STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225317	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Jewish Home	538 Robeson Street Fall River, MA 02720

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 36542 Based on record review and interview, the facility failed to ensure resident representatives were provided the opportunity to participate in the care planning process, to be included in decisions and changes in the care plan, and failed to ensure that care planning meetings were held to review and make changes in the care plan as needed for one Resident (#8), out of a total sample of 15 residents. Findings include: Review of the facility's policy titled Care Planning- Interdisciplinary Team, undated, indicated the following: -the resident, the resident's family and/or the resident's legal representative/guardian are encouraged to participate in the development of and revisions to the resident's care plan -care plan meetings are scheduled at the best time of the day for the resident and family when possible -if it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record Resident #8 was admitted to the facility in January 2021 and had an invoked Health Care Proxy. During an interview on 6/7/24 at 12:05 P.M., the Health Care Proxy of Resident #8 said she had not been invited to care plan meetings in about a year and a half. She said prior to then she was invited to care plan meetings and now she did not know when they were being held. During an interview on 6/11/24 at 1:20 P.M., the Administrator said the care plan process is initiated through the MDS (Minimum Data Set) process and care plans are held following the MDS to review a Resident's plan of care. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 2:00 P.M., Social Worker #2 said she started consulting at the facility in December 2023, two or three days per week. She said at that time she was provided with a list of residents and representatives to invite to the care plan meetings from the previous MDS nurse. She said the MDS nurse left in February and there had not been a process in place since that time and she was no longer given a list of residents or representatives to invite to care plan meetings or for which residents to have care plan meetings for. She said she was unable to locate any documentation to indicate the Resident's representative was invited to the care plan meeting.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 36542 Based on interviews and record review, the facility failed to ensure mail was delivered, unopened to residents. Specifically, the facility failed to maintain the privacy of Resident #2 by opening his/her mail, completing a form on their behalf and mailing the form back to an agency without ever having presented the mail to the Resident. Findings include: Resident #2 was admitted to the facility in February 2024. Review of the Minimum Data Set (MDS) assessment, dated 2/21/24, indicated Resident #2 scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Review of the medical record indicated Resident #2 was their own responsible person for financial and medical decisions. During an interview on 6/6/24 at 12:00 P.M., Resident #2 said the facility Receptionist, who was also responsible for the business office, had opened his/her mail from a community agency, filled out a form and returned the form to the agency. The Resident said the Receptionist had never asked if she could open the Resident's mail and had not notified the Resident that she had completed a form and mailed it back to the agency. The Resident said he/she had informed the Administrator about this when it occurred in March 2024 and was worried an additional package had been opened prior to the Resident receiving it. Review of the medical record indicated that on 3/21/24 Resident #2 was at the reception area yelling at the Receptionist. During an interview on 6/11/24 at 2:25 P.M., the Receptionist said the facility had an external billing company and she was responsible for coordination with that billing company, including resident bills, resident patient needs accounts and insurance status. She said she had accidentally opened the mail of Resident #2 and filled out a form and mailed it to a community agency. She said she could not recall what agency it was but that it was not from the Social Security Administration or Medicaid. She said the mail had been addressed to the Resident and not to the facility business office. She said the Resident continued to get their own monthly income, had not been paying the facility the patient paid amount, had been spending their money on shopping and would soon have an upcoming overdue bill. When asked why she had opened the mail, the Receptionist then discussed the Resident's psychosocial status prior to being at the facility. The Receptionist said when residents are admitted they sign a form indicating the facility can open their mail. Review of the admission packet for Resident #2 indicated Resident #2 signed the Admission Agreement in March 2024. The last page of the packet was titled Authorization for Facility to Open Certain Mail which authorized the facility to open mail sent by The Department of Social Services, the Social Security Administration and the Department of Health and Human Services. Review of the form indicated Resident #2 did not sign the form and had not consented for the facility to open certain mail. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 2:45 P.M., the Receptionist said she did not know Resident #2 did not sign the form to authorize the facility to open certain mail. During an interview on 6/12/24 at 7:33 A.M., the Administrator said she had not been the Administrator at the time of the incident and became aware of it following the surveyor inquiry on 6/11/24. She said the Receptionist opening the mail of Resident #2 was a violation of this Resident's rights.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49424 Based on policy review, record review, and interview, the facility failed to inform 3 out of 3 Residents, or their representatives, of potential liability for payment for non-covered services including estimated cost of services. Findings include: Review of the facility's policy titled Medicare Denials-Advance Beneficiary Notice, dated 6/2019, indicated but was not limited to the following: -The notice must note the care to be provided, the reason Medicare will not pay, and the estimated costs for the services. The Advanced Beneficiary Notice (SNF/ABN) is a form which provides information to residents and/or their representatives so they can decide if they wish to continue receiving the skilled services, they are receiving at the facility that may not be paid for by Medicare and assume financial responsibility. Review of the records for three Residents who had been taken off their Medicare Part A benefit indicated the facility failed to provide information to 3 out 3 Residents regarding potential financial liability on the SNF/ABN form. During an interview on 6/11/24 at 12:36 P.M., Social Worker #2 said she issues the ABN when she is made aware of the need. She said there should be a financial amount that is listed on the form for what the estimated cost would be if the resident or resident representative wished to continue services and/or know what the financial responsibility is expected to be. During an interview on 6/11/24 at 1:32 P.M., the Administrator said the Executive Assistant is responsible for putting the estimated cost per day so the resident or resident representative receiving the notice is aware of the estimated cost per day for services. She said the ABN form did not include the cost because the Residents have alternative insurance but agreed the cost per day should be identified in the event the resident or resident representative did not have insurance coverage and/or wished to continue to pay for services. During an interview on 6/11/24 at 3:16 P.M., the Executive Assistant said she provides the ABNs for the social service department to issue and she is responsible for putting the estimated cost on the forms, so residents and representatives know the estimated financial liability per day if they choose to continue services.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 36542 Based on interviews and record review, the facility failed to formulate a written grievance and follow up with one Resident (#2) following a voiced grievance. Specifically, Resident #2 voiced concerns regarding staff opening his/her mail, completing a form on their behalf and mailing the form back to an agency without ever having presented the mail to the Resident, and the Resident had not received follow up from the facility on the concern. Findings include: Review of the facility's policy titled Grievances, last revised December 2018, indicated the following: -The facility will support each resident's right to voice grievances and ensure that after a grievance has been received, the Grievance Official will collaboratively work with team members to resolve the issue and provide written grievance decisions to the resident. -If a resident has a complaint, a staff member should encourage and assist the resident to file a written grievance with the facility using the Grievance/Complaint form. -The Administrator will review the findings with the person investigating the complaint to determine what corrective actions need to be made. -The Resident will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. This report will be completed by the Administrator or Social Worker within five working days of the receipt of the grievance or complaint with the facility. Resident #2 was admitted to the facility in February 2024. Review of the Minimum Data Set (MDS) assessment, dated 2/21/24, indicated Resident #2 scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Review of the medical record indicated Resident #2 was their own responsible person for financial and medical decisions. During an interview on 6/6/24 at 12:00 P.M., Resident #2 said the facility Receptionist, who was also responsible for the business office, had opened his/her mail from a community agency, filled out a form and returned the form to the agency. The Resident said the Receptionist had never asked if she could open the Resident's mail and had not notified the Resident that she had completed a form and mailed it back to the agency. The Resident said he/she had informed the Administrator about this when it occurred in March 2024 and was worried an additional package had been opened prior to the Resident receiving it. The Resident said no one had followed up with him/her about how this concern was addressed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated that on 3/21/24 Resident #2 was at the reception area yelling at the Receptionist. The writer of the progress note indicated the Receptionist said Resident #2 was upset because his/her checks are being turned over to the facility and not given to [the Resident] entirely. The note indicated a Social Worker would follow up with the Resident. Further review of the medical record failed to indicate any follow up progress notes from the Social Worker to the Resident. Review of the facility provided Grievance binder failed to include a grievance for Resident #2. During an interview on 6/11/24 at 2:00 P.M., Social Worker #2 said she did not have a grievance for Resident #2. She said she was aware of the concern raised by Resident #2 about his/her mail being opened and that the Resident had reached out to the Ombudsman. She said the previous Administrator had been coordinating the follow up on this concern. During an interview on 6/11/24 at 2:25 P.M., the Receptionist said the facility had an external billing company and she was responsible for coordination with that billing company, including resident bills, resident patient needs accounts and insurance status. She said she had accidentally opened the mail of Resident #2, filled out a form and mailed it to a community agency. She said she could not recall what agency it was but that it was not from the Social Security Administration or Medicaid. She said the mail had been addressed to the Resident and not to the facility business office. The Receptionist said she had met with the Administrator at that time and will no longer open this Resident's mail. During an interview on 6/12/24 at 7:33 A.M., the Administrator said she had not been the Administrator at the time of the incident and became aware of it following the surveyor inquiry on 6/11/24. She said she was unable to locate any formal grievance or follow up that was provided to the Resident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36542 Based on interviews and record review, the facility failed to ensure potential misappropriation was reported to the Department of Public Health (DPH) no later than 24 hours in accordance with federal guidelines. Specifically, the facility failed to report when the previous facility allegedly kept $2,213.55 of Resident #19's personal money. Findings include: Review of the facility's policy titled Clinical Services: Abuse, revised March 2023, indicated the following: -Each resident has the right to be free from abuse, neglect and misappropriation of resident property. -Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. -The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and exploitation are reported immediately to the Administrator and Director of Nurses of the facility utilizing the chain of command. -The facility will notify the Department of Public Health and Local Law Enforcement no later than two hours after abuse allegation was received. Resident #19 transferred to the facility in January 2024 from another long term care facility. Review of the medical record indicated Resident #19 had a court appointed legal guardian. During an interview on 6/11/24 at 2:40 P.M., the Receptionist, who was responsible for resident Personal Needs Accounts, said when Resident #19 was admitted to the facility he/she arrived with a physical check (payable to the Resident from the previous facility of their personal funds) for their personal needs account. The Receptionist said she attempted to deposit the check and the check bounced and returned to have insufficient funds and the Resident never received their money. The Receptionist said she had informed her boss about the bounced check and had reached out to Social Security but the Resident still did not have his/her money. Review of documentation indicated Resident #19 had a Personal Needs Account with a balance of $2,213. 55 when he/she left the previous facility and was sent with a physical check. Review of the banking information indicated a check dated 1/19/24 was attempted to be deposited on 2/27/24 and returned for insufficient funds. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 5:25 P.M., the Administrator said she had started at the facility in May 2024 and was not aware that Resident #19 had a check from another facility that had bounced and Resident #19 had yet to receive their own money. During an interview on 6/11/24 at 5:30 P.M., Social Worker #2 said she was not aware there was a bounced check for Resident #19 and that Resident #19 had not received their money from the previous facility. Review of the Health Care Facility Reporting System (HCFRS) failed to indicate the facility had reported that the previous facility had not provided Resident #19 with their $2,213.55. During an interview on 6/12/24 at 7:30 A.M., the Administrator said the previous facility not providing Resident #19 with their money was misappropriation and should have been reported to the Department of Public Health.

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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 49424 Based on record review and staff interview, the facility failed to ensure that a baseline care plan was developed within 48 hours of admission, for two Residents (#20 and #153), out of a total sample of 15 residents, that included the instructions needed to provide effective, person-centered care of the resident, that met professional standards of practice. Specifically, the facility failed: 1. For Resident #20, to implement and initiate a baseline care plan to address mental health diagnoses; and 2. For Resident #153, to provide a copy of the baseline care plan summary to the Resident/Resident Representative. Findings include: Review of the facility's policy titled Care Plans- Baseline, dated 7/26/2017, indicated but was not limited to: -To assure that resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. - Include the minimum healthcare information necessary to properly care for a resident including but not limited to: a. Initial goals based on admission orders; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social Services; f. PASRR recommendations, if applicable. -A copy of the baseline care plan or summary must be provided to the resident or their representative at the time of the resident's 48-hour meeting. 1. Resident #20 was admitted to the facility in January 2024 with diagnoses including but not limited to anxiety disorder, bipolar disorder, and schizoaffective disorder, bipolar type. Review of the Minimum Data Set (MDS) assessment, dated 4/25/24, indicated Resident #20 scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating severe cognitive impairment. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review indicated that Resident #20 had a court appointed legal guardian. The Legal Guardian was unavailable for interview at the time of survey. During an interview on 6/10/24 at 12:09 P.M., Social Worker #1 said she completes an assessment in the electronic medical record titled Social Service 48-hour meeting but does not complete a baseline care plan or provide a copy to the resident at that time. During an interview on 6/11/24 at 2:11 P.M., Social Worker #2 said she completed the 48-hour meeting note seven days after Resident #20 was admitted . She said she did not complete an initial care plan to address the Resident's mental illness at that time or prior to the assessment. She said there has not been a process for baseline care plans since the MDS coordinator position has been vacant back to February. During an interview on 6/13/24 at 9:57 A.M., the Administrator said there have been changes in duties and responsibilities and the care planning process has had lapses due to changes in personnel. 36542 2. Resident #153 was admitted to the facility in May 2024 for short term rehabilitation. Review of the medical record indicated Resident #153 was alert and oriented and their own decision maker. During an interview on 6/6/24 at 2:30 P.M., Resident #153 said he/she did not know what his/her goals were to be able to return to the community and had never had an initial meeting with an interdisciplinary team within two days of admission. The Resident said they had arrived on a Thursday evening around 7:00 P.M., was evaluated by Physical Therapy on Friday and then did not see anyone again until Monday. He/she said they were upset by this and had requested to be discharged , but after meeting with one of the Physical Therapists had agreed to stay at the facility for two weeks. The Resident said he/she did not understand his/her medications including which as needed medications to take and why he/she was taking Potassium. He/she said no one had reviewed their medications with them upon admission. During an interview on 6/11/24 at 8:10 A.M., Social Worker #1 said she was new to the facility, new to long term care, and was learning about what to do for Residents. She reviewed the medical record and said there was no documentation to indicate a summary of the baseline care plan had been provided to Resident #153. She said Social Worker #2 worked at the facility on Tuesdays and Thursdays and was meeting with newly admitted Residents regarding the baseline care plans. During an interview on 6/11/24 at 12:37 P.M., Social Worker #2 said there had not been a summary of baseline care plans provided to Resident #153 within 48-hours of admission.

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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. 36542 Based on interviews and record review, the facility failed to ensure comprehensive care plans were developed for two Residents (#40 and #2) to include nutritional goals and interventions, out of a total sample of 15 residents. Findings include: Review of the facility's policy titled Care Plans- Comprehensive, dated as revised in July 2023, indicated the following: -an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, emotional and psychological needs is developed for each resident -the comprehensive care plan is designed to: incorporate identified problem areas, reflect the resident's expressed wishes regarding care and treatment goals, reflect treatment goals timetables and objectives in measurable outcomes -assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change 1. Resident #40 was admitted to the facility in December 2022 with a diagnosis of dysphagia (difficulty swallowing). Review of the medical record indicated Resident #40 had a significant weight loss in March 2024. Review of a nutrition progress note, dated 3/22/24, indicated Resident #40 had a significant weight loss of 10% over 30 days. The progress note indicated the intake remained fair, the Resident continued to receive a frozen nutritional supplement twice per day and an additional supplement (MedPass) was increased from one time per day to twice per day. Review of the Nutrition Quarterly Assessment, dated 4/23/24, indicated Resident #40 had weight loss in March with an increase in April 2024, had varying intake and received frozen nutrition supplements and MedPass, both twice per day. Review of the medical record failed to include a care plan to indicate the goals or interventions for the nutritional status of Resident #40. During an interview on 6/11/24 at 12:17 P.M., the Registered Dietitian said Resident #40 recently had weight loss and then gained the weight back. He said he had made changes to the interventions in the end of March by increasing the MedPass to twice per day. He said he was not responsible for creating nutritional care plans for Residents. He said the prior Minimum Data Set (MDS) nurse had completed the care plans, but that person was no longer at the facility. He said he was not sure who was creating or updating nutritional care plans for residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 1:20 P.M., the Administrator said there was no one in the facility currently in the MDS nurse position. She said the unit nurses were currently creating nursing care plans and each department was responsible for creating their own care plans (dietary, social services, activities, etc.). She said she did not know the Registered Dietitian was not creating nutritional care plans for Residents. 2. Resident #2 was admitted to the facility in February 2024 with a history of bariatric surgery. Review of the Minimum Data Set (MDS) assessment, dated 2/21/24, indicated Resident #2 scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. During an interview on 6/6/24 at 12:00 P.M., Resident #2 said he/she had bariatric surgery years prior and was following a high protein, low carbohydrate diet to maintain weight loss. He/she said they ordered and purchased their own protein drink supplements, high protein oatmeal and high protein yogurt. Review of the Nutrition Evaluation Comprehensive, dated 2/20/24, indicated Resident #2 had a diet order of regular, regular texture, thin liquids. The evaluation indicated the following: -Snacks/supplements: Core Power (a high protein milk shake) and indicated the Resident had a bunch that he/she had brought to the facility -Comments: Resident reported a history of bariatric surgery in 2020 and drinks protein drinks twice per day Review of the medical record for Resident #2 indicated there were no additional nutritional assessments or progress notes. Review of the care plans for Resident #2 failed to include a care plan to address nutritional needs. During an interview on 6/11/24 at 12:24 P.M., the Registered Dietitian said he had met with Resident #2 for an assessment when the Resident was admitted to the facility. He said he was not creating any care plans with goals and interventions for any of the residents. He said the previous MDS nurse was creating the care plans and he was not sure who was doing that now. He said he did not attend care plan meetings and did not do updates to interventions to any of the care plans. During an interview on 6/11/24 at 1:20 P.M., the Administrator said there was no one in the facility currently in the MDS nurse position. She said the unit nurses were currently creating nursing care plans and each department was responsible for creating their own care plans (dietary, social services, activities, etc.). She said she did not know the Registered Dietitian was not creating nutritional care plans for Residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225317	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Jewish Home	538 Robeson Street Fall River, MA 02720

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 48084 Based on record review, interview, and policy review, the facility failed to provide services that met professional standards of quality for one Resident (#303), out of a total sample of 15 residents. Specifically, the facility failed for Resident #303, to implement orders for the care and management of a Peripherally Inserted Central Catheter (PICC-a thin flexible tube inserted into a vein in the upper arm and guided into a large vein above the right side of the heart called the superior vena cava (SVC) used for intravenous (IV) medications), specifically for monitoring and flushing of a PICC line and changing the equipment for the PICC line. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. -Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, Title: PICC, dated as revised March 11, 2015, indicated but was not limited to the following: -PICC Management activities include dressing the PICC insertion area, accessing the PICC, administering solutions and medications when prescribed. -Nursing care responsibilities, including, but not limited to patient assessment, monitoring, medication administration, potential complications, and documentation criteria. Review of the facility's policy titled Charting and Documentation, undated, indicated but was not limited to the following: -All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. -The following information is to be documented in the resident's medical record: Treatments or services performed. -Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided, the name and title of the individual who provided care, whether the resident refused the procedure/treatment, and the signature and title of the individual documenting. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Infusion Devices/Pumps, dated as last revised 12/2021, indicated but was not limited to the following: -The chart documentation should include bag or cassette change at appropriate time interval, monitoring of catheter site at a minimum of every shift, and documentation to be done every shift and as needed (PRN). Resident #303 was admitted to the facility in April 2023 with diagnoses including Alzheimer's dementia, chronic kidney disease, heart disease, and urinary tract infection (UTI). Review of the Minimum Data Set (MDS) assessment, dated 4/16/24, indicated Resident #303 had severe cognitive impairment as evidenced by a score of 6 out of 15 on the Brief Interview for Mental Status (BIMS) and was dependent on staff for activities of daily living. Review of the Physician's Orders indicated but were not limited to the following: -Monitor PICC line site every shift (three shifts per day) for signs of redness, swelling, or warmth. -Meropenem Solution (antibiotic) 1 gram (gm) IV every 12 hours for bacterial infection for 14 days. -Vancomycin IV Solution (antibiotic) 1000 milligram (mg)/200 milliliters (ml) use 1g IV in the evening for bacterial infection for 14 days. -Change IV tubing every 24 hours at bedtime for IV antibiotic use for 14 days. -Sodium Chloride (NS) Flush Solution 0.9% use 10 ml IV three times a day for flush for 14 days. Flush PICC line with 10 ml NS prior to antibiotic infusion. -NS Flush Solution 0.9% use 10 ml IV three times a day for flush. Flush PICC line with 10 ml NS post antibiotic infusion. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2024 and June 2024 indicated the following: -Monitor PICC line site every shift for signs of redness, swelling, or warmth was not signed off as administered/completed on 5/31/24, 6/1/24, 6/2/24, 6/3/24 (all opportunities) and on 6/4/24 (2 of 3 opportunities). -Meropenem Solution 1 gm IV was signed off as administered as ordered (5/31/24-6/4/24) -Vancomycin IV Solution 1gm IV was signed off as administered as ordered. (6/1/24-6/4/24) -Change IV tubing every 24 hours was not signed off as administered/completed on 5/31/24, 6/1/24, 6/2/24, 6/3/24, and 6/4/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NS Flush Solution 0.9% use 10 ml IV three times a day prior to antibiotic infusion was not signed off as administered/completed on 5/31/24, 6/1/24, 6/2/24, 6/3/24 (all opportunities) and on 6/4/24 (2 of 3 opportunities). -NS Flush Solution 0.9% use 10ml IV three times a day post antibiotic infusion was not signed off as administered/completed on 5/31/24, 6/1/24, 6/2/24, 6/3/24 (all opportunities) and on 6/4/24 (2 of 3 opportunities). Review of the nursing progress notes failed to indicate Resident #303 had refused these treatments. Further review of the nursing progress notes indicated the following: -6/1/24 at 6:01 A.M., PICC line patent and no signs of infection. -6/2/24 at 11:55 P.M., PICC line flushed and patent. -6/3/24 at 6:20 A.M., Continues IV antibiotics, PICC line appears intact, no swelling or redness. The notes above indicated that the PICC line had been flushed on 2 of these 3 occurrences, however they failed to indicate if the PICC was flushed before and after the antibiotic administration as ordered and the MAR/TAR were not signed off. Additionally, the note indicated no signs of infection and/or swelling or redness on 2 of these 3 occurrences, however the MAR/TAR were not signed off. During an interview with Consulting Staff #1 and the new Director of Nurses (DON) on 6/12/24 at 10:38 A.M., Consulting Staff #1 said all those treatments should be signed off as administered/completed on the MAR/TAR as ordered and there should not be any blanks/unsigned boxes on the MAR/TAR. She said the treatments should be done per the orders and they were not. The DON nodded in agreement.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36542 Based on observations, interviews, and record reviews, the facility failed to ensure quality of care was provided, according to the plan of care, facility protocols, and professional standards of practice for two Residents (#28 and #38), out of 15 sampled residents. Specifically, the facility failed: 1. For Resident #28, to ensure wound care treatments were reflective of recommendations from the physician wound consultant and in line with the primary physician treatment plan; and 2. For Resident #38, to ensure wound care treatments and preventative recommendations from the physician wound consultant were implemented and provided in accordance with the treatment orders. Findings include: Review of the facility's policy titled Dressing, Dry/Clean, undated, indicated the following: -the purpose of this procedure is to provide guidelines for the application of dry, clean dressings -verify that there is a physician's order for this procedure -review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs -check the treatment record -document the date and time the dressing was changed 1. Resident #28 was admitted to the facility in April 2023. Review of the Minimum Data Set (MDS), assessment, dated 3/15/24, indicated Resident #28 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. Review of the nursing progress notes indicated that on 5/13/24 Resident #28 sustained a skin tear to the left shin with a new order to cleanse the left shin with normal saline, pat dry, apply Xeroform (a mesh medicated gauze), apply an ABD pad (gauze dressing that absorbs fluid) and wrap with Kling (rolled gauze) loosely twice per day until seen by wound consultant. Review of the Wound Evaluation and Management Summary from the wound consultant, dated 5/16/24, indicated Resident #28 had a skin tear to the left shin measuring 4.9 centimeters (cm) in length by 3.2 cm in width by 0.2 cm in depth. The recommended treatment indicated to cleanse with saline at the time of dressing and use a Hydrocolloid sheet (a thin, sterile, occlusive dressing with a flexible outer layer that helps isolate the wound) three times per week. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Wound Evaluation and Management Summary from the wound consultant, dated 5/30/24, indicated the skin tear to the left shin measured 5 cm in length by 5 cm in width by 0.2 cm in depth. The wound consultant recommendation indicated to discontinue the Hydrocolloid sheet, start a Collagen sheet, an ABD pad, followed by a gauze roll, followed by tape for retention once per day. Review of the Treatment Administration Record (TAR) for Resident #28 indicated the recommended order of a Collagen sheet was initiated on 6/6/24, 7 days after it was recommended. Review of the Wound Evaluation and Management Summary from the wound consultant, dated 6/6/24, indicated the skin tear to the left shin measured 4 cm in length by 4.5 cm in width by 0.2 cm in depth. The wound consultant recommendation indicated to discontinue the Collagen sheet, start Adaptic (designed to help protect the wound while preventing the dressing from adhering to the wound), followed by an ABD pad, followed by a gauze roll and tape for retention. Review of the TAR on 6/11/24 indicated the treatment order continued as Collagen sheet, ABD pad, gauze roll and tape. During an interview on 6/11/24 at 5:15 P.M., Resident #28 said no one had changed his/her dressing on this day, but it had been changed the day before. The Resident said the staff change the dressing every other day. The surveyor observed the Resident to have an adhesive bandage to the left shin, the surveyor did not observe gauze wrap. During an interview on 6/12/24 at 7:45 A.M., Nurse #1 said the process with the wound consultant was that if there was an extra nurse (a nurse not assigned to a medication cart) that nurse would complete wound rounds with the physician, otherwise the assigned unit nurse would complete the wound rounds with the wound consultant. She said she had not completed wound rounds with the wound consultant on 6/6/24. She said she was not sure who checked the Wound Evaluation and Management Summary to determine changes to the treatment or what the process was. She said Resident #28 has a dressing that is changed every Monday, Wednesday and Friday (indicating the previous order, which was discontinued on 6/6/24). During an interview on 6/12/24 at 8:00 A.M., Nurse #1 said she had changed the dressing for Resident #28 this morning and when removing the adhesive bandage, the skin tear started to bleed. She said she was not sure who put the adhesive bandage on Resident #28. During an interview on 6/12/24 at 9:10 A.M., Resident #28 said the skin tear had been improving until this morning when the adhesive bandage was removed and started bleeding. The surveyor observed the left shin to now have a gauze wrap. The Resident said the staff had not previously been wrapping the skin tear. During an interview on 6/12/24 at 2:00 P.M., the Assistant Director of Nurses said a nurse should have accompanied the wound consultant during wound rounds to verify any changes in treatment. She said the treatment orders should have been followed by the nurses and an adhesive bandage should not have been used on 6/11/24. She said the primary physicians have deferred to the wound consultant for treatment recommendations and the orders should be updated to reflect the wound consultant recommendations following the visits. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/24 at 1:50 P.M., Physician #2 said the expectation was for the facility to follow the recommendations from the wound consultant. 2. Resident #38 was admitted to the facility in March 2024 with a vascular ulcer to the left great toe. Review of the MDS assessment, dated 3/9/24, indicated Resident #28 scored 15 out of 15 on the BIMS indicating the Resident was cognitively intact. Review of the Wound Evaluation and Management Summary from the wound consultant, dated 3/28/24, indicated Resident #38 had a wound to the left great toe measuring 1.2 cm in length by 1.1 cm in width by 0. 2 cm in depth. The recommended treatment indicated to apply Calcium Alginate, followed by a gauze island border dressing every day. Additional recommendations indicated to apply lambswool between toes. Review of the TAR indicated the left great toe treatment order for Calcium Alginate was initiated on 4/2/24 and was not provided on 4/3, 4/4, 4/5, 4/7, 4/8, and 4/9/24. There was no indication the recommendation to apply lambswool between toes was implemented. Review of the Wound Evaluation and Management Summary from the wound consultant, dated 4/11/24, indicated Resident #38's wound to the left great toe measured 1 cm in length by 1 cm in width by 0.4 cm in depth. The recommended treatment indicated to apply a Collagen sheet followed by a gauze island border dressing every day. The recommendation to apply lambswool between toes continued. Review of the TAR indicated the left great toe treatment order for Collagen sheet was initiated on 4/13/24 and was not provided on 4/14, 4/17, 4/19, 4/22, 4/23, 4/26, 4/27, 5/1, 5/6, 5/7, 5/9, 5/13, 5/21 and 5/22/24. There was no indication the recommendation to apply lambswool between toes was implemented. Review of the Wound Evaluation and Management Summary from the wound consultant, dated 5/23/24, indicated Resident #38's wound to the left great toe measured 0.7 cm in length by 0.7 cm in width by 0.2 cm in depth. The recommended treatment indicated to continue the Collagen sheet, add Santyl (topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin), followed by a gauze island border dressing every day. The recommendation to apply lambswool between toes continued. Review of the TAR indicated the order for the Collagen sheet followed by the gauze island border dressing continued from 4/13/24 through 6/7/24. The addition of Santyl was not ordered as recommended in the treatment plan by the wound consultant on 5/23/24. Review of the TAR indicated no treatments were completed to the left great toe on 5/24, 5/27, 5/31, 6/4, and 6/5/24. Review of the Wound Evaluation and Management Summary from the wound consultant, dated 6/6/24, indicated Resident #38's wound to the left great toe measured 0.4 cm in length by 0.5 cm in width by 0.2 cm in depth. The recommended treatment indicated to discontinue the Collagen sheet and Santyl and to start Calcium Alginate followed by a gauze island with border dressing. The recommendation to apply lambswool between toes continued. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/6/24 at 8:45 A.M., Resident #38 said the wound consultant had been in this morning to look at the left great toe and had put on a new treatment. He/she said the staff do not change the dressings every day and that sometimes he/she had to remind the staff. During an interview on 6/7/24 at 1:52 P.M., Resident #38 said the wound consultant had changed the dressing at 8:00 A.M. the previous morning and no one had changed the dressing since. The surveyor observed a bandage to be attached by only one out of four sides and no longer covering the wound to the left great toe. The surveyor did not observe lambswool to be in place. Review of the TAR indicated the recommended treatment from 6/6/24 was implemented on 6/8/24. No treatment was provided to the left great toe on 6/7/24. During an interview on 6/11/24 at 3:48 P.M., Resident #38 said Nurse #1 had changed the dressing to the left great toe on this day. The surveyor observed the area to be bandaged and did not observe lambswool between the toes. During an interview on 6/12/24 at 7:50 A.M., Nurse #1 said the process for the wound consultant was that if there was an extra nurse that nurse would complete wound rounds with the physician otherwise the assigned unit nurse would complete the wound rounds with the wound consultant. She said she had not completed wound rounds with the wound consultant on 6/6/24. She said she was not sure who checked the Wound Evaluation and Management Summary to determine changes to the treatment or what the process was. She said the primary physicians defer to the wound consultant for treatment recommendations. She said she could not say why the orders did not match the recommendations or why the treatments were not provided as ordered. During an interview with observation on 6/12/24 at 11:38 A.M., Nurse #1 said she did not know about the lambswool recommendation for Resident #38 and lambswool was not being used. During an interview on 6/12/24 at 2:00 P.M., the Assistant Director of Nurses said the recommendations from the wound consultant should be followed, the treatment changes should be implemented timely, and the treatments should be completed as ordered. She said the recommendation for lambswool between the toes should have been reviewed for implementation. During an interview on 6/13/24 at 1:50 P.M., Physician #2 said the expectation was for the facility to follow the recommendations from the wound consultant.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41106 Based on record review and staff interview, the facility failed to ensure residents who use psychotropic medications, as needed, were limited to 14 days, or extended beyond 14 days with a documented clinical rationale and duration, for one Resident (#89), out of a total sample of 15 residents. Findings include: Review of the facility's policy titled PRN (as needed) Psychotropic Medications, dated issued 3/2018, indicated but was not limited to the following: -Residents do not receive PRN psychotropic medications unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. All PRN orders for psychotropic medications will not exceed 14 days, including those residents on Hospice. Resident #19 was admitted to the facility in January 2024 with a diagnosis of anxiety. Review of the Physician's Orders indicated the following: -Admit to Hospice for diagnosis of senile degeneration of the brain, effective 2/8/24. -Lorazepam give one tablet by mouth every two hours as needed for anxiety, effective 4/24/24 with an end date listed as indefinite. Review of the Consultant Pharmacist Recommendation to Prescriber indicated the pharmacy consultant completed a medication regimen review on 5/22/24 for the use of Lorazepam PRN without a specified stop date. Please note that Centers for Medicare and Medicaid (CMS) guidelines do not allow maintaining an open-ended order for PRN psychotropics on medication profiles including Hospice residents. Please consider adding a stop date to Lorazepam PRN, if appropriate. During an interview on 6/13/24 at 1:15 P.M., the Director of Nurses (DON) said she was not aware Hospice patients needed a stop date for their psychotropic medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 15214 Based on observation, manufacturer's suggestion for use, and interview, the facility failed to ensure that staff properly labeled all medications stored in 1 of 2 medication carts with the date opened or the Resident's name. Findings include: On 6/06/24 at 1:19 P.M., the surveyor inspected the Unit 3 medication cart with Nurse #1 and observed the following: -A bottle of Artificial Tears for Resident #17, not labeled when opened. -A bottle of Artificial Tears for Resident #8, not labeled when opened. Review of the manufacturer's suggestions for use indicated that Artificial Tears should be discarded 30 days after opening because the preservative inside can start to breakdown and allow bacteria to grow. -A bottle of Latanoprost 0.005% ophthalmic solution (used to treat certain kinds of glaucoma), not labeled with the Resident's name. -A vial of Levemir insulin (long-acting insulin used once to twice daily to control high blood sugar) for Resident #24, not labeled when opened. Review of the manufacturer's suggestions for use indicated that Levemir should be discarded 42 days after opening because the insulin loses its effectiveness at lowering blood glucose levels. -A bottle of Ketotifen 0.025% ophthalmic solution, (a medication used to treat allergic conjunctivitis) for Resident #30, not labeled when opened. Review of the manufacturer's suggestions for use indicated that Ketotifen should be discarded 15 days from the date it was opened. During an interview on 6/6/24 at 1:30 P.M., Nurse #1 said that the Artificial Tears eye drops should be discarded after 28 days. Nurse #1 said that eye medications must always be labeled with the resident's name and the date they would expire so that they can be properly discarded. Nurse #1 said that the Levemir insulin should not be used as she did not know when the Levemir insulin in the medication cart had been opened.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 36542 Based on interview and record review, the facility failed to take into consideration the dietary preferences of each resident. Specifically, the facility failed to accommodate preferences of Resident #2 for a high protein diet. The total sample was 15 residents. Findings include: Resident #2 was admitted to the facility in February 2024 with a history of bariatric surgery. Review of the Minimum Data Set (MDS) assessment, dated 2/21/24, indicated Resident #2 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. During an interview on 6/6/24 at 12:00 P.M., Resident #2 said he/she had bariatric surgery years prior and was following a high protein, low carbohydrate diet to maintain weight loss. The Resident said when he/she was admitted they had brought their own protein shakes but was now worried about the cost of ordering the protein shakes, which was $52 for 12 bottles. He/she said they were also ordering high protein oatmeal and yogurt. He/she said they had met with the Food Service Director, who had said he was unable to order high protein items for the Resident. The Resident said he/she had not seen the Registered Dietitian regarding the high protein since February when he/she was admitted and had their own protein drinks at that time. Review of the Nutrition Evaluation Comprehensive, dated 2/20/24, indicated Resident #2 had a diet order of regular, regular texture, thin liquids. The evaluation indicated the following: -Snacks/supplements: Core Power (a high protein milk shake) and indicated the Resident had a bunch that he/she had brought to the facility -Comments: Resident reported a history of bariatric surgery in 2020 and drinks protein drinks twice per day -Weight status: Resident reported weight gain over the last year of approximately 30 pounds -Summary: Resident has a large supply of Core Power which he/she drinks twice per day. Estimated intake provides approximately 1900 calories with 75 grams of protein with additional 340 calories and 52 grams from the Core [NAME] which is adequate to meet nutrition needs. Review of the medical record for Resident #2 indicated there were no additional nutritional assessments or progress notes. Review of the care plans for Resident #2 failed to include a care plan to address nutritional needs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Jewish Home	538 Robeson Street Fall River, MA 02720

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/24 at 1:15 P.M., the surveyor observed Resident #2 tell Nurse #1 that the Resident was gaining weight, was eating too many starches and had told the Food Service Director about the high protein shakes but he would not order them for the Resident. Review of the medical record indicated the Resident weighed 188 pounds at the previous facility with the most recent weight on 4/8/24 (two months prior to review) of 195.8, a gain of seven pounds in two months. During an interview on 6/11/24 at 12:24 P.M., the Registered Dietitian said he had completed the admission assessment for Resident #2 and had not seen the Resident since that time. He said he was supposed to see every Resident at least quarterly and referred to a list and found that Resident #2 had been due for an assessment on 5/20/24, but as of 6/11/24 he had not met with the Resident. He said he recalled the Resident had voiced that he/she had their own protein supplements in February 2024 and did not know what the plan was after the Resident had used their own supply. He said he had not discussed high protein food options with the Resident and which supplements, if any, that were available at the facility would be able to meet the Resident's needs. He said the facility does have a liquid protein and had not been asked to review this for the Resident. During an interview on 6/12/24 at 9:26 A.M., the Food Service Director said Resident #2 had asked him to order the protein shakes and he was unable to order those shakes. He said Resident #2 did not like the food that was served and had discussed not getting a grilled cheese, but instead getting a peanut butter and jelly sandwich at times. He said he did not know which items would constitute a high protein diet and the Registered Dietitian would need to discuss this with the Resident. He said he had not talked with the Registered Dietitian about Resident #2 and was not sure if the Registered Dietitian had met with the Resident about the protein requests.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41106 Based on record review and interview, the facility failed to designate a person who met the minimum qualifications to serve as the Food Service Director (FSD). Specifically, the facility did not employ a full-time dietitian, or have a qualified dietary employee who met the minimum qualifications to serve as the FSD. Findings include: During an interview on 6/6/24 at 8:45 A.M., the Food Service Director (FSD) said he is not a certified food service manager. He said he was going to take the test, but he has not registered for the class yet. He said he has not taken any formal training classes to be a food service manager at this time. He said he has work experience as a cook at a local restaurant and hospital, and he has completed the ServSafe course. The surveyor reviewed the FSD certificate which indicated he completed ServSafe Food Handler online course and exam 4/6/24. During an interview on 6/6/24 at 1:30 P.M., the Administrator said she was not aware the current FSD did not have the required qualifications to serve as the Food Service Director. She said the Dietitian only works eight hours a week at the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41106 Based on observation, interview, and test tray results, the facility failed to provide food to residents that was palatable and served at appetizing temperatures for both food and drinks. Findings include: During a Resident Group Meeting with the surveyor on 6/7/24 at 11:00 A.M., 14 residents attended the meeting and had the following food complaints: Food is mushy, overcooked, and cold. No fresh vegetables or fruit. The always available menu is not always available. The kitchen only makes a certain number of items and if they run out, the go to food is peanut butter and jelly or grilled cheese sandwiches. During an interview on 6/06/24 at 9:32 A.M., Resident #154 said the eggs are burnt/crispy on the edges and he/she could only eat the center of the egg. During an interview on 6/06/24 at 9:35 A.M., Resident #153 said he/she ordered poached eggs, but you can't eat the edges because they are too crisp. The Resident said last night he/she ordered a hot dog off the anytime menu and never got it. During an interview on 6/6/24 at 10:06 A.M., Resident #3 said the eggs were cold. During an interview on 6/06/24 at 12:45 P.M., Resident #45 said the food is cold every day, for all meals. During an interview on 6/06/24 at 3:40 P.M., Resident #16 said the food is always cold, no flavor or taste. On 6/11/24 at 7:50 A.M., the surveyor observed breakfast tray line service and made the following observations: -The plate warmer machine was not turned on and the plates were cold to touch. -The beverages were pre-poured on trays, sitting out at room temperature. -The puree eggs appeared pale compared to the regular eggs. On 6/11/24 at 8:21 A.M., the surveyor requested a test tray, which left the kitchen at 8:24 A.M. The last tray was served off the meal cart at 8:42 A.M. The surveyor tested the tray with Nurse #2 with the following results: -Scrambled eggs were 94 degrees Fahrenheit (F). The taste was palatable in flavor but cold. -Biscuit with sausage gravy was 91.7 degrees F. The taste was palatable in flavor but cold. -Oatmeal was 147.6 degrees F. The taste was palatable and hot. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Plastic glass of Milk was 56.2 degrees F. It was not cold or palatable. -Plastic container of Juice was 53 degrees F. It was not cold. During an interview on 6/11/24 at 8:42 A.M., Nurse #2 said the food tasted O.K., the food was warm. On 6/11/24 at 8:51 A.M., the surveyor requested a second test tray of the puree meal. The test tray left the kitchen at 8:55 A.M., on an open wheeled cart for service in the main dining room. The last tray served off the cart was at 9:00 A.M. The surveyor tested the tray with Dietary Staff #2 with the following results: -Puree eggs were 103 degrees F, pale in color, cold, and not tasty. -Puree biscuit was 110 degrees, light brown in color, cold, and tasted like toast. No sausage gravy flavor present. During an interview on 6/11/24 at 9:02 A.M., Dietary Staff #2 said the eggs were not good and the biscuit was bland and tasted more like toast. She said she could not taste any sausage in the puree biscuit. During an interview on 6/11/24 at 9:05 A.M., [NAME] #2 said he makes the puree eggs by adding water and the puree biscuit by water and toast. He said he did not add sausage gravy to the puree biscuit. On 6/11/24 at 11:45 A.M., the surveyor observed lunch meal service and observed the drinks sitting out on a tray at room temperature, and the plate warmer was turned on, but the plates were only slightly warm to touch. The surveyor requested a test tray which left the kitchen at 11:54 A.M. The last tray served off the cart was at 12:10 P.M. The surveyor tested the tray with Director of Nurses (DON) with the following results: -Chicken was 120.1 degrees F. The taste was salty, and the temperature was tepid (lukewarm). -Mashed potatoes with gravy were 129.0 F. They were palatable. -Broccoli was 108.4 F. It was cold. -Mandarin oranges were 76.3 F. They were room temperature. -Milk was 59.4 F. It was not cold to taste. -Orange flavored drink was 74.2 F. It was room temperature. During an interview on 6/11/24 at 12:14 P.M., the DON said the chicken and mashed potatoes were a little warm, the mandarin oranges were room temperature, and the broccoli was cold. The results of the test trays validated the residents' complaints of unpalatable, unappetizing, and cold food.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 36542 Based on observation, record review, and interview, the facility failed to ensure diets as ordered by the physician were served in proper form for one Resident (#40), out of a total of 15 sampled residents. Specifically, the facility failed to ensure the physician's order to have nectar thick liquids (liquids that have been altered to a thicker consistency for people who have difficulty swallowing) was followed for Resident #40. Findings include: Resident #40 was admitted to the facility in December 2022 with a diagnosis of dysphagia (difficulty swallowing). Review of the Physician's Orders for Resident #40 indicated the Resident was on a ground texture diet with nectar thick liquids. Review of the care plans for Resident #40 failed to include the Resident's diet or nutritional goals. On 6/11/24 at 8:50 A.M., the surveyor observed Resident #40 in his/her room having breakfast. The surveyor observed the Resident to have a half cup of coffee left, which was not thickened and a cup of apple juice which was also not thickened. During an interview on 6/11/24 at 8:50 A.M., Nurse #1 said the coffee and the apple juice were both not thickened and should have been thickened by staff. During an interview on 6/11/24 at 8:51 A.M., Certified Nursing Assistant (CNA) #1 said she had brought the breakfast tray to Resident #40 and had not thickened the liquids prior to leaving the room. She said the process was for the nursing staff to thicken the liquids when giving the meal trays to a resident and there was a plastic storage container of thickener on the unit. On 6/11/24 at 12:12 P.M., the surveyor observed Resident #40 in his/her room with their lunch tray. The Resident's lunch tray was observed to have thickened coffee and thickened cranberry juice. The surveyor picked up the cup of cranberry juice and when shaking the cup the substance did not move. During an interview on 6/11/24 at 2:50 P.M., CNA #1 said when a resident needs thickened liquids she gets the container of thickener and uses one and a half teaspoons of thickener in the cup. She said they do not use a specific measuring spoon or scoop, but a plastic disposable soup spoon (rounder than a teaspoon). She said she does one and a half teaspoons because two teaspoons was too thick. The CNA showed the surveyor the unlabeled (no brand listed) plastic storage container on top of the unit refrigerator and said this was the thickener. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 3:00 P.M., the surveyor observed the unit kitchenette to have the unlabeled plastic storage container on top of the unit refrigerator and a canister of Thick and Easy thickener in the unit cabinet. There were no directions for use on the plastic storage container of thickener. The surveyor observed a Thick and Easy Thickener Mixing Chart on the unit refrigerator which indicated the following for nectar thick liquids: 4 fluid ounces (fl oz): 1 T (tablespoon) plus 1 tsp (teaspoon) 6 fl oz: 2 T 8 fl oz: 2 T plus 2 tsp During an interview on 6/12/24 at 4:00 P.M., the Food Service Director said he would obtain the instructions for the thickener in the plastic storage container for the surveyor. During an interview on 6/12/24 at 8:26 A.M., the Food Service Director said the facility now utilized an instant food thickener from Sysco (wholesale food distributor) and he posted the directions on the unit cabinet on this day. He said the kitchen staff have a large canister of the thickener and they put some in the plastic storage containers for the units. He said the nursing staff will use the plastic disposable teaspoons to add the thickener to the liquids. He said the kitchen does not provide measuring spoons with the plastic container of thickener. He said the kitchen staff does not supply the canisters of Thick and Easy and he does not know where it came from. Review of the Sysco instant food thickener directions indicated the following would create nectar thick liquids per 4 fluid ounces: water, clear juices, coffee, tea: 1 Tbsp (tablespoon) orange juice, 2% milk: 2 and a half teaspoons The Sysco thickener directions were not the same as the Thick and Easy thickener directions. During an interview on 6/12/24 at 8:32 A.M., CNA #2 said she had thickened the orange juice and the coffee for Resident #40 today. She said she used a plastic round soup spoon and used about 1 and a half of them. She said someone else had thickened the milk of Resident #40. The CNA and the surveyor observed the milk to not be able to move in the cup. The CNA said the milk was too thick for this Resident as the Resident's diet order was for nectar thick and not honey thick (a thicker consistency). During an interview on 6/12/24 at 10:30 A.M., the Assistant Director of Nurses said the process was for the kitchen staff to send up the plastic storage container of thickener. She said the staff should be using measuring spoons to measure the thickener but was not sure if the kitchen was sending the measuring spoons with the container. The surveyor and the Assistant Director of Nurses observed the two types of thickener on Unit 3 with two types of directions. The Assistant Director of Nurses said the kitchen had recently started purchasing a different thickener and she had not realized that the directions for thickening had been different. She said she was responsible for staff education and none of the staff had been educated on the change in thickener and the new directions for use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 41106 Based on observation and interview, the facility failed to follow their policy and professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Ensure the main kitchen was pest free and maintained in a sanitary condition; 2. Ensure residents were not served undercooked, unpasteurized shell eggs; 3. Ensure food items were properly labeled and dated in the main kitchen refrigerators; 4. Ensure staff practiced proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another) and ensure the use of gloves was limited to a single use task; and 5. Ensure staff obtained cooked food temperature prior to serving to residents. Findings include: 1. Review of the facility's policy titled Cleaning and Sanitation of Dining and Food Service Areas, undated, indicated but was not limited to the following: -The food and nutrition service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with written, comprehensive cleaning schedules. -The Director of Food and Nutrition services will determine all cleaning and sanitation tasks needed for the department. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: -6-501.111 Controlling Pests. Insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments. -6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: -(B) Routinely inspecting the PREMISES for evidence of pests -(D) Eliminating harborage conditions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/6/24 at 8:05 A.M., the surveyor observed the main kitchen floor to be dirty with food particles around the entire kitchen floor, the floor tile grout had a black grimy build-up with embedded food particles, the walls were visibly dirty, and there was dirt and debris underneath the metal tables throughout the kitchen. There was standing water in both dish rooms on the floor, and by the three bay sink. In addition, there were small, black flies on the ceiling by the main serving stationing, dish room to the left of the kitchen, and in and around the floor drain in the first dish room. -On 6/11/24 at 7:50 A.M., the surveyor observed the main kitchen walls and made the following observations: -The walls above the prep sink were stained with food particles, it appeared an attempt was made to wash the walls but only halfway up the wall. -On 6/12/24 at 9:00 A.M., the surveyor and the Food Service Director (FSD) did a final tour of the kitchen and observed the black flies in the first dish room and around the floor drain on the left side of the kitchen, on the walls, and on the ceiling by the service table. There was observed standing water on the floor of the second dish room (last used the evening before per the FSD), the faucet was slowly running in the three bay sink, the sink with the garbage disposal (tape across the top) had standing water, under the flat top grill had large amount of food crumbs under the grill, there was water draining into the floor drain from underneath the counter with the steam oven on it, the floor tile grout throughout the kitchen had built up of a black substance which had food debris imbedded in it. The surveyor was able to scrape the black substance off the floor and remove particles of food. The floor drain in the first dish room was observed to have a build-up of organic matter. During an interview on 6/12/24 at 9:05 A.M., the FSD said the floor was scrubbed last night and this was as clean as they could get the floor. He said the stuff won't come out of the cracks. The FSD said the flies have been a problem and the staff have been educated about keeping the kitchen clean and making sure the water is shut off and cleaned off. He said the dietary staff needs to do a better job. During an interview on 6/13/24 at 12:05 P.M., the Administrator said she was aware of the pest issues as it relates to the kitchen sanitation. She said the floor requires a deeper cleaning and power washing to remove the debris. 2. Review of the facility's policy titled General HACCP (Hazard analysis and critical control point) Guidelines for Food Safety, undated, indicated but was not limited to the following: -Note: The use of pasteurized shell eggs or egg products is preferable. Waivers to allow undercooked unpasteurized eggs are not acceptable. Use pasteurized eggs for safe consumption of undercooked eggs (Sunnyside up fried eggs, soft, cooked eggs, etc.) Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: 3-8 Special Requirements for Highly Susceptible Populations. 3-801.11 Pasteurized Foods, Prohibited Re-Service, and Prohibited Food. In a food establishment that serves a highly susceptible population: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(2) A partially cooked animal FOOD such as lightly cooked FISH, rare MEAT, soft-cooked EGGS that are made from raw EGGS, and meringue. On 6/6/24 at 9:10 A.M., the surveyor observed a white box labeled Fresh Shell, Eggs, Large White, Grade AA. Further markings on the box indicated they were United Egg Producers (UEP) Certified (uepcertified. com). The box did not indicate the eggs were pasteurized and the eggs were not marked as pasteurized. Review of uepcertified.com website indicated store labels definitions included but was not limited to the following: -UEP Certified: Eggs marked with these logos are laid on farms following UEP Certified or UEP Certified Cage-Free Guidelines to ensure optimal [NAME] welfare. -Pasteurized: Regulated by FDA, shell eggs are heated to temperatures just below the coagulation point to destroy pathogens. This type of egg may provide benefits for immune-compromised individuals. Review of the facility's food order delivered to the facility on [DATE] and 6/6/24, indicated but was not limited to the following: -On 6/6/24 15 dozen, WHLFCLS eggs shell, large white, USDA AA, with item #4838340 were delivered to the facility. -On 5/30/24 15 dozen, WHLFCLS eggs shell, large white, USDA AA, with item #4838340 were delivered to the facility. -There were no purchases of pasteurized eggs on either invoice. During an interview on 6/6/24 at 9:15 A.M., the Food Service Director (FSD) said their eggs are pasteurized, and they cook the residents' eggs to order. The surveyor and the FSD reviewed the white box of eggs in the walk-in refrigerator and the box was only with the markings UEP Certified. There were no observed markings indicating the eggs were pasteurized. On 6/6/24 at 9:26 A.M., the surveyor observed [NAME] #1 cooking fried eggs and plating undercooked eggs (yolk was runny) for a resident's breakfast meal. The surveyor observed the Dietary Aide covering the plated eggs and loading them onto the delivery truck. On 6/6/24 at 9:31 A.M., the surveyor observed Resident #154's breakfast plate and observed partially eaten undercooked eggs. A review of Resident #154's breakfast meal ticket indicated over medium. On 6/6/24 at 9:34 A. M., the surveyor observed Resident #153 breakfast plate and partially eaten undercooked fried eggs. A review of Resident #153's breakfast meal ticket indicated two poached eggs or fried eggs. On 6/6/24 at 9:50 A.M., the surveyor observed Resident #39's breakfast plate and partially eaten undercooked fried eggs. A review of Resident #39's breakfast meal ticket indicated two over easy eggs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/6/24 at 10:04 A.M., the surveyor observed Resident #303's breakfast plate and partially eaten undercooked fried eggs. A review of Resident #303's meal breakfast ticket indicated scrambled eggs. On 6 6/24 at 10:06 A. M., the surveyor observed Resident #7 breakfast plate and partially eaten undercooked fried eggs. A review of Resident #7's breakfast meal ticket indicated two eggs over medium. On 6/6/24 at 10:07 AM, the surveyor observed Resident #3 breakfast plate and partially eaten undercooked fried eggs. A review of Resident #3's breakfast meal ticket indicated large portion scrambled eggs. During an interview on 6/6/24 at 10:10 A.M., the FSD said he called his regional boss and was told the eggs were pasteurized and they could serve poached or medium eggs. During an interview on 6/11/24 at 2:57 P.M., the Administrator said she thought the eggs were pasteurized. During a telephonic interview on 6/12/24 at 8:28 A.M., the facilities Food Delivery Vendor Customer Representative said food item #4838340 was regular unpasteurized eggs. He said pasteurized eggs have pasteurized in the product name on the order sheet. 3. On 6/6/24 at 8:05 A.M., the surveyor observed the main kitchen and made the following observations: Reach-in refrigerator on the right side: -Fourteen green plastic bowls of diced fruit, six covered with tin foil and eight with ill-fitting plastic lids. Six of the tin foil covered pears cup were sitting inside the cups which had plastic lids and were in contact with the liquid base of the fruit. They were not dated or labeled. -A puddle of clear liquid on the bottom shelf, and a large piece of brown paper saturated with the clear liquid. -Tray of drinks, five had dark liquids, five had red liquid, four had clear liquid, one nosey cup (cut out on top of the cup) with clear liquid, and green plastic bowl covered with tin foil, not labeled, dated, or covered. -One cardboard container of Ready Care thickened, labeled open 3/26/24. Instructions on the container indicated the following: After opening, may be kept up to 7 days under refrigeration. -One open Fortified Nutritional Shake Vanilla, not dated when opened. Instructions on the containing indicated the following: After opening, consume product within 4 days if properly refrigerated. Reach-in refrigerator on the left side: -Large metal bowl of a bean mix, not labeled or dated. -Medium metal pan, uncovered which contained a red puree mix, not labeled, or dated. (continued on next page)

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	225317	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Jewish Home	538 Robeson Street Fall River, MA 02720

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Plastic clear container with a yellow food product, not labeled or dated. Walk-in refrigerator: -Plastic clear container with chopped fruit, not labeled or dated. -Plastic clear container of sliced cheese, not labeled or dated. -Metal pan with unidentified food, not labeled or dated. -Metal pan of small pancakes, not dated. -Metal pan of unidentified fruit, not labeled or dated. -Small metal pan containing three hardboiled eggs, not dated. -Clear metal container of jelly, with jelly dripping on the outside of the container, not dated. -Clear round container of an unidentified white food, not labeled or dated. -Clear round container of an unidentified food, not labeled and dated 5/26/24. -Container of low-fat cottage cheese, with a manufacturer's best use by date of 6/1/24, and an open date of 5/9. During an interview on 6/6/24 at 8:31 A.M., the FSD said the food should be labeled and dated and should be thrown out if more than three days old. 4. Review of the facility's policy titled Bare Hand Contact with Food and Use of Plastic Gloves, undated, indicated but was not limited to the following: -Single use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from food handlers' hands to the food product being served. -staff will use good hygienic practices and techniques with access to proper hand washing facilities (available soap, hot water, and disposable towels and/or heat/air drying methods). -Staff will use clean barriers such as single-use gloves, tongs, usually deli paper and spatulas when handling food. -Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used only for one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. -Gloves are just like hands. They get soiled. Any time a contaminated surface is touched, the gloves must be changed, and hands must be washed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-After coughing or sneezing into hands, using a handkerchief or tissue, using tobacco or touching hair or face. -After handling boxes, crates, or packages. -During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. -When switching between working with raw food and working with ready-to-eat food. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. On 6/6/24 at 9:15 A.M., the surveyor observed [NAME] #1 leave the service station wearing gloves, enter the walk-in refrigerator and retrieve two unpasteurized eggs, return to the stove, and crack the eggs into a frying pan. [NAME] #1 was then observed touching resident plates and handling ready-to-eat biscuits with her gloved hands. [NAME] #1 did not change her gloves or perform hand hygiene after cracking the raw, unpasteurized eggs. On 6/6/24 at 9:16 A.M., the surveyor informed the FSD of the observations of [NAME] #1. The surveyor heard the FSD tell [NAME] #1 to remove her gloves and perform hand hygiene. On 6/6/24 at 9:17 A.M., the surveyor observed [NAME] #1 remove her gloves and wash her hands in the prep sink by the stove. [NAME] #1 then dried her hands on the front of her apron and returned to serving breakfast. The paper towel dispenser was observed to be empty. On 6/6/24 at 9:19 A.M., the FSD said [NAME] #1 should have changed her gloves and washed her hands after cracking the eggs. He said she should not have used her apron to dry her hands, and instead should have dried her hands with paper towels. The FSD pointed across the kitchen to the hand washing sink which was observed to have paper towels. On 6/11/24 at 11:45 A.M., the surveyor observed [NAME] #2 leave the tray line wearing gloves, open the oven, remove a tray of hamburgers, and place them on the stove. [NAME] #2 opened a hamburger bun package, retrieved a bun with his gloved hands and placed the hamburger on the bun. [NAME] #2 then returned to lunch service line and continued to plate food. [NAME] #2 was not observed to change his gloves. On 6/11/24 at 11:59 A.M., the surveyor observed a Dietary Aide wearing gloves assembling the resident lunch trays when she sneezed in the direction of her right arm. The Dietary Aide continued to work and was not observed to perform hand hygiene after sneezing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/11/24 At 2:57 P.M., the FSD said the dietary staff should change gloves anytime their gloves get dirty, they change jobs, or handle raw meats or eggs. 5. Review of the facility's policy titled General HACCP Guidelines for Food Safety, undated, indicated but was not limited to the following: -Educate and monitor food and nutrition service staff on the following: -food temperatures for meal service: -check to be sure staff takes food temperatures correctly and records temperatures. -teach staff what to do if temperatures are in the temperature danger zone. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: - 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above . Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: 3-401.11 Raw Animal Foods. (A) Except as specified under (B) and in (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked: (2) 68oC (155oF) for 17 seconds for . nonINTACT MEATS . During observation and interview on 6/11/24 at 7:50 A.M., the surveyor observed [NAME] #2 start breakfast service, plating his first plate. The surveyor asked [NAME] #2 to view his breakfast temperature log. [NAME] #2 said he has not temped the food yet. [NAME] #2 stopped the tray service, looked for a thermometer, temped the tray table, and recorded the holding temperatures. Review of the recorded temperatures indicated that the pureed eggs were 131 degrees Fahrenheit (F) and not being held above 135 degrees F. On 6/11/24 at 11:45 A.M., the surveyor observed [NAME] #2 removing a tray of hamburgers from the oven and placing them on the stove. [NAME] #2 was then observed plating a hamburger on a bun for a resident, and the dietary staff placed the hamburger on the truck for delivery. The surveyor did not observe [NAME] #2 record an internal cooked temperature of the hamburgers (minimum of 155 degrees F) prior to service or a holding temperature to ensure they were held above 135 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/11/24 at 2:57 P.M., the FSD said the cooks should take the temperature of the food before serving it to the residents. He said if the temperature is not high enough, the food should be cooked longer.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on observation, interviews, and record review, the facility failed for one Resident (#303), out of a sample of 15 residents, to ensure Enhanced Barrier Precautions (EBP) were implemented and Personal Protective Equipment (PPE) was utilized when providing high contact resident care as required. Findings include: Review of the facility's policy titled Clinical Services-Subject: Precautions to Prevent Infection, dated as last revised 12/2023, indicated but was not limited to the following: -Purpose to comply with all Federal, State, and local heath requirements as well as appropriate Infection Prevention Standards. -EBP fall between standard and contact precautions and require gown and glove use for certain residents during specific high contact resident care activities that have been found to increase risk for Multi-Drug Resistant Organisms (MDRO) transmission. -Residents defined at risk are those with indwelling medical devices. -High Risk Resident Care Activities include dressing, bathing/showering, transferring, providing hygiene, changing linen, changing brief, or assisting with toileting, device care or use of a device (central line, urinary catheter, feeding tube etc.), and wound care. IMPLEMENTATION OF PRECAUTIONS: -When implementing precautions ensure staff have awareness of facility expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. -Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE. -For EBP, signage should also clearly indicate the high contact resident care activities that require the use of gown and gloves. -Make PPE, including gowns and gloves, available immediately outside of the resident room. SUMMARY OF PPE USE CHART -EBP: All residents with any of the following: Infection or colonization with a novel or targeted MDRO (when contact precautions do not apply), wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-PPE used for these situations: High Risk Resident Care Activities include dressing, bathing/showering, transferring, providing hygiene, changing linen, changing brief, or assisting with toileting, device care or use of a device (e.g., central line, urinary catheter, feeding tube), and wound care. -Required PPE: gloves and gown prior to the high contact care activity. Review of the Centers for Disease Control (CDC) EBP sign in use at the facility indicated the following: -EBP: EVERYONE MUST: Clean their hands, including before entering and when leaving the room. -PROVIDERS AND STAFF MUST ALSO: Wear gloves and gowns for the following Activities: dressing, bathing/showering, transferring, providing hygiene, changing linen, changing brief, or assisting with toileting, device care or use of a device (central line, urinary catheter, feeding tube), and wound care. Review of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety, and Oversight (QSO) Memo QSO-24-08-NH, dated 3/20/24 indicated but was not limited to the following: -Subject: EBP in Nursing Homes to Prevent the spread of MDROs. -In July 2022, the CDC released updated EBP recommendations and therefore CMS is updating guidance accordingly. -The new guidance is effective April 1, 2024. Resident #303 was admitted to the facility in April 2023 with diagnoses including Alzheimer's dementia, chronic kidney disease, heart disease, and urinary tract infection (UTI). Review of the Minimum Data Set (MDS) assessment, dated 4/16/24, indicated Resident #303 had severe cognitive impairment as evidenced by a score of 6 out of 15 on the Brief Interview for Mental Status (BIMS) and was dependent on staff for activities of daily living. Review of the medical record indicated Resident #303 had a peripherally inserted central catheter (PICC) line (a thin flexible tube inserted into a vein in the upper arm and guided into a large vein above the right side of the heart called the superior vena cava (SVC) used for intravenous (IV) medications) inserted in May 2024 at an acute care hospital and was discharged back to the facility on [DATE] for IV antibiotics due to a bacterial infection. Review of the Physician's Orders indicated but were not limited to the following: -Monitor PICC line site every shift (three shifts per day) for signs of redness, swelling, or warmth. -Meropenem Solution (antibiotic) 1 gram (gm) IV every 12 hours for bacterial infection for 14 days. -Vancomycin IV Solution (antibiotic) 1000 milligram (mg)/200 milliliters (ml) use 1gm IV in the evening for bacterial infection for 14 days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor made the following observations: -6/11/24 at 9:45 A.M., no EBP sign was on or next to the door to Resident #303's room, no PPE cart was positioned outside of the room. -6/11/24 at 2:47 P.M., Nurse #2 brought Resident #303 to his/her room with the surveyor. Nurse #2 had no PPE on and removed Resident #303's arm from the sweatshirt to view the PICC line dressing, inspect/touch the dressing to ensure proper adherence and to show the surveyor the date of the last dressing change. Nurse #2 then proceeded to put Resident #303's arm back into the shirt and maneuver the shirt over the PICC line still with no PPE on. During an interview on 6/11/24 at 2:50 P.M., Nurse #2 said Resident #303 was not on any precautions or EBP. She said EBP was for residents with wounds/open areas or a colostomy (surgical procedure creating an opening for the intestine through an incision in the abdomen for drainage of stool into a colostomy bag) but not for residents with a PICC line. She said Resident #303 did not require any extra PPE. The surveyor made the following observations: -6/13/24 at 7:56 A.M., EBP sign was hanging on the wall next to Resident #303's door and a PPE cart was set up at the entrance to the room. -6/13/24 at 7:56 A.M., Certified Nursing Assistant (CNA) #4 was in the room with gloves on and no gown. Resident #303 was sitting in a reclining Broda chair (used for positioning), the mechanical lift was next to the bed. CNA #4 was washing/styling the Resident's hair. CNA #4 then removed gloves and brought Resident #303 into the hallway. CNA #3 had been standing in the doorway and now stood next to Resident #303 in the hallway. CNA#4 got a sweater and then CNA #3 and CNA #4 with no gloves on finished dressing the Resident, by putting the sweater on over the PICC line and bare arms. During an interview on 6/13/24 at 8:01 A.M., CNA #4 said Resident #303 must be on precautions for a rash on his/her buttocks. She said the sign says to wear a gown and gloves but confirmed she did not wear a gown with washing, dressing, transferring the Resident into the Broda chair or when she put the sweater on, and she should have. She said the precautions are new, he/she was never on them before, and she didn't realize Resident #303 was on them until the surveyor asked about the sign at the doorway. During an interview on 6/13/24 at 8:04 A.M., CNA #3 said Resident #303 is on precautions for the antibiotics he/she is on. She said Resident #303 has an IV so maybe that is why, but she was unsure and said that it is new today. She said the sign says to wear a gown and gloves for things like dressing so they should have had a gown and gloves on when they put the sweater on the Resident, but they did not. During an interview with Consulting Staff #1 and the new Director of Nurses (DON) on 6/12/24 at 10:38 A.M., Consulting Staff #1 said EBP is for anyone with an opening, wounds, catheter, PICC lines, colostomy, feeding tube etc. She said Resident #303 should be on EBP and staff should have PPE (gown and gloves) on while dressing/changing the Resident's shirt and when touching/caring for the PICC line. The DON nodded in agreement.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48084 Based on record review and interview, the facility failed to implement an Antibiotic Stewardship Program to measure and improve how antibiotics are prescribed by clinicians and include antibiotic use protocols and monitoring antibiotic use in line with the facility antibiotic stewardship program. Specifically, the facility failed to ensure accurate monitoring of infections and antibiotic use was completed for 12 infection occurrences of 12 Residents (#2, #253, #43, #303, #45, #38, #24, #255, #12, #1, #36, and #45) from the March, April, and May 2024 line list. Findings include: Review of the facility's policy titled Antibiotic Stewardship, undated, indicated but was not limited to the following: -The purpose of the Antibiotic Stewardship program is to monitor the use of antibiotics in our residents. -Orientation, training, and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affect individual residents and the overall community. -When a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders. -When a nurse calls the physician/prescriber to communicate a suspected infection, he/she will have the following information available: signs and symptoms, when symptoms were first observed, resident hydration status, and infection type. -When antibiotics are prescribed over the phone, the primary care practitioner will assess the resident within 72 hours of the telephone order. -When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Review of the line listing of infections for March, April and May 2024 indicated but were not limited to the following: 1.Resident #2 Facility Line List documentation was as follows: -Onset Date: 3/5; Treatment: Azithromycin (antibiotic). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All other entries on the log were blank. (Category, Symptoms, Culture, Site, Results, if Infection cleared, Comments, Final Status (hospital/facility acquired infection (HAI) or community acquired infection (CAI), and if it Counts (as a true infection/met infection criteria). Review of the medical record including physician's orders, nursing progress notes, and Physician/Nurse Practitioner (NP) progress notes indicated the following: -3/5/24: Azithromycin 250 milligram (mg) tablet, give 500 mg by mouth in the afternoon for one day (3/5). -3/5/24: Azithromycin 250 mg by mouth in the afternoon for four days (3/6-3/9). -Nursing and Physician/NP progress notes failed to indicate any symptoms or why the Resident was on an antibiotic. Review of the McGeer Criteria for Infection Surveillance Checklist (McGeer-a standardized tool utilized to review symptoms and determine if the infection is a true infection and deter unnecessary antibiotic use) failed to indicate any symptoms or why the Resident was on the antibiotic. Review of the Medication Administration Record (MAR) indicated Resident #2 completed the full course of antibiotics. 2. Resident #253 Facility Line List documentation was as follows: Category: UTI; Onset Date: 3/7; Symptoms: H-Hematuria (blood in the urine); Culture Date: - ; Site: - ; Results: UNC (uncultured) ; Treatment: Linezolid (antibiotic); Infection Cleared Yes/No: Yes; Comment: (left blank); Final Status (HAI/CAI): HAI; Count Yes/No: No. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -3/7/24: Linezolid 600 mg give one tablet by mouth two times a day for infection for 7 days. -2/23/24: Xarelto 20 mg (blood thinner) give one tablet by mouth in the evening. -Nursing progress notes indicated Resident #253 was transferred to an acute care hospital on 3/3/24 with hematuria and returned to the facility. The progress notes failed to indicate any symptoms or why the Resident was placed on an antibiotic on 3/7/24. -The facility failed to provide any paperwork from the brief hospitalization . -Physician (MD)/NP progress note dated 3/8/24 indicated Resident was being evaluated for acute cystitis with hematuria likely because of the UTI and the Xarelto making him/her more likely to have bleeding after recent stent placement. Please stop taking the Xarelto for the next 2-3 days so the bleeding will slow down. Once the dark bloody urine becomes lighter/more pink or yellow, may resume Xarelto. Follow up with urology as scheduled. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes failed to indicate Resident #253 had a diagnosis of UTI and failed to indicate the order was written to hold the Xarelto. Review of McGeer Criteria for Infection Surveillance Checklist, dated 3/7, indicated the infection did not meet UTI criteria. Review of the MAR indicated Resident #253 completed the full course of antibiotics. 3. Resident #43 Facility Line List documentation was as follows: Category: UTI; Onset Date: DR; Symptoms: DR-Drainage; Culture Date: 3/14; Site: check mark; Results: pseudo; Treatment: Cefpodoxime (antibiotic); Infection Cleared Yes/No: (left blank); Comment: (left blank); Final Status (HAI/CAI): HAI; Count Yes/No: Yes. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -3/4/24: Resident was experiencing increased vaginal discharge and treated with Flagyl (antibiotic). -3/14/24: Resident was seen by Gynecologist on 3/14/24 and a vaginal swab was done. -3/26/24: Daughter reported to facility vaginal discharge was positive for pseudomonas and needed treatment with antibiotics. -Review of the Gynecologist/Women's Health Summary indicated Resident had Acute Vaginitis, Wound Culture was positive for pseudomonas aeruginosa and was prescribed Cefpodoxime. The facility failed to provide a copy of McGeer Criteria for Infection Surveillance Checklist from 3/14/24. Further review of the Nursing and MD/NP progress notes failed to indicate Resident had a UTI as coded on the line listing. 4. Resident #303 Facility Line List documentation was as follows: Category: UTI; Onset Date: 3/28; Symptoms: CF-Confusion, AG-Agitation; Culture Date: - ; Site: - ; Results: - ; Treatment: Cephalexin (antibiotic); Infection Cleared Yes/No: (left blank); Comment: rMLOA (returned from medical leave of absence) diagnosed (DX) UTI; Final Status (HAI/CAI): HAI; Count Yes/No: No. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Jewish Home	538 Robeson Street Fall River, MA 02720

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Progress notes indicated resident was confused and agitated, no urinary symptoms were documented. - McGeer Criteria for Infection Surveillance Checklist, dated 3/28/24, indicated return from MLOA dx UTI, symptoms confusion and agitation, did not meet criteria. -3/28/24: Cephalexin for UTI. -Progress notes failed to indicate the culture from the hospital was obtained and reviewed with the physician for continued use of antibiotics. 5. Resident #45 Review of the medical record including physician's orders, nursing progress notes, lab results and Physician/NP progress notes indicated the following: -3/21/24: Resident complained of dysuria (pain on urination) and dark colored urine and requested a urine specimen be obtained. -MAR indicated a urine specimen was obtained. -Review of the Urinalysis and Culture and Sensitivity (UA C&S) indicated the urine was obtained on 3/24/24 and resulted on 3/26/24 with >100,000 streptococcus-like species. -Progress notes failed to indicate the MD/NP were notified of the urine culture when it resulted. -NP note dated 4/1/24 indicated Urinalysis was reviewed and Resident started on Vantin (antibiotic) 600 mg twice daily for 7 days for a UTI. (Treatment was initiated 6 days after the culture resulted.) Review of the McGeer Criteria for Infection Surveillance Checklist, dated 4/4/24, indicated the Resident met the criteria. Resident #45 was not on the line list for March 2024. 6. Resident #38 Facility Line List documentation was as follows: Category: UTI; Onset Date: 4/9; Symptoms: CF-Confusion; Culture Date:4/3; Site: urine; Results: e-coli; Treatment: Levaquin (antibiotics); Infection Cleared Yes/No: yes; Comment: (left blank); Final Status (HAI/CAI): HAI; Count Yes/No: No. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -Progress notes failed to indicate any urinary symptoms. -UA C&S report indicated the specimen was obtained on 4/3/24 and resulted 4/6/24. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Progress notes failed to indicate MD/NP were notified when the urine culture resulted. -4/9/24: New order for Levaquin for a UTI. (3 days after the culture resulted) Review of the McGeer Criteria for Infection Surveillance Checklist, dated 4/9/24, indicated symptom was change in mental status and criteria was not met. 7. Resident #24 Facility Line List documentation was as follows: Category: UTI; Onset Date:4/7; Symptoms: CF-confusion; Culture Date:4/7; Site: urine; Results: e-coli; Treatment: Macrobid (antibiotic); Infection Cleared Yes/No: yes; Comment: (left blank); Final Status (HAI/CAI): HAI; Count Yes/No: No. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -4/7/24: Resident with increased confusion, nurse requested UA C&S. -4/7/24: Resident transferred to hospital due to confusion. -4/7/24: started on Macrobid for UTI. -4/9/24: Culture resulted 30,000 yeast and gram-positive organisms; no sensitivity report. -4/9/24: NP reviewed C&S no new order. -Progress notes failed to indicate NP was made aware Resident was started on antibiotics prior to final culture report and that he/she wanted to continue treatment. -Review of the McGeer Criteria for Infection Surveillance Checklist, dated 4/7 indicated >100,000 e-coli, which does not match the C&S report in medical record. 8. Resident #255 Facility Line List documentation was as follows: Category: UTI; Onset Date: 4/13; Symptoms: CF-confusion; Culture Date: (left blank); Site: urine; Results: at acute care hospital; Treatment: Cefuroxime (antibiotic); Infection Cleared Yes/No: discharge/no; Comment: rMLOA; Final Status (HAI/CAI): HAI; Count Yes/No: No. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -4/13/24: Resident transferred to hospital for increased confusion. -Hospital report indicated urine culture was pending. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/13/24: new order for Cefuroxime for UTI. -Progress notes failed to indicate the culture report was obtained from the hospital and reported to the MD/NP for review of continued antibiotic use. Review of the McGeer Criteria for Infection Surveillance Checklist, dated 4/13/24, indicated Resident returned from MLOA with UTI, did not meet criteria. Review of the April MAR indicated Resident #255 completed the full course of antibiotics. 9. Resident #12 Facility Line List documentation was as follows: Category: UTI; Onset Date:4/22; Symptoms: none; Culture Date: prophylaxis; Site: -; Results:- ; Treatment: Macrobid (antibiotic); Infection Cleared Yes/No: N/A ; Comment: prophylaxis; Final Status (HAI/CAI): HAI; Count Yes/No: No. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -4/15/24: NP note indicated to obtain labs and a urine; symptoms vomiting/diarrhea and weakness. -4/20/24: urine was pending. -4/22/24: UA C&S reviewed with NP and Macrobid started. Review of the McGeer Criteria for Infection Surveillance Checklist, dated 4/22/24, indicated E.coli, criteria not met, was on antibiotic prophylaxis, urine per daughter request. The Line List failed to include accurate data regarding urine specimen versus prophylactic treatment. 10. Resident #1 Facility Line List documentation was as follows: Category: UTI; Onset Date: 5/7; Symptoms: fall; Culture Date:- ; Site:- ; Results: -; Treatment: Cefpodoxime (antibiotic); Infection Cleared Yes/No: yes; Comment: rMLOA dx UTI; Final Status (HAI/CAI): HAI; Count Yes/No: No. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -5/6/24: sent to hospital after a fall and returned with new order for Cefpodoxime for UTI. -Notes failed to indicate any urinary symptoms. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hospital report indicated urine positive for E.coli; sensitivity report not included. -Notes failed to indicate urine culture was obtained from hospital and/or MD/NP was contacted to discuss need to continue antibiotic treatment. Review of the McGeer Criteria for Infection Surveillance Checklist, dated 5/7/24, indicated status post fall, sent to hospital, and returned with DX UTI. The Line List failed to indicate the urine was obtained and/or the result. Review of the May MAR indicated Resident #1 had completed the full course of antibiotics. 11. Resident #36 Facility Line List documentation was as follows: Category: UTI; Onset Date: 5/10; Symptoms: fall; Culture Date:- ; Site: -; Results:- ; Treatment: Cephalexin; Infection Cleared Yes/No: yes; Comment: rMLOA; Final Status (HAI/CAI):HAI; Count Yes/No: No. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -5/10/24: status post fall sent to hospital; returned 3 hours later with new order for Cephalexin. -Notes failed to indicate any urinary symptoms. -Hospital report indicated urine culture was pending. -Progress Notes failed to indicate urine culture was obtained from hospital and reviewed with MD/NP for continued use of antibiotic. Review of the McGeer Criteria for Infection Surveillance Checklist, dated 5/10/24, indicated s/p fall rMLOA dx UTI, criteria not met. Review of the May MAR indicated Resident #36 had completed the full course of antibiotics. 12. Resident #45 Facility Line List documentation was as follows: Not on the line list. Review of the medical record including physician's orders, nursing progress notes, and Physician/NP progress notes indicated the following: -5/27/24: Resident complained of chills and pelvic pain, afebrile. New order to obtain a urine and start Bactrim (antibiotic) for 7 days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/27/24: Bactrim for UTI started. 5/28/24: Urine obtained. -5/31/24: Culture resulted <10,000 gram negative -Progress notes failed to indicate results were reviewed on 5/31/24 with MD/NP for continued use of antibiotics. The McGeer Criteria for Infection Surveillance Checklist was not provided by the facility. Review of the May MAR indicated Resident #45 had completed the full course of antibiotics. During an interview on 6/12/24 at 10:38 A.M., Consulting Staff #1 said they use McGeer criteria for infections and complete the line listing monthly. She said she had been doing the Line Listing at the facility due to multiple changes in management. She said she uses the criteria to determine if infections are true infections or if the resident was just on an antibiotic. She said when a resident goes to the hospital they try to get the culture results to follow up review with MD/NP. She said she doesn't always get them and does not document in the medial record. She said she always follows up with the provider if an antibiotic was started without a culture to see if they want to continue or stop treatment and they always want to continue the antibiotic for the full course regardless of results or symptoms. She said she does not have any documentation of any follow up conversations with the providers. She said she doesn't document it in the medical record or anywhere. She said the medical record should have documentation of the symptoms and conversations with MD/NP and they often do not. During the interview, the surveyor reviewed the March, April, and May line list with Consulting Staff #1, and she said the following: -Resident #2, she was unsure why he/she was on antibiotics. -Resident #253, she didn't know why the Xarelto was not put on hold and was unable to provide the hospital paperwork for that visit. -Resident #43, she didn't know why the line list didn't match the information in the medical record as the resident did not have a diagnosis of a UTI. Additionally, she said the facility should have followed up with the provider and not waited until the daughter inquired and provided information. -Resident #303, there should be follow documentation that the antibiotic use was reviewed in a couple days and there was not. -Resident #45, she did not know why there was a delay in treatment as the results should have been reported the same day they came in. -Resident #38, she didn't know why the line list didn't match the information in the medical record. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #24, she didn't know why the line list didn't match the information in the medical record. -Resident #255, there should be follow up documentation that the antibiotic use was reviewed in a couple days and there was not. -Resident #12, she didn't know why the line list didn't match the information in the medical record and there was an order written for a urine on 4/17/24 but she was unsure why, as there was no documentation. -Resident #1, there should be follow up documentation that the antibiotic use was reviewed in a couple days and there was not. -Resident #36, there should be follow up documentation that the antibiotic use was reviewed in a couple days and there was not. -Resident #45, the urine should have been obtained prior to starting the antibiotic and not the other way around and they should have followed up when the culture came back. Additionally, she said her expectation is if a resident went to the hospital, specifically the emergency room , and came back with an order for an antibiotic, staff would call to try and get the results and update the provider. She said she would expect this information to be given in report and staff would know to do so, however she said that she had not told them specifically to do so. She said anytime staff are getting orders for urines there should be documentation of symptoms and discussion with the provider. She said the notes are not always there and that is why the line list doesn't have all the information it should have. During an interview on 6/13/24 at 12:10 P.M., Physician #1 said his expectation is that the team is strictly following Antibiotic Stewardship guidelines and it is a challenge. He said it is especially challenging with agency nurses and covering providers outside of the normal business hours. He said they will call with minimal symptoms and get an order for treatment when they should be waiting until the urine is resulted before starting treatment, and when they go the emergency room and return on an antibiotic there should be follow up with culture results. He said no one routinely calls him to discuss whether to continue or discontinue treatment in these cases. He said in general his expectation is treatment would continue if a resident was symptomatic and/or culture indicated treatment was appropriate. He said he would expect treatment to be stopped if the culture was negative or low numbers and if they were not symptomatic. Additionally, he said if a provider orders a urine and antibiotics, they should be getting the urine before starting the antibiotic and never the other way around. He said when cultures result, the facility should be calling his office that day to initiate treatment. The surveyor reviewed the line list and discussed the number of urines that did not meet criteria, yet treatment continued (14 of 16) and he said he thinks they are over prescribing antibiotics, and the process needs improvement. Additionally, he said he thinks they are getting too many urines and treatment is being initiated without follow up, so things are falling through the cracks and our number are not where we want them to be.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41106 Based on observation, interview, and documentation review, the facility failed to implement an effective pest control program, as evidenced by small black flies and sanitation concerns in the main kitchen, and small black flies in the main dining room throughout the survey. Findings include: Review the facility's policy titled Pest Control, undated, indicated but was not limited to the following: -Routine pest control procedures will be in place. If pests are seen in the kitchen the Director of Food and Nutrition services or designee shall be informed describing where the pest was seen and when. Appropriate action will be taken to eliminate any reported pest situation in the department. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: -6-501.111 Controlling Pests. Insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments. -6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: -(B) Routinely inspecting the PREMISES for evidence of pests -(D) Eliminating harborage conditions. Review of the facility's Pest Control Binder indicated but was not limited to the following: -There were no pest sightings recorded in the pest sighting log. -Pest Contractor (PC) visit, dated 10/23/23, indicated: Pest findings, drain flies in the kitchen. Heavy organic build-up in grout in around the drains and the dish pit areas. Recommend routine cleaning to deter fly breeding in these areas. Added a logbook to the kitchen. -PC visit, dated 10/27/23, indicated: Drain flies in the kitchen could not locate logbook, sanitation observations included heavy water buildup and organic buildup in dish pit areas. -PC visit, dated 2/1/24, indicated: Sanitation; food debris on kitchen floor. The area needs to be sanitized, and excessive moisture on the kitchen floor, moisture needs to be dried. No pest activity. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-PC visit, dated 2/26/24, indicated: Small flies in the kitchen, no entries in the pest logbook, red eye fruit flies observed in the kitchen. Inspected the kitchen area to inspect for possible sources for fruit flies. PC did find multiple sources and pointed them out to the kitchen Manager and how to address them. Sanitation: food debris on kitchen floor, this area needs to be sanitized. Sanitation: excessive moisture under sinks and dishwashing areas that build up in corners and along baseboards along with food debris allowing conducive breeding conditions for fruit flies. Moisture needs to be dried. Sanitation: moisture and food debris not being cleaned off carts in the kitchen. Carts in the kitchen need to be wiped down and dried after use. Sanitation: there were buckets under the sink in the dishwasher area that collected moisture, buckets need to be cleaned and dried out and removed under the sink. -PC visit, dated 3/6/24, indicated: Mainly Black-Eyed fruit flies were found throughout the kitchen. Sanitation conditions: Include standing water under dishwashing stations, food and organic matter build up along baseboards, food collected insides of sink drains and garbage disposals, clean glasses are wet when they are placed on the drying rack. -PC visit, date 3/25/24, indicated: No concerns at this time. Maintenance Director mentioned they had addressed many of the sanitation conditions. I pointed out last visit and since then there has been very little to no small fruit fly activity. Continue maintenance program. -PC visit, dated 5/1/24, small flies beginning to show up again in the kitchen. No entries in the pest logbook. Black Eyed fruit flies in the kitchen. Inspected kitchen for sources of flies, pointed out these conditions to the Maintenance Director and sent photos. Sanitation: food debris on kitchen floor, these areas need to be sanitized. Structural; baseboard pulling away from wall near ovens, baseboards need to be fixed to prevent moisture and food debris from being caught between baseboards. Behavioral: hose left running and water was dripping onto the floor creating stagnant water buildup, hose should be shut off when not in use. Sanitation: debris build up and get caught on top of floor drain covers, drain covers need to be cleaned. Sanitation: sugar packets in and on top of the floor drains, floors need to be swept better before washing. Sanitation: organic matter build-up in the floor drains, floor drains need to be cleaned. -PC visit, dated 5/30/24, indicated: small flies in the kitchen, no logbook entries. Small flies in the kitchen. Please note the fly issue will not improve until the kitchen staff does a better job cleaning and drying things. Continue maintenance program. Sanitation food debris on kitchen floor this area needs to be sanitized structural baseboards pulling away from wall near ovens. Baseboards need to be fixed to prevent moisture and food debris from being caught between baseboards. Behavioral- hose left running and water dripping onto the floor creating stagnant water build up, hose should be shut off when not in use. Sanitation debris build up and getting caught on top of the floor drain covers, drain covers need to be cleaned. Sanitation organic matter build up in floor drains floor drains need to be cleaned. Sanitation, moderate amounts of standing water on the floor, floors need to be dried more thoroughly. Sanitation, clean glasses not dried and left dripping in crates. Glasses and cups should be dried more thoroughly before being placed down and should not be left to drip dry when moisture can collect such as in the crates. During a Resident Group Meeting with the surveyor held in the main dining room on 6/7/24 at 11:00 A.M., fourteen Residents attended the meeting and reported the following: -There are gnats in both parts of the dining room and in the resident rooms. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-During Resident Council the surveyor observed residents to be swatting away small black flies. During an interview on 6/06/24 at 3:40 P.M., Resident #16 said there are bugs/flies in the main dining room. On 6/6/24 at 8:05 A.M., the surveyor observed the main kitchen floor to be dirty with food particles around the entire kitchen floor, floor tile grout had a black grimy build-up with embedded food particles, the walls were visible dirty, dirt and debris underneath the metal tables throughout the kitchen. There was standing water in both dish rooms on the floor, and by the three Bay sink. In addition, there were black small black flies on the ceiling by the main serving stationing, dish room to the left of the kitchen, and in and around the floor drain in the first dish room. On 6/6/24 at 3:05 P.M., the surveyor observed the main dining room and observed small black flies on the wall ice machine and coffee station to the left of the entrance to the kitchen, the wall to right of the entrance to the main kitchen, the wall by the windows, the wall by the entrance to the main dining room. The ice machine drain was observed to be draining slowly, leaving standing water. On 6/11/24 at 7:50 A.M., the surveyor observed the main kitchen walls and made the following observations: -The walls above the prep sink were stained with food particles, it appeared an attempt was made to wash the walls but only halfway up the wall. -The prep sink was dirty with a large amount of food particles and standing water. -There were many small black flies on the wall by the main entrance to the kitchen. -There were small black flies on the ceiling over the serving steam table. -There were small black flies on the walls in the room that housed the reach-in refrigerator. -There were small black flies on the walls, the shelving unit drying dishes, in and around the drain in by the first dishwasher room on the left of the kitchen. -The drain in the dish room was found to have standing water and build-up food debris. On 6/11/24 at 8:27 A.M., the surveyor observed walls of main dining room with multiple small flies, along the wall leading to the kitchen, near the ice machine (flying and on the wall), and above the coffee carafes and on the wall adjacent to the coffee carafes. During an interview on 6/11/24 at 8:28 A.M., the Activity Director said the bugs have been increasing with the warmer weather and were not here during the winter months. On 6/11/24 at 11:42 A.M., the surveyor observed multiple small black flies, flying around the area of the ice machine in the main dining room. In addition, there were numerous small black flies on the walls by the windows, behind the ice and coffee machine, entrance to the kitchen and entrance into the main dining room. (continued on next page)

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/12/24 at 9:00 A.M., the surveyor and the FSD did a final tour of the kitchen and reviewed the black flies in the first dish room and around the floor drain on the left side of the kitchen, on the walls and ceiling by the service table. There was observed standing water on the floor of the second dish room (last used the evening before per the FSD), the faucet was slowly running in the three bay sink, the sink with the garbage disposal (tape across the top) had standing water, under the flat top grill had large amount of food crumbs under the grill, there was water draining into the floor drain from underneath the counter with the steam oven on it, the floor tile grout throughout the kitchen had built up of a black substance which had food debris imbedded in it. The surveyor was able to scrape the black substance off the floor and remove a particle of food. The floor drain in the first dish room was observed to have a build-up of organic matter. During an interview on 6/12/24 at 9:05 A.M., the FSD said the floor was power washed last night and that was as clean as they could get the floor. He said the stuff won't come out of the cracks. The FSD said the flies have been a problem and the staff have been educated about keeping the kitchen clean and making sure the water is shut off and cleaned off. He said the dietary staff needs to do a better job. During a telephonic interview on 6/11/24 at 4:45 P.M., the Pest Control Contractor (PCC) said there has been an ongoing issue with small flies in the kitchen and the overall sanitation of the kitchen which has not been addressed. PCC said the sanitation issues included the food and grease build up under the stove and on the floors, standing water on the floors, clogged floor drains, running water found in the sinks, not drying the floors after the dish machine is run leaving standing water. PCC said he had recommended on 5/1/24 and 5/30/24 the baseboard around the kitchen area, between the two dishwashing rooms be fixed. In addition, he has recommended the drains be cleaned out and the organic manner removed from the drains. He indicated the flies could only be eradicated if the kitchen sanitation is maintained and the facility goes ahead with the fogging of the kitchen. During an interview on 6/13/24 at 12:05 P.M., the Administrator said she was aware of the pest issues as it relates to the kitchen sanitation.