2-3 times a week for a duration of 6-8 weeks. -no evidence that a PT evaluation had been completed related to the Orthopedic Physician's referral given on 10/8/24. -a request for a rehabilitation screen from the facility nursing department dated 2/10/25, due to increased pain in the Resident's bilateral knees (four months after the initial Physician's referral). -a Physician's order on 2/11/25 to obtain a PT evaluation for bilateral knee stiffness/pain. Review of a Rehabilitation Screen signed and dated by Rehabilitation Staff #1 on 2/24/25, indicated that Resident #74: -was approached on 2/12/25 for a skilled PT evaluation but the Resident was not feeling well due to nausea and diarrhea -Occupational Therapy (OT) evaluation would be completed that week. Review of the Occupational Therapy Evaluation completed for Resident #74 on 2/26/25, indicated: -no assessment of knee pain or stiffness. Review of Resident #74's clinical record failed to indicate evidence the Resident was re-approached by Physical Therapy for a PT evaluation after symptoms of nausea and diarrhea had resolved. During an interview on 4/28/25 at 10:39 A.M., Rehabilitation Staff #1 said she was not aware the Resident had been seen by an Orthopedic Physician in October 2024 or that there had been a PT referral from the Orthopedic Physician. Rehab Staff #1 said she was not in the facility at that time, and she would look for any evidence that Resident #74 had been seen by a PT. Rehab Staff #1 said Resident #74 was not seen by PT in February 2025, the Resident was evaluated by Occupational Therapy for a decline in function even though the order was specified for PT to address knee pain and stiffness. Rehab Staff #1 said that the Rehabilitation Department may have been short staffed at the time the order for PT was written. The surveyor and Rehab Staff #1 reviewed the Occupational Therapy documentation, and Rehab Staff #1 said there was no assessment of knee stiffness or pain on the OT Evaluation as indicated in the Physician's order for Physical Therapy on 2/11/25. During a follow-up interview on 4/28/25 at 10:55 A.M., Rehab Staff #1 said she had no evidence that Resident #74 had been seen by PT in October 2024 to address the referral from the Orthopedic Physician written on 10/8/24. Rehab Staff #1 said Resident #74 should have been seen by a Physical Therapist as ordered by the Physician at that time but had not been seen.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, and interview, the facility failed to adhere to infection prevention and control standards of multi-resident use medical equipment to prevent the development and transmission of communicable diseases and infections for one Resident (#108), out of a total sample of 25 residents. Specifically, the facility staff failed to clean and disinfect a blood glucose monitor (BGM- device used to measure the amount of glucose [sugar] in a person's blood) after using the BGM to obtain a blood glucose level for Resident #108 and before storing in the medication cart with clean equipment. Findings Include: Review of the facility policy titled: Disinfecting Shared Resident Equipment indicated the following: -It is the policy of the facility to clean/disinfect shared equipment in order to decrease the risk of infection. -Disinfecting all resident shared equipment with the method recommended depending on the object's intended use and type of contamination will be done routinely. On 4/24/25 at 9:41 A.M., during a medication administration observation, the surveyor observed Nurse #5 obtain a blood glucose level on Resident #108 using a BGM. The surveyor observed Nurse #5 take the BGM back to the medication cart, place the BGM on top of the medication cart and documented the blood glucose level in Resident #108's electronic medical record. Nurse #5 was then observed to place the BGM on top of other equipment inside the drawer of the medication cart. During an interview on 4/24/25 at 9:50 A.M., Nurse #5 said she forgot to clean the BGM after she used the monitor on Resident #108. Nurse #5 said she should have cleaned and disinfected the BGM before putting it back into the medication cart with the other clean equipment. During an interview on 4/24/25 at 9:53 A.M., Unit Manager (UM) #1 said that all shared resident care equipment should be cleaned and disinfected between each resident use. UM #1 said that Nurse #5 should have cleaned and disinfected the BGM after she used it to obtain a blood glucose level on Resident #108, and before placing the BGM into the medication cart. During an interview on 4/29/25 at 9:24 A.M., the Infection Preventionist (IP) said that Nurses were expected to clean and disinfect the BGM with either a purple top disinfectant wipe or a bleach wipe after each use to prevent the spread of infection.