

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/10/2025
NAME OF PROVIDER OR SUPPLIER  Fall River Jewish Home		STREET ADDRESS, CITY, STATE, ZIP CODE  538 Robeson Street Fall River, MA 02720	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, record review, and interview, the facility failed to ensure one Resident (#56), out of a total sample of 16 residents, was assessed by the Interdisciplinary Care Team for self-administration of all their medications and had a physician's order to self-administer medications.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.</li> </ul> <p>Review of the facility's policy titled Safety and Supervision of Residents, last revised April 2018, indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.</li> <li>- As part of their overall evaluation, the staff and/or practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident.</li> <li>- The staff and/or practitioner will document their findings and the choices of residents who are able to self-administer medications.</li> <li>- Self-administered medications must be stored in a safe and secure place which is not accessible by other residents.</li> <li>- The staff and practitioner will periodically (for example, during quarterly MDS reviews) re-evaluate a resident's ability to continue to self-administer medications.</li> </ul> <p>Resident #56 was admitted to the facility in March 2025 with diagnoses including myocardial infarction (heart attack) and tachycardia (a heart rate faster than 100 beats per minute at rest).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Minimum Data Set (MDS) assessment, dated 5/28/25, indicated Resident #56 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS indicated the Resident was able to perform activities of daily living with supervision.</p> <p>During an interview with observation on 6/8/25 at 8:22 A.M., the surveyor observed Resident #56 sitting on the edge of his/her bed with the following:</p> <ul style="list-style-type: none"> <li>- A napkin on his/her bed which contained: <ul style="list-style-type: none"> <li>- One white capsule broke in half,</li> <li>- One yellow oval pill,</li> <li>- One red and white oval capsule,</li> <li>- One round pink tablet,</li> <li>- One yellow round tablet,</li> <li>- Three small oval white tablets,</li> <li>- Three medium sized round tablets,</li> <li>- Two large round tablets, and</li> <li>- One small round tablet.</li> </ul> </li> <li>- Three medication cups on his/her overbed table which contained: <ul style="list-style-type: none"> <li>- One with one round white medium sized tablet,</li> <li>- One with four round white medium sized tablets, and</li> <li>- One with one yellow oval pill and one red oval capsule.</li> </ul> </li> <li>- A plastic cup containing two 2 milliliter (ml) nebulizer vials on his/her nightstand.</li> </ul> <p>Resident #56 said the nurses would give him/her all their pills in the morning and leave them, then he/she would sort their medication for accuracy before he/she would take them.</p> <p>On 6/8/25 at 12:05 P.M., the surveyor observed a medication cup on Resident #56's overbed table which contained three white round pills and, on their nightstand, the surveyor observed a plastic cup which contained two 2 ml nebulizer vials.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up interview with observation on 6/9/25 at 8:20 A.M., the surveyor observed a plastic cup on Resident #56's nightstand containing two 2 ml nebulizer vials. Resident #56 said the nurse had brought him/her their medication this morning, the nurse would not leave their medication for him/her to check because the surveyors were in the facility. Resident #56 said he/she wanted the nurse to give him/her their medications and so he/she could check them over prior to taking them. Resident #56 he/she wanted to be able self-administer his/her medications.</p> <p>On 6/10/25 at 8:25 A.M., the surveyor observed a plastic cup on Resident #56's nightstand containing two 2 ml nebulizer vials and, on their chair, a medication cup with a yellow oval pill.</p> <p>Review Resident #56 Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Acetaminophen (Tylenol) Tablet 325 milligrams (mg), give 2 tablets by mouth every 12 hours as needed for pain, dated 3/14/25 (discontinued)</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for pain, dated 3/14/25 (discontinued 3/14/24)</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for temperature of 100 F or above, dated 3/14/25 (discontinued 3/14/24)</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 12 hours as needed for temperature of 100 Fahrenheit (F) or above, dated 3/14/25 (discontinued)</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 12 hours for pain, dated 3/14/25 (discontinued)</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 12 hours as needed for pain, dated 5/21/25 (discontinued)</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 12 hours for pain, dated 5/21/25 (discontinued)</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 12 hours as needed for temperature of 100 F or above, dated 5/21/25 (discontinued)</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 6 hours for pain, dated 6/8/25</li> <li>- Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 6 hours for temperature of 100 F or above, dated 6/8/25</li> <li>- Colace (stool softener) 100 mg capsule, give 1 capsule in the morning every other day, dated 3/14/25 (discontinued)</li> <li>- Colace 100 mg capsule, give 1 capsule one time daily, dated 4/15/25 (discontinued)</li> <li>- Colace 100 mg capsule, give 1 capsule in the morning, dated 5/21/25 (discontinued)</li> </ul> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Colace 100 mg capsule, give 1 capsule every 24 hours as needed for constipation, dated 6/8/25 (discontinued)</p> <p>- Budesonide Inhalation (nebulizer, used to decrease inflammation of the airways) 0.5 mg/2 milliliter, give 2 ml inhalation two times a day for COPD 5/21/2025</p> <p>Review of Resident #56's medical record failed to indicate:</p> <ul style="list-style-type: none"> <li>- he/she had a care plan to self-administer their medications, and</li> <li>- a physician's order for self-administration of medications.</li> </ul> <p>During an interview on 6/10/25 at 10:22 A.M., the Charge Nurse said if a resident voiced a desire to self-administer their medications, they would need an assessment, a physician's order, and care plan which indicated the medications he/she could self-administer. The Charge Nurse said the medications should not have been left with Resident #56 as they had not been assessed to take all of his/her medications independently.</p> <p>On 6/10/25 at 3:30 P.M., the facility provided the surveyor with a Medication Self-Administration Assessment, dated 3/14/25, which indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Medications:</li> <li>- Tylenol 325 mg, 2 tablets every 6 hours as needed</li> <li>- Colace 100 mg, 1 tablet every 24 hours as needed</li> <li>- Does the resident wish for the staff to prepare medications and leave at bedside per request: YES</li> <li>- Signed by the Charge Nurse on 3/17/25</li> </ul> <p>Further review of the Medication Self-Administration Assessment, dated 3/14/25, failed to indicate Resident #56 was assessed by the Interdisciplinary Care Team to self-administer his/her nebulizer and had not identified any medications other than Colace and Tylenol.</p> <p>During an interview on 6/10/25 at 3:20 P.M., the Director of Nursing (DON) said residents would be assessed for self-administration of medications upon admission and if/when they requested to do so and a physician's order was needed for self-administration of medications.</p>		

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<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on interview, and record review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) and Notice of Medicare Non-coverage (NOMNC) were issued with the required information for a Resident (#217) out of three applicable residents reviewed. Specifically, the facility failed to issue the SNF ABN notice and NOMNC, so the Resident/Resident Representative could decide if they wished to continue receiving skilled services that may not be paid for by Medicare, and were aware of the financial responsibility they may have to assume.</p> <p>Findings include:</p> <p>The NOMNC, Form CMS-10123, is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization.</p> <p>The SNF ABN, CMS-10055, is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.</p> <p>Resident #217 was admitted to the facility in January 2025.</p> <p>Review of Form CMS-20052 indicated Resident #217 had a last covered day of Part A Service on 3/21/25. The discharge from Medicare Part A service was facility/provider initiated, and the Resident remained in the facility.</p> <p>Upon request of the ABN and NOMNC for Resident #217, the facility was unable to provide the notices for review.</p> <p>During an interview on 6/9/25 at 8:29 A.M., the Administrator said the social service department was responsible for issuing ABN and NOMNC forms. He said the facility identified the previous social worker was not issuing all of the required notices. He said the Resident should have been informed of the information on the forms.</p> <p>During an interview on 06/09/25 at 8:40 A.M., the Social Worker said she was not working at the facility at the time this notice was supposed to be issued. She said this Resident should have received an ABN to be informed of the estimated cost, reason Medicare may not pay, and the date the resident may have out of pocket expenses.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on record review and interview, the facility failed to implement written policies and procedures for the investigation of allegations of abuse, protection of residents during investigations and reporting of allegations and investigative findings for one Resident (#50), out of a total sample of 16 residents. Specifically, the facility failed to initiate their abuse policy after an allegation of potential abuse was reported on a grievance form dated 2/25/25.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Clinical Services, Subject: Abuse, dated March 2023, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>- Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated and reported.</li> </ul> <p>-Action:</p> <ul style="list-style-type: none"> <li>-Immediately protect Resident from alleged abuse.</li> <li>-Immediately suspend employee pending investigation.</li> <li>-The facility will notify the Department of Public Health (DPH) and Local Law Enforcement no later than two hours after abuse allegation was received.</li> <li>-Investigation: The administrative staff or nursing supervisor assumes responsibility for: <ul style="list-style-type: none"> <li>-Immediate investigation into the alleged incident (during the shift it occurred on).</li> <li>-Interview resident and other resident witnesses. This interview is to be dated, documented and signed by supervisor.</li> <li>-Interview staff member implicated. Have employee document their knowledge/version of incident in written narrative that is dated and signed.</li> <li>-Interview staff witnesses or other available witnesses. Witnesses are to document incident in a written narrative that is dated and signed. Interview relevant staff on that unit and obtain written statement.</li> </ul> </li> <li>-Facility investigation will be completed within 72 hours of the incident. Documentation of investigation to be completed by initiating an Incident and Accident Report, obtaining statements from identified potential witnesses, completing necessary evaluations, and maintaining a timeline of events.</li> <li>-Reporting/Documentation Requirements: The Administrator, Director of Nursing or their designee assumes responsibility for notification of the incident and preliminary internal investigation results to the State Health Department and other regulatory agencies per individual state reporting requirements.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #50 was admitted to the facility in June 2024 with diagnoses including dementia and diabetes mellitus.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 3/31/25, indicated Resident #50 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15. The MDS further indicated Resident #50 was independent for most activity of daily living tasks.</p> <p>Review of the facility's Grievance book indicated a grievance reported by Resident #50 dated 2/25/25. The grievance indicated on 2/25/25, Resident #50 reported to the Director of Social Services that a nurse went into the Resident's room and threw a shopping bag at him/her. The Resident was very upset and angry that he/she was yelled at. The grievance indicated that the Director of Social Service met with the Resident and the nurse and had a conversation about approach and the nurse apologized. The grievance form was signed by the Director of Social Services and the Administrator on 2/25/25.</p> <p>During an interview on 6/9/25 at 9:03 A.M., the Administrator said the 2/25/25 grievance was complete and there was no additional investigation or interview documentation to accompany the grievance.</p> <p>Review of the Health Care Facility Reporting System (HCFRS-system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 6/9/25, failed to indicate the facility submitted a report on 2/25/25 for an allegation of abuse.</p> <p>During an interview on 6/9/25 at 9:35 A.M., the Administrator and surveyor reviewed the 2/25/25 grievance reported by Resident #50. He said the Resident can be difficult at times and he did not consider the incident anything more than the Resident being accusatory and difficult. He said he did not think the report of a nurse throwing at bag at the Resident and yelling at the Resident as a potential abuse. He said he considered it a customer service issue and education was provided to all staff on the facility's customer service expectations. The Administrator said if he felt it was an allegation of abuse, he would have suspended the nurse pending an investigation, conducted an investigation and reported it to DPH.</p> <p>During an interview on 6/9/25 at 11:00 A.M., the Administrator said he had just submitted a report to HCFRS for Resident #50's allegation of potential abuse on 2/25/25.</p> <p>Refer to F609, F610.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interviews, the facility failed to report a potential allegation of abuse for one Resident (#50), out of a total sample of 16 residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Clinical Services, Subject: Abuse, dated March 2023, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>- Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated and reported.</li> <li>-The facility will notify the Department of Public Health (DPH) and Local Law Enforcement no later than two hours after abuse allegation was received.</li> </ul> <p>Resident #50 was admitted to the facility in June 2024 with diagnoses including dementia and diabetes mellitus.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 3/31/25, indicated Resident #50 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15. The MDS further indicated Resident #50 was independent for most activity of daily living tasks.</p> <p>Review of the facility's Grievance book indicated a grievance reported by Resident #50 dated 2/25/25. The grievance indicated on 2/25/25, Resident #50 reported to the Director of Social Services that a nurse went into the Resident's room and threw a shopping at him/her. The Resident was very upset and angry that he/she was yelled at. The Resident was told he/she would be moving rooms that afternoon. The grievance indicated that the Director of Social Service met with the Resident and the nurse and had a conversation about approach and the nurse apologized. The grievance form was signed by the Director of Social Services and the Administrator on 2/25/25.</p> <p>Review of the Health Care Facility Reporting System (HCFRS-system used in Massachusetts by facilities to report suspected abuse/misappropriation) on 6/9/25, failed to indicate the facility submitted a report on 2/25/25 for an allegation of abuse.</p> <p>During an interview on 6/9/25 at 9:35 A.M., the Administrator and surveyor reviewed the 2/25/25 grievance reported by Resident #50. He said the Resident can be difficult at times and he did not consider the incident anything more than the Resident being accusatory and difficult. He said he did not think the report of a nurse throwing at bag at the Resident and yelling at the Resident as a potential abuse. He said he considered it a customer service issue and education was provided to all staff on the facility's customer service expectations. The Administrator said if he felt it was an allegation of abuse, he would have reported it to DPH.</p> <p>During an interview on 6/9/25 at 11:00 A.M., the Administrator said he just submitted a report to HCFRS for Resident #50's allegation of potential abuse on 2/25/25.</p> <p>Refer to F610.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and interviews, the facility failed to investigate a potential allegation of abuse for one Resident (#50), out of a total sample of 16 residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Clinical Services, Subject: Abuse, dated March 2023, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>- Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated and reported.</li> </ul> <p>-Action:</p> <ul style="list-style-type: none"> <li>-Immediately protect Resident from alleged abuse.</li> <li>-Immediately suspend employee pending investigation.</li> <li>-Investigation: The administrative staff or nursing supervisor assumes responsibility for:</li> <li>-Immediate investigation into the alleged incident (during the shift it occurred on).</li> <li>-Interview resident and other resident witnesses. This interview is to be dated, documented and signed by supervisor.</li> <li>-Interview staff member implicated. Have employee document their knowledge/version of incident in written narrative that is dated and signed.</li> <li>-Interview staff witnesses or other available witnesses. Witnesses are to document incident in a written narrative that is dated and signed. Interview relevant staff on that unit and obtain written statement.</li> <li>-Facility investigation will be completed within 72 hours of the incident. Documentation of investigation to be completed by initiating an Incident and Accident Report, obtaining statements from identified potential witnesses, completing necessary evaluations, and maintaining a timeline of events.</li> </ul> <p>Resident #50 was admitted to the facility in June 2024 with diagnoses including dementia and diabetes mellitus.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 3/31/25, indicated Resident #50 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15. The MDS further indicated Resident #50 was independent for most activity of daily living tasks.</p> <p>(continued on next page)</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC-a flexible tube inserted through a vein in one's arm and passed through to larger veins near the heart, used to deliver medications intravenously (IV)), consistent with professional standards of practice for two Residents (#12 and #166), out of a total of 2 residents receiving intravenous therapy. Specifically, the facility failed to change the PICC dressing per professional standards.</p> <p>Findings include:</p> <p>Review of the facility policy titled Central Venous Catheter Care and Dressing Changes, undated, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>- The purpose of the procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or well dressings.</li> <li>- Maintain sterile dressing (transparent semi-permeable membrane (TSM) dressing or sterile gauze) dressing for all central vascular access devices.</li> <li>- Change the dressing if it becomes damp, loosened or visibly soiled and: <ul style="list-style-type: none"> <li>- at least every 7 days for TSM dressing;</li> <li>- at least every 2 days for sterile gauze dressing (including gauze under a TSM unless the site is not obscured.</li> </ul> </li> </ul> <p>Review of the Centers for Disease Control and Prevention (CDC) Guidelines for the Prevention of Intravascular Catheter-Related Infections, last revised October 2017, indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Catheter Site Dressing Regimens: <ul style="list-style-type: none"> <li>- Replace dressings used on short-term CVC (central vascular catheter) sites every 2 days for gauze dressings.</li> <li>- Replace dressings used on short-term CVC sites at least every 7 days for transparent Dressings.</li> </ul> </li> </ul> <p>(<a href="https://www.cdc.gov/infection-control/media/pdfs/Guideline-BSI-H.pdf">https://www.cdc.gov/infection-control/media/pdfs/Guideline-BSI-H.pdf</a>)</p> <p>Review of the National Library of Medicine (NLM), dated 5/15/23, indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Gauze (a fabric dressing that does not stick to the skin) dressings to be changed every 48 hours, and transparent semi permeable dressings every seven days.</li> </ul> <p>(<a href="https://pmc.ncbi.nlm.nih.gov/articles/PMC8765739/">https://pmc.ncbi.nlm.nih.gov/articles/PMC8765739/</a>)</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Fall River Jewish Home		STREET ADDRESS, CITY, STATE, ZIP CODE  538 Robeson Street Fall River, MA 02720	
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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Resident #12 was admitted to the facility in May 2025 with diagnoses including staphylococcal arthritis (serious joint infection that can lead to significant damage if not treated promptly).</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 5/21/25, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS assessment indicated Resident #12 had a central line and received intravenous (IV) antibiotic medication.</p> <p>Review of Resident #12's current Physician Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Change transparent dressing to PICC every 7 days and as needed, dated 6/8/2025</li> <li>- Change transparent dressing to PICC every 7 days, dated 6/8/2025, discontinued 6/8/25</li> </ul> <p>During an interview 6/10/25 at 8:37 A.M., the surveyor observed Resident #12 in bed with a PICC line in his/her right upper arm. There was a 2 centimeter (cm) x 2 cm split gauze over the insertion point of the PICC line covered with transparent dressing, dated 6/4/25. Resident #12 said he/she had received IV antibiotics through his/her PICC line.</p> <p>During an interview on 6/10/25 at 10:36 A.M., Nurse #2 said when he would change a PICC line dressing prior to applying the transparent dressing he would first cover the PICC line at the insertion point with gauze. Nurse #2 observed Resident #12's PICC line dressing and said he had changed the dressing on 6/4/25 and prior to applying the transparent dressing he had covered the PICC line with gauze at the insertion point. Nurse #2 said PICC line dressings were changed every seven days and as needed. Nurse #2 said he followed the facility policy for PICC line dressings.</p> <p>2. Resident #166 was admitted to the facility in May 2025 with diagnoses of cellulitis (a bacterial skin infection affecting the deeper layers of the skin and underlying tissue).</p> <p>Review of the MDS assessment, dated 6/5/25, indicated Resident #166 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS assessment indicated Resident #166 had a central line and received IV antibiotic medication.</p> <p>Review of Resident #166's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Change transparent dressing to PICC one time only for IV maintenance for 1 Day 24 hours post insertion or on admission AND every day shift every 7 days AND as needed, dated 5/29/2025</li> </ul> <p>On the following days and times, the surveyor observed Resident #166 in bed with a PICC line in his/her right upper arm. There was a 2 cm x 2 cm gauze over the insertion point of the PICC line covered with a transparent dressing, dated 6/5/25:</p> <ul style="list-style-type: none"> <li>- 6/8/25 at 9:07 A.M.,</li> <li>- 6/9/25 at 8:35 A.M., and</li> <li>- 6/10/25 at 8:33 A.M.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/8/25 at 9:07 A.M., Resident #166 said he/she had received two different antibiotics through his/her PICC line. Resident #166 said the last time his/her dressing was changed was on 6/5/25.</p> <p>During an interview on 6/10/25 at 10:36 A.M., Nurse #2 said when he would change a PICC line dressing prior to applying the transparent dressing he would first cover the PICC line at the insertion point with gauze. Nurse #2 observed Resident #166's PICC line dressing and said he had changed the dressing on 6/5/25 and prior to applying the transparent dressing he had covered the PICC line with gauze at the insertion point. Nurse #2 said PICC line dressings were changed every seven days and as needed. Nurse #2 said he followed the facility policy for PICC line dressings.</p> <p>During an interview on 6/10/25 at 11:00 A.M., the Regional Clinical Coordinator observed the PICC line dressings for Residents #12 and #166 and said both PICC lines were covered with gauze and transparent dressing. The Regional Clinical Coordinator said PICC line dressings were changed every seven days and as needed, according to facility policy. The Regional Clinical Coordinator reviewed the facility policy and the dressings for Resident #12 and Resident #166 and said the gauze dressings should have been changed every two days per facility policy and infection control purposes.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation and interview, the facility failed to ensure all drugs and biologicals used in the facility were stored in a safe and secure manner as required. Specifically, the facility failed to ensure one of two medication carts was clean and free of loose pills and debris.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Storage of Medication, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>-The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.</li> <li>-The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</li> </ul> <p>On 6/9/25 at 3:53 P.M., the surveyor observed the Unit Two medication cart to have a large amount of loose pills and paper debris on the bottom of the second, third, and fourth drawers.</p> <p>During an interview on 6/9/25 at 3:53 P.M., Nurse #3 said the medication cart should be clean and free of loose pills and debris. Nurse #3 said she was unaware when the medication cart was last cleaned, but it was supposed to have been cleaned weekly on the night shift.</p> <p>During an interview on 6/9/25 at 4:17 P.M., the Director of Nursing (DON) observed the Unit Two medication cart and said the medication cart was cleaned weekly on the 11:00 P.M. to 7:00 A.M. shift and was last cleaned last Friday. The DON said the expectation was for medication carts to be clean and free of loose pills and debris.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation and interviews, the facility failed to ensure residents received food prepared by methods that conserve nutritive value, flavor, and appearance, and was palatable, attractive, and at a safe and appetizing temperature for two of two test trays.</p> <p>Findings include:</p> <p>Review of Food Committee Minutes indicated the following resident concerns and facility solutions:</p> <p>a) 1/6/25</p> <p>RESIDENT CONCERNS: Food cold when arrives to resident rooms;</p> <p>SOLUTIONS: The kitchen is trying to keep the food hotter. Kitchen manager is looking into new food trucks.</p> <p>b) 3/6/25</p> <p>SOLUTIONS: In process of ordering new food delivery carts.</p> <p>c) 4/28/25</p> <p>SOLUTIONS: In process of ordering new food delivery carts.</p> <p>d) 5/8/25</p> <p>RESIDENT CONCERNS: The residents saying their food is cold when they get it in their rooms;</p> <p>SOLUTIONS: The Kitchen Manager is still trying to get new food trucks so it will keep the food hotter;</p> <p>CONCLUSION: Four Residents in attendance let the Kitchen Manager know the breakfast and lunch food is hotter.</p> <p>During the initial resident screening on 6/8/25, the survey team identified the following concerns expressed by residents about food palatability:</p> <ul style="list-style-type: none"> <li>-Resident #60 said the food was always cold, the tea is even cold;</li> <li>-Resident #16 said the food was not always hot but can get reheated;</li> <li>-Resident #48 said the food was cold at times;</li> <li>-Resident #58 said the scrambled eggs were cold;</li> <li>-Resident #39 said the breakfast eggs were cold today;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #61 said the food served was cold, his/her lunch was a bit warmer but not warm enough.</p> <p>On 6/8/25, the surveyor observed the following on Unit 3:</p> <p>-7:54 A.M., one meal truck that enclosed trays within it and two pushcarts with no walls or doors to enclose the breakfast trays.</p> <p>-8:01 A.M., the surveyor observed tray pass begin on Unit 3.</p> <p>-8:25 A.M., Resident #60 indicated the food is always cold and he/she did not receive his/her breakfast yet.</p> <p>-8:38 A.M., the surveyor informed a Certified Nursing Assistant (CNA) of Resident #60 with no breakfast tray. The CNA collected the Resident's breakfast tray from the push cart.</p> <p>-8:40 A.M., Resident #60 received his/her breakfast.</p> <p>The surveyor observed Resident #60's breakfast tray on the open pushcart for 46 minutes prior to the Resident receiving his/her meal.</p> <p>On 6/9/25, the surveyor observed the following:</p> <p>-8:30 A.M., Resident #61 said his/her breakfast was lukewarm;</p> <p>-8:35 A.M., Resident #166 said his/her eggs were cold.</p> <p>On 6/9/25 at 10:30 A.M., 11 Residents attended the Resident Council Meeting. Two of the three Residents from Unit 3 and four of the eight Residents from Unit 2 said the food is cold, not hot enough, and this applied to all meals all days of the week. The Residents said food temperatures are improving but were still not good.</p> <p>On 6/9/25 at 11:12 A.M., the Ombudsman said the residents were concerned with the food not being warm.</p> <p>On 6/9/25 at 11:51 A.M., the surveyor observed the lunch tray line.</p> <p>12:32 P.M. - a regular texture test tray was made.</p> <p>12:34 P.M. - the test tray left the kitchen in an enclosed meal truck.</p> <p>12:35 P.M. - the meal truck arrives on Unit 2. A nurse began reconciling meal tickets with the food on each plate, which consisted of raising and lowering the plate dome. She reviewed two meals which were immediately delivered to residents. Subsequently, she pulled the remaining trays one at a time from the meal truck, reviewed each ticket against the food on the plate, and placed the tray back into the meal truck.</p> <p>12:41 P.M. - the nurse had finished reconciling the remainder of the trays on the food truck.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12:52 P.M. - the last tray was served from the meal truck.</p> <p>On 6/9/25 at 12:54 P.M., the Food Service Director (FSD) and the surveyor performed the test tray together. The food temperatures were observed to be:</p> <ul style="list-style-type: none"> <li>-roasted chicken 135F</li> <li>-roasted potatoes and onions 119F</li> <li>-green beans 131F</li> </ul> <p>The surveyor and FSD sampled the food. The surveyor observed the food to be visually appealing with good flavor and texture. The surveyor observed the chicken to be adequately warm and the potatoes and green beans to be lukewarm and a less desirable temperature. The FSD said the potatoes and green beans could be warmer.</p> <p>On 6/9/25 at 12:25 P.M.:</p> <ul style="list-style-type: none"> <li>-Resident #61 said his/her lunch was barely lukewarm and could have been warmer.</li> <li>-Resident #41 said lunch tasted great but was lukewarm.</li> <li>-Resident #14 said lunch could be hotter.</li> <li>-Resident #50 said lunch was lukewarm.</li> </ul> <p>On 6/10/25 at 7:45 A.M., the surveyor observed breakfast tray line.</p> <p>8:05 A.M. - a test tray was made and placed on a pushcart which had no walls or doors to enclose the tray.</p> <p>8:06 A.M. - test tray leaves kitchen.</p> <p>8:07 A.M. - test tray arrives on Unit 3.</p> <p>On 6/10/25 at 8:12 A.M., the FSD and surveyor performed a test tray together. The food temperatures were observed to be:</p> <ul style="list-style-type: none"> <li>-scrambled eggs 120F</li> <li>-oatmeal 127F</li> <li>-muffin (no temperature taken)</li> <li>-juice 48F</li> </ul> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The FSD and surveyor sampled the food. The surveyor observed the breakfast food to be visually appealing with good flavor and texture. The surveyor observed the scrambled eggs to be lukewarm and the oatmeal to be barely warm and cooler than the eggs. The FSD said he thought the egg temperature was fair and he was surprised by the oatmeal temperature as the oatmeal is typically hotter.</p> <p>On 6/10/25 at 8:25 A.M., Resident #56 said breakfast was cold.</p> <p>On 6/10/25 at 8:33 A.M., Resident #166 said breakfast was cold today, especially the eggs.</p> <p>During an interview on 6/10/25 at 11:50 A.M., the Administrator said he was unaware of pushcarts (with no walls or doors to enclose meals) being used regularly for meal pass. The Administrator said he expected food to be served per regulations and at an appetizing temperature with hot foods served hot.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility failed to follow their 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:</p> <ol style="list-style-type: none"> <li>1. Ensure the main kitchen grout and coving was maintained in a sanitary and safe condition; and</li> <li>2. Ensure the refrigerators in two of two unit kitchenettes were maintained in a sanitary and safe condition.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised January 2023, indicated but was not limited to the following: <ul style="list-style-type: none"> <li>1-2 Definitions 1-201 Applicability and Terms Defined</li> <li>1-201.10 Statement of Application and Listing of Terms.</li> </ul> </li> </ol> <p>Easily Cleanable.</p> <p>(1) Easily cleanable means a characteristic of a surface that: (a) Allows effective removal of soil by normal cleaning methods; (b) Is dependent on the material, design, construction, and installation of the surface; and (c) Varies with the likelihood of the surface's role in introducing pathogenic or toxigenic agents or other contaminants into food based on the surface's approved placement, purpose, and use.</p> <p>Smooth means:</p> <p>(3) A floor, wall, or ceiling having an even or level surface with no roughness or projections that render it difficult to clean.</p> <p>6-201.12 Floors, Walls, and Ceilings, Utility Lines. Floors that are of smooth, durable construction and that are nonabsorbent are more easily cleaned. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible and that insect and rodent harborage is minimized.</p> <p>6-201.13 Floor and Wall Junctures, Coved, and Enclosed or Sealed. (A) In FOOD ESTABLISHMENTS in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be coved and closed to no larger than 1 mm (one thirty-second inch).</p> <p>On 6/9/25 at 12:59 P.M., the surveyor observed, in the main kitchen, several areas of compromised floor grout that was crumbling and/or deeply recessed. The surveyor observed some of these areas to be near the dish room with the tile and grout wet. Additionally, the surveyor observed areas of grout with a thick layer of gray buildup. The surveyor scratched the gray film with a fingernail indicating it was malleable, putty-like substance.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/9/25 at 12:59 P.M., the surveyor observed two different types of flooring in the main kitchen, ceramic tile and a vinyl-type flooring. The surveyor observed, near the dish room, raised vinyl flooring where the tile and vinyl flooring met to have small crumbs under the raised vinyl and the grout to be wet. At a different juncture where tile met vinyl flooring, the surveyor observed the vinyl to sit above the tile floor plane. Along that juncture, the surveyor observed a line of gray, putty-like buildup.</p> <p>On 6/9/25 at 12:59 P.M., the surveyor observed compromised floor/wall junctures throughout the main kitchen. There were several areas where coving peeled away from the wall, leaving gaps and/or protruding coving. The surveyor observed cracked and crumbling grout in areas of the floor/wall juncture, and a missing door frame at a floor/doorframe juncture.</p> <p>During an interview on 6/10/25 at 8:45 A.M., the Food Service Director (FSD) said he expected the main kitchen floor to be easily cleanable with no compromised grout or junctures.</p> <p>During an interview on 6/10/25 at 11:50 A.M., the Administrator said he expected the kitchen floor and junctures/coving to be in good repair and easily cleanable.</p> <p>2. Review of the 2022 Food Code by the FDA, revised 1/2023, indicated but was not limited to the following:</p> <p>3-305 Preventing contamination from the premises</p> <p>3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination</p> <p>Review of the facility's policy titled Cleaning and Sanitation of Dining and Food Service Areas, undated, indicated but was not limited to:</p> <p>Policy: The food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule.</p> <p>Procedure:</p> <ul style="list-style-type: none"> <li>-The director of food and nutrition services will determine all cleaning and sanitation tasks needed for the department.</li> <li>-Staff will be trained on the frequency of cleaning as necessary.</li> <li>-A cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed.</li> <li>-Staff will be held accountable for cleaning assignments.</li> </ul> <p>On 6/9/25 at 9:50 A.M., the surveyor observed in the Unit 2 kitchenette refrigerator, pools of dried orange liquid under the crisper drawers.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/9/25 at 9:54 A.M., the surveyor observed in the Unit 3 kitchenette refrigerator, a Resident's plastic grocery bag containing food set on top of an orange and red sticky substance. The surveyor had to use force to lift the bag from the shelf and remove from the sticky substance.</p> <p>On 6/10/25 at 11:01 A.M., the surveyor observed a sticky red and orange substance on the bottom shelf of the Unit 3 kitchenette refrigerator.</p> <p>On 6/10/25 at 11:10 A.M., the surveyor observed the same pools of dried orange liquid under the crisper drawers of the Unit 2 kitchenette refrigerator. The surveyor also observed the bottom crisper drawer had dry, crusted spillage that was a milky white color. In that drawer were single-serve gelatin cups, a Tupperware container of peanut butter, and bottles of water.</p> <p>During an interview on 6/10/25 at 11:50 A.M., the Administrator said he expected Unit refrigerators to be kept clean. He said the refrigerators should be cleaned on a regular and as needed basis. The Administrator said the kitchen and unit staff are responsible for and should coordinate efforts to keep the refrigerators clean.</p> <p>During an interview on 6/10/25 at 11:55 A.M., the FSD said dietary cleaned the unit refrigerators on a weekly basis. The FSD said he expects the kitchenette refrigerators to be clean and free of spills.</p>		

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NAME OF PROVIDER OR SUPPLIER  Fall River Jewish Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) program with documentation of the development, implementation, and evaluation of corrective actions or performance improvement activities and failed to maintain a QAPI program which addressed the full range of care and services including clinical care.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Quality Assurance Performance Improvement, last reviewed 2/28/23 indicated the following:</p> <ul style="list-style-type: none"> <li>-QAPI plan addresses:</li> <li>-clinical care including quality measures, falls, medication errors, pressure ulcers, incident reports, infection control and quality of life including concerns brought up through resident council</li> <li>-the Administrator is responsible and accountable for developing, leading and closely monitoring a QAPI program</li> <li>-the QAPI Committee meets monthly and maintains minutes of all activity</li> <li>-the Committee maintains a QAPI manual that houses meeting minutes, project [NAME], performance improvement projects (PIP), data, data analysis and sample performance improvement support tools</li> <li>-the information gathered is analyzed and compared to benchmarks and/or targets established by the facility</li> <li>-QAPI teams analyze data regularly as part of their project assignments</li> <li>-PIP projects are developed based on a prioritizing process with a minimum of one project at a time</li> <li>-the QAPI Committee makes plans describing what areas of the process we are going to change (where breakdowns were observed), utilizing the Performance Improvement Plan and Monitoring Tool; using a structured Root Cause Analysis and Plan-Do-Study-Act depending on the issue/opportunity</li> <li>-the QAPI Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements</li> <li>-if changes to the process have not resulted in the goal of the PIP, further changes are made and monitoring of the process takes place again</li> </ul> <p>During an interview on 6/10/25 at 2:00 P.M., the Administrator said the QAPI Committee met monthly to discuss any major issues and projects that were being worked on.</p> <p>Review of the QAPI manual included the following monthly minutes:</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>January 2025:</p> <ul style="list-style-type: none"> <li>-pharmacy consultant reviewed new regulatory requirement,</li> <li>-laboratory vendor change in February 2025,</li> <li>-update to the Facility Assessment,</li> <li>-awaiting the next 5-star report for measurable results</li> <li>-sent Survey Readiness Folder including pathways to departments for self-assessment and development of QAPI projects based upon their findings</li> </ul> <p>February 2025: no meeting minutes included</p> <p>March 2025: no meeting minutes included</p> <p>April 2025: no meeting minutes included</p> <p>May 2025: no meeting minutes included</p> <p>During an interview on 6/10/25 at 2:00 P.M., the Administrator said he started working at the facility at the end of January 2025 and facilitated the QAPI Committee meetings since February 2025. He said the QAPI Committee meets monthly and has discussions. He said there were no meeting minutes for the monthly meetings from February through May 2025. He said the departments work on different things and there were no projects until March 2025 when the facility initiated a QAPI project for concerns with food temperature. He said that he had never heard that there had always needed to be a project.</p> <p>Review of QAPI manual for February 2025 included the following:</p> <ul style="list-style-type: none"> <li>-a sheet titled Nursing Report for QA, dated February 2025 listed the following identified areas of potential concern: falls, call light response time, reportable events, antibiotics, bruises and weights; under the section labeled Current PIPs it listed None.</li> <li>-a sheet titled Department: Maintenance: which listed things that were worked on during the month (replaced kitchen light bulbs, dryer repair came in, extinguishers checked, etc.)</li> <li>-a sheet titled Activity Department: which indicated the amount of residents seen for bedside visits and what activity was provided (picture book, hand massages, etc.)</li> <li>-a sheet titled Therapy QAPI which listed the percentage of residents seen per payer source</li> </ul> <p>Review of the QAPI manual for March 2025 included the same lists from February without any indication of corrective actions or monitoring with one additional department sheet:</p> <p>Dietary: Food temperatures: plan weekly audits to be completed until compliant.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the QAPI manual for April 2025 included the same lists from March 2025 without any indication of corrective actions or monitoring including:</p> <p>Dietary: no information provided regarding how the food temperature audits were going and what corrective actions were identified</p> <p>Nursing: added a PIP of provider notes to be added to the electronic medical record, with no indication of corrective actions or what monitoring would be conducted</p> <p>Review of the QAPI manual for May 2025 included the same lists from April 2025 without any indication of corrective actions or monitoring including but not limited to:</p> <p>Dietary: new food truck arrived, no additional information was provided regarding the monitoring of the corrective action</p> <p>Nursing: provider notes to be added to electronic medical record with no indication of the corrective action being implemented or the status of the project</p> <p>During an interview on 6/10/25 at 2:00 P.M., the Administrator said the QAPI Committee met and held discussions about how the potential areas were going, but no data could be provided, adding we worked on these areas, we don't necessarily write down the information of goals or data.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) program with documentation of the development, implementation, and evaluation of corrective actions or performance improvement activities. Specifically, the facility failed to develop and implement appropriate plans of action for resident concerns regarding food temperatures.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Quality Assurance Performance Improvement, last reviewed 2/28/23, indicated the following:</p> <ul style="list-style-type: none"> <li>-QAPI plan addresses: <ul style="list-style-type: none"> <li>-clinical care including quality measures, falls, medication errors, pressure ulcers, incident reports, infection control and quality of life including concerns brought up through resident council</li> <li>-the Administrator is responsible and accountable for developing, leading and closely monitoring a QAPI program</li> <li>-the QAPI Committee meets monthly and maintains minutes of all activity</li> <li>-the Committee maintains a QAPI manual that houses meeting minutes, project [NAME], performance improvement projects (PIP), data, data analysis and sample performance improvement support tools</li> <li>-the information gathered is analyzed and compared to benchmarks and/or targets established by the facility</li> <li>-QAPI teams analyze data regularly as part of their project assignments</li> <li>-PIP projects are developed based on a prioritizing process with a minimum of one project at a time</li> <li>-the QAPI Committee makes plans describing what areas of the process we are going to change (where breakdowns were observed), utilizing the Performance Improvement Plan and Monitoring Tool; using a structured Root Cause Analysis and Plan-Do-Study-Act depending on the issue/opportunity</li> <li>-the QAPI Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements</li> <li>-if changes to the process have not resulted in the goal of the PIP, further changes are made and monitoring of the process takes place again</li> </ul> </li> </ul> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/10/25 at 2:00 P.M., the Administrator said he started working at the facility at the end of January 2025 and facilitated the QAPI Committee meetings since February 2025. He said the QAPI Committee meets monthly and has discussions. He said there were no meeting minutes for the monthly meetings from February through May 2025. He said the departments work on different things and there were no projects until March 2025 when the facility initiated a QAPI project for concerns with food temperature.</p> <p>Review of the QAPI manual for March 2025 included the following on a typed up page:</p> <p>Dietary: Food temperatures self-identified; weekly audits three times per week for one month then two times a week for 60 days, if audits are 100%; if the issue continues audits will continue until food temperatures are compliant with state regulations</p> <p>Review of Food Committee Minutes indicated the following resident concerns:</p> <p>-1/6/25: Food cold when arrives to resident rooms; The kitchen is trying to keep the food hotter. Food Service Director (FSD) is looking into new food trucks.</p> <p>-3/6/25: In process of ordering new food delivery carts.</p> <p>-4/28/25: In process of ordering new food delivery carts.</p> <p>-5/8/25: The residents say their food is cold when they get it in their rooms; The FSD is still trying to get new food trucks so it will keep the food hotter; four residents in attendance let the FSD know the breakfast and lunch food was hotter.</p> <p>Review of the QAPI manual for April 2025 included the same typed up page from March 2025, now dated April 2025. The page failed to indicate how the food temperature audits were going and what corrective actions were identified.</p> <p>Review of the QAPI manual for May 2025 included the same lists from April 2025 without any indication of corrective actions or monitoring including but not limited to:</p> <p>Dietary: new food truck arrived, no additional information was provided regarding the monitoring of the corrective action</p> <p>On 6/8/25 at 7:54 A.M., the surveyor observed one meal truck that enclosed trays within it and two pushcarts with no walls or doors to enclose the breakfast trays. The last breakfast tray from the push cart was delivered at 8:40 A.M.</p> <p>On 6/9/25 at 10:30 A.M., at the Resident Group the residents said food temperatures were improving but were still not good.</p> <p>On 6/10/25 at 8:05 A.M., the surveyor observed the breakfast tray line with the FSD. The kitchen staff were observed by the surveyor and the FSD to place breakfast trays on the open push carts.</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/10/25 at 2:00 P.M., the Administrator said the FSD was conducting test tray audits and he had the audits available for review. He said in terms of corrective action the facility had purchased a new food truck for meal delivery, but he was unaware that some of the meals had continued to be served from open push carts and the FSD had not mentioned this as part of the QAPI. He said there was no documentation to indicate the goal of how many test trays should be within temperature range or any documentation to evaluate the effectiveness of the corrective action of ordering a new food truck.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on document review and interview, the facility failed to maintain an infection prevention and control program to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to implement control measures for Legionella (bacteria that can cause Legionnaires' disease, a serious type of pneumonia) and other opportunistic waterborne pathogens that could grow and spread in the facility's water system.</p> <p>Findings include:</p> <p>Review of Centers for Medicare &amp; Medicaid Services (CMS) Memorandum titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease, revised July 2018, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>- In manmade water systems, Legionella can grow and spread to susceptible hosts, such as persons who are at least [AGE] years old, smokers, and those with underlying medical conditions such as chronic lung disease or immunosuppression. Legionella can grow in parts of building water systems that are continually wet, and certain devices can spread contaminated water droplets via aerosolization. Examples of these system components and devices include:</li> <li>- Hot and cold-water storage tanks</li> <li>- Water heaters</li> <li>- Water-hammer arrestors</li> <li>- Pipes, valves, and fittings</li> <li>- Expansion tanks</li> <li>- Water filters</li> <li>- Electronic and manual faucets</li> <li>- Aerators</li> <li>- Faucet flow restrictors</li> <li>- Showerheads and hoses</li> <li>- Centrally-installed misters, atomizers, air washers, and humidifiers</li> <li>- Non-steam aerosol-generating humidifiers</li> <li>- Eyewash stations</li> <li>- Ice machines</li> </ul> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- Hot tubs/saunas</li> <li>- Decorative fountains</li> <li>- Cooling towers</li> <li>- Medical devices (such as CPAP machines, hydrotherapy equipment, bronchoscopes, heater-cooler units)</li> </ul> <p>CMS expects Medicare and Medicare/Medicaid certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Facilities must have water management plans and documentation that, at a minimum, ensure each facility:</p> <ul style="list-style-type: none"> <li>- Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, non-tuberculous mycobacteria, and fungi) could grow and spread in the facility water system.</li> </ul> <p>Review of the facility's policy titled Water Management Program to Reduce Growth and Spread, last reviewed March 24, 2025, indicated but was not limited:</p> <ul style="list-style-type: none"> <li>- Policy: It is the policy of the facility to reduce the risk of the growth and spread of Legionella.</li> <li>- Procedure: The facility will identify and manage hazardous conditions that support growth and the spread of Legionella.</li> <li>- The facility must conduct a risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system and assess how much risk hazardous conditions in those water system pose.</li> <li>- Based on the risk assessment, implement a water management program that includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections and environmental testing for pathogens.</li> <li>- Specify testing controls and acceptable ranges for control measures and document results of testing and corrective actions when control limits are not maintained.</li> <li>- Control measures to reduce the hazardous conditions whenever possible to prevent Legionella growth and spread.</li> <li>- Review the elements of the water management program at least once a year to make sure the program is running as designed and is effective.</li> </ul> <p>Review of the Water Management Program indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>- Policy and Procedure Acknowledgement, dated 3/19/25</li> </ul> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/10/25 at 11:44 A.M., the Regional Director of Maintenance said last year the facility implemented as part of the control measures to prevent Legionella growth, the facility would flush the water system quarterly. He said he could not provide evidence of the flushing or say when it was last done.</p> <p>The Director of Maintenance provided the surveyor with a schematic of the facility and a diagram of control measures and corrective actions. The schematic and diagram did not refer to a flushing schedule.</p> <p>During an interview on 6/10/25 at 11:39 A.M., the Director of Maintenance said he had been working at the facility for six months and had not flushed the water system.</p> <p>The facility failed to provide documentation of water flushing.</p>		