STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on record review and interviews, the facility failed to obtain consents for psychotropic medications explaining the risks and benefits of treatment, prior to administering psychotropic medication for two Residents (#74 and #81) out of a sample of 26 Residents. Findings Include: Review of the facility policy titled Psychoactive Drug Monitoring, revised June 2022, indicated the following: -All psychoactive medication requires consent for use from the resident or legally responsible party prior to administration of medication. 1. Resident #74 was admitted to the facility in March 2024 with a diagnosis of manic depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/24/24, indicated that Resident #74 scored a 10 out of 15 on the Brief Interview for Mental Status exam indicating the Resident had moderate cognitive impairment. The MDS further indicated Resident #74 was being administered an antidepressant medication. Review of Resident #74's active physician's orders indicated the following order: -Paxil oral tablet 20 Mg (Paroxetine HCL, an antidepressant) Give 20 Mg by mouth at bedtime related to bipolar disorder current episode mixed, mild, initiated 5/10/24. Review of Resident #74's Medication Administration Record on 6/17/24 indicated that Paxil was administered every day in June leading up to, and including, 6/17/24. Review of Resident #74's medical record failed to include signed consent for the administration of Paxil. During an interview on 6/11/24 at 9:25 A.M., Nurse Unit Manager (#1) said consents must be signed for all psychotropic medications, including antidepressants such as Paxil. Nurse Unit Manager #1 said she could not find the consent for Paxil in Resident #74's chart. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 2:19 P.M., the facility Social Worker (#1) said Resident #74 did not have a consent completed for Paxil until today, and that there should have been a consent completed before the Paxil was administered. During an interview on 6/18/24 at 9:27 A.M., the Director of Nurses said that psychotropic medications require a consent to be signed for administration before administering the medication. 49880 2. Resident #81 was admitted to the facility on [DATE] with diagnoses that include depression, adult failure to thrive and mood disorder. Review of Resident #81's most recent Minimum Data Set (MDS) assessment, dated 4/17/24, indicated a Brief Interview for Mental Status exam score of 7 out of a possible 15, indicating Resident has severe cognitive impairment. The MDS further indicated that Resident #81 takes an antianxiety medication. Review of medication management progress note, dated 3/1/24, indicated Today this NP (Nurse Practitioner) has been asked to see the patient due to increased anxiety and agitation. The progress note further indicated to start ativan twice daily for 14 days. Further review of the progress note documented N/A (not applicable) in regards to obtaining informed consent and discussing with the guardian the risks and benefits of the medication being prescribed. Review of Resident #81's active physician's orders indicated, lorazepam/ Ativan (a psychotropic medication used to treat anxiety) 0.5 milligrams (mg) two times a day for anxiety, dated 3/5/24. Review of Resident #81's medical record failed to indicate a signed psychotropic consent for the use of Ativan. During an interview on 6/18/24 at 7:57 A.M., Nurse Unit Manager (#1) reviewed Resident #81's medical record and said there was no psychotropic consent for Ativan present. Nurse Unit Manager #1 said that sometimes the social worker will obtain consents for psychotropic medications. During an interview on 6/18/24 at 9:11 A.M., the facility Social Worker (#1) said that she had not obtained the psychotropic consent for Ativan for Resident #81. During an interview on 6/18/24 at 9:27 A.M., the Director of Nurses (DON) said that psychotropic medications require a consent to be signed for administration before administering the medication.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, policy review and interview the facility failed to notify the physician of a significant change in status for five Residents (#48, #79, #58, #9 and #60) out of a total sample of 26 residents. Specifically: -The facility failed to notify the physician or nurse practitioner when residents' blood glucose levels fell below parameters, or when insulin was held due to hypoglycemia. Findings include: Review of the facility policy Nursing Care of the Resident with Diabetes Mellitus (undated) indicated: -In type I (insulin-dependent diabetes mellitus) the body does not produce any significant amounts of insulin. -Normal blood glucose parameter is defined as 80-130 mg/dl (milligrams per deciliter) before meals and under 180 mg/dl after meals. -Conditions associated with diabetes include, but are not limited to, hypoglycemia, in which blood sugar levels are below the reference parameter, and hyperglycemia, in which blood sugar levels are above the reference parameter. Reference ranges for hypoglycemia are: -55-70 mg/dl, mild -40-55 mg/dl, moderate -Under 40 mg/dl, severe Symptoms associated with onset of hypoglycemia may include, but are not limited to: -Weakness -Increased heart rate -Blurred vision -Stupor (severe) -Unconsciousness (severe) -Convulsions (severe) (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Coma (severe) Complications because of prolonged and poorly controlled diabetes include: -Heart disease -Kidney disease -Nerve, foot, and skin damage. For asymptomatic and responsive residents with hypoglycemia (under 70 mg/dl, or less than the physician-ordered parameter) the protocol requires, but is not limited to: -Nursing staff should document findings, notification to MD and any new orders given in progress note. Review of the facility's quality control log for blood glucometer readings dated March, April, May, and June 2024 indicated there were no significant variances and that the facility's glucometers were accurate and functioned normally. Findings include: 1. Resident #9 was admitted to the facility in October 2022, and had diagnoses which included type II diabetes mellitus, hypertension, and dementia. Review of Resident #9's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 3 out of a possible 15, indicating severe cognitive impairment. Resident #9 was dependent on staff for most activities of daily living. Resident #9's current care plan indicated he/she was diagnosed with diabetes mellitus and was at-risk for: difficulty controlling blood glucose levels, skin breakdown, nutritional problems, generalized pain, neuropathy, and retinopathy (nerve damage). Interventions included, but were not limited to: -Follow the hypoglycemic protocol as indicated. See Medication Administration Record (MAR). Review of Resident #9's MARs dated May and June 2024, indicated a physician's order dated 5/13/24, Basaglar KwikPen subcutaneous solution pen-injector 100 units per milliliter insulin glargine (a long acting insulin) inject 20 units subcutaneously at bedtime for type II diabetes. Hold if BS [blood sugar] less than 150. The MAR indicated on the following dates nursing staff failed to notify the physician or nurse practitioners (NP) that the Resident's blood glucose level was below 150, per facility policy. -5/14/24 at 8:11 P.M., glucose level 137. Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. -5/15/24 at 8:53 P.M., blood glucose 144. Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-5/17/24 at 7:17 P.M., blood glucose 117. Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. -5/25/24 at 8:16 P.M., blood glucose 138. Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. -5/27/25 at 7:59 P.M., blood glucose 110. Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. -6/2/24 at 8:26 P.M., blood glucose 71. Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. -6/4/24 at 7:53 P.M., blood glucose 31 (severe). Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. -6/10/24 at 9:29 P.M., blood glucose 147. Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. -6/16/24 at 7:38 P.M., blood glucose 94. Review of the MAR and nursing progress notes indicated there was no physician or NP notification regarding the glucose level below 150. Resident #9's MARs dated May and June 2024 indicated a physician's order dated 6/16/23 to notify provider if blood glucose is below 70. The Resident's MAR and progress notes make no reference to nursing staff notifying the provider on the following dates: -5/13/24 at 7:30 A.M. blood glucose 65 -5/13/24 at 11:30 A.M., blood glucose 56 -5/30/24 at 4:30 P.M., blood glucose 69 -6/4/24 at 7:53 P.M., blood glucose 31 (severe). Review of Resident #9's Nurse Practitioner (NP) and physician progress notes dated May and June 2024 did not reference his/her low blood glucose levels, and levels outside the ordered parameters. On 6/17/24 at approximately 9:00 A.M., the surveyor attempted to contact Nurse #5 regarding her failure to notify the physician or NP about Resident #9's low blood glucose levels on 5/14/24, 5/17/24, 5/27/24 and 6/4/24. Nurse #5 did not respond to voice mail messages or texts. During an interview with Nurse #8 on 6/17/24 at approximately 2:10 P.M., regarding Resident #9's low glucose levels on 5/15/24, 5/17/24, 6/10/24 and 6/16/24, she said she did not notify the physician or NP. On 6/17/24 at approximately 10:40 A.M., the surveyor attempted to contact Nurse #9 regarding Resident #9's low glucose level on 5/25/24. Nurse #9 did not respond to voice mail messages or texts. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Nurse #6 on 6/17/24 at approximately 3:05 P.M., regarding Resident #9's low blood glucose level on 6/2/24. Nurse #6 said she did not notify the physician or NP. During an interview with Unit Manager #1 on 6/14/24 at approximately 11:00 A.M., regarding Resident #9's low blood glucose levels on 5/13/24 at 7:30 A.M. and 11:30 A.M., or on 5/30/24. Unit Manager #1 said she did not notify the physician or NP. During an interview with the Director of Nursing (DON) on 6/13/24 at 10:20 A.M., he said nursing staff should have followed Resident #9's physician's orders and the facility's hypoglycemic protocol. The DON reviewed the Resident's MAR for May and June 2024 and said nursing staff should have notified the physician or NP on those dates when the Resident's blood glucose was low. The DON said the Resident's blood glucose level of 31 on 6/4/24 was critically low. During an interview with the Medical Director on 6/14/24 at 11:37 A.M., she said nursing staff should follow the physician's orders and the hypoglycemic protocol for insulin-dependent diabetics. The Medical Director said that when a resident's blood glucose is under 70 nursing staff should give carbohydrates, notify the physician, monitor, and document responses to interventions. The Medical Director said that blood glucose levels below 50 are critical and the resident would likely need to be hospitalized for treatment and testing to determine if an underlying infection has caused hypoglycemia. The Medical Director said short term effects of critically low blood glucose levels can include hypoglycemic coma and death. The Medical Director said long term effects of untreated hypoglycemia include heart disease, kidney disease, neuropathy, nerve damage to the eyes and generalized weakness. 2. Resident #79 was admitted to the facility in August 2023, and had diagnoses which included type II diabetes mellitus, renal failure, hypertension, and dementia. Review of Resident #79's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 9 out of a possible 15, indicating moderate cognitive impairment. Resident #79 was dependent on staff for most activities of daily living. Review of Resident #79's current care plan indicated he/she had a diagnosis of diabetes and had difficulty controlling his/her blood glucose level. Interventions included: -Give me diabetic medication per my doctor's orders. -Follow the hypoglycemic protocol as indicated. See MAR. Review of Resident #79's physician order dated 11/30/23, indicated Humalog injection solution (insulin Lispro). Inject as per sliding scale. Review of Resident #79's MAR dated March 2024 indicated that on 3/21/24 at 10:35 P.M., his/her blood glucose was 15 (severe). There is no indication on either the MAR or progress notes that nursing staff notified the physician or NP about the Resident's severely low blood glucose level. Review of Resident #79's Nurse Practitioner (NP) and physician progress notes dated March, April and June 2024 did not reference the blood glucose level of 15. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/17/24 at approximately 2:10 P.M. with Nurse #10, she said the entry on Resident #79's MAR dated 3/21/24 of 15 must have been a typo. Nurse #10 said she did not notify the physician or NP. 3. Resident #48 was admitted to the facility in March 2024 and had diagnoses which included diabetes, hypertension, and cerebral vascular accident. Review of Resident #48's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 8 out of a possible 15, indicating moderate cognitive impairment. Resident #48 was dependent on staff for most activities of daily living. Review of Resident #48's current care plan indicated he/she had a diagnosis of diabetes and difficulty controlling his/her blood glucose level. Interventions included: -Give me diabetic medication per my doctor's orders. -Follow the hypoglycemic protocol as indicated. See me MAR. Review of Resident #48's physician's order dated 4/12/24 indicated Insulin lispro injection solution 100 units/milliliter. Inject as per sliding scale. Review of Resident #48's MAR dated May 2024 indicated that on 5/6/24 at approximately 4:00 P.M., his/her blood glucose level was 19 (severe). The MAR and progress notes indicated Nurse #12 did not notify the physician or NP about the Resident's severely low blood glucose level. Review of Resident #48's Nurse Practitioner (NP) and physician progress notes dated May and June 2024 did not reference the blood glucose level of 19. During an interview on 6/17/24 at approximately 1:10 P.M. with Nurse #12, she said she did not notify the physician or NP about the Resident's severely low blood glucose level. 4. Resident #58 was admitted to the facility in December 2023, and had diagnoses which included diabetes and hypertension. Review of Resident #58's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 15 out of a possible 15, indicating intact cognition. Resident #58 requires some assistance for most activities of daily living. Review of Resident #58's current care plan indicated he/she had a diagnosis of diabetes and difficulty controlling his/her blood glucose level. Interventions included: -Give me diabetic medication per my doctor's orders. -Follow the hypoglycemic protocol as indicated. See MAR. Review of Resident #58's physician's order dated 11/9/23, indicated Insulin lispro injection solution 100 units/milliliter. Inject as per sliding scale. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #58's MAR dated April 2024 indicated that on 4/8/24 at approximately 11:00 A.M., his/her blood glucose level was 67, and on 4/9/24 at approximately 11:00 A.M. the blood glucose level was 66. The MAR and progress notes indicated nursing staff did not notify the physician regarding the Resident's low blood glucose level. Review of Resident #58's physician and NP progress notes dated April and May 2024 indicated they did not reference the Resident's low blood glucose levels on 4/8/24 and 4/9/24. On 6/17/24 at approximately 2:00 P.M., the surveyor attempted to contact Nurse #11 regarding Resident #58's blood glucose levels on 4/8/24 of 67, and of 66 on 4/9/24. Nurse #11 did not respond to voicemail messages or texts. 49880 5. Resident #60 was admitted to the facility in October 2023 with diagnoses that include type II diabetes, dementia, and obesity. Review of Resident #60's Minimum Data Set (MDS) assessment, dated 4/24/24, indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating that the Resident has moderate cognitive impairment. The MDS further indicated that the Resident received insulin injections and hypoglycemic medication. According to the Centers for Disease Control (CDC), dated 5/14/24, a normal hemoglobin A1C level is below 5.7. Review of Resident #60's medical record indicated a hemoglobin A1C (a blood test that shows the average blood sugar level over the past two to three months) result of 8.0 on 3/25/24, indicating an elevated level. Review of Resident #60's physician's orders indicated the following: -Lantus Solution (a long-acting insulin) 25 units subcutaneously at bedtime, dated 10/31/23. -Humalog injection, give 3 units subcutaneously before meals, dated 12/5/23. -Humalog injection (a fast-acting insulin) inject as per sliding scale before meals and at bedtime -Blood sugar is 151-200 give 2 units of insulin -Blood sugar is 201-250 give 4 units of insulin -Blood sugar is 251-300 give 6 units of insulin -Blood sugar is 301-350 give 8 units of insulin -Blood sugar is 351-400 give 10 units of insulin -Call MD/NP (Physician/ Nurse Practitioner) if blood sugar over 400, dated 12/5/23. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #60's active diabetes care plan, dated 11/15/23, indicated because I have diabetes, I am at risk for having difficulty controlling my blood sugars with interventions that include the following: -Follow the hypoglycemic protocol as indicated. See my MAR (medication administration record). -Watch me for signs of hypo/hyperglycemia (low and high blood sugars). Review of Resident #60's MAR failed to indicate orders for the facility's hypoglycemic protocol. Review of Resident #60's eMAR (electronic medication administration record) progress notes indicated the following: -A progress note dated 4/24/24 at 8:12 A.M., indicated that Resident #60 had a blood sugar of 77 and scheduled Humalog insulin was held. The progress note failed to indicate that a Physician or Nurse Practitioner (NP) was notified that the medication was not administered. -A progress note dated 5/2/24 at 4:03 P.M., triggered from the MAR indicated that Humalog insulin was not administered before dinner. The documented blood sugar at that time was 103, and the MAR documentation indicated the medication was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/6/24 at 10:05 A.M., triggered from the MAR indicated that Humalog insulin was not administered. The documented blood sugar at the time was 92, and the MAR documentation indicated the medication was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/12/24 at 11:57 A.M., indicated that Resident #60 had a blood sugar of 87 and that the scheduled dose of Humalog insulin at that time was held. The MAR indicated that the medication was not given. The progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/22/24 at 7:48 A.M., indicated that Resident #60 had a blood sugar of 74 and that the scheduled dose of Humalog insulin was held at this time. The MAR indicated that the medication was not given. The progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/23/24 at 7:56 A.M., indicated that Resident #60 had a blood sugar of 109 and that Humalog insulin was not administered. Progress notes failed to indicate that the Physician or NP were notified that the medication was not administered. -A progress note dated 5/24/24 at 4:25 P.M., indicated that Resident #60 had a blood sugar of 100 and per the MAR, the scheduled Humalog insulin was held. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-A progress note dated 5/24/24 at 8:12 P.M., indicated that Resident #60 had a blood sugar of 111. Review of the MAR at this time indicated that scheduled Lantus insulin was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/29/24 at 7:47 A.M., indicated that Resident #60 had a blood sugar of 77 and that the scheduled dose of Humalog insulin was not administered. Review of progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 6/4/24 at 7:55 A.M., indicated that Resident #60 had a blood sugar of 81 and that the scheduled dose of Humalog insulin was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 6/17/14 at 7:51 A.M., indicated that Resident #60 had a blood sugar of 111 and that the scheduled dose of Humalog insulin was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. Review of Resident #60's blood sugar readings indicated the following: -On 4/26/24 at 5:36 P.M., a blood glucose reading of 48 and at 5:55 P.M., a blood glucose reading of 57. On 4/26/24 at 7:32 P.M., and at 11:35 P.M., blood sugars levels of 74 were documented. Review of nursing progress notes on 4/26/24 indicated that orange juice was provided to the resident, but failed to indicate that a Physician or NP was notified of the hypoglycemic episode. Review of NP progress and visit notes dated from 4/26/24 to 5/29/24 failed to indicate that she was aware that insulin was being held at times for Resident #60. During an interview on 6/17/24 at 12:41 P.M., Nurse #1 said that he is assigned to care for Resident #60. He said that before breakfast Resident #60 had a blood sugar of 111, so he held his/her 3 units of Humalog insulin. Nurse #1 said that he did not have orders to hold it and that the Resident was not symptomatic of low blood sugars. Nurse #1 further said that he did not notify the Physician or NP that the medication was held. Nurse #1 said that a Physician or NP should be notified if a medication is held either due to parameters or nursing judgement and that it should be documented in a progress note. During an interview on 6/17/24 at 1:53 P.M., Unit Manager #1 said that if a nurse feels that a Resident's blood sugar is too low for insulin they will hold it, but that a Physician or NP should be notified. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/17/24 at 12:24 P.M., NP #1 said that she is rarely notified by the facility of low blood sugars for residents. NP #1 also said that if nursing staff provided an intervention for low blood sugars or if scheduled insulin was being held by the nurse she would expect to be notified. NP #1 said that the current order for Humalog insulin for Resident #60 does not have hold parameters, so if a nurse was holding it, she should be notified. She said she was not aware that the insulin was held before breakfast on 6/17/24 for Resident #60 and would not have recommended that it be held. NP #1 said that she assumes that all medications are administered as ordered unless she is told otherwise. NP #1 said that not being notified that medications are held could lead to her over or under dosing a resident with insulin or other medications. During an interview on 6/18/24 at 9:35 A.M., the Director of Nurses said that nurses can hold medications per parameters of the order or for nursing judgment, but if the medication is held the Physician or NP should be made aware and it should be documented in a progress note. During an interview with the Medical Director on 6/14/24 at 11:37 A.M., she said nursing staff should follow the physician's orders and the hypoglycemic protocol for insulin-dependent diabetics. The Medical Director said that when a resident's blood glucose is under 70 nursing staff should notify the physician or NP. The Medical Director said that blood glucose levels below 50 are critical and the resident would likely need to be hospitalized for treatment and testing to determine if an underlying infection caused the hypoglycemia. The Medical Director said short term effects of critically low blood glucose levels can include hypoglycemic coma and death. The Medical Director said long term effects of untreated hypoglycemia include heart disease, kidney disease, neuropathy, nerve damage to the eyes and generalized weakness. Refer to F684 and F726

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review, policy review and interview the facility failed to ensure a plan of care was developed and implemented, with safeguards to prevent further potential abuse, following an allegation of rape was made by one Resident (#70) out of a total sample of 26 residents. Specifically, Resident #70 reported an allegation of rape by a family member, was sent to the hospital for a rape kit assessment and returned to the facility. The investigation into this allegation is ongoing by the District Attorney's office, and since the allegation was made on 4/26/24 the facility failed to develop a plan to protect the resident or other residents of the facility in the event that the alleged perpetrator came to the facility to visit Resident #70. Findings include:: The facility policy titled Resident's Right Program & Abuse Program, revised 6/2022, indicated the following: -It is the policy of Mill Town Health and Rehab is dedicated to maintain an environment free of abuse, neglect and exploitation. The resident has a right to be free from verbal, sexual, physical and mental abuse, corporal punishment, deprivation and involuntary seclusion. Residents will not be subjected to abuse by anyone including but not limited to facility staff, other residents, consultants, volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals (caretakers). 6. The facility will identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. The facility will conduct an analysis of the following: -areas in the facility where abuse is more likely to occur (i.e. secluded areas). -the distribution of staff on each shift in sufficient numbers to meet the needs of the residents and assure that staff assigned have knowledge of individual care. 12. During and after the investigation, the residents will be protected from harm through frequent supervision by staff. Section titled: Investigation of Resident Abuse, neglect, Mistreatment, Misappropriation of Resident Property Complaints/Allegations. 8. If an allegation is made of resident abuse, neglect, mistreatment, exploitation, or misappropriation of resident property against a non-employee (family member, visitor, vendor, volunteer, contract employee, consultant, etc.) the individual is immediately suspended from duty escorted from the building, and not permitted to return pending the results of the investigation. Resident #70 was admitted to the facility in December 2023 and has diagnoses that includes generalized anxiety disorder. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 3/6/24, indicated that on the Brief Interview for Mental Status exam Resident #70 scored an 11 out of 15, indicating moderately impaired cognition. On 6/10/24 at 1:12 P.M., the surveyor met with Resident #70. Resident #70 almost immediately began crying and shaking as he/she told the surveyor that he/she had been raped by his/her brother in law a month or two ago while out of the facility for a visit with family. Resident #70 said that he/she does not receive support services at the facility but needs them. As well, Resident #70 expressed how sad he/she was because his/her sister was mad at Resident #70 when Resident #70 tried to tell her about the rape. Resident #70 said that the sister and brother in law are the only family that he/she has. Review of the record indicated the following: -Nurses note dated 4/26/24 at 10:40 A.M.: This RN was notified by activity's assistant that resident was in the dining room crying and stating my brother raped me. SW present on unit and notified of situation. She took resident off the floor to discuss. -Social Service note dated 4/26/24 at 12:34 P.M.: SW was informed by nurse that Resident #70 told activity assistant that his/her brother-in-law raped him/her. SW asked if Resident #70 wanted to speak to her. He/she was in day room in activities waiting for his/her nails to be painted. Resident #70 open to conversation & [NAME] (sic) Resident #70 to her office. Resident #70 told SW that her brother-in-law raped him/her. SW asked more questions regarding details & collected information for statement. He/she reports being afraid of him & scared to tell us sooner. He/she states they are my only family. Resident #70 also reporting that his/her stomach hurts & that it hurts to pee. He/she also reports vomiting & having diarrhea when at his/her family's home. Resident #70 weepy & in distress while reporting all this information. He/she is agreeable to be sent to the hospital. IDT informed. SS will continue to follow. -Social Service note dated 5/30/24 indicating that Resident #70's case is now being worked on with the District Attorney's (DAs) office. On 6/13/24 from approximately 10:10 A.M., to 10:25 A.M., while the surveyor was on Resident #70's unit, the surveyor observed a man and a woman on the unit waiting for Resident #70. There were several residents in the vicinity of the pair. At approximately 10:24 A.M., Resident #70 was observed to approach the two, and focusing only on his/her sister, appear happy and excited. The three then got on the elevator and left the unit and premises. As the elevator door was closing the Resident could be heard introducing the pair as his/her sister and brother in law to someone on the elevator. During an interview on 6/14/24 at 10:27 A.M., SW #1 said that on 6/5/24 the staff on Resident #70's unit received a call from Resident #70's brother in law stating that he and Resident #70's sister wanted to take Resident #70 out the next week. SW #1 who said that the facility has not discussed restrictions on the alleged perpetrator entering the building or going up on the resident units since the allegation on 4/26/24. SW #1 thinks that it is probably not a good idea that the alleged perpetrator be in the building and that if he is he should have restrictions and be supervised by a staff. She said that the risk is he would harm another resident when allowed to be in the building without supervision. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW #1 said that she called the police on 6/5/24 and they said investigation was still pending. As well, she was updated on 6/13/24 by the Protective Service worker that the District Attorney's office said that the investigation was ongoing. SW #1 said that she saw the alleged perpetrator from her office when he arrived to pick up Resident #70 the previous day but that she did not speak with him and was not aware that he went up to the unit. During an interview on 6/14/24 at 1:11 P.M., with the Nursing Home Administrator (NHA) and Director of Nursing (DON), they indicated that a plan had not been put in until today, after the surveyor brought to their attention a concern that the facility did not have a plan in place to protect the resident and other facility residents from the alleged perpetrator during an ongoing investigation. The NHA said that he was not aware that the alleged perpetrator had been in the building on a resident unit on 6/13/24 however there was not a plan to restrict this access. During an interview on 6/17/24 at 8:48 A.M., the Nurse Unit Manager (#1) said that she accompanied Resident #70 to the hospital where a rape kit test with was performed on 4/26/24. Nurse Unit Manager #1 said that she has not seen the sister or brother in law since the allegation was first made on 4/26/24, however there was not a plan established if they were to show up at the facility. She added I was surprised when they told me on Thursday (6/13/24) that they were taking him/her out to lunch because an allegation had been made and the facility did not know the outcome of the allegation yet.

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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. 41105 Based on observation, record review and interview the facility failed to implement the plan of care for two Residents (#15 and #13) out of a total sample of 26 residents. Specifically: 1. For Resident #15 the facility failed to ensure built up utensils and a nosey cup were provided with meals as indicated in the plan of care. 2. For Resident #13 the facility failed to a.) ensure his/her bed was maintained in the low position as indicated in the plan of care and b.) complete weekly skin assessments as ordered by the physician. Findings include: The facility policy titled Adaptive Equipment-Guideline, dated March 2024, indicated the following: 3. When it is determined which adaptive feeding equipment is most appropriate for the resident to utilize, the rehab department will complete an in-service for nursing staff and fill out a diet slip with the types of adaptive feeding equipment to be utilized. 5. Resident care plans will be updated to include the adaptive equipment that will be utilized with each meal. 9. Dietary will ensure the adaptive feeding equipment will be added to the resident's meal ticket The facility policy titled Activities of Daily Living (ADL) support, dated 6/2022, indicated the following: 13. Follow recommendations for safety devices-low bed, floor mats, alarms, etc as per CNA (Certified Nursing Assistant) care plan. 1. For Resident #15 the facility failed to ensure built up utensils and a nosey cup were provided with meals as indicated in the plan of care. Resident #15 was admitted to the facility in May 2022 and has diagnoses that include includes dysphagia (difficulty chewing and swallowing) oropharyngeal phase, dementia, muscle weakness and spinal stenosis. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/15/24, indicated that on the Brief Interview for Mental Status exam Resident #15 scored a 15 out of 15 indicating intact cognition. The MDS further indicated Resident #15 had no behaviors. Review of the current Activities of Daily Living care plan included the following intervention: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-EATING: The resident is able to: continual supervision to assist as needed. Needs encouragement to eat, as well as needing hand over hand at times in order to initiate. Resident #15 uses a scoop plate, weighted utensils and a nosey cup. (sic). Review of the current nutrition care plan indicated: a potential nutritional due to hx. (history) of malnutrition, hx. weight loss trend, swallowing issues, GERD, anemia. Interventions on the care plan include: -scoop bowl/plate, nosey cup with meals per OT. Review of the care plan failed to indicate Resident #15 refused to use the nosey cup or built up utensils. On 6/10/24 at 8:23 A.M., Resident #15 was observed in his/her room in bed with breakfast on a tray table directly in front of him/her. The Resident had a regular cup and regular utensils, rather than a nosey cup or built up utensils as indicated on the plan of care. On 6/11/24 at 8:11 A.M., Resident #15 was observed in the unit dining room for breakfast. The Resident had a regular cup and regular utensils, rather than a nosey cup or built up utensils as indicated on the plan of care. The surveyor continued to make the following observations: -Between 8:14 A.M., and 8:21 A.M., Resident was attempting to feed self with the regular utensils, however often raised the utensil from the plate to his/her mouth at a rapid, what appeared to be uncontrolled speed, and several times dropped the scrambled eggs on his/her chest. -At 8:22 A.M., while drinking juice from the regular cup, Resident #15's nose was observed to hit the top of the cup causing the juice to run down his/her chin. On 6/11/24 at 12:07 P.M., Resident #15 was observed in the facility's main dining room and lunch was served to him/her. The Resident had no utensils and his/her beverage was in a regular cup, not a nosey cup. -At 12:08 PM., the Activities Director exited the kitchen and placed a regular fork, knife and spoon beside Resident #15, rather the the built up utensils and nosey cup as indicated on the plan of care. On 6/12/24 at 7:50 A.M., a staff person delivered breakfast to Resident #15 in his/her room. The surveyor continued to make the following observations: -At 7:54 A.M., the Resident was observed with a regular cup and regular utensils, rather than a nosey cup or built up utensils as indicated on the plan of care. On 06/13/24 at 7:59 A.M., the Activities Director delivered breakfast to Resident #15 who was in bed, then exited the room. The surveyor continued to make the following observations: -At 8:03 A.M., the Resident was observed with a regular cup and regular utensils, rather than a nosey cup or built up utensils as indicated on the plan of care. (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 6/13/24 at 9:49 A.M., Resident #15's Certified Nursing Assistant (CNA) #2 said that Resident #15 sometime used a cup with a lip in it (nosey cup) and that when he/she did not use one it was because the kitchen forgot to send one up. CNA #2 said that she was not aware that Resident #15 was supposed to have built up utensils. During an interview on 6/13/24 at 10:31 A.M., with the Nurse Unit Manager (#1) she said that Resident #15 was supposed to have weighted silverware and a nosey cup with all meals. She said that all adaptive equipment is supposed to come up from the kitchen on Resident #15's tray and that she noticed there was no nosey cup this morning but she was not sure if anyone called the kitchen to have one sent up and she did not notice the weighted silverware was not on the tray. During an interview on 6/18/24 at 10:41 A.M. with the Director of Nursing (DON) he said that he had discontinued Resident #15's adaptive equipment in 2022 and was not aware it was added back to the care plan. The DON said that he was not aware that the Resident sometimes received the equipment and used it. 2a. Resident #13 was admitted to the facility in September 2019 and has diagnoses that include dysphagia (difficulty chewing and swallowing) oropharyngeal stage and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/27/24, indicated that on the Brief Interview for Mental Status exam Resident #13 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #13 had no behaviors and required substantial to maximal assistance with bed mobility. Review of the current Falls care plan indicated Resident #13 is at risk for falling r/t CVA AEB Hx of falls, cognitive deficit, decreased safety awareness, daily use of psychotropic medications, & decline in function, recent fall history. The care plan included the following intervention: -Bed in low position. Review of the care plan failed to indicate that Resident #13 refused to have his/her bed maintained at the low position or that Resident #13 changed the bed position. On 6/10/24 at 8:15 A.M., Resident #13 was observed in his/her room in bed. The bed was at a regular height. On 6/10/24 at 11:52 A.M., Resident #13 was observed in his/her room in bed and the bed was positioned at a regular height. On 6/11/24 at 8:00 A.M., Resident #13 was observed in his/her bed and the bed was positioned at a regular height. A staff person was observed to deliver breakfast to Resident #13, then exited the room, without adjusting the height of the bed to the low position, as indicated in the plan of care. On 6/11/24 at 11:57 A.M., Resident #13 was observed in his/her bed and the bed was positioned at a regular height. A staff person was observed to deliver lunch to Resident #13, then exited the room, without adjusting the height of the bed to the low position, as indicated in the plan of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 7:41 A.M., Resident #13 was observed in bed asleep and the bed was positioned at a regular height. On 6/13/24 at 7:47 A.M., Resident #13 was observed in bed and the bed was positioned at a regular height. On 6/13/24 at 9:31 A.M., Resident #13 was observed in bed asleep and the bed was positioned at a regular height. On 6/17/24 at 7:50 A.M., Resident #13 was observed in bed and the bed was positioned at a regular height. The surveyor continued to make the following observations: -At 7:57 A.M., a CNA delivered breakfast to the Resident in his/her room and then exited. -At 8:00 A.M., the surveyor observed the bed was still at a regular height. During an interview on 6/17/24 at 8:22 A.M., with Resident #13's Certified Nursing Assistant (CNA) #1 she said that Resident #13's bed was supposed to be in the low position The surveyor and CNA #1 then together observed Resident #13 in bed at a regular height. CNA #1 said that the bed was currently not in the low position and she lowered the bed. During an interview on 6/17/24 at 8:33 A.M., the Nurse Unit Manager (#1) said that she was not aware that the residents bed was supposed to be in the low position. During an interview on 6/18/24 at 10:41 A.M., the Director of Nursing said that Resident #13's bed should be in the lowest position as indicated on the plan of care. 2b. For Resident #13 the facility failed to perform the weekly skin evaluation as ordered by the physician. Resident #13 was admitted to the facility in September 2019 and has diagnoses that include dysphagia (difficulty chewing and swallowing) oropharyngeal stage and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/27/24, indicated that on the Brief Interview for Mental Status exam Resident #13 scored a 3 out of a possible 15, indicating severely impaired cognition. Review of the current physician orders include the following order: -Weekly Skin Check complete evaluation, start date 7/15/22. Review of the current skin care plan indicated: The Resident is at risk for skin breakdown due to decreased mobility; impaired cognition, incontinence, and generalized weakness, use of psych meds , significant weight loss hx (history) of CVA (stroke). Interventions on the care plan include: -Weekly comprehensive skin assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Norton Plus assessment (as scale to determine risk of developing pressure ulcers), dated 2/6/24, indicated Resident #13 scored an 8 which is indicative of Resident #13 being at high risk for developing pressure ulcers. Review of the clinical record failed to indicate a skin assessment evaluation had been completed since 10/25/23. During an interview on 6/17/24 at 8:22 A.M., Resident #13's Certified Nursing Assistant (CNA) #1 said that Resident #13 required total care and did not refuse care. CNA #1 said that Resident #13's skin was intact. During an interview on 6/17/24 at 8:33 A.M., Nurse Unit Manager (#1) said she reviewed the record and verified that no skin assessments had been done since 10/25/23. Nurse Unit Manager #1 said that the assessments were supposed to auto-populate by the computer system but Resident #13's was accidentally deactivated. During an interview on 6/17/24 at 10:18 A.M., the Director of Nursing said that in October 2023 the facility changed systems, and Resident #13's assessment was accidentally deactivated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41105 Based on observation, record review and interview the facility failed to ensure supervision and assistance for Activities of Daily Living (ADLs) was provided to three Residents (#15, #13 and #14) out of a total sample of 26 residents. Specifically: 1. For Resident #15 the facility failed to ensure continual supervision, and assist as needed, was provided with meals. 2. For Resident #13 the facility failed to ensure supervision and assistance with meals was provided. 3. For Resident #14 the facility failed to provide assistance with showers. Findings include: The facility policy titled Activities of Daily Living (ADL) support, dated 6/2022, indicated the following: 1. Resident will perform selfcare with ADLs at the level on the CNA care plan or care card or assigned tasks. If the resident shows a decline in ADL function the nurse will be notified. 4. Assist the resident to be clean, neat and well-groomed including nail care and having fingers and toenails to be cut/trimmed per policy. 5. Assure adequate intake at each meal by encouraging, cueing, prompting and or feeding as needed. Notify nurse of changes in resident's normal intake. 1. For Resident #15 the facility failed to ensure continual supervision, and assist as needed, was provided with meals. Resident #15 was admitted to the facility in May 2022 and has diagnoses that include dysphagia (difficulty chewing and swallowing) oropharyngeal phase, dementia, muscle weakness and spinal stenosis. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/15/24, indicated that on the Brief Interview for Mental Status exam Resident #15 scored a 15 out of 15 indicating intact cognition. The MDS further indicated Resident #15 had no behaviors. Review of the current Activities of Daily Living care plan included the following intervention: -EATING: The resident is able to: continual supervision to assist as needed. Needs encouragement to eat, as well as needing hand over hand at times in order to initiate. Resident #15 uses a scoop plate, weighted utensils and a nosey cup. (sic). Review of the current nutrition care plan included the following interventions: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor/document/report PRN any s/sx (symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Review of the current impaired swallowing care plan included the following intervention: -Please supervise me when eating or drinking meals and snacks and when taking my medication. -If I start to cough during meals, please no more food or liquids until my cough resolves and you are sure I am okay. Follow up with MD/NP as needed. On 6/10/24 at 8:23 A.M., Resident #15 was observed in his/her room in bed with breakfast on a tray table directly in front of him/her. Resident #15 was making no attempt to self- feed. There were no staff present to provide supervision or hand over hand assistance, as indicated in the plan of care. On 6/12/24 at 7:50 A.M., a staff person delivered breakfast to Resident #15 in his/her room. The surveyor continued to make the following observations: -At 7:54 A.M., Resident #15 was observed eating sausage with his/her hands. There were no staff present to provide supervision or hand over hand assistance, as indicated in the plan of care. On 06/13/24 at 7:59 A.M., the Activities Director delivered breakfast to Resident #15 who was in bed, then exited the room leaving Resident #15 without supervision or hand over hand assistance as indicated in the plan of care. The surveyor continued to make the following observations: -At 8:03 A.M., Resident #15 was observed eating scrambled eggs with his/her hands and he/she remained without supervision or assistance. During an interview on 6/13/24 at 9:49 A.M., with Resident #15's Certified Nursing Assistant (CNA) #2 said supervision with meals means that a resident either eats in the supervised dining room, or if they are in their room the staff need to stay with the resident for the entire meal and assist as needed. CNA #2 said that Resident #15 sometimes eats alone in his/her room and because Resident #15 usually finished all the food she assumed he was able to manage with utensils and did not need assistance. During an interview on 6/13/24 at 10:31 A.M., with the Nurse Unit Manager (#1) said she said that residents that require continual supervision with meals eat in the day room, and require staff to stay with them if they eat in their room. The surveyor shared the observations during survey of Resident #15 eating unsupervised in his/her room and with his/her hands. Nurse Unit Manager #1 said I have to be honest; I have been on a cart on another unit so much lately I feel like a fish out of water and not in the loop with what is going on with him/her. During an interview on 6/18/24 at 10:41 A.M. with the Director of Nursing (DON) he said that supervision with meals would indicate that staff should check in on the Resident if he/she were eating in his/her room. However, the DON said that if the Resident is now eating meals with his/her hands the Resident should be assessed by rehabilitation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) For Resident #13 the facility failed to ensure supervision and assistance with meals was provided. Resident #13 was admitted to the facility in September 2019 and has diagnoses that include dysphagia (difficulty chewing and swallowing) oropharyngeal stage and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/27/24, indicated that on the Brief Interview for Mental Status exam Resident #13 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #13 required supervision or touching assistance with eating. Review of the current physician orders indicated the following: -An order with a start date of 7/20/23: Pt (patient) must be out of bed and supervised at meals. Review of the current Activities of Daily Living (ADL) care plan indicated Resident #13 has an ADL self-care performance deficit r/t Dementia, Limited Mobility, Stroke, and Anoxic Brain Damage, & depression with decreased motivation. Resident will not initiate or follow through with a task. The care plan included the following intervention: -Eating - continual supervision of 1/assist as needed. Assist with hot liquids. Review of the current Nutrition care plan indicated Resident #13 is a potential nutrition concern due to hx. (history) of dysphagia, complicated by BMI >30. Recent significant weight loss with variable po (by mouth) intake at times. Food intolerance's: lactose. The care plan included the following interventions: -Monitor s/sx (signs and symptoms) dysphagia (coughing, choking, runny nose). On 6/10/24 at 8:15 A.M., Resident #13 was observed in his/her room in bed. A staff person entered the room, set up breakfast on a tray table directly in front of Resident #13 and then exited the room leaving Resident #13 alone unsupervised and unassisted. On 6/10/24 at 11:52 A.M., Resident #13 was observed in his/her room in bed. A staff person entered the room, set up lunch on a tray table directly in front of Resident #13, and then exited the room leaving Resident #13 alone unsupervised and unassisted. The surveyor continued to make the following observations: -By 12:00 P.M., Resident #13 remained alone unsupervised and unassisted. The surveyor observed that Resident #13 would take bites of food, and then begin pulling pieces of food out of his/her mouth without fully swallowing. -By 12:09 P.M., Resident #13 began using his/her hands to eat peas and carrots and remained alone, unsupervised and unassisted. On 6/11/24 at 8:00 A.M., a staff delivered breakfast to Resident #13 who was in his/her room in bed, then exited the room, leaving Resident #13 alone, unsupervised and unassisted. The surveyor continued to make the following observations: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-By 8:20 A.M., Resident #13 had received no supervision or assistance since the meal was served 20 minutes earlier and he/she stared at the food making no attempt to self- feed. On 06/11/24 at 11:57 A.M., a staff delivered lunch to Resident #13 who was in his/her room in bed, then exited the room, leaving Resident #13 alone, unsupervised and unassisted. The surveyor continued to make the following observations: -By 12:05 P.M., Resident #13 had received no supervision or assistance since the meal was served 8 minutes earlier and he/she stared at the food making no attempt to self- feed. On 6/12/24 at 7:56 A.M., a staff delivered breakfast to Resident #13 who was in his/her room in bed, then exited the room, leaving Resident #13 alone, unsupervised and unassisted. The surveyor continued to make the following observations: -By 8:12 A.M., Resident #13 remained alone and had not been provided with supervision or assistance since the initial observation 16 minutes earlier. On 6/13/24 at 7:47 A.M., a staff delivered breakfast to Resident #13 who was in his/her room in bed, then exited the room, leaving Resident #13 alone, unsupervised and unassisted. The surveyor continued to make the following observations: -By 8:03 A.M., Resident #13 remained alone and had not been provided with supervision or assistance since the initial observation 16 minutes earlier. Resident #13's eyes were closed and he/she was eating scrambled eggs with his/her hands. On 6/17/24 at 7:57 A.M., a Certified Nursing Assistant (CNA) delivered breakfast to Resident #13 who was in his/her room in bed, then exited the room, leaving Resident #13 alone, unsupervised and unassisted. The surveyor continued to make the following observations: -At 8:00 A.M., Resident #13 was observed to to use his/her left hand to place scrambled eggs on a fork, however while attempting to raise the eggs to his/her mouth the eggs fell on Resident #13's chest. -By 8:08 A.M., Resident #13 remained alone and had not been provided with supervision or assistance since the initial observation 11 minutes earlier. Resident #13's eyes were closed, and he/she was eating scrambled eggs with his/her hands. During an interview on 6/17/24 at 8:22 A.M., with Resident #13's Certified Nursing Assistant (CNA) #1 she said that Resident #13 eats his/her meals in the unit dining room. During an interview on 6/17/24 at 8:33 A.M., with the Nurse Unit Manager (#1) she said that residents that require continual supervision with meals eat in the day room, and require staff to stay with them if they eat in their room. Nurse Unit Manager #1 said that the Physician's order to be out of bed for meals should be followed. During an interview on 6/18/24 at 10:41 A.M., with the Director of Nursing he said that staff should follow physician orders. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45343 3. Resident #14 was admitted to the facility in May 2021 with diagnoses including chronic obstructive pulmonary disease (COPD), spinal stenosis, and chronic pain. Review of Resident #14's most recent Minimum Data Set (MDS) assessment, dated 3/26/24, indicated the Resident #14 had Brief Interview for Mental Status exam score of 14 out of a possible 15 indicating that he/she is cognitively intact. The MDS further indicated that Resident #14 requires supervision/touch assistance of one person for bathing. During an interview on 6/10/24 at 8:33 A.M., Resident #14 said he/she has not received a shower in over a week. Resident #14 said his/her shower days are Tuesdays and Fridays, but he/she has not been assisted with a shower in over a week. Review of Resident #14's care card (a form that shows all resident care needs) indicated Resident #14 required assistance of 1-2 staff members for bathing tasks. Review of the shower schedule for the unit on 6/11/24 at 6:40 A.M., indicated Resident #14 is scheduled to have weekly showers on Tuesdays and Fridays, no shift indicated. Further review of the documentation related to Resident #14's showers for the past 30 days indicated he/she has received 5 showers, with the last being 9 days prior on 6/2/24. During an interview on 6/13/24 at 9:37 A.M., Certified Nursing Assistant (CNA) #4 said the residents have a shower schedule that CNAs follow and if the resident refuses several times, CNAs will let the nurse know and they will document the refusal. During an interview on 6/13/24 at 9:44 A.M., Nurse (#2) said if the CNA has attempted to provide care and the resident refuses, the CNA will notify the nurse. The nurse will also attempt to provide care and if the resident refuses the nurse will document the refusal. During an interview on 6/13/24 at 1:32 P.M., the Director of Nursing (DON) said multiple attempts should be made by the CNA to provide care, and if the resident refuses care, the CNA should notify the nurse and document the refusal on the Activities of Daily Living (ADL) sheet. The DON said the nurse should also try to provide care and if the resident continues to refuse, the nurse should document the refusal and the team would come up with a better shower schedule for the resident. Review of Resident #14's medical record failed to indicate Resident #14 refused care.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, policy review and interview for 5 residents (#48, #79, #58, #9 and #60) out of a total sample of 26 residents, the facility failed to ensure it administered insulin to residents diagnosed with diabetes, according to physician orders and facility policy. Specifically: 1. The facility failed to follow physician orders for when to give or hold insulin based on blood glucose levels. 2. The facility failed to follow its policy and procedures for hypoglycemia and hyperglycemia. Findings include: According to the Merk Manual Professional Version (revised October 2023) a plasma glucose level of less than 70 mg/dL (milligrams per deciliter), in patients treated with glucose-lowering medications such as insulin, is considered hypoglycemia and should be treated to avoid a further decrease in blood glucose and consequences of hypoglycemia. Review of the facility policy Nursing Care of the Resident with Diabetes Mellitus (undated) indicated: -In type I (insulin-dependent diabetes mellitus) the body does not produce any significant amounts of insulin. -Normal blood glucose parameter is defined as 80-130 mg/dl before meals and under 180 mg/dl after meals. -Conditions associated with diabetes include, but are not limited to, hypoglycemia, in which blood sugar levels are below the reference parameter, and hyperglycemia, in which blood sugar levels are above the reference parameter. -The nurse will closely monitor the diabetes management of cognitively impaired residents. Reference ranges for hypoglycemia are: -55-70 mg/dl, mild -40-55 mg/dl, moderate -Under 40 mg/dl, severe Symptoms associated with onset of hypoglycemia may include, but are not limited to: -Weakness -Increased heart rate (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Blurred vision -Stupor (severe) -Unconsciousness (severe) -Convulsions (severe) -Coma (severe) Complications because of prolonged and poorly controlled diabetes include: -Heart disease -Kidney disease -Nerve, foot, and skin damage. For asymptomatic and responsive residents with hypoglycemia (under 70 mg/dl, or less than the physician-ordered parameter) the protocol requires nursing staff to: -Give the resident an oral form of rapidly absorbed glucose (juice or soda). -Recheck blood glucose in 15 minutes. -If blood glucose is over 130 mg/dl administer diabetic medications. -If blood glucose if under 70 mg/dl repeat oral glucose and recheck blood glucose in 15 minutes; or, -If no improvement, notify physician for further orders. -Document findings, notification to MD and any new orders given in progress note. The healthcare provider may designate an individualized parameter for hypoglycemia based on the resident's history of glycemic control. If so, use this number (along with clinical symptoms) to determine whether intervention with oral glucose is necessary. The facility's hypoglycemia protocol indicated documentation should reflect the carefully assessed diabetic resident and include, but is not limited to the following: -Level of consciousness -Assessment of the skin -Emotional reactions, moods -Assessment of pain (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Motor weakness -Urinary symptoms -Bowel dysfunction -Blood pressure -Blood glucose results Review of the facility's quality control log for blood glucometer readings dated March, April, May, and June 2024 indicated there were no significant variances and that the facility's glucometers were accurate and functioned normally. Findings include: 1. Resident #9 was admitted to the facility in October 2022, and had diagnoses which included type II diabetes mellitus, hypertension, and dementia. Review of Resident #9's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 3 out of a possible 15, indicating severe cognitive impairment. Resident #9 was dependent on staff for most activities of daily living. Resident #9's current care plan indicated he/she was diagnosed with diabetes mellitus and was at-risk for: difficulty controlling blood glucose levels, skin breakdown, nutritional problems, generalized pain, neuropathy, and retinopathy (nerve damage). Interventions included, but were not limited to: -Give me diabetic medication per my doctor's orders. -Follow the hypoglycemic protocol as indicated. See Medication Administration Record (MAR). -Watch me for signs of hypoglycemia and hyperglycemia. Review of Resident #9's MARs dated May and June 2024, indicated a physician's order dated 5/13/24, Basaglar KwikPen subcutaneous solution pen-injector 100 units per milliliter insulin glargine (a long acting insulin) inject 20 units subcutaneously at bedtime for type II diabetes. Hold if BS [blood sugar] less than 150. The MAR indicated on the following dates nursing staff failed to follow the physician's orders and incorrectly administered insulin glargine when blood glucose levels were less than 150 mg/dl. -5/14/24 at 8:11 P.M., glucose level 137. The MAR indicated Nurse #5 attempted to administer 20 units of insulin glargine, but Resident #9 refused. The MAR also indicated that at this same time Nurse #5 administered 20 units of insulin glargine into the abdomen, contrary to the orders. -5/15/24 at 8:53 P.M., blood glucose 144. The MAR indicated Nurse #8 administered 20 units of insulin glargine, contrary to the orders. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-5/17/24 at 7:17 P.M., blood glucose 117. The MAR indicated Nurse #5 administered 20 units of insulin glargine, contrary to the orders. -5/25/24 at 8:16 P.M., blood glucose 138. The MAR indicated Nurse #9 administered 20 units of insulin glargine, contrary to the orders. -5/27/25 at 7:59 P.M., blood glucose 110. The MAR indicated Nurse #5 administered 20 units of insulin glargine, contrary to the orders. -6/2/24 at 8:26 P.M., blood glucose 71. The MAR indicated Nurse #6 administered 20 units of insulin glargine, contrary to the orders. -6/4/24 at 7:53 P.M., blood glucose 31 (severe). The MAR indicated Resident #9 refused the dose of insulin glargine. The MAR also indicated that at this same time Nurse #5 administered 20 units of insulin glargine into Resident #9's abdomen, contrary to orders. -6/10/24 at 9:29 P.M., blood glucose 147. The MAR indicated Nurse #8 administered 20 units of insulin glargine, contrary to the orders. -6/16/24 at 7:38 P.M., blood glucose 94. The MAR indicated Nurse #8 administered 20 units of insulin glargine, contrary to the orders. Resident #9's MARs dated May and June 2024 indicated a physician's order dated 6/16/23, If FSBG [finger stick blood glucose] is less than or equal to 70 and Resident is responsive and able and willing to swallow, treat with 15-20 grams of carbohydrates and assess response. Recheck FSBG in 15 minutes (4-6 ounces of orange juice) every 15 minutes as needed related to type II diabetes mellitus with hyperglycemia. If FSBG is still less than or equal to 70, retreat by mouth (4-6 ounces of orange juice). If FSBG is greater than 70, monitor resident and offer a snack within 30 minutes. Notify provider. The MAR indicated on the following dates nursing staff failed to follow the physician's orders and the hypoglycemic protocol for treatment of blood glucose levels less than 70. The Resident's MAR and progress notes make no reference to nursing staff giving carbohydrates, rechecking blood glucose levels, or notifying the provider on the following dates: -5/13/24 at 7:30 A.M. blood glucose 65, obtained by Unit Manager #1 -5/13/24 at 11:30 A.M., blood glucose 56, obtained by Unit Manager #1 -5/30/24 at 4:30 P.M., blood glucose 69, obtained by Unit Manager #1 -6/4/24 at 7:53 P.M., blood glucose 31 (severe), obtained by Nurse #5. Resident #9's MAR dated May 2024 and June 2024, indicated a physician's order dated 6/16/23, Assess and monitor Resident response to hypoglycemic treatment as needed as related to type II diabetes mellitus with hyperglycemia. Nursing progress notes and the MARs indicated nursing staff failed to document that any interventions or monitoring occurred when the Resident's blood glucose was below 70 on 5/13/24, 5/30/24 and 6/4/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #9's Nurse Practitioner (NP) and physician progress notes dated June 2024 did not reference the blood glucose level of 31 obtained on 6/4/24. On 6/17/24 at approximately 9:00 A.M., the surveyor attempted to contact Nurse #5 regarding her administration of insulin and failure to follow the hypoglycemic protocol for Resident #9 on 5/14/24, 5/17/24, 5/27/24 and 6/4/24. Nurse #5 did not respond to voicemail messages or texts. During an interview on 6/17/24 at approximately 2:10 P.M., Nurse #8 said that on 5/15/24, 5/17/24, 6/10/24 and 6/16/24, she made an error by administering insulin to the Resident when his/her blood glucose was below the parameter set by the physician. On 6/17/24 at approximately 10:40 A.M., the surveyor attempted to contact Nurse #9 regarding her administration of insulin to Resident #9 on 5/25/24. Nurse #5 did not respond to voicemail messages or texts. During an interview on 6/17/24 at approximately 3:05 P.M., Nurse #6 said she must have made an error when administering insulin to Resident #9 on 6/2/24 because the blood glucose level was below the parameter set by the physician. During an interview on 6/14/24 at approximately 11:00 A.M., Unit Manager #1 said she did not recall Resident #9's hypoglycemic episodes on 5/13/24 and 5/30/24. Unit Manager #1 said she did not recall that Resident #9 had low blood glucose levels on these dates, but that if Resident #9 was hypoglycemic she would have offered orange juice. Unit Manager #1 said she did not recall the facility's hypoglycemic protocol, which included retaking blood glucose levels after giving carbohydrates, and documenting the encounter on the MAR and progress notes. During an interview on 6/13/24 at 10:20 A.M., the Director of Nursing (DON) said nursing staff should have followed Resident #9's physician's orders and the facility's hypoglycemic protocol. The DON reviewed the Resident's MAR for May and June 2024 and said nursing staff should have held the insulin glargine on the dates when the Resident's blood glucose was below 150. The DON said that nursing staff should have followed physician orders, and notified the physician on those dates when the Resident's blood glucose was below 70. The DON said the Resident's blood glucose level of 31 on 6/4/24 was critically low. During an interview on 6/14/24 at 11:37 A.M., the Medical Director said nursing staff should follow the physician's orders and the hypoglycemic protocol for insulin-dependent diabetics. The Medical Director said that when a resident's blood glucose is under 70 nursing staff should give carbohydrates, notify the physician, monitor and document responses to interventions. The Medical Director said that blood glucose levels below 50 are critical and the resident would likely need to be hospitalized for treatment and testing to determine if an underlying infection has caused hypoglycemia. The Medical Director said short term effects of critically low blood glucose levels can include hypoglycemic coma and death. The Medical Director said long term effects of untreated hypoglycemia include heart disease, kidney disease, neuropathy, nerve damage to the eyes and generalized weakness. 2. Resident #79 was admitted to the facility in August 2023, and had diagnoses which included type II diabetes mellitus, renal failure, hypertension, and dementia. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #79's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 9 out of a possible 15, indicating moderate cognitive impairment. Resident #79 was dependent on staff for most activities of daily living. Review of Resident #79's current care plan indicated he/she had a diagnosis of diabetes and had difficulty controlling his/her blood glucose level. Interventions included: -Give me diabetic medication per my doctor's orders. -Follow the hypoglycemic protocol as indicated. See MAR. Review of Resident #79's physician order dated 11/30/23, indicated Humalog injection solution (insulin Lispro). Inject as per sliding scale. Review of Resident #79's MAR dated March 2024 indicated that on 3/21/24 at 10:35 P.M., his/her blood glucose was 15 (severe). There was no indication on either the MAR or progress notes that nursing staff initiated the hypoglycemic protocol or notified the physician regarding the Resident's severely low blood glucose level. Review of Resident #9's Nurse Practitioner (NP) and physician progress notes dated March, April and June 2024 did not reference the blood glucose level of 15 obtained on 3/21/24. During an interview on 6/17/24 at approximately 2:10 P.M., Nurse #10, said the entry on Resident #79's MAR dated 3/21/24 of 15 must have been a typo. Nurse #10 said that if Resident #79's blood sugar was 15 she would have initiated the hypoglycemic protocol and notified the physician. 3. Resident #48 was admitted to the facility in March 2024 and had diagnoses which included diabetes, hypertension, and cerebral vascular accident. Review of Resident #48's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 8 out of a possible 15, indicating moderate cognitive impairment. Resident #48 was dependent on staff for most activities of daily living. Review of Resident #48's current care plan indicated he/she had a diagnosis of diabetes and difficulty controlling his/her blood glucose level. Interventions included: -Give me diabetic medication per my doctor's orders. -Follow the hypoglycemic protocol as indicated. See me MAR. Review of Resident #48's physician's order dated 4/12/24 indicated Insulin lispro injection solution 100 units/milliliter. Inject as per sliding scale. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #48's MAR dated May 2024 indicated that on 5/6/24 at approximately 4:00 P.M., his/her blood glucose level was 19 (severe). The MAR and progress notes indicated Nurse #12 did not initiate the hypoglycemic protocol or notify the physician regarding the Resident's severely low blood glucose level. The code on the MAR (#9) indicated see progress notes. Review of the 5/6/24 nursing progress notes did not reference the blood glucose level of 18, or initiating the hypoglycemic protocol, or notifying the physician. Review of Resident #48's Nurse Practitioner (NP) and physician progress notes dated May and June 2024 did not reference the blood glucose level of 19 obtained on 5/6/24. During an interview on 6/17/24 at approximately 1:10 P.M., Nurse #12 said the entry on Resident #48's MAR dated 5/6/24 of 19 must have been a typo. Nurse #12 said that if Resident #48's blood sugar was 19 she would have initiated the hypoglycemic protocol and notified the physician. 4. Resident #58 was admitted to the facility in December 2023, and had diagnoses which included diabetes and hypertension. Review of Resident #58's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status examination score of 15 out of a possible 15, indicating intact cognition. Resident #58 requires some assistance for most activities of daily living. Review of Resident #58's current care plan indicated he/she had a diagnosis of diabetes and difficulty controlling his/her blood glucose level. Interventions included: -Give me diabetic medication per my doctor's orders. -Follow the hypoglycemic protocol as indicated. See MAR. Review of Resident #58's physician's order dated 11/9/23, indicated Insulin lispro injection solution 100 units/milliliter. Inject as per sliding scale. Review of Resident #58's MAR dated April 2024 indicated that on 4/8/24 at approximately 11:00 A.M., his/her blood glucose level was 67, and on 4/9/24 at approximately 11:00 A.M. the blood glucose level was 66. The MAR and progress notes indicated nursing staff did not initiate the hypoglycemic protocol or notify the physician regarding the Resident's low blood glucose level. Review of Resident #58's physician progress note dated 4/15/24 does not reference his/her hypoglycemic events on 4/8/24 and 4/9/24. On 6/17/24 at approximately 2:00 P.M., the surveyor attempted to contact Nurse #11 regarding Resident #58's blood glucose level on 4/8/24 of 67, and his/her blood glucose level of 66 on 4/9/24. Nurse #11 did not respond to voicemail messages or texts. 49880 5. Resident #60 was admitted to the facility in October 2023 with diagnoses that include type 2 diabetes, dementia, and obesity. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #60's Minimum Data Set (MDS) Assessment, dated 4/24/24, indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating that the Resident had moderate cognitive impairment. The MDS further indicated that the Resident received insulin injections and hypoglycemic medication. According to the Centers for Disease Control (CDC), dated 5/14/24, a normal hemoglobin A1C level is below 5.7 Review of Resident #60's medical record indicated a hemoglobin A1C (a blood test that shows the average blood sugar level over the past two to three months) result of 8.0 on 3/25/24, indicating an elevated level. Review of Resident #60's physician's orders indicated the following: -Lantus Solution (a long-acting insulin) 25 units subcutaneously at bedtime, dated 10/31/23. -Humalog injection, give 3 units subcutaneously before meals, dated 12/5/23. -Humalog injection (a fast-acting insulin) inject as per sliding scale before meals and at bedtime: -Blood sugar is 151-200 give 2 units of insulin, -Blood sugar is 201-250 give 4 units of insulin -Blood sugar is 251-300 give 6 units of insulin -Blood sugar is 301-350 give 8 units of insulin -Blood sugar is 351-400 give 10 units of insulin -Call MD/NP (Physician/ Nurse Practitioner) if blood sugar over 400, dated 12/5/23. Review of Resident #60's active diabetes care plan, dated 11/15/23, indicated because I have diabetes, I am at risk for having difficulty controlling my blood sugars with interventions that include the following: -Follow the hypoglycemic protocol as indicated. See my MAR (medication administration record). -Watch me for signs of hypo/hyperglycemia (low and high blood sugars). Review of Resident #60's MARs dated April, May and June 23, 2024 failed to indicate orders for the facility's hypoglycemic protocol. Review of Resident #60's eMAR (electronic medication administration record) progress notes indicated the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-A progress note dated 4/24/24 at 8:12 A.M., indicated that Resident #60 had a blood sugar of 77 and scheduled Humalog insulin was held. The progress note failed to indicate that a Physician or Nurse Practitioner (NP) were notified that the medication was not administered. -A progress note dated 5/2/24 at 4:03 P.M., triggered from the MAR indicated that Humalog insulin was not administered before dinner. The documented blood sugar at that time was 103, and the MAR documentation indicated the medication was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/6/24 at 10:05 A.M., triggered from the MAR indicated that Humalog insulin was not administered. The documented blood sugar at the time was 92, and the MAR documentation indicated the medication was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/12/24 at 11:57 A.M., indicated that Resident #60 had a blood sugar of 87 and that the scheduled dose of Humalog insulin at that time was held. The MAR indicated that the medication was not given. The progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/22/24 at 7:48 A.M., indicated that Resident #60 had a blood sugar of 74 and that the scheduled dose of Humalog insulin was held at this time. The MAR indicated that the medication was not given. The progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/23/24 at 7:56 A.M., indicated that Resident #60 had a blood sugar of 109 and that Humalog insulin was not administered. Progress notes failed to indicate that the Physician or NP were notified that the medication was not administered. -A progress note dated 5/24/24 at 4:25 P.M., indicated that Resident #60 had a blood sugar of 100 and per the MAR, the scheduled Humalog insulin was held. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/24/24 at 8:12 P.M., indicated that Resident #60 had a blood sugar of 111. Review of the MAR at this time indicated that scheduled Lantus insulin was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 5/29/24 at 7:47 A.M., indicated that Resident #60 had a blood sugar of 77 and that the scheduled dose of Humalog insulin was not administered. Review of progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A pro progress note dated 6/4/24 at 7:55 A.M., indicated that Resident #60 had a blood sugar of 81 and that the scheduled dose of Humalog insulin was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. -A progress note dated 6/17/14 at 7:51 A.M., indicated that Resident #60 had a blood sugar of 111 and that the scheduled dose of Humalog insulin was not administered. Progress notes failed to indicate that a Physician or NP were notified that the medication was not administered. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #60's blood sugar readings indicated the following: On 4/26/24 at 5:36 P.M., a blood glucose reading of 48 and at 5:55 P.M., a blood glucose reading of 57. On 4/26/24 at 7:32 P.M., and at 11:35 P.M., blood sugars levels of 74 were documented. Review of nursing progress notes on 4/26/24 indicated that orange juice was provided to the resident, but failed to indicate that a Physician or Nurse Practitioner was notified of the hypoglycemic episode . Review of the Nurse Practitioner progress and visit notes dated from 4/26/24 to 5/29/24 failed to indicate that she was aware that insulin was being held at times for Resident #60. During an interview on 6/17/24 at 12:41 P.M., Nurse #1 said that he was assigned to care for Resident #60. He said that before breakfast Resident #60 had a blood sugar of 111, so he held his/her 3 units of Humalog insulin. Nurse #1 said that he did not have orders to hold it and that the Resident was not symptomatic of low blood sugars. Nurse #1 further said that he did not notify the Physician or NP that the medication was held. Nurse #1 said that a Physician or NP should be notified if a medication is held either due to parameters or nursing judgement and that it should be documented in a progress note. During an interview on 6/17/24 at 1:53 P.M., Unit Manager #1 said that if a nurse feels that a Resident's blood sugar is too low for insulin they will hold it, but that a Physician or NP should be notified. During an interview on 6/17/24 at 12:24 P.M., Nurse Practitioner (NP) #1 said that she is rarely notified by the facility of low blood sugars for residents. NP #1 also said that if nursing staff provided an intervention for low blood sugars or if scheduled insulin was being held by the nurse she would expect to be notified. NP #1 said that the current order for Humalog insulin for Resident #60 does not have hold parameters, so if a nurse was holding it, she should be notified. She said she was not aware that the insulin was held before breakfast on 6/17/24 for Resident #60 and would not have recommended that it be held. NP #1 said that she assumes that all medications are administered as ordered unless she is told otherwise. NP #1 said that not being notified that medications are held could lead to her over or under dosing a resident with insulin or other medications. During an interview on 6/18/24 at 9:35 A.M., the Director of Nurses said that nurses can hold medications per parameters of the order or for nursing judgment, but if the medication is held the Physician or NP should be made aware and it should be documented in a progress note. Refer to F726

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, interview and observation, the facility failed for 1 (Resident #5) of 26 sampled residents to set the air mattress pressure to the correct, physician-ordered setting. Specifically, the physician order indicated the air mattress should be set to 100 pounds (lbs.) and for three days the pressure was set to 400 lbs. Findings include: Resident #5 was admitted to the facility in April 2021, and had diagnoses which included diabetes and cerebral vascular accident. Resident #5 received hospice services. Review of Resident #5's Minimum Data Set (MDS) assessment dated [DATE], indicated he/she had moderately impaired cognitive skills for daily decision making, dependence on staff for most activities of daily living, and was at-risk for the development of pressure ulcers. The MDS indicated the Resident had a pressure-relieving mattress. Review of Resident #5's current care plan indicated he/she was at risk for the development of pressure ulcers. Interventions included the use of pressure relieving devices. Review of Resident #5's physician order dated 8/3/23, indicated he/she may have an air mattress to relieve pressure, to ensure setting is at 100 [lbs.], is on and functioning and to be checked every shift. Review of Resident #5's most recent weight in March 2024 indicated he/she weighed 91 pounds. On 6/10/24 at 8:14 A.M., the surveyor observed Resident #5 lying asleep in bed on an air mattress set to 400 lbs. On 6/11/24 at 8:31 A.M., the surveyor observed Resident #5 lying asleep in bed on an air mattress set to 400 lbs. On 6/13/24 at 8:38 A.M., the surveyor observed Resident #5 lying in bed on an air mattress set to 400 lbs. The surveyor attempted to interview Resident #5, but he/she did not respond to questions. On 6/13/24 at 9:33 A.M., the surveyor observed Resident #5 lying in bed on an air mattress set to 400 lbs. During an interview with Unit Manager #1 on 6/13/24 at 9:33 A.M., she said Resident #5 weighed approximately 96 pounds. The surveyor and Unit Manager #1 observed that Resident #5's air mattress pressure was set to 400 pounds. Unit Manager #1 said the Resident's air mattress pressure should be set to 100 pounds due to his/her weight.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45763 Based on observation, record review and interview, the facility failed to ensure the environment was free from accident hazards for one Resident (#74) out of a total sample of 26 residents. Specifically, the facility failed to implement an intervention intended to prevent further falls after Resident #74 sustained a fall. Findings include: Review of the facility policy titled Falls, revised June 2022, indicated the following: - It is the policy of Mill Town Health and Rehab to make every effort possible to identify any resident at risk for a fall, prevent a fall and if a fall occurs to fully investigate the incident to identify any practices that need to be revised to further support the goal of fall prevention and resident safety. - If a fall occurs, an Incident and Accident Investigation and an Incident/Accident Report is to be completed by the licensed nurse. The licensed nurse or department head will immediately obtain written statements from the CNA's (certified nursing assistants) and other assigned staff, as applicable, on the Post Fall Report. A CQI Falls Assessment Tool is to be completed by a licensed nurse at the time of the fall. All of the documentations are to be completed and attached to the incident/Accident report with a Fall Screen or Evaluation Request, as indicated. A. The charge nurse on duty will immediately assess the resident for any injury, pain and V/S. He/she will then implement a fall prevention plan immediately to prevent any future occurrences and document on the resident Care Plan and CNA Care Card once the resident is deemed stable. - The supervisor will be notified by the charge nurse if a fall occurs. The supervisor will assess the fall. Supervisor will update and add information, as needed, to the CQI Falls Assessment Tool as well as to check for accuracy of the incident report, and then co-sign. The supervisor will also assess and add interventions to the care plan as needed. - The Resident's care plan needs to be reviewed and updated every time a fall occurs to make sure the appropriate interventions are listed. All other logs and assignment sheets updated as needed for staff communication. - All reports must be completed prior to weekly risk meeting and submitted to Director of Nursing (DON). - An At Risk meeting is held weekly. The team, at minimum, includes DON, Nursing Supervisors, SDC (Staff Development Coordinator), Activity Director, Social Services, MDS (Minimum Data Set) staff, Reports from CNA's and a representative from the Therapy department. Other department heads/staff are welcome (and encouraged) to attend. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Care Plan, CNA Care Card, Incident Report and CQI Falls Assessment Tool are to be brought to the meeting with the resident's chart. - The team reviews residents who fell in the previous week, including incident outcome, follow up care plan and make any further recommendations necessary. - The meeting also focuses on resident falls within the past month to continuously assess root cause/etiology of falls, evaluate effectiveness of current and new interventions, discuss additional new interventions, and assure new interventions followed through. Resident #74 was admitted to the facility in March 2024 with a diagnosis of dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/24/24, indicated that Resident #74 scored a 10 out of 15 on the Brief Interview for Mental Status exam indicating the Resident had moderate cognitive impairment. Review of the Incident Investigation Summary Statement, dated 3/20/24, indicated Resident #74 had experienced an unwitnessed fall in his/her room on 3/20/24. Review of the Fall/Incidents Risk Meeting Notes, dated 3/21/24, indicated Resident #74 had sustained an unwitnessed fall on 3/20/24 with the following intervention: -Education on Call light use Review of the Incident Investigation Summary Statement, dated 3/22/24, indicated Resident #74 had experienced an unwitnessed fall in his/her bathroom on 3/22/24. Review of the CQI Falls and Incident Assessment Tool indicated that the immediate new intervention/preventative measure was to advise to use call light at all times. Review of the Fall/Incidents Risk Meeting Notes, dated 3/28/24, indicated Resident #74 had sustained an unwitnessed fall on 3/22/24 and that the Resident had not called for help on the 2nd shift. Review of Resident #74's Falls care plan indicated that Resident #74 was at moderate risk for falls related to confusion, deconditioning, gait/balance problems, psychoactive drug use, unaware of safety needs: -education regarding call light usage for safety, initiated 3/22/24. Review of the falls care plan indicated that the intervention discussed at the 3/21/24 risk meeting to prevent future falls was not integrated into the Resident's care plan until 3/22/24, two days after the fall. During an interview on 6/17/24 at 12:04 P.M., Certified Nursing Assistant (CNA) #5 said that Resident #74 has fallen in the past, and that the Resident occasionally rushes when getting out of bed. During an interview on 6/17/24 at 12:37 P.M., Nurse (#2) said that after a resident falls they would be assessed, the physician would be notified, the fall would be discussed at risk, and new interventions would be implemented into the resident's care plan immediately. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/24 at 12:50 P.M., Nurse Unit Manager (#2) said that after a resident falls, the nurse fills out the Incident Investigation Summary Statement, which would include updating the resident's care plan. Nurse Unit Manager #2 said the resident would then be discussed at risk meeting and that if an intervention was discussed at risk meeting it should be integrated in the care plan immediately, during the risk meeting. Nurse Unit Manager #2 said that if the post-falls procedure wasn't followed that it would put Resident #74 at risk for future falls. During an interview on 6/17/24 at 1:07 P.M., the Director of Nursing (DON) said that after a resident falls the resident would be assessed, an incident report would be completed, the physician and family would be notified, and an intervention would be put in place immediately to prevent future falls. The DON said that if an intervention was discussed at risk he would expect it to be implemented and integrated into the care plan immediately. The DON said that if the post-falls procedure was not followed it would put the Resident at risk for future falls.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review, policy review and interview the facility failed to ensure a plan of care was developed for Trauma Informed Care, with individualized interventions, for three Residents (#70, #24 and #26) who have a history of trauma out of a total sample of 26 residents. Specifically: 1. For Resident #70, the facility failed to develop a trauma care plan, with individualized triggers and interventions, following an allegation of rape made by Resident #70 and failed to complete a PTSD assessment quarterly and following the allegation of rape. 2. For Resident #24, the facility failed to develop a comprehensive trauma care plan, with individualized triggers. 3. For Resident #26, the facility failed to develop a comprehensive trauma care plan, with individualized triggers. Findings include:: The facility policy titled Trauma Informed Care Policy and Procedure, dated 9/2022, indicated the following: -Trauma: Individual trauma results from an event, a series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental physical, social, emotional or spiritual well-being. Trauma which produces Traumatic Stress, occurs when our coping mechanisms are overwhelmed by outside events. -Procedure: 1. Facility residents will be assessed for past trauma and for signs/symptoms of traumatic stress upon admission, quarterly, annually and as needed. 2. If the results of these assessments reveal the presence of trauma or traumatic stress, the interdisciplinary team, in collaboration with the resident and with the approved resident's representative(s), will create a culturally sensitive plan of care to help prevent re-traumatization and to optimize quality of life. 3. These plans of care shall include prevention, intervention and treatment services that address traumatic stress and may include but are not limited to: -A description of the resident's behavior(s) that is/are triggered by traumatic stress; -Interventions that should be employed to avoid traumatic triggers; -De-escalation interventions that should be employed when the resident is assessed to be exhibiting trauma-induced behaviors; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Directing staff behavior and interventions to help prevent re-traumatization. 1. For Resident #70 the facility failed to develop a trauma care plan, with individualized triggers and interventions, following an allegation of rape made by Resident #70 and failed to complete a PTSD assessment quarterly and following the allegation of rape. Resident #70 was admitted to the facility in December 2023 and has diagnoses that include neoplasm of unspecified behavior of the brain (tumor) and generalized anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/6/24, indicated that on the Brief Interview for Mental Status exam Resident #70 scored an 11 out of 15, indicating moderately impaired cognition. On 6/10/24 at 1:12 P.M., the surveyor met with Resident #70. Resident #70 almost immediately began crying and shaking as he/she told the surveyor that he/she had been raped by his/her brother in law a month or two ago while out of the facility for a visit with family. Resident #70 said that he/she does not receive support services at the facility but needs them. As well, Resident #70 expressed how sad he/she was because his/her sister was mad at Resident #70 when Resident #70 tried to tell her about the rape. Resident #70 said that the sister and brother in law are the only family that he/she has. Review of the record indicated the following: -Nurses note dated 4/26/24 at 10:40 A.M.: This RN was notified by activity's assistant that resident was in the dining room crying and stating my brother raped me. SW (Social Worker) present on unit and notified of situation. She took resident off the floor to discuss. -Social Service note dated 4/26/24 at 12:34 P.M.: SW was informed by nurse that Resident #70 told activity assistant that his/her brother-in-law raped him/her. SW asked if Resident #70 wanted to speak to her. He/she was in day room in activities waiting for his/her nails to be painted. Resident #70 open to conversation & [NAME] (sic) Resident #70 to her office. Resident #70 told SW that her brother-in-law raped him/her. SW asked more questions regarding details & collected information for statement. He/she reports being afraid of him & scared to tell us sooner. He/she states they are my only family. Resident #70 also reporting that his/her stomach hurts & that it hurts to pee. He/she also reports vomiting & having diarrhea when at his/her family's home. Resident #70 weepy & in distress while reporting all this information. He/she is agreeable to be sent to the hospital. IDT informed. SS will continue to follow. Further review of the record indicated the following: -The record failed to indicate that a Trauma Informed Care Review Assessment was completed following the alleged rape. The only Trauma Informed Care Review Assessment was completed on 12/5/23. -The facility failed to develop a care plan to address Resident #70's traumatic event following a rape allegation that required a visit to the emergency room for a rape kit test and subsequent involvement by the District Attorney's (DAs) office and Protective Services. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/24 at 1:43 P.M., the facility SW (#1) says that the trauma assessment is completed by nursing and she completes a trauma care plan on admission. SW #1 said that a care plan should have been developed following the recent alleged rape and that she was not sure if a trauma assessment should have been done. During a follow-up interview on 6/13/24 at 2:33 P.M., SW #1 said that she had discussed the situation with the Director of Nursing (DON) and that the DON said that trauma assessments are completed quarterly and with a change and that Resident #70 should have had a trauma assessment after the rape allegation. 45343 2. Resident #24 was admitted to the facility in September 2022, and diagnoses including traumatic Post-Traumatic Stress Disorder (PTSD), bipolar, anxiety, and dementia. Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 3/12/24, indicated that Resident #24 had a Brief Interview for Mental Status exam score of 12 out of 15 indicating he/she has moderate cognitive impairments. Review of the PTSD care plan indicated Resident #24 has a diagnosis of PTSD. The care had the following interventions: -Arrange for me to see a psychiatrist if my physician thinks it would help. -Connect me with a psychotherapist if my physician thinks it would help me. -Monitor me to make sure that I can sleep. -Monitor my appetite, watch me for weight gain or loss. -Spend time with me so I have someone to talk to allow me to vent my feelings. -Watch for signs that I may harm myself. -Watch me for decreased interest in the things I used to enjoy doing as this may be a sign that my depression is getting worse. Review of Resident #24's care plan failed to indicate the development of a comprehensive trauma informed care plan with identified resident specific triggers and interventions for his/her diagnosis of PTSD. During an interview 6/13/24 at 1:41 P.M., the Social Worker (#1) said residents with PTSD should be formally assessed and a care plan should be developed with resident specific triggers identified. 3. Resident #26 was admitted to the facility in September 2023, and diagnoses including traumatic Post-Traumatic Stress Disorder (PTSD), depression, and anxiety. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #26's most recent Minimum Data Set (MDS) assessment, dated 3/19/24, indicated that Resident #24 had a Brief Interview for Mental Status exam score of 15 out of 15 indicating he/she is cognitively intact. Review of the PTSD care plan indicated Resident #26 has a diagnosis of PTSD. The care had the following interventions: -Administer medications as ordered. Monitor/document for side effects and effectiveness. -Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these. -Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) -Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. -Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. -Review of daily documentation indicating facility are implementing all interventions to the best of their ability, resident challenging impacting ability to implement all interventions daily. Review of Resident #26's care plan failed to indicate the development of a comprehensive trauma informed care plan with identified resident specific triggers and interventions for his/her diagnosis of PTSD. During an interview 6/13/24 at 1:41 P.M., the Social Worker (#1) said residents with PTSD should be formally assessed and a care plan should be developed with resident specific triggers identified.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45343 Based on record review, policy review, staff education record review, Facility Assessment review, and interviews, the facility failed to ensure that the three out of thirteen nurses (Nurse #5, #6, and #10) completed annual training and competencies related to the provision of care and services for five insulin dependent Residents (#48, #79, #58, #9, and #60) out of a total sample of 26 Residents. Specifically, the facility failed to: 1.Notify the physician or nurse practitioner when residents' blood glucose levels fell below parameters, or when insulin was held due to hypoglycemia. 2.Follow physician orders for when to give or hold insulin based on blood glucose levels. Findings Include: According to the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies and training in areas as indicated in the facility assessment: Medication: Awareness of any limitations of administering medications, administration of medications that residents need, by route; oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc. Assessment/management of polypharmacy. Management of Medical Conditions: Assessment, early in identification of problem/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), gastroenteritis, infections such as UTI and gastroenteritis, pneumonia, hypothyroidism. According to Management of Diabetes and Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association (February 2016), several organizations have developed diabetes guidelines for patients living in long term care settings. Almost all of these guidelines emphasize the need to individualize care goals and treatments related to diabetes, the need to avoid sliding scale insulin (SSI) as a primary means of regulating blood glucose, and the importance of providing adequate training and protocols to long term care staff who may be operating without the presence of a practitioner for prolonged periods. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled, Employee Compliance Training and Education, last revised 2022, indicated but was not limited to the following: -Milltown Health and Rehabilitation as part of its continued commitment to compliance with legal requirements, shall conduct initial employment training and mandatory annual compliance program and policy education and training for all employees. The facility also conducts mandatory periodic specific education and training. The facility employee attendance and participation in training programs is a condition of continued employment and failure to comply with training requirements will result in disciplinary action up to and including termination of employment. -Attendance at educational and training sessions is the responsibility of each employee and will be documented by the Compliance Officer. Review of the Milltown Health and Rehab Facility Assessment Tool, undated, indicated the following: Staff training/education and competencies: 2.Services and Care We Offer Based on our Residents ' Needs: Management of Medical Conditions: -Assessment. -Early identification of problems disorientation. -Management of medical and psychiatric symptoms. -Conditions such as heart failure. -Diabetes. -Chronic Obstructive Pulmonary Disease (COPD) -Gastroenteritis, infections such as UTI. -Pneumonia. -Hypothyroidism. Medications: -Awareness of any limitations of administering. -Medications. -Administration of Medication that residents need. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-By route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc. 3.4 Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education training competency instructions and testing policies. Some examples of annual clinical competencies include but are not limited to the following: -Person centered care. -Infection Control. -Medication administration. -Resident assessments. -Measurements (e.g., BP (blood pressure), wt (weight), etc. -Specialized services (e.g., colostomy care, etc.). Resident #9 was admitted to the facility in October 2022, with diagnoses that included type II diabetes mellitus, hypertension, and dementia. Review of the medical record indicated on 5/14/24, 5/17/24, 5/27/24, and 6/2/24 Nurse #5 and Nurse #6 failed to follow the physician ' s order and incorrectly administered insulin glargine when blood glucose levels were less than 150mg/dl. Additionally, on 5/13/24, 5/30/24 and 6/4/24 Nurse #5 failed to follow the physician ' s order, the hypoglycemic protocol and notify the physician for treatment of blood glucose levels less than 70 mg/dl. Resident #79 was admitted to the facility in August 2023, with diagnoses that included type II diabetes mellitus, renal failure, hypertension, and dementia. Review of Resident #79 ' s Medication Administration Record (MAR) dated March 2024 indicated that on 3/21/24 his/her blood glucose was 15 (severely low). There was no indication on the MAR or progress notes that nursing staff followed the physician ' s orders, initiated the hypoglycemic protocol, or notified the physician regarding Resident #79 ' s severely low blood glucose level. During an interview on 6/17/24 at approximately 2:10 P.M., Nurse #10, said the entry on Resident #79's MAR dated 3/21/24 of 15 must have been a typo. Nurse #10 said that if Resident #79's blood sugar was 15 she would have initiated the hypoglycemic protocol and notified the physician. Resident #48 was admitted to the facility in March 2024, with diagnoses that included diabetes, hypertension, and cerebral vascular accident. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #48's MAR dated May 2024 indicated that on 5/6/24 at approximately 4:00 P.M., his/her blood glucose level was 19 (severely low). The MAR and progress notes failed to indicate Nurse #12 initiated the hypoglycemic protocol or notify the physician regarding the Resident's severely low blood glucose level. The code on the MAR (#9) indicated see progress notes. Review of the 5/6/24 nursing progress notes did not reference the blood glucose level of 18, or initiating the hypoglycemic protocol, or notifying the physician. During an interview on 6/17/24 at approximately 1:10 P.M., Nurse #12 said the entry on Resident #48's MAR dated 5/6/24 of 19 must have been a typo. Nurse #12 said that if Resident #48's blood sugar was 19 she would have initiated the hypoglycemic protocol and notified the physician. Resident #58 was admitted to the facility in December 2023, with diagnoses that included diabetes and hypertension. Review of Resident #58's MAR dated April 2024 indicated that on 4/8/24 at approximately 11:00 A.M., his/her blood glucose level was 67, and on 4/9/24 at approximately 11:00 A.M. the blood glucose level was 66. The MAR and progress notes failed to indicate nursing staff initiated the hypoglycemic protocol or notify the physician regarding the Resident's low blood glucose level. On 6/17/24 at approximately 2:00 P.M., the surveyor attempted to contact Nurse #11 regarding Resident #58's blood glucose level on 4/8/24 of 67, and his/her blood glucose level of 66 on 4/9/24. Nurse #11 did not respond to voicemail messages or texts. Resident #60 was admitted to the facility in October 2023 with diagnoses that include type II diabetes, dementia, and obesity. Review of the medical record indicated on 4/2/4/24, 5/2/24, 5/6/24, 5/12/24, 5/22/24, 5/23/24, 5/24/24, 5/29/24, 6/4/24, and 6/17/24 Resident #60 ' s scheduled Humalog insulin was held. The progress notes failed to indicate that a Physician or Nurse Practitioner was notified that the medication was not administered. During an interview on 6/17/24 at 12:41 P.M., Nurse #1 said that he was assigned to care for Resident #60. He said that before breakfast Resident #60 had a blood sugar of 111, so he held his/her 3 units of Humalog insulin. Nurse #1 further said that he did not notify the Physician or NP that the medication was held. Nurse #1 said that a Physician or NP should be notified if a medication is held either due to parameters or nursing judgement and that it should be documented in a progress note. The Director of Nursing provided the surveyor with the education files for thirteen nurses. Review of the education records for three of thirteen licensed nurses failed to indicate that annual competencies for medication administration, specifically for insulin dependent residents, were completed in 2023 or thus far in 2024 for Nurse #5, #6, and #10. During an interview on 6/18/24 at 11:32 A.M., the Director of Nursing said the facility holds two annual competency fairs and it would be the expectation that all nursing competencies would be completed yearly to ensure all staff are competent in the care they provide. The Director of Nursing was unable to provide annual competency documentation for Nurse #5, #6 and #10 by the conclusion of survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on record review, policy review and interview, the facility failed to ensure recommendations from the Monthly Medication Reviews (MMRs) conducted by the consultant pharmacist were addressed and acknowledged by the physician in a timely manner for one Resident (#81) out of a total sample of 26 Residents. Findings Include: Review of facility policy titled Drug Regimen Review, dated as effective 6/2022, indicated: -The consultant Pharmacist reviews the medication regimen of each active resident at least monthly. Findings and recommendations are reported to the Director of Nursing and the Medical Director. -3. The consultant Pharmacist documents potential or actual medication therapy problem and communicate them to the responsible prescriber, unit manager and the Director of Nursing (DON) and the Medical Director. [sic] -4. The consultant Pharmacist documents all potential or actual significant nursing documentation problems found relating to medications and communicates them in writing to the DON and Medical Director. Resident #81 was admitted to the facility on [DATE] with diagnoses that include depression, adult failure to thrive and mood disorder. Review of Resident #81's most recent Minimum Data Set (MDS) assessment, dated 4/17/24, indicated a Brief Interview for Mental Status exam score of 7 out of a possible 15 indicating that Resident #81 has severe cognitive impairment. The MDS further indicated that the Resident takes an antipsychotic medication. Review of Resident #81's current physician orders indicated the following: -Risperdal (an antipsychotic medication) 1 milligram (mg) by mouth in the morning for unspecified dementia, unspecified severity, with other behavioral disturbance, dated as updated 5/8/24. -Risperdal 0.5 mg by mouth at bed time for unspecified dementia, unspecified severity, with other behavioral disturbances, dated as updated 5/8/24. Review of Consultant Pharmacist Recommendation forms provided to surveyor indicated the following: -On 1/15/24: The Resident is receiving the antipsychotic medication Risperdal to treat dementia without behavioral disturbance. Please clarify this diagnosis in PCC (Point Click Care, a medical records program). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/25/24: The Resident is receiving the antipsychotic medication Risperdal to treat dementia without behavioral disturbance. Please clarify this diagnosis in PCC (currently says unspecified mood) -On 3/20/24: The Resident is receiving the antipsychotic medication Risperdal to treat dementia without behavioral disturbance. -On 4/16/24: The Resident is receiving the antipsychotic agent Risperdal- but lacks an allowable diagnosis to support its use. The 4/16/24 recommendation has a physician's signature dated 5/8/24 with recommendations from the physician to Add Dx [diagnosis] of Hallucinations/ psychosis with dementia Review of the medical record indicated that the facility failed to enter the recommended diagnosis into the medical record. Review of the medical record indicated that on 5/8/24 the diagnosis Unspecified dementia, unspecified severity, with behavioral disturbance was added to the medical record of Resident #81. During an interview on 6/18/24 at 7:57 A.M., Nurse Unit Manager (#1) said that her process for managing MMRs completed by the consultant Pharmacist is to separate them by provider and place them in the physician communication books to be addressed. Once signed off by the Physician or Nurse Practitioner, either she or another staff nurse will institute the recommendations or orders. Nurse Unit Manager #1 said that their was a period of time that interim physicians were covering the facility and they would not sign off on the pharmacy recommendations. During an interview on 6/18/24 at 9:27 A.M., the Director of Nurses (DON) said that once the monthly consultant Pharmacist recommendations are completed they are emailed to the facility and dispersed to the appropriate units. The DON said that he would expect that within 7-10 days the recommendations are addressed and put into place and that the pharmacy recommendations for Resident #81 were not addressed timely or appropriately. The DON said that he was not aware physicians were not willing to address recommendations during a period of interim physician and Nurse Practitioner coverage in the facility, and if he knew he would have addressed it with them.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45763 Based on observation, policy review and interview, the facility failed to store and prepare food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure food was labeled, and that dented cans of food were not stored with usable cans. Findings include: Review of the facility's policy titled Dietary - Food Storage, dated February 2022, indicated the following: -It is the policy that storage of all food items will be stored in a sanitary environment and all food purchased will be stored in accordance with required temperatures and storage areas. -Any bulging, leaking, or dented cans which indicates food spoilage are not to be used and removed from the storage area. (sic.) -Prepared foods shall be kept covered, labeled with contents and dated. On 6/10/24 at 7:56 A.M., the surveyor made the following observations during the initial walkthrough of the kitchen: -A significantly dented can of ready-to-eat peppers on the can-rack in the dry-storage area. -A package of salami, opened, wrapped, but undated in the walk-in refrigerator. -A package of deli meat, wrapped and dated 5/12 in the walk-in refrigerator. The deli meat appeared pale, and had a pungent odor consistent with decay. -A package of deli meat, wrapped but unlabeled and undated in the walk-in refrigerator. -A package of deli meat wrapped, labeled turkey and dated 5/29 in the walk-in refrigerator. -A container labeled egg salad, wrapped and dated 6/5 in the walk-in refrigerator. -A gallon of milk, opened but undated in the walk-in refrigerator. -A bottle of orange juice, opened but undated in the walk-in refrigerator On 6/10/24 at 8:45 A.M., the surveyor made the following observations in the refrigerator of the third-floor unit: -Two bottles of orange juice, opened but undated. -A bottle of milk, opened but undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/24 at 9:00 A.M., the surveyor made the following observations in the refrigerator of the second-floor unit: -A bottle of apple juice, opened but unlabeled. -A bottle of cranberry juice, opened but undated. -A bottle of orange juice, opened but undated. -A bottle of milk, opened but undated. During an interview on 6/10/24 at 8:52 A.M., Nurse (#2) said all drinks stored in the unit refrigerators should be dated once opened. During an interview on 6/10/24 at 8:10 A.M., the Food Service Director (FSD) said all prepared and opened food and drinks, including milk, must be labeled and dated. The FSD said mayonnaise- based salads should be discarded after three days, and deli meat should be discarded seven days after opening. The FSD said cans of food must be checked when received and dented cans should not be placed on the rack, instead they should be set aside in his office to be returned to the vendor. The FSD also said that in addition to being checked when received, the can rack is checked every Monday for dented cans. The FSD said the can of peppers should not have been on the can rack. The FSD also said that the deli meats and egg salad should have been discarded. During an observation and follow-up interview on 6/11/24 at 7:33 A.M., the surveyor observed a significantly dented can of cranberry sauce on the can-rack in the dry-storage area. The FSD said the dented can of cranberry sauce must have been missed during Mondays weekly can check and must be set aside for the vendor. The FSD said juices should be dated when opened and discarded two days after they were opened.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation, interview, and record review the facility failed to provide rehabilitation services for one Resident (#53) out of a total sample of 26 residents. Specifically, the facility failed to evaluate a Resident's hand after a hand splint in place for limited range of motion was discontinued due to Resident refusals, and after the Nurse Practitioner documented that she was concerned about Resident #53's nails digging into his/her palm due to a possible hand contracture. Findings include: Review of the facility policy, titled Rehabilitation screen/referral - guideline, dated December 2023, indicated the following: -To screen the resident's functional and clinical status, determine the need for skilled rehabilitation intervention and/or to address problem-specific issues, rehabilitation screening and referrals may be requested, from nursing, therapy, family member and/or caregivers. The rehabilitation screen and referral form will be utilized as a communication tool between nursing and rehab for changes in the residents' status warranting a screening to determine if further assessment and or intervention is warranted as well as recommendations and clarification for resident's needs. -The rehabilitation screen is a brief professional review of the resident by observation, review of the medical record, interview of the resident, facility staff or family member. This does not require a physician's order. This is not a billable service, however, a referral to therapy may result directly in an evaluation and a screen may not be indicated. If further assessment is indicated during the screening process, then an evaluation is necessary. -A member of the rehabilitation team (registered and/or assistant) will complete the rehabilitation referral/screen to ensure clinically appropriate rehab services are provided to all residents. Screening information should be gathered through chart review, consultation with nursing, resident interview. -Upon review, the appropriate therapy discipline will make the determination if a comprehensive evaluation is indicated. This will be documented in the screening/referral form. -After the screen is completed, the resident will receive recommendations for skilled rehab services, or a follow up from nursing via the rehabilitation and screening and referral form. Therapist will sign and date upon completion of screen form. -Rehabilitation manager will review the screen outcome and assess for any further need or follow up with the therapist and/or nursing. -If it is determined that the resident can benefit from a comprehensive evaluation, the clinician will proceed with the evaluation request per facility procedures. Resident #53 was admitted to the facility in April 2021 with diagnoses including stroke and hemiparesis (a medical condition that causes weakness on one side of the body). (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 3/26/24, indicated that Resident #53 was unable to complete a Brief Interview for Mental Status exam as the Resident was rarely/never understood. The MDS further indicated that Resident #53 had impairment of range of motion on one side impacting both the upper and lower extremity. On 6/10/24 at 9:17 A.M., the surveyor observed Resident #53 in his/her room. Resident #53's right hand was tightly closed, and the Resident was not wearing a splint. Review of Resident #53's care plans indicated the following: The resident had a cerebral vascular accident (CVA/stroke) affecting; Right Hemiparesis, Swallowing Issues, Falls, Receptive and Expressive Aphasia, with the following intervention: -Monitor/document mobility status. If resident is presenting with problems or paralysis, obtain order for Physical Therapy and Occupational therapy to evaluate and treat. -The resident has potential for pressure ulcer development related to incontinence, limited mobility, HTN (hypertension), PAD (peripheral artery disease), [NAME] (a pressure sore risk evaluation scale) score less than 15, CVA with left hemi (hemiparesis) refused to wear splint OT gave her. -Resident refused to wear the black wrist and finger splint given to her by OT (occupational therapy), initiated 7/7/23 -The resident has potential for pressure ulcer development. -The resident requires hand splints, initiated 8/1/23. Review of Resident #53's OT (Occupational Therapy) Discharge Summary, dated 5/4/23, indicated the following goals: Short term goal #1.0 - met on 5/9/23. Patient will tolerate wearing splint/orthotic 70 percent of the recommended scheduled time daily, discharge (5/9/23) good tolerance to wearing his/her splint. Short term goal #2.0 - met on 5/9/23. OT to complete written instructions for caregivers and patient to follow for wearing schedule/how to don and doff orthotic right wrist, discharge (5/9/23) caregivers nursing managers are carrying over the recommended orthotic wearing schedule. Review of the OT readmission screening form, dated 10/14/23, indicated that Resident #53 did not have a change in condition or safety status, a need to modify or create a functional maintenance program, or a potential for the Resident to decline further without intervention. The readmission screening form indicated that therapy evaluation was not indicated. Review of Resident #53's physician orders indicated the following discontinued order: (continued on next page)

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	225318	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Splinting Schedule Black tone inhibition Splint OT has completed education to Nurse manager for the floor on how to don and doff the splint /orthotic Requesting Nursing / CNA staff have the patient put on and wear the Black wrist and finger splint for TWO HOURS during day shift take off after two hours and check skin condition, discontinued on 2/15/24. Further review of the physician's orders failed to indicate an active order for rehab services to evaluate Resident #53. Review of the Nurse Practitioner's (NP) progress note, dated 5/16/24, indicated Resident #53's hand was contracted and that the Resident's nails were applying pressure to his/her palm. Further review of the progress note indicated that the NP would have orthotic evaluate Resident #53 for a hand splint. Review of Resident #53's medical record failed to indicate the Resident was evaluated by the orthotic's service that the NP consulted. During an interview on 6/13/24 at 8:26 A.M., the NP said that on 5/15/24 she had evaluated Resident #53 and was concerned that the Resident's hand was contracted. The NP said that she had consulted an orthotics service from outside of the facility to evaluate the Resident for a splint, the NP said she wanted something in place to keep the Resident's hand open to promote skin integrity and avoid progression of the possible contracture. The NP said that the contracted orthotics provider had come out on 5/29/24, but had not evaluated Resident #53, the NP said she became aware on the weekend following the 5/29/24 visit, that the Resident had not been evaluated. The NP said that insurance often denied therapy services for residents admitted for long-term care so she kind of gave up placing orders for in-house therapy evaluations. During an interview on 6/17/24 at 11:21 A.M., the Consulting Orthotic Provider said the NP consulted him to evaluate Resident #53 for a splint because she was concerned about a hand contracture. The Consulting Orthotic Provider said he had planned to see Resident #53 on 5/29 when he was in the building but that he had forgotten to do so and had not evaluated the Resident. During an interview on 6/13/24 at 8:19 A.M., Nurse #2 said that if the NP had a concern about limited range of motion and made a recommendation for a resident to be evaluated by rehabilitation services that an order would be placed, and that this would be communicated to the rehabilitation department. During an interview on 6/13/24 at 8:52 A.M., the Director of Rehab Services (DOR) said residents were screened for the need for rehabilitation services quarterly, and on readmission from the hospital. The DOR said therapy staff were constantly on the floor observing for resident's need of services, and that if nursing determines a resident would benefit from evaluation that they would communicate this to the rehab department. The DOR said that if the NP had a recommendation for an evaluation that the NP would place an order; the DOR also said she reviews the NP and MD notes daily. The DOR said that if a resident who had a splint put in place began refusing/not tolerating the splint that this would prompt an OT evaluation for the purpose of exploring an alternate method for protecting the skin and promoting the ability for staff to provide hygiene. The DOR said the NP had not reached out about her concern regarding Resident #53, and that the NP had not placed an order for evaluation. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/24 at 9:42 A.M., the Occupational Therapist said that he had worked with Resident #53 in May of 2023 and that the Resident was discharged from therapy services with a hand splint; the Occupational Therapist said that at that time nursing staff was educated regarding the Resident's splint and that an order was in place. The Occupational Therapist said that in order to address Resident #53's splint refusals or explore alternatives that he would need to evaluate the Resident, and that he had not evaluated the Resident for his/her splint or splint alternative since May of 2023. During a follow-up interview on 6/13/24 at 10:45 A.M., the Occupational Therapist said he had not been notified that Resident #53 was refusing his/her hand splint, and that there were alternatives that could be trialed for Resident #53. During an interview on 6/13/24 at 11:03 A.M. the Regional Rehabilitation Staff said the goal would be to maintain range of motion and skin integrity and that when a resident refuses a splint that the resident should be evaluated for an alternative such as a rolled-up face cloth. During an interview on 6/17/24 at 12:50 P.M., Unit Manager #2 said that if a resident begins refusing an orthotic device, such as a splint, that the physician and rehabilitation services must be notified promptly. Unit Manager #2 said that she would have expected whoever discontinued Resident #53's splint order to follow up with the physician and rehabilitation services. Unit Manager #2 said Resident #53's splint had been used to prevent a contracture which the Resident was at risk for due to his/her diagnosis of hemiparesis. During a follow-up interview on 6/18/24 at 7:28 A.M., the DOR said there was not always enough staffing to cover the needs of the building, and that the screening conducted by the OT on 10/24/23 could have prompted an evaluation for the hand splint refusal.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45763 Based on records reviewed and interviews the facility failed to ensure nursing maintained an accurate medical record for one Resident (#35) out of a sample of 26 residents. Specifically, for Resident #35 nursing documented they obtained blood pressure from his/her right arm when they did not. Findings include: Resident #35 was admitted to the facility in January 2024 with a diagnosis of end stage renal disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/26/24, indicated that Resident #35 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating Resident #35 had moderate cognitive impairment. The MDS further indicated Resident #35 received dialysis treatment. Review of Resident #35's active physician orders indicated the Resident had a fistula in his/her right arm. Review of Resident #35's care plans indicated the Resident received Hemodialysis three times a week and had a right arm fistula with the following intervention: -Do not draw blood or take blood pressure in arm with graft. On 6/10/24 at 9:17 A.M., the surveyor observed a sign above Resident #35's bed indicating that blood draws and blood pressure readings should not be taken from his/her right arm. Review of Resident #35's blood pressure readings indicated nursing obtained his/her blood pressure using his/her right arm on the following dates: 3/25/24, 4/3/24, 4/5/24, 4/8/24, 4/14/24, 4/17/24, 4/19/24, 4/22/24, 4/24/24, 4/26/24, 4/28/24, 4/29/24, 5/1/24, 5/3/24, 5/10/24, 5/13/24, 5/15/24, 5/17/24, 5/19/24, 5/20/24, 5/22/24, 5/25/24, 5/29/24, 5/31/24, 6/2/24, 6/3/24, 6/9/24, 6/12/24, 6/16/24. During an interview on 6/11/24 at 8:45 A.M., Resident #35 said staff never take blood pressure readings from his/her right arm, and that staff only use his/her left arm for blood pressure readings. During an interview on 6/11/24 at 11:23 A.M., Nurse Unit Manager (#1) said that Resident #35's right arm was not used for blood pressure readings, and that she had documented that she measured the blood pressure using the right arm in error. During an interview on 6/11/24 at 11:30 A.M., Nurse (#2) said blood pressure readings should not be taken using Resident #35's right arm and that she had documented that the readings were taken using the right arm in error. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 7:23 A.M., Nurse (#3) said blood pressure readings were not taken from Resident #35's right arm, and that she had documented that the readings were taken from the right arm in error. During an interview on 6/11/24 at 11:33 A.M., The Director of Nursing (DON) said his expectation was that nurses accurately document which arm the blood pressure was taken from, and that documentation should reflect exactly what was completed by nursing.