STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225322	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sachem Center for Health and Rehabilitation	66 Central Street East Bridgewater, MA 02333

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 43935 Based on review of Resident Council Minutes, resident and staff interviews, and policy review, the facility failed to ensure staff documented, addressed, and promptly resolved concerns brought forward during Resident Council Meetings held from 8/7/23 through 1/12/24. Findings include: Review of the facility's policy titled Resident Council, undated, indicated but was not limited to the following: - the purpose of Resident Council is to provide a forum for: discussions of concerns and suggestions for improvement, consensus building and communication between the residents and facility - a Resident Council response form will be utilized to track issues and their resolutions, the facility department related to any issues will be responsible for addressing items of concern Review of the Resident Council Meeting Minutes, dated 8/7/23, indicated but were not limited to the following: Nursing: - Nursing staff are often talking on their phones in their native language during care with residents. - Certified Nurse Assistants (CNAs) chatting very loudly in the halls with each other throughout the night, residents are requesting consideration. Review of the Resident Council Meeting Minutes, dated September, indicated but were not limited to the following: Dietary: - No diet cola or diet ginger ale on the units Nursing: (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Nursing improvement on call light response times and wearing name tags There was no evidence this was a voiced concern by the Resident council the prior month. There was no indication that the concerns of nursing staff speaking on the phone in their native language were addressed or responded to, nor was a response documented regarding the staff chatting loudly in the halls throughout the night. Review of the Resident Council Meeting Minutes, dated 10/27/23, indicated but were not limited to the following: Dietary: - Wrong salad dressings coming up on trays, receiving Italian when the preference is Ranch. There was no response or follow up documented regarding the lack of diet cola or ginger ale on the units. Nursing: - Starting to answer call lights in a timely manner - Nursing improvement on getting residents up in time for morning activities. There was no evidence this was a voiced concern by the Resident Council the prior two months. Housekeeping: - Housekeeping moving furniture to clean the floors. Residents are requesting Housekeeping ask permission before rearranging their furniture. Review of the Resident Council Meeting Minutes, dated 11/12/23, indicated but were not limited to the following: Dietary: There was no indication the residents' concerns of not receiving the correct salad dressings were addressed. Nursing: - Nursing improvement in call light response times, wearing name tags, and getting residents up on time for activities. There was no evidence that these were voiced concerns, only documentation speaks to improvement, in the prior two months. Housekeeping: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no response to the prior month's concern or any documentation under the Housekeeping section of the meeting minute notes. Review of the Resident Council Meeting Minutes, dated 12/28/23, indicated but were not limited to the following: Nursing: - Starting to answer call lights in a timely manner and residents are being washed up in time for activities. There was no documentation of these concerns that were previously voiced in Resident Council in the prior three months. - Improvement with talking on the phone in other languages while providing direct care with residents. This is a follow up to a concern voiced by the Resident council in August 2023, four months prior to a documented resolution. Housekeeping: - Housekeeping has been asking prior to moving residents' furniture when cleaning the floors. This was follow up to a concern voiced by the Resident council in October 2023, two months prior to a documented resolution. Overall: Residents appreciate the nighttime staff making improvements to make it quieter at later hours of the night. This was a follow up to a concern voiced by the Resident Council in August 2023, four months prior to a documented resolution. Review of the Resident Council Meeting Minutes, dated 1/12/24, indicated but were not limited to the following: Dietary: - More diet cola has been ordered for the units This was a follow up to concern voiced by the Resident Council in September 2023, four months prior to a documented resolution. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/31/24 at 10:00 A.M., the surveyor held a Resident Group meeting with 11 residents in attendance. The residents said they felt their concerns were not addressed timely and they were not ever aware of any follow up occurring on the facility side. They said they bring things up in the meeting repeatedly for numerous meetings and when there was no resolution, they become frustrated and stop mentioning things they feel need improvement. They said if something is improved upon the improvement was not sustained and it did not seem to them as though the facility was paying attention to their concerns. The Resident Council said they were unaware of what the meeting minutes indicated and the Resident Council President said he/she had not ever had the opportunity to read and review the meeting minutes and felt it would be helpful. During an interview on 2/1/24 at 8:27 A.M., the Activity Director (AD) said the process for Resident Council is she takes attendance and then goes over the previous month's concerns. Upon reviewing the Resident Council Meeting Minutes from 8/7/23 through 1/12/24, she said she was unsure when any concerns were brought forward as the timeline for the initiation of a concern was unclear and not always documented in the meeting minutes, but the minutes indicated improvements and ongoing work. She said she discusses the meeting minutes with the administrator and interdisciplinary team the next day at morning meeting and they were notified of the concerns verbally and if they requested, they could receive a copy of the meeting minutes. She said she did not provide the departments with any documentation of a concern or receive any documentation back for the resolution of a concern, but if something was at the level of a grievance she would complete a grievance form and forward it to the appropriate department head. During an interview on 2/1/24 at 9:22 A.M., the Activities Director reviewed the Resident Council policy and said she did not use the Resident Council response forms and that may be a factor in why there is no documentation to show when concerns are brought forward, disseminated to the respective department heads or resolved. She said the policy for Resident Council was not being followed in that regard and the process could be improved.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49425 Based on interviews, record review, and policy review, the facility failed to notify the physician and the Resident's responsible party about a change in condition, specifically a significant weight loss of 10.95% in one month, and to re-evaluate the potential need to alter the treatment plan for one Resident (#71), out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Weight Measurement, dated as revised February 2022, included but was not limited to: - Residents with a weight variance of 5% more or less than the previous month will be re-weighed. - The charge nurse will notify the physician, responsible party and dietician when a 5% more or less variance is noted. Review of the facility's policy titled Change in a Resident's Condition or Status, undated, indicated but was not limited to the following: - Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition - The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental conditioning - Significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and requires interdisciplinary review and/or revision to the care plan Resident #71 was admitted to the facility in June 2023 with diagnoses including: dysphagia (difficulty swallowing), hemiparesis (weakness of one side of the body), hypertension (high blood pressure), and diabetes type II. Review of the Minimum Data Set (MDS) assessment, dated 12/19/23, included but was not limited to the following: -Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the Resident was cognitively intact. -Section K of the MDS, which indicated swallowing/nutritional status, and triggered for weight loss of 5% or more in the last month or 10% or more in the last 6 months. -Section K also indicated that Resident #71 was not on a prescribed weight loss regimen. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #71's health care proxy (HCP) was invoked on 8/16/23 due to an acute change in condition experiencing hallucinations and remained invoked at the time of survey. Review of the medical record indicated the following weights for Resident #71: - 11/07/23: 210 pounds (lbs.) - 12/05/23: 187 lbs. - 12/06/23: 187 lbs. - 12/07/23: 187 lbs. (loss of 10.95% in one month) - 12/08/23: 188.2 lbs. - 01/07/24: 184.8 lbs. Review of Resident #71's weights from 11/07/23 to 12/07/23 indicated a significant weight loss of 10.95%. Review of Resident #71's Progress Notes, dated 12/1/23 through 2/2/24, failed to indicate any documentation of notification of the significant weight loss to the Physician, Nurse Practitioner, Dietitian, or HCP. During an interview on 2/2/24 at 11:11 A.M., Nurse #9 said if there are any changes in a resident's weight of three pounds they will obtain daily weights for three days. If the three weights demonstrate the loss or gain is accurate, it is reported to the MD or Nurse Practitioner and the Director of Nursing (DON). Nurse #9 reviewed the record and was unable to locate any documentation the weight loss had been reported to the MD, Nurse Practitioner, HCP, or Director of Nurses. During an interview on 2/6/24 at 3:36 P.M., the HCP for Resident #71 said she was unaware of any weight loss, as no one from the facility had notified her. She said she visits often, and it had never been brought to her attention, prior to the surveyor contacting her. During an interview on 2/6/24 at 3:41 P.M., the Dietitian said he was aware of the significant weight loss. The Dietitian said he had not made recommendations or notified the provider of Resident #71's significant weight loss. During an interview on 2/6/24 at 4:27 P.M., the DON said she was not aware of Resident #71's significant weight loss and the Resident was not followed at the weekly risk meeting. She said her expectation was for the physician, HCP, and dietitian to be notified of any significant weight loss, per facility policy, and it was not followed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43935 Based on document review, policy review, and interviews, the facility failed to maintain a grievance process that supported the resident's right to formulate grievances anonymously and consistently document a resolution with acknowledgement. The total sample was 21 residents. Specifically, the facility failed to: 1. Have information on how to file a grievance in resident care and public areas and have forms accessible, so residents and/or visitors were able to anonymously notify the facility of their concerns; and 2. Document evidence of a concern of missing items being resolved with an acknowledged by the complainant for Resident #14. Findings include: Review of the facility's policy titled Administration, Grievance Policy, undated, indicated but was not limited to the following: - The facility will support the resident/responsible party to voice grievances/concerns regarding treatment, care, management of funds, lost articles and any violation of resident rights. - The resident/responsible party can bring forward their concerns verbally or by the written grievance process - Grievance forms are available on the nursing units and in the front lobby where applicable. - Upon receipt of the completed form the social worker will follow up with the person who filed the grievance and discuss the resolution and have the complainant sign or verbally acknowledge that they are in agreement with the issue being resolved. 1. During an initial tour of the facility on 1/30/24, the surveyors did not observe the availability of grievance/concern forms on any of the three nursing units or in any resident common areas throughout the facility. During an interview on 1/31/24 at 9:30 A.M., the Social Worker said she was the grievance officer and responsible for maintaining the grievance and missing items forms and ensuring they were complete. On 1/31/24 at 9:54 A.M., the surveyor observed a sign posted on the main bulletin board beside the large resident dining room on the first floor main hallway that said: Attention all residents and family members grievance forms are located at the nurses' stations. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/31/24 at 10:00 A.M., the surveyor held a Resident Group Meeting. The residents said they could not locate grievance forms on their units and grievance forms or missing item forms can only be completed if the Social Worker was available. They said no one else helped them with the process. On 2/1/24 at 9:26 A.M., the surveyor again observed the posted sign in the first floor main hallway indicating grievance forms were located at the nurses' stations. However, throughout the tour of the Passport, Joppa, and Sachem unit there were no forms or holders for grievance forms available at the nurses' stations for residents or their families to access anonymously without having to notify staff. During an interview on 2/2/24 at 1:50 P.M., the Social Worker said the grievance process allows residents or their responsible parties to communicate grievances verbally or in writing and the resident and/or their family could request a form from staff or request staff assist them with a written form as necessary. She said the forms are available behind the nurses' stations and on her office door in the basement (a non-resident area). The residents would have to request a form from staff to complete. She said grievance forms are not left available in the lobby as the policy indicates. She said the residents should be able to complete a grievance form anonymously or without notifying staff, but since they don't have access to the forms at this time they cannot and the process needed to change. 2. On 1/31/24 at 10:00 A.M., the surveyor held a Resident Group Meeting with 11 residents in attendance. The residents said missing items are a rampant problem at the facility. Resident #14 said he/she had experienced many missing items concerns and the concerns don't seem to be taken seriously or investigated thoroughly and go without resolution. During an interview on 1/31/24 at 11:07 A.M., the Social Worker said the missing items process follows the grievance process and she adjusted the form for ease of use and maintains a separate book for these concerns for organizational purposes. She said she investigates all missing items and brings a resolution forward to the residents and does the best she can to resolve the issue. Review of the Missing Items Documentation Form, undated, included the following: - Date of report - Person filling out report - Description of missing items - When was item last seen and by whom - Summary of investigation - Resolution - Administrator review The form does not have an area indicating the resolution was communicated, to whom, when, and/or if the Resident agrees that the concern is resolved. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the missing items book provided by the Social Worker indicated Resident #14 had a missing items form completed on 4/11/23, that indicated but was not limited to the following: - Description of missing items: black metal rosary beads, rose ankle socks, two lipsticks in a black tube with flowers on it: one shade pink, one shade poppy - When was item last seen and by whom: a few days ago by the resident - Summary of investigation: activities and social worker looked on 4/11/23 - Resolution: items not inventoried, lipsticks could be used, interventions in place for the resident The form failed to indicate that Resident #14 was made aware of the investigation outcome, or a resolution to the missing items. During an interview on 2/2/24 at 1:50 P.M., the Social Worker reviewed the missing items documentation form for Resident #14. She said the items were not found or located on the inventory sheet for the Resident. She said she believed the Resident was encouraged to use his/her lock box, but that the lock boxes were small, maybe six inches long by four inches wide, and could not hold much. She said this Resident had many issues with missing items and there were some conversations about getting the Resident a larger lock box, but there was no documentation to demonstrate that occurred or that the Resident was made aware of the resolution to the grievance. She said the process and forms need to change to capture all the required information.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49424 Based on observation, interview, and record review, the facility failed to protect one Resident's (#33) right to be free from neglect. Specifically, for Resident #33, the facility failed to respond to requests for pain medications for at least 75 minutes for a Resident with a Stage 4 pressure injury (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle tendon, ligament, cartilage, or bone) of the sacral region. Findings include: Review of the facility's policy titled Abuse, dated March 2023, indicated but was not limited to the following: -Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Resident #33 was admitted to the facility in April 2022 with diagnoses which included but were not limited to osteomyelitis (infection of the bone) and a Stage 4 pressure injury of the sacral region. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/17/24, indicated Resident #33 had intact cognitive function as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of the January 2024 Physician's Orders included the following pain medication: -Dilaudid Oral Tablet 2 MG give 1 tablet by mouth every 12 hours as needed for pain On 1/31/24 at 7:10 A.M., the surveyor observed Resident #33 request pain medication from Nurse #4. The surveyor observed Nurse #4 tell Resident #33 that he/she would have to wait because the breakfast meal was on the way up from the kitchen. The surveyor observed the Resident shifting his/her weight in the wheelchair, had a furrowed brow, and was grimacing. The surveyor observed the Resident tell Nurse #4 that he/she was in a lot of pain. On 1/31/24 at 7:18 A.M., the surveyor observed Unit Manager #2 tell Nurse #4 to give Resident #33 his/her pain medication. Nurse #4 responded the breakfast trays were going to be on the unit shortly. On 1/31/24 at 7:18 A.M. through 7:58 A.M., the surveyor observed Nurse #4 distribute breakfast trays, feed a resident breakfast, provide cigarettes to the Maintenance Assistant for residents who were going out to smoke. On 1/31/24 at 7:59 A.M., the surveyor observed Nurse #4 engage in non-resident related conversation with Unit Manager #2. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/31/24 at 8:03 A.M., the surveyor observed Nurse #4 get water for another resident. During an interview on 1/31/24 at 8:09 A.M., Nurse #4 said Resident #33 had requested pain medications before breakfast, and she was going to give the requested medication with his/her morning medication. She said she was not supposed to give medications or take vital signs during breakfast. On 1/31/24 at 8:17 A.M., the surveyor observed Resident #33 yell out from his/her room What is taking so long? I'm in so much pain and so sore, I asked for pain medication a while ago. Nurse #4 responded, I know, I'm coming. On 1/31/24 at 8:23 A.M., the surveyor heard Resident #33 yelling out Please, I'm in pain! On 1/31/24 at 8:25 A.M., the surveyor observed Nurse #4 give Resident #33 the requested pain medication. The surveyor observed Resident #33 wait at least 75 minutes for the requested pain medication. During an interview on 1/31/24 at 8:26 A.M., the Resident said he/she asked for pain medications before breakfast and had been in pain since he/she got out of bed at 5:30 A.M. Resident #33 said his/her pain was a 9 out of 10 (on a pain scale of 1-10 with 10 being the worst pain) and if it was any higher he/she would have to go to the hospital. During a telephone interview on 1/31/24 at 3:18 P.M., Unit Manager #2 said she did hear Resident #33 request pain medication and she had told Nurse #4 to give the medication to Resident #33 since he/she was in pain. She said her expectation was that the Nurse would have administered the medication when requested, as she was told because the Resident was in pain. During an interview on 1/31/24 at 3:27 P.M., the Director of Nurses (DON) said her expectation was that the Resident would have received his/her medication when they asked and not have to wait until after breakfast to receive his/her requested pain medication since Resident #33 was in pain. During an interview on 2/1/24 at 7:15 A.M., Resident #33 said he/she was in pain and was waiting for pain medication that was requested an hour ago and that he/she did not know why it was taking so long. On 2/1/24 at 7:25 A.M., the surveyor observed Nurse #5 tell the Assistant Director of Nurses (ADON) that he/she was waiting for the next nurse to come relieve her and only one additional resident needed medication and indicated which resident (not Resident #33). On 2/1/24 at 7:39 A.M., the surveyor observed Nurse #5 give Resident #33 the requested pain medication at least 24 minutes after he/she asked for it. During an interview on 2/1/24 at 4:36 P.M., the DON said that she met with Resident #33 who told her that he/she had a lengthy delay (over an hour) for pain medication administration on 1/31/24 and 2/1/24 and on 1/31/24 the Resident said he/she was told to wait for the medication until after breakfast. The DON said the Resident should not have to wait for pain medication. The DON said the incident did meet the definition of neglect. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/1/24 at 4:48 P.M., the ADON said these two incidents with Resident #33 met the definition for neglect. Refer to F607, F609, F610, F697

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43935 Based on record review, policy review, and interview, the facility failed to ensure an abdominal binder (an elastic compression belt-like device that encircles the abdomen) was assessed as a potential restraint for one Resident (#48), out of a total sample of 13 residents. Findings include: Review of the facility's policy titled Use of Restraints, undated, indicated but was not limited to the following: - Restraints shall be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully - When the use of a restraint is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation of the need for the restraint will be documented - Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body - Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to: treat a medical symptom, protect the resident's safety, and help the resident attain the highest level of his/her physical or psychosocial well-being - Prior to placing a resident in restraints, there shall be a pre-restraint assessment and review to determine the need for restraint. The assessment shall be used to determine underlying cause of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms - Restraints should only be used upon the written order of a physician and after obtaining consent from the resident or their representative Resident #48 was admitted to the facility in December 2023 and had the following diagnoses: dysphagia (difficulty swallowing) and metabolic encephalopathy (an alteration in brain chemistry). Review of the Brief Interview for Mental Status (BIMS), dated 3/4/24, indicated Resident #48 was cognitively intact with a score of 14 out of 15. The Resident's healthcare proxy (HCP) was activated in December 2023 and remained active for medical decisions at the time of survey (3/7/24). Review of the current Physician's Orders for Resident #48, dated 3/7/24, indicated but were not limited to the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Abdominal binder at all times, remove for care and skin checks. Check placement three times a day. (2/20/24) Review of the medical record for Resident #48 failed to indicate: -the abdominal binder had been assessed as a potential restraint or any alternative had been trialed or considered prior to the use of the abdominal binder; and -a written or verbal consent had been received by Resident's HCP prior to the use of the restraint. During an interview on 3/7/24 at 10:48 A.M., Family Member #1 said Resident #48 had an abdominal binder in place while on medical leave from the facility from 2/23/24 through 2/28/24. She said Resident #48 frequently plays with and attempts to self-remove his/her G-tube. She said she has inquired about the use of the abdominal binder since the Resident returned to the facility on [DATE]. Review of the current care plans for Resident #48 indicated, but were not limited to the following: Problem: Initiated: 2/5/24 Resident has a behavior problem attempting to pull out feeding tube (G-tube); at times pulls on the G-tube (revised: 2/29/24) Goal: Initiated: 2/5/24 Resident #48 will have fewer episodes of attempting to pull out feeding tube (revised: 2/6/24) Interventions: Initiated: 2/5/24 Administer medications as ordered; explain procedures to the resident and provide time to adjust; if reasonable discuss the resident's behavior and explain why it is inappropriate; intervene as necessary - approach in a calm manner and divert attention Problem: Initiated: 12/31/23 Resident #48 has dysphagia (revised: 1/5/24) Goal: Initiated: 12/31/23 Resident will be free from signs or symptoms of aspiration (the drawing of fluid into the lungs) (revised: 1/15/24) Interventions: G-tube care Q-shift (1/25/24) Abdominal (ABD) Binder at all times to avoid resident from pulling at the g-tube. May remove for care, monitor skin for breakdown with care (2/20/22) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the February 2024 Treatment administration record (TAR) for Resident #48 indicated, but was not limited to the following: - Abdominal binder at all times, remove for care and skin checks, check placement three times a day (2/20/24) was signed off as being in place by the licensed nurses on the following days: 2/20/24, 2/21/24, 2/23/24 (9:00 A.M. only), 2/28/24 (5:00 P.M. only), and 2/29/24 - On 2/23/24 from 1:00 P.M., through 2/28/24 at 1:00 P.M. the Resident was documented as being unavailable related to their hospitalization The TAR failed to indicate the Resident was monitored for or exhibited any behaviors of attempting to self-remove or pulling at the G-tube throughout the month of February 2024 Review of the March 2024 TAR for Resident #48 indicated, but was not limited to the following: - Abdominal binder at all times, remove for care and skin checks, check placement three times a day (2/20/24) was signed off as being in place by the licensed nurses on the following days: 3/1/24 at 1:00 P.M. and 5:00 P.M. only, 3/2/24 all three scheduled times, 3/3/24 all three scheduled times, 3/4/24 at 9:00 A.M. and 5:00 P.M., 3/5/24 all three scheduled times, 3/6/24 at 5:00 P.M. The TAR failed to indicate the Resident was monitored for or exhibited any behaviors of attempting to self-remove or pulling at the G-tube from March 1st through March 7, 2024 During an interview on 3/7/24 at 2:33 P.M., Physician #1 said he provided the facility with an order to use an abdominal binder on the Resident since the Resident has behaviors and pulls at their G-tube to help preserve the tube and maintain the Resident's safety. He said the Resident was successful in removing their G-tube on 2/23/24 and was hospitalized and upon the Resident's return he continued to order for the abdominal binder to be used at all times to prevent the Resident from harming themselves and removing their G-tube. He said he is unaware of the facility process to determine if an alternative device or intervention could be tried or has been assessed. He said it is the facility's responsibility to ensure the behaviors are monitored and they evaluate the use of the device and the Resident's tolerance to the device and would expect that they followed their policies. He said to the best of his knowledge Resident #48 wears the abdominal binder and he has not been contacted to say the Resident cannot tolerate the device. He said he felt at this time to protect the Resident if the HCP is agreeable the abdominal binder would likely be the best option to ensure the integrity of the G-tube if the Resident is attempting to self-remove it. He said his expectation is that the facility communicates if there is a problem. Review of the daily skilled notes and progress notes for Resident #48 from 2/12/24 to current (3/7/24) indicated but were not limited to the following: - 2/12/24 at 6:32 A.M., Resident tugging at G-tube while feeding is running, redirection not successful - 2/21/24 at 2:18 A.M., Resident received new order for abdominal binder at all times. Remove for care and skin checks. Check placement three times a day (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/21/24 at 3:47 P.M., Resident continues to pull at G-tube causing leakage, abdominal binder ordered and tolerated - 2/22/24 at 2:43 P.M., Abdominal binder in place - 2/23/24 at 8:35 A.M. To emergency room (ER) for G-tube replacement - 2/24/24 at 1:49 P.M., Resident sent toER on [DATE] to have G-tube replaced after he/she pulled it out - 3/1/24 at 11:14 A.M. (Administration note) Abdominal binder at all times - will not keep in place The daily skilled notes and progress notes from 2/12/24 to 3/7/24 failed to indicate alternatives were attempted prior to the use of the abdominal binder or that the Resident exhibited any behaviors involving pulling at the G-tube or trying to remove the G-tube with the exception of the above notations. During an interview on 3/7/24 at 3:45 P.M., Nurse #4 said she didn't realize the abdominal binder could be considered a restraint until after she reviewed the facility policy definition of a restraint, but it could be a restraint and the facility should have completed a physical restraint assessment and documented the Resident's tolerance to the device. She said she didn't realize the order for the binder was still in place and written to be at all times. During an interview on 3/7/24 at 3:47 P.M., Nurse #1 said on review of the facility policy the abdominal binder does meet the definition of a potential restraint and the facility should have completed a physical restraint assessment for the Resident at the time the order was received and upon re-admission to the facility following the Resident's hospitalization . He said the device should be monitored to determine if the Resident can tolerate the device and self-remove the device and although he believes the Resident could likely remove the device on review of the medical record, he did not see that information documented anywhere. During an interview on 3/7/24 at 3:58 P.M., the Director of Nurses (DON) said Resident #48 had an order for an abdominal binder to be in place at all times due to the Resident having behaviors of pulling on the G-tube. She said the order was received prior to the Resident being hospitalized for self-removing their G-tube and remains active at this time. She reviewed the facility policy for restraint use and said the abdominal binder should have been assessed to determine whether it was a restraint for the Resident, as the binder does meet the definition of a potential physical restraint. She said the binder would likely be a restraint for the Resident but since she doesn't have an assessment done it's hard to tell. She said the policy for restraint use was not followed as it should have been and her expectation is that facility policies are followed. She said she would look to see if she had any other information on the Resident's use of the abdominal binder and whether it was considered a restraint for the Resident and get back to the survey team. During a follow up interview on 3/7/24 at 5:02 P.M., the DON said there was no documentation on an assessment of the device for Resident #48 to determine whether it was a restraint.

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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.

49424

Based on observation, policy review and interview, the facility failed to ensure staff implemented the facility's abuse policy for one Resident (#33), out of a total sample of 21 residents. Specifically, the facility failed to implement their policy for reporting and investigating an allegation of neglect for Resident #33 who was in pain and not administered pain medications for over an hour.

Findings include:

Review of the facility's policy titled Abuse, dated March 2023, indicated but was not limited to the following:

-Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated and reported.

-Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

-Reporting timeline requirements for all allegations 2-hour requirement to report to the Department of Public Health and Local Law Enforcement.

-Facility investigation will be completed within 72 hours of the incident, documentation of investigation to be: completing an Incident and Accident report, obtaining statements from identified potential witnesses, completing necessary evaluations (pain, skin, body checks), and maintaining a timeline of events.

Resident #33 was admitted to the facility in April 2022 with diagnoses which included but was not limited to osteomyelitis (infection of the bone), Stage 4 pressure ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone) of sacral region.

Review of the most recent Minimum Data Set (MDS) assessment, dated 1/17/24, indicated Resident #33 had intact cognitive function as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15.

On 1/31/24 at 7:10 A.M., the surveyor observed Resident #33 request pain medication from Nurse #4. The surveyor observed Nurse #4 tell Resident #33 that he/she would have to wait because the breakfast meal was on the way up from the kitchen. The surveyor observed the Resident shifting his/her weight in the wheelchair, had a furrowed brow, and was grimacing. The surveyor observed the Resident tell Nurse #4 that he/she was in a lot of pain.

On 1/31/24 at 7:18 A.M., the surveyor observed Unit Manager #2 tell Nurse #4 to give Resident #33 his/her pain medication. Nurse #4 responded the breakfast trays were going to be on the unit shortly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/24 from 7:18 A.M. through 8:09 A.M. the surveyor observed Nurse #4 to be on the unit and not administering pain medication to Resident #33. During an interview on 1/31/24 at 8:09 A.M., Nurse #4 said Resident #33 did request pain medications before breakfast and she was going to give the requested medication with his/her morning medication. On 1/31/24 at 8:17 A.M., the surveyor heard Resident #33 yell out from his/her room What is taking so long? I'm in so much pain and so sore, I asked for pain medication a while ago. At 8:23 A.M., the surveyor heard Resident #33 yelling out Please, I'm in pain! At 8:25 A.M., the surveyor observed Nurse #4 give Resident #33 the requested pain medication. The surveyor observed that Resident #33 waited at least 75 minutes for their requested pain medication. During an interview on 1/31/24 at 8:26 A.M., the Resident said he/she asked for pain medications before breakfast and has been in pain since he/she got out of bed at 5:30 A.M. Resident #33 said his/her pain was a 9 out of 10 (on a pain scale of 1-10 with 10 being the worst pain) and if it was any higher he/she would have to go to the hospital. During an interview on 2/1/24 at 7:15 A.M., Resident #33 said that he/she asked for pain medications from the night nurse an hour prior and had not received them. On 2/1/24 at 7:25 A.M. the surveyor observed Nurse #5 tell the Assistant Director of Nurses (ADON) that she was waiting for the next nurse to come relieve her and only one additional resident needed medication and indicated the Resident (which was not Resident #33). On 2/1/24 at 7:39 A.M., the surveyor observed Nurse #5 give Resident #33 the requested pain medication, at least 24 minutes after he/she asked for it. During an interview on 2/1/24 at 4:36 P.M., the Director of Nurses (DON) said she had met with Resident #33 who told her he/she had a lengthy delay (over an hour) for pain medication administered on 1/31/24 and 2/1/24 and on 1/31/24 the Resident said he/she was told to wait for the medication until after breakfast. The DON said the Resident should not have to wait for pain medication. The DON said she had not initiated an investigation into Resident #33 not receiving pain medication when requested. The DON said that the incident did meet the definition of neglect. During an interview on 2/1/24 at 4:48 P.M., the ADON said these two incidents with Resident #33 met the definition for neglect. During an interview on 2/2/24 at 3:08 P.M., the Social Worker said that she was informed of the two events with Resident #33 not receiving medication when asked. She said that she would leave it up to the DON to investigate and follow the facility abuse policy since she was already aware. During an interview on 2/6/24 at 3:25 P.M., the Administrator said neither incident of Resident #33 waiting for pain medications were neglect because there was no willful intent. He was unable to provide any investigative information for how the facility came to this conclusion. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/24 at 3:25 P.M., the DON said the first incident on 1/31/24 was not neglect because the nurse did not administer the medication because she misunderstood about giving medications during mealtimes and the second incident on 2/1/24 was being reviewed. She said there were no investigations available for either incident and neither incident had been reported to the Department of Public Health. At the time of the survey team exit, neither the DON nor the Administrator were able to provide statements, investigative materials, or resident statements regarding the two incidents that the DON acknowledged met the definition of neglect. Refer to F609, F610, F697

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49424 Based on observation, policy review, and interview, the facility failed to ensure an allegation of neglect was reported for one Resident (#33), out of a total sample of 21 residents. Specifically, the facility failed to report an allegation of neglect to the State Survey Agency (Department of Public Health) for Resident #33, who was experiencing pain of a 9 (on a scale of 1-10 with 10 being the worst pain), and who was not administered pain medications for over an hour. Findings include: Review of the facility's policy titled Abuse, dated March 2023, indicated but was not limited to the following: -Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated and reported. -Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. -Reporting timeline requirements for all allegations 2-hour requirement to report to the Department of Public Health and Local Law Enforcement. Resident #33 was admitted to the facility in April 2022 with diagnoses which included but is not limited to osteomyelitis (infection of the bone) and Stage 4 pressure ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone) of sacral region. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/17/24, indicated Resident #33 had intact cognitive function as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 1/31/24 at 7:10 A.M., the surveyor observed Resident #33 request pain medication from Nurse #4. The surveyor observed Nurse #4 tell Resident #33 that he/she would have to wait because the breakfast meal was on the way up from the kitchen. The surveyor observed the Resident shifting his/her weight in the wheelchair, had a furrowed brow, and was grimacing. The surveyor observed the Resident tell Nurse #4 that he/she was in a lot of pain. On 1/31/24 from 7:18 A.M. through 8:09 A.M., the surveyor observed Nurse #4 to be on the unit and not administering pain medication to Resident #33. During an interview on 1/31/24 at 8:09 A.M., Nurse #4 said Resident #33 had requested pain medications before breakfast, and she was going to give the requested medication to the Resident with his/her morning medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/24 at 8:17 A.M., the surveyor heard Resident #33 yell out from his/her room What is taking so long? I'm in so much pain and so sore, I asked for pain medication a while ago. At 8:23 A.M., the surveyor heard Resident #33 yelling out Please, I'm in pain! On 1/31/24 at 8:25 A.M., the surveyor observed Nurse # 4 give Resident #33 the requested pain medication. The surveyor observed that Resident #33 waited at least 75 minutes for his/her requested pain medication. During an interview on 1/31/24 at 3:27 P.M., the Director of Nurses (DON) said that her expectation was that the Resident would have received his/her medication when they asked and not have to wait until after breakfast to receive his/her requested pain medication since Resident #33 was in pain. During an interview on 2/1/24 at 7:15 A.M., Resident #33 said that he/she asked for pain medications from the night nurse an hour prior and had not received them. On 2/1/24 at 7:25 A.M., the surveyor observed Nurse #5 tell the Assistant Director of Nurses (ADON) that she was waiting for the next nurse to come relieve her and only one additional resident needed medication and indicated the Resident (which was not Resident #33). On 2/1/24 at 7:39 A.M., the surveyor observed Nurse #5 give Resident #33 the requested pain medication, at least 24 minutes after he/she asked for it. During an interview on 2/1/24 at 4:36 P.M., the Director of Nurses (DON) said she had met with Resident #33 who told her he/she had a lengthy delay (over an hour) for pain medication administered on 1/31/24 and 2/1/24 and on 1/31/24 the Resident said he/she was told to wait for the medication until after breakfast. The DON said the Resident should not have to wait for pain medication. The DON said that the incident did meet the definition of neglect. She said she had not reported the neglect to the Department of Public Health. During an interview on 2/1/24 at 4:58 P.M., the ADON said she trains staff on abuse and neglect in orientation and that these two incidents meet the definition of neglect. During an interview on 2/2/24 at 3:08 P.M., the Social Worker said that she was informed of the two events with Resident #33 not receiving medication when requested. She said that she would leave it up to the DON to follow the facility abuse policy since she was already aware. During an interview on 2/6/24 at 3:25 P.M., the Director of Nurses said the first incident on 1/31/24 was not neglect because the nurse did not administer medication because she misunderstood about providing medications during mealtimes and the second incident on 2/1/24 was being reviewed. She said neither incident had been reported to the Department of Public Health. During an interview on 2/6/24 at 3:25 P.M, the Administrator said the incidents for Resident #33 were not reported because they were not neglect. He said the acts had to be deliberate and he did not believe the two incidents were. Refer to F610, F697

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49424 Based on observation, policy review, and interview, the facility failed to ensure staff implemented the facility's abuse policy for one Resident (#33), out of a total sample of 21 residents. Specifically, the facility failed to follow their policy for investigating an allegation of neglect for Resident #33 who was experiencing pain of a 9 (on a pain scale of 1-10 with 10 being the worst pain), and who waited over an hour for pain medication. Findings include: Review of the facility's policy titled Abuse indicated but was not limited to the following: -Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated and reported. -Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. -Reporting timeline requirements for all allegations 2-hour requirement to report to the Department of Public Health and Local Law Enforcement) -Facility investigation will be completed within 72 hours of the incident, documentation of investigation to be: completing an Incident and Accident report, obtaining statements from identified potential witnesses, completing necessary evaluations (pain, skin, body checks), and maintaining a timeline of events. Resident #33 was admitted to the facility in April 2022 with diagnoses which included but is not limited to osteomyelitis (infection of the bone) and Stage 4 pressure ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone) of sacral region. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/17/24, indicated Resident #33 had intact cognitive function as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 1/31/24 at 7:10 A.M., the surveyor observed Resident #33 request pain medication from Nurse #4. The surveyor observed Nurse #4 tell Resident #33 that he/she would have to wait because the breakfast meal was on the way up from the kitchen. The surveyor observed the Resident shifting his/her weight in the wheelchair, had a furrowed brow, and was grimacing. The surveyor observed the Resident tell Nurse #4 that he/she was in a lot of pain. On 1/31/24 from 7:18 A.M. through 8:09 A.M., the surveyor observed Nurse #4 to be on the unit and not administering pain medication to Resident #33. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/24 at 8:09 A.M., Nurse #4 said Resident #33 had requested pain medications before breakfast, and she was going to give the requested medication to the Resident with his/her morning medication. On 1/31/24 at 8:17 A.M., the surveyor heard Resident #33 yell out from his/her room What is taking so long? I'm in so much pain and so sore, I asked for pain medication a while ago. At 8:23 A.M., the surveyor heard Resident #33 yelling out Please, I'm in pain! On 1/31/24 at 8:25 A.M., the surveyor observed Nurse #4 give Resident #33 the requested pain medication. The surveyor observed that Resident #33 waited at least 75 minutes for his/her requested pain medication. During an interview on 1/31/24 at 3:27 P.M., the Director of Nurses (DON) said that her expectation was that the Resident would have received his/her medication when they asked and not have to wait until after breakfast to receive his/her requested pain medication since Resident #33 was in pain. During an interview on 2/1/24 at 7:15 A.M., Resident #33 said that he/she asked for pain medications from the night nurse an hour prior and had not received them. On 2/1/24 at 7:25 A.M., the surveyor observed Nurse #5 tell the Assistant Director of Nurses (ADON) that she was waiting for the next nurse to come relieve her and only one additional resident needed medication and indicated the Resident (which was not Resident #33). On 2/1/24 at 7:39 A.M., the surveyor observed Nurse #5 give Resident #33 the requested pain medication, at least 24 minutes after he/she asked for it. During an interview on 2/1/24 at 4:36 P.M., the DON said she had met with Resident #33 who told her he/she had a lengthy delay (over an hour) for pain medication administration on 1/31/24 and 2/1/24 and on 1/31/24 the Resident said he/she was told to wait for the medication until after breakfast. The DON said the Resident should not have to wait for pain medication. The DON said that the incident did meet the definition of neglect. She said she had not initiated an investigation. During an interview on 2/1/24 at 4:58 P.M., the Assistant Director of Nurses (ADON) said she trains staff on abuse and neglect in orientation and that these two incidents meet the definition of neglect. During an interview on 2/2/24 at 3:08 P.M., the Social Worker said she was informed of the two events with Resident #33 not receiving medication when requested. She said she would leave it up to the DON to investigate and follow the facility abuse policy since she was already aware. During an interview on 2/6/24 at 3:25 P.M., the Director of Nurses said the first incident on 1/31/24 was not neglect because the nurse did not administer medication because she misunderstood about not giving medications when residents were eating meals and the second incident on 2/1/24 was being reviewed. She said there were no investigative materials including staff or resident statements for the two incidents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/24 at 3:25 P.M, the Administrator said the incidents for Resident #33 were not neglect because the acts had to be deliberate and he did not believe the two incidents were. He was unable to provide any investigative information for how the facility came to this conclusion. Refer to F697

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 43935 Based on interviews and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately completed to reflect the functional limitation status for one Resident (#9), in a total sample of 21 residents. Findings include: Resident #9 was admitted to the facility in July 2019 with diagnoses including: multiple sclerosis, dementia, and cognitive communication deficit. On 1/30/24 at 9:02 A.M., the surveyor observed Resident #9 sitting in a Broda chair (positioning chair) in his/her room with a closed left hand. During an interview on 1/31/24 at 8:09 A.M., Nurse #9 said the Resident's left hand is contracted closed and is not usable. Review of the medical record for Resident #9 indicated but was not limited to the following: - A licensed monthly summary, completed 1/8/23, indicated functional limitation related to contractures and limited range of motion (ROM) - A Nurse Practitioner's note, dated 2/6/23, indicated Resident had muscle rigidity, extremity stiffness, and contractures - A licensed monthly summary, completed 3/3/23, indicated functional limitation related to contractures and limited ROM - A Nurse Practitioner's note, dated: 4/3/23, indicated Resident had muscle rigidity, extremity stiffness, and contractures Review of the MDS assessments on record for Resident #9 indicated the following: - Assessment reference date (ARD) 1/10/2024; Section G, functional status question G0400, limitation in ROM: upper extremity (shoulder, elbow, wrist, hand) = no impairment - ARD 10/11/2023; Section G, functional status question G0400, limitation in ROM: upper extremity (shoulder, elbow, wrist, hand) = no impairment - ARD 7/12/2023; Section G, functional status question G0400, limitation in ROM: upper extremity (shoulder, elbow, wrist, hand) = no impairment - ARD 4/13/2023; Section G, functional status question G0400, limitation in ROM: upper extremity (shoulder, elbow, wrist, hand) = no impairment (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	- ARD 2/22/2023; Section G, functional status question G0400, limitation in ROM: upper extremity (shoulder, elbow, wrist, hand) = no impairment The MDS failed to accurately reflect the Resident had an upper extremity ROM limitation throughout the year 2023 and during the first MDS of 2024. During an interview on 2/6/24 at 10:17 A.M., the MDS Nurse reviewed the five MDS assessments identified by the surveyor and said the MDS assessments were incorrect and they should have been coded with a reply of Yes to question G0400 and a modification was required. Refer to F656 and F688

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 43935 Based on record review, policy review, and interview, the facility failed to provide the resident and their representative with a summary of the baseline care plan for two Residents (#65 and #74), out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Care plans - Baseline, dated as revised July 2023, indicated but was not limited to the following: - a baseline care plan will be developed and implemented to assure a resident's immediate care needs are met and maintained - a baseline care plan will be developed within 48 hours of the resident's admission The facility policy does not indicate that a summary of the baseline care plan is provided to the resident or their representative as required. 1. Resident #65 was admitted to the facility in December 2023 with diagnoses including: neurocognitive disorder with Lewy bodies, metabolic encephalopathy, anxiety disorder, unspecified psychosis, and type 2 diabetes mellitus. Review of the medical record included the most recent Brief Interview for Mental Status (BIMS) which indicated a score of 2 out of 15, indicating the Resident was severely cognitively impaired, and his/her healthcare proxy (HCP) was activated. During an interview on 1/31/24 at 2:43 P.M., Family Member #1 said she does not feel the facility always communicates with her well in regard to Resident #65. She said she has not ever had a care plan meeting and is not aware of what the Resident's base line care plan information contains and was never provided with a copy of these documents and feels she has input that would be beneficial to the Resident's care. Review of the medical record for Resident #65 failed to indicate the family or resident were offered or provided a copy of the baseline care plans. 2. Resident #74 was admitted to the facility in January 2024 with diagnoses including: chronic respiratory failure, status post tracheostomy, and dysphagia (difficulty swallowing). Review of the most recent BIMS indicated a score of 15 out of 15, indicating the Resident was cognitively intact. During an interview on 2/6/24 at 9:22 A.M., the Resident said he/she had never had anyone review the goals of their care or been offered a copy of his/her baseline care plan information. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/2/24 at 1:38 P.M., the Social Worker said the first care plan meeting is held with residents or their families at or around day 21 of their stay. She said she does hold a 48-hour initial meeting to discuss discharge or long-term care plans, but care plans are not reviewed at that time and she does not offer the residents or their families a copy of their base line care plans. During an interview on 2/6/24 at 9:38 A.M., the Director of Nurses said she does not have any knowledge of baseline care plan meetings and all care plan meetings are scheduled and managed by the Social Worker. She said the Social Worker holds a 48-hour initial meeting with residents and/or their families, but she was not aware that baseline care plans were not discussed at that time or that a copy of the baseline care plans were not offered to the resident or their families.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on observation, record review, policy review, and interview, the facility failed to ensure person-centered comprehensive care plans were developed and/or implemented for five Residents (#16, #56, #9, #65, and #71), out of a total sample of 24 residents. Specifically, the facility failed: 1. For Resident #16, to develop and implement resident centered individualized care plan with behavioral interventions for the use of antipsychotic medications; 2. For Resident #56, to implement interventions on the activities care plan; 3. For Resident #9, to develop and implement a comprehensive plan of care for the care and management of a known left-hand contracture; 4. For Resident #65, to develop and implement resident centered individualized care plans for the use of psychotropic medications and resident centered needs related to their cognitive deficits; and 5. For Resident #71, to develop and implement a comprehensive plan of care for nutritional monitoring and evaluation. Findings include: Review of the facility's policy titled Care Plans-Comprehensive, dated as last revised July 2023, indicated but was not limited to the following: -An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, emotional, and psychological needs is developed for each resident. -Each resident's comprehensive care plan is designed to: a. incorporate identified problem areas; b. incorporate risk factors associated with identified problems; c. identify professional services that are responsible for each element of care; d. reflect currently recognized standards of practice for problem areas and conditions. -Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident. -The care planning/interdisciplinary team is responsible for the review and updating of the care plans: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. when there is a significant change in the resident's condition; b. when the desired outcome is not met; c. when a resident is readmitted to the facility; and d. at least quarterly. 1. Resident #16 was admitted to the facility in August 2022 with diagnoses which included major depressive disorder, anxiety disorder, insomnia, and visual hallucinations. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/8/23, indicated Resident #16 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS), needed maximum assistance and/or was dependent with activities of daily living (ADLs), and took psychotropic medications, including antipsychotics. Review of the current Physician's Orders indicated but were not limited to the following: -Olanzapine Tablet 2.5 milligrams (mg) give one tablet by mouth two times a day for psychotic disorder (9/29/23) (antipsychotic medication). Review of the Medication order history for Olanzapine indicated Resident #16 had started this medication 6/29/23 and the dose was increased on 9/29/23. Review of the current Comprehensive Care Plan failed to indicate a care plan had been developed for the use of psychotropic medications, specifically for the use of antipsychotic medications. During an interview on 1/31/24 at 3:00 P.M., Nurse #7 said there should be a specific antipsychotic medication use care plan just like there is an antianxiety and antidepressant medication use care plan. During an interview on 2/5/24 at 12:30 P.M., the Assistant Director of Nurses (ADON) said she was unsure what care plans should be in place as the Director of Nurses (DON) does most of the care plans. During an interview on 2/5/24 at 4:18 P.M., the ADON said she thinks the psychotropic medication use care plan is all they use, but the Resident does not have that one or a specific antipsychotic use care plan and he/she should. During an interview on 2/5/24 at 5:00 P.M., the DON said there should be a psychotropic medication use care plan and there was not. During an interview on 2/6/24 at 2:30 P.M., Unit Manager #2 said there should be a psychotropic medication use care plan but the Minimum Data Set (MDS) Nurse handles most of that. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/24 at 4:01 P.M., MDS Nurse #1 said she does not do all of the care plans, but there should be a general psychotropic medication use care plan and a specific antipsychotic care plan and there was not one for Resident #16 until yesterday. She said the social worker put the antipsychotic medication use care plan in, but it should have been there since the medication was started in June 2023. 2. Resident #56 was admitted to the facility in September 2021 with diagnoses which included Alzheimer's disease, dementia, depression, and malnutrition. Review of the most recent MDS assessment, dated 12/13/23, indicated Resident #56 was rarely or never understood, did not speak and was unable to participate in interviews. He/she was dependent on staff for ADLs and wheelchair bound. Review of the Activities Care Plan indicated but was not limited to the following: Focus: Resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to Alzheimer's Disease. Goal: Resident will maintain involvement in cognitive stimulation, social activities, as desired through review date. Interventions: -Invite and assist Resident to scheduled activities. -Resident prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as listening to music, sensory/tactile stimulation, and hand massages. The surveyor made the following observations: -1/30/24 at 9:30 A.M., Resident sitting in small day room on the unit in high back wheelchair, humming and chewing on a towel. -1/30/24 at 3:33 P.M., Resident sitting in small day room on the unit, chewing on a towel, news channel on the television (Resident not watching the television). -1/31/24 at 8:20 A.M., Resident sitting in small day room on the unit, chewing on his/her shirt, towel on his/her lap. Resident was facing the doorway/wall, television had Local News channel on (Resident not watching the television). -1/31/24 at 9:03 A.M., Resident sitting in small day room on the unit, hands in mouth, gnawing on fingers, with towel on his/her lap. Resident was moaning at times. -1/31/24 at 10:30 A.M., Resident sitting in small day room on the unit, hands in mouth, shirt pulled up with stomach exposed. Resident has been in same position and hasn't left the day room since 8:00 A.M. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/31/23 at 10:45 A.M., Resident still sitting in the small day room on the unit with no staff engagement, hands/fingers are in his/her mouth. -1/31/24 at 12:10 P.M., Resident sitting in the small day room on the unit, chewing on his/her shirt, TMZ (celebrity gossip news) on the television (Resident not watching the television), no staff engagement observed. Resident was moaning at times. -1/31/23 at 12:30 P.M., Certified Nursing Assistant (CNA) #2 entered the small day room and put a towel in Resident #56's hands. -1/31/24 at 12:40 P.M., Resident sitting in small day room on the unit alone with fingers in his/her mouth and towel in other hand. -1/31/23 at 12:43 P.M., the Assistant Director of Nurses (ADON) entered the small day room, removed the towel from the Resident's hands and left the room. The Resident was left sitting alone in the small day room with TMZ on the television (Resident was not watching the television). -1/31/24 at 1:07 P.M., Resident sitting in small day room alone, asleep in wheelchair, TMZ Divorce Court on the television (Resident not watching the television). -1/31/24 at 2:02 P.M., CNA #2 brought Resident from the small day room to his/her room and put him/her back to bed. Resident was left in the room with no music, no television, and no light on with curtain partially drawn. -2/1/24 at 12:36 P.M., Resident in his/her bed awake with no television or music on. -2/5/24 at 11:41 A.M., Resident in bed awake with no television or music on. Resident chewing on sheet/blanket. -2/5/24 at 5:00 P.M., Resident in bed awake with no television or music on, the room was dark. Resident chewing on a towel. -2/6/24 at 9:35 A.M., Resident in bed with no television or music on. -2/6/24 at 2:04 P.M., Resident lying in bed awake with no music or television on. Resident playing with shirt and blanket. Resident #56 was not observed to be involved in simple, structured activities such as listening to music, sensory/tactile stimulation, and hand massages at any time during the survey process, as indicated on the care plan. During an interview on 1/31/24 at 12:25 P.M., CNA #2 said Resident #56 always just sits in the small day room and chews on his/her fingers and shirt, so they give him/her a towel to chew on. During an interview on 1/31/24 at 3:00 P.M., Nurse #4 and Nurse #7 said there were not usually any small activities or 1:1 activities on this unit so residents that do not go to the large group just sit in the small day room on the unit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/31/24 at 3:00 P.M., Nurse #4 said Resident #56 mostly just sits in the small day room. During an interview on 2/5/24 at 1:05 P.M., Nurse #4 said she does not see Resident #56 go to any activities or do any individual activities. The Resident usually sits in the small day room on the unit or in bed. Additionally, she said the Resident is always chewing on something, either his/her hand/fingers, a shirt, towel, or blanket. During an interview on 2/5/24 at 3:45 P.M., the Activity Director said Resident #56 likes music and sensory blankets and the Room Visit Monitoring Form would have those activities on it and it did not. Review of the current Room Visit Monitoring Form for Resident #56 with the Activities Director indicated the Resident had a visit consisting of menu and/or menu/Chronicle (Chronicle is the daily one page news for Seniors noting historical events from that date), meaning he/she was given a Chronicle page and/or a menu and his/her response to the activity was coded as S 17 times and once was coded as A. Per the document key, S means Sleeping and the A means Active (participation). There was one family visit documented and one visit documented as 1:1 (one to one) check in and the response to that visit was coded as S or sleeping. Review of the Room Visit Monitoring Form failed to indicate Resident #56 had been engaged in simple, structured activities such as listening to music, sensory/tactile stimulation, and hand massages, per the care plan. During an interview on 2/6/24 at 2:30 P.M., Unit Manager #2 said Resident #56 never goes to activities and they do not do small group activities on that unit, so he/she just sits there and if they stay in bed, he/she just lies there. She said sometimes he/she has a teddy bear but no other sensory objects, teethers, or blankets to utilize. She said the Resident should be brought to small group activities or have 1:1 with activities as they don't do much with the Resident. 43935 3. Resident #9 was admitted to the facility in July 2019 with diagnoses including: multiple sclerosis (MS), dementia, and cognitive communication deficit. On 1/30/24 at 9:02 A.M., the surveyor observed Resident #9 sitting in a Broda chair (positioning chair) in his/her room with a closed left hand. The surveyor did not observe a brace or assistive device in the room or on the Resident. During an interview on 1/31/24 at 8:09 A.M., Nurse #9 said the Resident's left hand is contracted closed and is not usable. Review of the medical record for Resident #9 indicated but was not limited to the following: - Two licensed monthly summaries, completed on 1/8/23 and 3/3/23 respectively, indicated functional limitation related to contractures and limited range of motion (ROM) - Two Nurse Practitioner's (NP) notes, dated 2/6/23 and 4/3/23, respectively, indicated Resident had muscle rigidity, extremity stiffness, and contractures (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident's current care plans as of 1/31/24 failed to indicate the Resident had a left-hand contracture or any interventions in place to prevent potential complications related to the left-hand contracture. During an interview on 2/1/24 at 4:34 P.M., the Director of Nurses (DON) said Resident #9 had been known to have the left-hand contracture since at least October of 2023 when she started. On review of the medical record, she said she does not know why there is no real mention of the contracture or why there was no care plan in place to manage the contracture and prevent complications. Refer to F658 and F688 4. Resident #65 was admitted to the facility in December 2023 with diagnoses including: neurocognitive disorder with Lewy bodies, metabolic encephalopathy, anxiety disorder, unspecified psychosis, and type 2 diabetes mellitus. Review of the medical record included the most recent BIMS which indicated a score of 2 out of 15, indicating the Resident was severely cognitively impaired and his/her healthcare proxy (HCP) was activated. During an interview on 1/31/24 at 2:43 P.M., Family Member #1 said the facility does not always communicate well with her. She said she has never had a care plan meeting to discuss Resident #65's care or things she would like for the Resident. Review of the current care plans for Resident #65 indicated but were not limited to the following: FOCUS: - Resident has impaired cognition/dementia or impaired thought process related to (r/t) dementia, impaired decision making, long-term and short-term memory loss (initiated: 1/3/24) INTERVENTIONS: - Provide a program of activities that accommodates Resident #65's abilities (SPECIFY) (initiated: 1/3/24) FOCUS: - Resident has been prescribed psychotropic medications: Specify target behaviors: antianxiety, antipsychotic (revised: 1/3/24) GOAL: - Maximize Resident's functional potential and well-being while minimizing hazards associated with drug related side effects (revised: 1/3/24) During an interview on 2/2/24 at 12:32 P.M., the Activity Director (AD) said she has not attended a care plan meeting for the Resident and is not aware of whether or not one has occurred yet. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/2/24 at 1:08 P.M., the AD reviewed Resident #65's care plans and said they are not specific or individualized to the Resident's needs or preferences as they relate to activities to provide life enhancement and should be more detailed to better reflect the Resident and for the staff to know how to engage him/her with activities. During an interview on 2/2/24 at 1:38 P.M., the Social Worker said residents usually have their first care plan meeting around day 21 of their stay. She said Resident #65 had not yet had a care plan meeting and she needed to call his/her family to schedule one. Resident #65 was past the 21-day mark for a first comprehensive care plan meeting with the interdisciplinary team and his/her family. During an interview on 2/6/24 at 8:51 A.M., Nurse #9 said she could not speak to the development or initiation of care plans or the meetings because they were managed exclusively by the management team and the unit nurses are not involved. She said she would not know one way or another if Resident #65 had a care plan meeting and the managers take care of those pieces. She said the nursing admission assessment does not trigger any care plans automatically for residents upon admission that she knows of. During an interview on 2/6/24 at 9:38 A.M., the DON reviewed Resident #65's care plans and said they are not individualized or specific to the Resident and sections that prompt the staff to specify are incomplete. She said the care plans should be more individualized and resident centered with preferences. She said care plan meetings are scheduled and managed by social services. She said the care plan development process is supposed to be the nurses on the units create the care plans and then management will beef them up, but the process needs to be improved. 49425 5. Review of the facility's policy titled Weight Measurement, dated as revised February 2022, included but was not limited to: - All residents will be weighed at a minimum monthly - Residents with a weight variance of 5% or more or less than the previous month will be re-weighed. - The charge nurse will notify the physician, responsible party and dietician when a 5% more or less variance is noted. - The dietician will review the resident weight and make recommendations accordingly. - When a significant weight fluctuation of 5% more or less is noted, the resident will be weighed based on determination of the Interdisciplinary Team (IDT). - The resident plan of care will be updated accordingly. Resident #71 was admitted to the facility in June 2023 with diagnoses including: dysphagia (difficulty swallowing), hemiparesis, hypertension, and diabetes type II. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 12/19/2023, included but was not limited to the following: - BIMS score of 15 out of 15, which indicated the resident is cognitively intact. - Section K of the MDS, which indicated swallowing/nutritional status, and triggered for weight loss of 5% or more in the last month or 10% or more in the last 6 months. - Section K also indicated that Resident #71 was not on a prescribed weight loss regimen. Review of Resident #71's current Physician's Orders indicated the Resident was on a 2 Gm (gram) NA+(sodium) diet with regular consistency texture and thin liquids, and small portions. Review of Resident #71's Nutritional Quarterly Assessment, dated 11/29/23, indicated but was not limited to the following: - Nutritional plan: discontinue super cereal and super pudding (high calorie, high nutrient food) due to good intake and to encourage gradual weight loss Review of Resident #71's weights from 11/07/2023 to 12/07/2024 indicated a significant weight loss of 10. 95%. Review of Resident #71's comprehensive care plan failed to indicate a nutritional care plan had been developed. During an interview on 02/06/24 at 3:41 P.M., the Registered Dietitian said he was aware of the significant weight loss. He said when the resident was admitted he/she was around 210 pounds, and now he/she was in the 180 range. During an interview on 02/06/24 at 4:02 P.M., the MDS nurse said the quarterly MDS, dated [DATE], indicated a weight loss of greater than 5% without a prescribed weight loss regimen and was completed by the dietitian. She said the dietitian is responsible for creating the nutritional care plan. The MDS nurse reviewed the record and said there was no nutritional care plan for Resident #71. During an interview on 02/06/24 at 4:27 P.M., the Director of Nurses said her expectation for residents with weight loss is to obtain three re-weights, notify the MD or Nurse Practitioner, HCP and dietitian, and update the care plan accordingly. She said the dietitian creates the initial nutritional care plan, and her expectation is for the Resident to have one in the medical record but there was not one.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48362 Based on observations, interviews, and record review, the facility failed to ensure one Resident (#60), out of a total sample of 21 residents, received care and treatment in accordance with professional standards. Specifically, the facility failed, for Resident #60, to administer scheduled pain medication as ordered. Findings include: 49425 Review of the facility's policy titled Administering Medications, undated, included but was not limited to the following: - Medications are administered in accordance with prescriber orders, including any required time frame. - Medication errors are documented, reported, and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to inform process changes and or the need for additional staff training. - If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. Resident #60 was admitted to the facility in January 2023 with a diagnosis of cerebral vascular accident (stroke). Review of the Minimum Data Set (MDS) assessment for Resident #60, dated 10/25/23, included a Brief Interview for Mental Status (BIMS) score of 0 out of 15 indicating severe cognitive impairment. Review of the Physician's Orders, active as of 1/31/24, indicated but was not limited to the following: - Acetaminophen (pain medication) 325 milligrams (mg) give 2 tablets to equal 650 mg by mouth three times a day for pain. (scheduled medication) On 1/31/24 at 10:10 A.M., the surveyor observed Nurse #4 preparing medication for administration as follows: -Acetaminophen 325 mg two tablets to equal 650 mg, placed into plastic medication cup. Nurse #4 then entered Resident #60's room with the medication cup and asked the Resident if they had pain. Resident #60 answered No, and Nurse #4 then took the medication cup out of the room and disposed of the tablets in the sharp's container located on her medication cart. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/24 at 2:22 P.M., Nurse #4 said she did not administer the medication as ordered because the Resident said he/she did not have any pain at the moment. She said she should not have held the medication without an order, but she has been busy.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on observation, record review, policy review, and interview, the facility failed to provide an activities program designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, for two Residents (#56 and #65), out of a total sample of 21 residents. Specifically, the facility failed: 1. For Resident #56, to provide an activities program that would meet his/her individual interests to enhance his/her quality of life; and 2. For Resident #65, to plan for or provide an activities program that would meet his/her individual interests to enhance his/her quality of life. Findings include: Review of the facility's policy titled Activity Program, undated, indicated but was not limited to the following: -Activity programs designed to meet the needs of each resident are available on a daily basis. -Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. -Our activity programs consist of individual and small and large group activities that are designed to meet the needs and interests of each resident. -Adequate space and equipment are provided to ensure that needed services identified in the resident's plan of care are met. 1. Resident #56 was admitted to the facility in September 2021 with diagnoses which included Alzheimer's disease, dementia, depression, and malnutrition. Review of the Minimum Data Set (MDS) assessment, dated 12/13/23, indicated Resident #56 was rarely or never understood, did not speak and was unable to participate in interviews. He/she was dependent on staff for activities of daily living (ADLs) and was wheelchair bound. The surveyor made the following observations: -1/30/24 at 9:30 A.M., Resident #56 sitting in small day room on the unit in high back wheelchair, humming and chewing on a towel. -1/30/24 at 3:33 P.M., Resident sitting in small day room on the unit, chewing on a towel, news channel on the television (Resident not watching the television). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/31/24 at 8:20 A.M., Resident sitting in small day room on the unit, chewing on his/her shirt, towel on his/her lap. Resident was facing the doorway/wall, television had Local news channel on (Resident not watching the television). -1/31/24 at 9:03 A.M., Resident sitting in small day room on the unit, hands in mouth, gnawing on fingers, with towel on his/her lap. Resident was moaning at times. -1/31/24 at 10:30 A.M., Resident sitting in small day room on the unit, hands in mouth, shirt pulled up with stomach exposed. Resident has been in same position and hasn't left the day room since 8:00 A.M. -1/31/23 at 10:45 A.M., Resident sitting in the small day room on the unit with no staff engagement, hands/fingers are in his/her mouth. -1/31/24 at 12:10 P.M., Resident sitting in the small day room on the unit, chewing on his/her shirt, TMZ (celebrity gossip news) on the television (Resident not watching the television), no staff engagement observed. Resident was moaning at times. -1/31/23 at 12:30 P.M., Certified Nursing Assistant (CNA) #2 entered the small day room and put a towel in Resident #56's hands. -1/31/24 at 12:40 P.M., Resident sitting in small day room on the unit alone with fingers in his/her mouth and towel in other hand. -1/31/23 at 12:43 P.M., the Assistant Director of Nurses (ADON) entered the small day room, removed the towel from the Resident's hands and left the room. The Resident was left sitting alone in the small day room with TMZ on the television (Resident was not watching the television). -1/31/24 at 1:07 P.M., Resident sitting in small day room alone, asleep in wheelchair, TMZ Divorce Court on the television (Resident not watching the television). -1/31/24 at 2:02 P.M., CNA #2 brought Resident from the small day room to his/her room and put him/her back to bed. Resident was left in the room with no music, no television, and no light on with curtain partially drawn. -2/1/24 at 12:36 P.M., Resident in his/her bed awake with no television or music on. -2/5/24 at 11:41 A.M., Resident in bed awake with no television or music on. Resident chewing on sheet/blanket. -2/5/24 at 5:00 P.M., Resident in bed awake with no television or music on, the room was dark. Resident chewing on a towel. -2/6/24 at 9:35 A.M., Resident in bed with no television or music on. -2/6/24 at 2:04 P.M., Resident lying in bed awake with no music or television on. Resident playing with shirt and blanket. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Activities Assessment, dated 12/9/23, indicated but was not limited to the following: -Resident is unable to initiate independent activities. Recreation provides weekly 1:1 (one to one) visits. -Resident enjoys watching tv, listening to music, and does best with tactile stimulation/sensory visits. -Resident needs prompting to successfully engage in activities. Review of the Activities Care Plan indicated but was not limited to the following: Focus: Resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to Alzheimer's Disease Goal: Resident will maintain involvement in cognitive stimulation, social activities, as desired through review date. Interventions: -Invite and assist Resident to scheduled activities. -Resident prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as listening to music, sensory/tactile stimulation, and hand massages. During an interview on 1/30/24 at 9:30 A.M., Resident's roommate said he/she chews on his/her fingers or shirt, so they give him/her a towel to chew on. During an interview on 1/31/24 at 12:25 P.M., CNA #2 said Resident #56 always just sits in the small day room and chews on his/her fingers and shirt, so we give him/her a towel to chew on. During an interview on 1/31/24 at 3:00 P.M., Nurse #4 and Nurse #7 said there are not usually any small activities or 1:1 activities on this unit so residents that do not go to the large group just sit in the small day room on the unit. During an interview on 1/31/24 at 3:00 P.M., Nurse #4 said Resident #56 mostly just sits in the small day room. During an interview on 2/5/24 at 1:05 P.M., Nurse #4 said she does not see Resident #56 go to any activities or do any individual activities. The Resident usually sits in the small day room on the unit or in bed. Additionally, she said the Resident is always chewing on something, either his/her hand/fingers, a shirt, towel, or blanket. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/24 at 3:45 P.M., the Activity Director said the Room Visit Monitoring Form is the daily log of room visits, 1:1, and individual activities like hand massage. She said everything gets logged there and then put into the computer. They don't log it anywhere else, so all those type of visits/activities would be on that worksheet. She said she doesn't save them once the sheet is full, they get a new one. The surveyor requested to review the activity report, but the Activity Director said she does not know how to run a report of the last three months of activities for the Resident. The Activity Director said Resident #56 likes music and sensory blankets and the Room Visit Monitoring Form would have those activities on it. Review of the current Room Visit Monitoring Form for Resident #56 with the Activity Director indicated the Resident had a visit consisting of menu and/or menu/Chronicle (Chronicle is the daily one page news for Seniors noting historical events from that date), meaning he/she was given a Chronicle page and/or a menu. His/Her response to the activity was coded as S 17 times and once was coded as A. Per the document key, S means Sleeping and the A means Active (participation). There was one family visit documented and one visit documented as 1:1 check in and the response to that visit was coded as S or sleeping. No other activities were documented. When asked by the surveyor if providing a menu and or Chronicle to a resident that is unable to discuss the documents and was asleep would be an appropriate activity, the Activity Director said, well no, his/her family would have to do the menu and he/she should have other activities logged on the form but she does not. During an interview on 2/6/24 at 9:20 A.M., the Activity Director said she did not have the reports as requested on 2/5/24 and would check on them because she asked for them to be printed yesterday. The surveyor printed a 31 day look back for each activity task in the computer. These reports were generated and printed on 2/6/24 between 9:53 A.M. and 9:57 A.M. Review of the reports indicated there was one room visit documented on 1/31/24 at 10:19 A.M. The reports failed to indicate any other activities for Resident #56. The other activities included church, listening to music, morning greeting, music entertainment, parties, receive sacraments, manicure/nails painted, sensory programs, visit family/friends, watching TV/Movies, being around pets, and resident council all had zero visits logged into the computer, and each report read No Data Found. During an interview on 2/6/24 at 2:30 P.M., Unit Manager #2 said the Resident sometimes gets up but not always, and if he/she does get up they usually sit in the small day room. Additionally, she said Resident #56 never goes to activities and they do not do small group activities on that unit, so he/she just sits there and if they stay in bed, he/she just lies there. Unit Manager #2 said TMZ, Divorce Court and [NAME] News are not appropriate shows to engage the Resident. Additionally, she said the Resident always chews on something (fingers, shirt, towel, or blanket). She said she thinks it's a behavior of some sort or a coping mechanism. She said she had been asking why since she started but was told he/she always does it. She said sometimes he/she has a teddy bear but no other sensory objects, teethers, or blankets to utilize. She said the Resident should be brought to small group activities or have 1:1 with activities, as they don't do much with the Resident. 43935 2. Resident #65 was admitted to the facility in December 2023 with diagnosis including: neurocognitive disorder with Lewy bodies, metabolic encephalopathy, anxiety disorder, unspecified psychosis, and type 2 diabetes mellitus. (continued on next page)

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the medical record included the most recent Brief Interview for Mental Status (BIMS) which indicated a score of 2 out of 15, indicating the Resident was severely cognitively impaired, and his/her healthcare proxy (HCP) was activated.

During an interview on 1/31/24 at 2:43 P.M., Family Member #1 said she does not feel the facility always communicates with her well in regard to Resident #65. She said she comes in daily for about five hours a day in the late afternoon and feels Resident #65 is bored and has nothing to do and is often in bed when she arrives at the facility. She said the Resident was very active prior to being admitted and would fold laundry for long periods of time or check the mail frequently and open envelopes or play cards and doesn't feel that he/she is engaged in anything while they have been at the facility and it may be contributing to his/her restlessness. She said, There is a big lack of activities or things to do and doesn't feel the staff try to engage him/her in things. She said she usually has to bring the Resident to activities herself and she has never seen the staff offer to bring the Resident to any type of activity. She said she brings cloth napkins for the Resident to fold sometimes when she visits and that keeps them busy. She said her biggest worry is the Resident being bored which she fears would result in behaviors related to the Resident's disease process.

Throughout the survey, the surveyor made the following observations of Resident #65:

- 1/30/24 at 9:01 A.M., Resident lying in bed with eyes closed

- 1/30/24 at 9:46 A.M., Resident dressed lying in bed looking out the window, smiling when engaged by surveyor, the television was not on and there was no music playing in the room.

- 1/31/24 at 11:56 A.M., Resident lying in bed, not engaged, or participating in any activity, no music or television on in the room.

- 2/1/24 at 7:35 A.M., Resident in bed with eyes closed

- 2/1/24 at 1:11 P.M., Resident out of bed in his/her wheelchair self-propelling without a destination, the Resident was unable to answer questions

- 2/2/24 at 9:38 A.M., Resident observed in bed, waving at surveyor on approach, there was no music or television on in the room

- 2/2/24 at 10:44 A.M., Resident was transported to the unit dayroom for activities by CNA #4

- 2/2/24 at 11:37 A.M., Resident was observed sitting in his/her wheelchair in the unit dayroom, sitting beside the activity assistant shuffling papers

- 2/6/24 at 11:09 A.M., Resident self-propelling and wandering in his/her wheelchair in the hallways

- 2/6/24 at 11:23 A.M., Resident self-propelling and wandering in his/her wheelchair in the hallways

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/1/24 at 1:14 P.M., Nurse #9 said Resident #65 typically stays in his/her room in the mornings and the staff get him/her up for lunchtime. She said the Resident's family comes in every day and she will take the Resident off the unit to big activities like music, or bring the Resident to the activity room and if she is present then the Resident will stay. She said the staff try to encourage the Resident to attend activities, but the Resident usually leaves the activities on their own. She said she is not aware of anything the Resident enjoys doing for activities and the Resident is still relatively new to the facility. During an interview on 2/2/24 at 9:59 A.M., CNA #4 said she provides care to the Resident every day she works. She said Resident #65 sleeps later into the morning and she usually gets them into their wheelchair between 10:30 A.M. and 11:30 A.M. daily. She said when she brings the Resident to activities, he/she doesn't seem to engage too much and sometimes will self-propel in their wheelchair out of the activity area. She said she is not aware of what kind of activities the Resident might enjoy. She said the Resident seems to do better with activities when his/her family member is present and the family has brought the Resident to things off the unit like music. Review of the Activity Interview for daily and activity preferences for Resident #65, dated as signed 1/3/24, indicated but was not limited to the following: Section B Interview for activity preferences: - The following items were marked as very important: listen to music, be around animals, do your favorite activities, go outside in good weather - The following items were marked as not very important: do things with groups of people Section C Primary respondent for daily and activity preferences - Resident Review of the current care plans for Resident #65 indicated but were not limited to the following for activities: FOCUS: - Resident has impaired cognition/dementia or impaired thought process related to dementia, impaired decision making, long-term and short-term memory loss (initiated: 1/3/24) INTERVENTIONS: - Provide a program of activities that accommodates Resident #65's abilities (SPECIFY) (initiated: 1/3/24) FOCUS: - Resident is dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits, immobility (initiated: 1/4/24) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GOAL: - Resident will maintain involvement in cognitive stimulation, social activities as desired throughout review date (revised: 1/4/24) INTERVENTIONS: - Ensure that activities the Resident is attending are: compatible with physical and mental capabilities; compatible with known interests and preferences, adapted as needed, compatible with individual needs and abilities and age appropriate. (revised: 1/4/24) - Invite Resident to scheduled activities (revised: 1/4/24) - Introduce Resident to residents with similar background, interests, and encourage/facilitate interactions (revised: 1/4/24) - Resident needs 1:1 bedside in room visits and activities if unable to attend out of room events (revised: 1/4/24) - Resident needs assistance to be escorted to activities (revised: 1/4/24) Resident #65's care plans failed to indicate their preference for music, animals, and going outside. During an interview on 2/2/24 at 12:32 P.M., the Activity Director said activities performs a preference interview and an activity review and assessment upon admission and quarterly. She reviewed the Resident's record and said the activity preference assessment review could not be located and she would have to look further into it. During an interview on 2/2/24 at 1:08 P.M., the Activity Director said the activity review assessment was started on 12/29/23 but was not locked as completed until today and could not be viewed in the system. She said the Resident does attend some activities and she would provide activity participation logs to the surveyors. She reviewed the Resident's care plans and said the activity care plans were not individualized to the Resident for activities that would provide life enhancement and more details were required. She said the staff could better engage the Resident if the care plans were more personalized for the Resident to indicate what activities were most beneficial for him/her. During an interview on 2/2/24 at 1:14 P.M., Activity Assistant #1 said she knows Resident #65 well and he/she does not typically stay or engage in activities easily when he/she attends. She said she finds the best method is to keep the Resident close to her, when his/her family is not present. She said today the Resident attended activities, and although could not participate in the trivia seemed happy to shuffle papers and sit beside her. She said she completed a puzzle during a 1:1 with the Resident the other day and that seemed to go well. She said she is unaware of what the Resident's activity preferences are or what they enjoy. She said the Resident does best and seems most engaged in activities when their family member is present with them. Review of the Activities Initial Review assessment for Resident #65, dated as signed 2/2/24, indicated but was not limited to the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sachem Center for Health and Rehabilitation	66 Central Street East Bridgewater, MA 02333

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section A: Past Activity Interests: - Resident enjoys independent activities of interest, as well as, some group activities. - Resident enjoys music, movies and active activities. - Resident is known to wander so hands on stimulation activities are the best. Section C: Current activity participation: - There was an answer of yes to the following questions: Resident wishes to participate in activities, group activities, 1:1 with staff and independent activities Section D: Limitations/Special needs: - There was an answer of yes to the following questions: activities should be modified to accommodate cognitive deficits, communication deficits, assistance should be provided to get Resident to an activity COMMENT: Resident does best when sitting near recreation staff during activities for any required assistance. Review of Resident #65's activity involvement logs, both on paper and computerized, indicated the following from 12/29/23 through 2/6/24: - Out of 40 days of activity participation opportunities the Resident participated in activities on 11 days. During an interview on 2/6/24 at 9:38 A.M., the Director of Nurses was made aware of the activity concerns for Resident #65 and she reviewed the current care plan for the Resident. She said there was no way to know what the Resident enjoys or would prefer to participate in by viewing the care plan. She said she knows the Resident and he/she does not engage easily and typically would leave an activity. She said she does not know why activity staff would not or have not left a radio for music in the Resident's room since the assessment indicated music was important, they probably should.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations, interviews, and record review, the facility failed to ensure three Residents (#69, #33, and #73), out of a total sample of 21 residents, received care and treatment to promote healing of pressure injuries. Specifically, the facility failed: 1. For Resident #69, to implement treatments as ordered for a stage 4 pressure injury (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) on the coccyx and a deep tissue injury (DTI) (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation reveals a dark wound bed) on the left buttock; 2. For Resident #33, to complete weekly skin checks per physician's orders, obtain wound care orders per wound physician recommendations for a stage 4 pressure ulcer, transcribe orders into the electronic medical record, provide wound care per physician orders in line with current professional standards, and ensure staff were properly trained on the maintenance and inflation of ROHO cushion (specialty air inflated wheelchair cushion to promote wound healing); and 3. For Resident #73, to implement treatments as ordered to a stage 3 pressure injury (full-thickness loss of skin in which fat is visible in the ulcer and granulation tissue and rolled wound edges are often present) on the left buttock. Findings include: Review of the facility's policy titled Pressure Ulcers/Skin Breakdown- Clinical Protocol, undated, indicated but was not limited to the following: -the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressing and application of topical agents. -the physician will help identify medical interventions related to wound management; for example removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment. Review of the facility's policy titled Dressings, Dry/Clean, undated, indicated but was not limited to the following: -Purpose: to provide guidelines for the application of dry, clean dressings -Preparation: verify that there is a physician's order for the procedure; review the resident's care plan, current orders, and diagnosis to determine if there are special resident needs; check the treatment record -Documentation: the following should be recorded in the resident's medical record, treatment sheet or designated wound form: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-date and time dressing was changed -wound appearance, including wound bed, edges, presence of drainage -name and title (or initials) of the individual changing the dressing -type of dressing used and wound care given -all assessment data (wound bed color, size, drainage) -how the resident tolerated the procedure -any problems or complaints made by the resident -the signature and title (or initials) of the person recording the data 1. Resident #69 was admitted to the facility in January 2024 with diagnoses of rectal cancer, Stage 4 pressure injury to the coccyx, and a Deep Tissue Injury (DTI) to the left buttock. Review of the Minimum Data Set (MDS) assessment, dated 1/18/24, indicated Resident #69 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. Review of Section M: Skin Conditions of the MDS assessment indicated the Resident had a Stage 4 pressure ulcer/injury and an unstageable pressure ulcer/injury. The assessment also indicated Resident #69 was receiving pressure ulcer/injury care including the application of non-surgical dressings and ointments. Review of the care plans for Resident #69 indicated the Resident had a Stage 4 pressure injury to the coccyx and a DTI on the left buttock with interventions to measure the area weekly and to complete treatments as ordered. A. Review of the January 2024 Medication and Treatment Administration Records (MAR and TAR) indicated the following treatment order for the coccyx was initiated on 1/6/24: normal saline wash (NSW) followed by DCD (sic) every day shift for wound observations. Review of the medical record indicated Resident #69 was seen by the Wound Physician Consultant on 1/9/24. Review of the Initial Wound Evaluation Management Summary indicated Resident #69 had a Stage 4 pressure injury to the coccyx measuring 3.8 centimeters (cm) in length by 1.5 cm in width by 2.2 cm in depth. The treatment recommendation was to add Santyl (debriding ointment used to rid wound bed of dead tissue), and add Alginate Calcium (absorbent gel forming debriding agent to rid wound bed of dead tissue) once daily for 30 days followed by a gauze island with border dressing. Review of the Nursing Progress Note, dated 1/9/24, indicated Resident #69 was seen by the Wound Physician with new orders. Review of the Skin Assessment, dated 1/10/24, indicated there was a new order for the pressure injury to the coccyx to apply Alginate Calcium, apply Santyl, followed by a gauze island with border dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2024 MAR and TAR indicated a treatment order was initiated on 1/17/24 for the coccyx area to change the border gauze dressing and not use Santyl, every evening and night shift, and the order for NSW followed by DCD every day continued through the month. Review of the 1/19/24 Wound Evaluation and Management Summary from the Wound Physician indicated to continue the Alginate Calcium, discontinue the Santyl, add an ABD pad and discontinue the gauze island border. Review of the Skin Assessment, dated 1/21/24, indicated Resident #69 was seen by the Wound Physician on 1/19/24, the coccyx wound had excess drainage and there was a new order for Alginate Calcium once daily followed by ABD pad once daily. Review of the 1/23/24 Wound Evaluation and Management Summary from the Wound Physician indicated to continue the Alginate Calcium, add Benzocaine spray followed by an ABD pad. Review of the Skin Assessment, dated 1/26/24, indicated the coccyx treatment was for Alginate Calcium, Santyl followed by an ABD pad, and a Benzocaine spray. Review of the January 2024 MAR and TAR failed to indicate the treatment of Alginate Calcium and Santyl followed by a gauze island with border dressing was implemented between 1/9/24 and 1/18/24 and failed to indicate the treatment of Alginate Calcium followed by an ABD pad was implemented from 1/19/24 through 1/31/24. Review of the January and February 2024 MARs and TARs failed to indicate the Alginate Calcium was implemented, the gauze island border was discontinued, the ABD pad was ordered or the Benzocaine spray was added to the treatment. B. Review of the January 2024 TAR indicated the following treatment order for the left buttock was initiated on 1/6/24: NSW followed by DCD (sic) every day shift for wound observations. Review of the Initial Wound Evaluation Management Summary, dated 1/9/24, indicated Resident #69 had an unstageable DTI of the left buttock measuring 4 cm in length by 1.5 cm in width with 0.1 cm depth. The treatment recommendation was to add Santyl and Alginate Calcium once daily for 30 days followed by a gauze island with border dressing. Review of the Nursing Progress Note, dated 1/9/24, indicated Resident #69 was seen by the Wound Physician with new orders. Review of the Skin assessment dated [DATE] indicated there was a new order for the unstageable DTI of the left buttock to Alginate Calcium, apply Santyl followed by gauze island with border dressing. Review of the January MAR and TAR indicated the treatment for NSW followed by DCD (sic) was ordered from 1/6/24 through 1/17/24. On 1/17/24 the treatment order changed from once per day to three times per day (every shift) and continued as NSW followed by DCD (sic). Review of the 1/19/24 Wound Evaluation and Management Summary from the Wound Physician indicated to continue the treatment to the left buttock of Alginate Calcium, Santyl, and a gauze island with border dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 1/23/24 Wound Evaluation and Management Summary from the Wound Physician indicated to continue the Alginate Calcium, continue the Santyl, add Benzocaine spray, followed by gauze island with border dressing. Review of the Skin Assessment, dated 1/26/24, indicated the treatment for the left buttocks was for Alginate Calcium, Santyl, followed by gauze island with border dressing. Review of the January and February 2024 MARs and TARs failed to indicate the Alginate Calcium was implemented, the Santyl was implemented, the gauze island with border dressing was added or the Benzocaine spray was added to the treatment. During an interview on 2/6/24 at 10:21 A.M., Resident #69 said he/she had been seen by the nurse this morning and the wound dressing had already been changed. The Resident said he/she did not know what kind of treatment was applied to the wounds, but did know that the Wound Physician said he was going to order a spray to help with the pain and the staff had not been using any spray since the Wound Doctor had said this about two weeks prior. During an interview on 2/6/24 at 11:48 A.M., Nurse #3 said she was caring for Resident #69 on this day, but the wound treatments had been completed by the Unit Manager and the Assistant Director of Nurses. Nurse #3 and the surveyor reviewed the current MAR and TAR for 2/6/24. Nurse #3 said she was unable to determine what treatment was completed for Resident #69 as there were only orders for both areas to have a NSW followed by a DCD (sic). During an interview on 2/6/24 at 12:34 P.M., Unit Manager #2 said she had provided the wound treatments to Resident #69 this morning. Unit Manager #2 and the surveyor reviewed the MARs and TARs for Resident #69. The Unit Manager said according to the medical record she was unable to tell which treatment she did this morning. She said she thought the treatment orders were on the TARs. She said for the Coccyx she thought the treatment was for NSW followed by an ABD. She said the Wound Physician did not want a gauze island with border dressing on the coccyx wound because of the tape and only wanted the ABD pad. She said she did not use Alginate Calcium on the coccyx this morning. She said she was not sure why there was an order to change the gauze island border on the coccyx twice per day and she could not say what the evening and night staff were putting on the coccyx wound, an ABD or a gauze island with border. Unit Manager #2 said for the left buttock she had applied Alginate Calcium and a gauze island with border dressing. She said she did not use Santyl this morning. She said she was not sure why the treatments on the TARs did not reflect the recommendations from the Wound Physician, but the Primary Physician was aware of the recommendations and the treatments should have been ordered per the Wound Physician recommendations. In addition, she said she was not sure what a DCD meant or what type of dressing the staff were using when the order indicated this. Review of the current active Physician's Orders included an order for the following: Alginate Calcium, Santyl, once daily, then cover with ABD once daily to the coccyx area with an order date of 1/21/24 and no start date. During an interview on 2/6/24 at 12:45 P.M., Unit Manager #2 said the order for Alginate Calcium, Santyl and ABD written on 1/21/24 had not been implemented in the electronic medical record correctly and was not available on the MAR or TAR for the nurses to administer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with record review on 2/6/24 at 12:40 P.M., Unit Manager #2 said the order for NSW followed by DCD for both the coccyx and the left buttock included orders for wound observation including drainage, odor, outcome and site and surround skin description. She said the order was changed in mid January 2024 and when the nurses were documenting the completion of the order the electronic medical record no longer required documentation for the wound observation. She said the nurses should document the wound observations daily but was unable to find the documentation in the medical record. During an interview on 2/6/24 at 1:20 P.M., the Assistant Director of Nurses (ADON) said she regularly conducted wound rounds with the Wound Physician. She said the Wound Physician would give her verbal recommendations and send the Wound Evaluation and Management Summary with the written recommendations. She said when recommendations were made the Primary Physician was contacted. She reviewed the medical record for Resident #69 at this time and said there was no indication the Primary Physician had declined any of the Wound Physician recommendations and did not recall the Primary Physician declining any wound treatments for Resident #69. She said the most recent treatments the Wound Physician recommended should be the current treatment orders for the coccyx and the left buttock for Resident #69. The ADON said she was not sure why there was an order to change the gauze island with border on the coccyx twice per day. She said she was not sure what DCD was, that maybe it was a dry dressing, but could not say what type of dressing the nurses would be putting on the wounds. She said the Wound Physician had recommended Benzocaine spray to both the coccyx and the left buttock wounds on the most recent visit and had suggested that the staff obtain it from a local store instead of waiting for the item to be ordered. She said Benzocaine spray was used to make the Resident more comfortable during a dressing change. She said the staff had gone out to get the Benzocaine spray and it was at the facility. She said the treatment orders should have been updated to include the Benzocaine spray to be used during the treatments, but the medical record did not reflect that it was being used. 48084 2. Resident #33 was admitted to the facility in April 2022 with diagnoses which included pressure ulcer of the sacral region stage 4 and osteomyelitis. Review of the MDS assessment, dated 1/17/24, indicated Resident #33 was cognitively intact as evidenced by a score of 15 out of 15 on the BIMS, required maximum assistance/was dependent for Activities of Daily Living (ADLs) and had an unhealed stage 4 pressure ulcer, which was present on admission. Review of the current Physician's Orders indicated but was not limited to the following: -Skin Integrity check reminder-complete weekly skin check evaluation every evening shift on Friday. (9/12/23) -ROHO Cushion to wheelchair when in use, check placement and inflation every day and every evening shift. (1/23/24) -Treatment (pressure ulcer sacral region) cleanse with normal saline, pat dry, apply Calcium Alginate, Santyl ointment, and cover with a superabsorbent silicone dressing daily and as needed. (7/12/23) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lidocaine 4% External Cream (for pain) apply to sacral wound topically every dayshift and as needed for pain management. (10/3/23) Review of the current Care Plans indicated but were not limited to the following: Focus: Resident #33 has a pressure ulcer to the left sacral region. Goal: Pressure Ulcer will show signs of healing and remain free from infection. Interventions: -Administer treatments as ordered and monitor for effectiveness. -Assess/record/monitor wound healing. Measure length, width, depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the doctor. -Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate. Review of the weekly Skin Assessments from June 2023 through February 2024 failed to indicate a weekly skin assessment had been completed between 7/17/23 and 9/15/23. During an interview on 2/6/24 at 2:30 P.M., Unit Manager #2 said all residents should have a skin check/assessment done weekly. During an interview on 2/5/24 at 12:30 P.M., the ADON said all residents should have weekly skin checks/assessments completed on the computer. During an interview on 2/06/24 at 1:40 P.M., the DON said all residents should have weekly skin assessments completed and was unsure why these ones were not done. Review of the Skin Assessment, dated 11/1/23, indicated Resident #33 had been seen by the wound physician on 10/31/23 and had a new order for his/her sacrum for Collagen rope with Silver (antimicrobial dressing used to restores balance and help jump start stalled wounds), followed by superabsorbent silicone dressing daily. Additionally, the skin check indicated the Physician would be notified of new recommendation for antibiotic. Review of the Skin Assessment, dated 11/7/23 indicated to continue the treatment of Collagen rope with Silver, followed by superabsorbent silicone dressing daily to his/her sacrum and per the Wound Physician to start a six-week course of antibiotic to treat osteomyelitis and to re-assess in six weeks. Review of the Skin Assessment, dated 11/28/23, indicated treatment was Collagen rope with Silver, followed by superabsorbent silicone dressing daily to his/her sacrum. Review of the Skin Assessment, dated 12/5/23, indicated treatment was Collagen rope with Silver, followed by superabsorbent silicone dressing daily to his/her sacrum. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/24 at 12:30 P.M., the ADON said she does weekly rounds with the Wound Physician, reviews the recommendations, writes the new orders, documents on the Skin Assessment the weekly measurement and new orders. During review of Resident #33's medical record including Physician Orders, TAR, Skin Assessments, Wound Care Summaries with the ADON she said the Calcium Alginate and Santyl treatment is not the same as Collagen rope with Silver and the order was never entered into the electronic medical record when it should have been in October 2023, so Resident #33 had been getting the wrong treatment since October 2023. Review of the Wound Physician's Wound Evaluation and Management Summaries from June 2023 through February 2024 indicated but were not limited to the following: -7/11/23, Stage 4 Pressure Wound was deteriorated due to infection. Wound treatment plan was to change the treatment to Calcium Alginate and Santyl ointment followed by superabsorbent silicone dressing and recommended to start intravenous antibiotics for six weeks for clinical osteomyelitis (Resident had documented historical/chronic osteomyelitis to the sacral area prior to admission). -9/26/23, Stage 4 Pressure Wound treatment plan was to add Lidocaine 4% cream to current treatment of Calcium Alginate and Santyl followed by superabsorbent silicone dressing. -10/24/23, Stage 4 Pressure Wound treatment plan included a recommendation to consider a six-week course of antibiotics for exposed bone. -10/31/23, Stage 4 Pressure Wound was not at goal and treatment plan was to change the treatment to Lidocaine 4% cream, followed by Collagen rope with Silver and to cover with superabsorbent silicone dressing and to consider a six-week course of antibiotics for exposed sacrum. -11/7/23, Stage 4 Pressure Wound was not at goal and treatment plan was to continue the treatment of Lidocaine 4% cream, followed by Collagen rope with Silver and to cover with superabsorbent silicone dressing and to consider a six-week course of antibiotics for exposed sacrum. -11/14/23 and 11/21/23, had the same treatment and antibiotic notes in treatment plan for the Sacral Stage 4 Pressure Wound as the 11/7/24 summary. -The Wound Evaluation & Management Summaries from 11/28/23 through 1/23/24 continued to list the treatment plan as Lidocaine 4% Cream, followed by Collagen rope with Silver and to cover with superabsorbent silicone dressing. Review of the Physician's Orders indicated an order for Lidocaine 4% Cream was obtained on 10/3/23 (seven days after the Wound Physician recommended it). Review of the Physician's Orders failed to indicate an order was obtained for antibiotics due to exposed bone from 10/24/23 through 11/21/23, as recommended by the Wound Physician. Further review of the Physician's Orders failed to indicate an order was obtained for the Collagen rope with Silver covered with superabsorbent silicone dressing from 10/31/23 through 2/6/24, as recommended by the Wound Physician. (continued on next page)

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the progress notes (including nurse, physician, and nurse practitioner notes) failed to indicate the recommendation to change the sacral wound treatment and to consider a six-week course of antibiotics had been reviewed with the Physician from 10/24/23 through 2/6/24.

During an interview on 2/5/24 at 4:05 P.M., the ADON said Resident #33 had been getting the wrong treatment since October 2023 the Physician and Wound Physician do not want to change it now because he/she is doing well.

During an interview on 2/1/24 at 2:39 P.M., Nurse Practitioner #1 said she typically goes with whatever the Wound Physician recommends, unless she adamantly disagrees but that is rare. She said the staff typically text her when the Wound Physician makes recommendations to obtain new orders and she was not aware recommendations were made in October to change the treatment or for the six-week course of antibiotics.

The surveyor made observations of wound care on 2/1/24 at 9:06 A.M., which included but was not limited to the following:

-Nurse #1 had supplies on the overbed table (skin cleanser, Calcium Alginate, Santyl, Lidocaine, Opti foam dressing).

-Nurse #1 removed soiled dressing.

-Nurse #1 sprayed the Skintegrity wound cleanser on the wound and patted the wound with gauze to dry.

-Nurse #1 applied the Lidocaine 4% to the periwound (skin surrounding edge of wound) with a cotton swab.

-Nurse #1 applied the Santyl ointment to the wound bed, sides of wound and the periwound.

-The wound perimeter was noted to be macerated (softening and breakdown of skin from prolonged exposure to moisture).

-Nurse #1 layered two 2x2 inch DermaGinate (Calcium Alginate) pads on top of each other in opposite directions (there was now eight points instead of four on a square the way the two pads were layered).

-Nurse #1 then put the Calcium Alginate in the wound bed, pushing the center of the two layered pads into the wound. The pads were notably larger than the wound bed and hung over the wound covering the entire periwound and healthy tissue surrounding the wound.

-Nurse #1 applied the Opti foam dressing over the Calcium Alginate.

Review of the Santyl ointment website (https://santyl.com) indicated but was not limited to the following:

-Apply Santyl ointment out to the edges of the wound.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Sachem Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 66 Central Street East Bridgewater, MA 02333	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-New epithelial and granulation tissue grows from the wound edges. -Take care not to extend beyond the wound surface. Review of the Calcium Alginate website (https://dermarite.com) indicated but was not limited to the following: -Conforms readily to any wound bed. -Absorbent gel forming debriding agent. -Alginate should be folded cut to the shape of the wound and applied directly. During an interview on 2/1/24 at 9:38 A.M., Nurse #1 said during wound care she put the Lidocaine to the periwound, then Santyl to wound base and periwound, and put the Calcium Alginate into the wound extending over the wound edges to help with drainage. During an interview on 2/6/24 at 12:51 P.M., ADON said Calcium Alginate should just cover the wound itself; should not cover intact skin. During an interview on 2/06/24 at 1:40 P.M., the DON said the Calcium Alginate should be cut to fit and only be placed in wound bed; should avoid intact skin. During an interview on 2/6/24 at 2:30 P.M., Unit Manager #2 the Santyl should only have been put in the wound bed and not on the edges or the periwound and the Calcium Alginate should have been cut to fit in the wound and not extend over the wound or on the outside of the wound on healthy skin as it can damage healthy skin. Further Review of the Progress Notes indicated but were not limited to the following: -12/22/23, a wheelchair cushion was ordered and pending delivery. -12/29/23, wheelchair cushion was still pending delivery. -1/5/24, the ROHO cushion was in place. -1/10/24, Resident inquired about new cushion and did not get out of bed because he/she wants the new cushion. The cushion was in the building, but therapy had to do a full evaluation for safety. -1/12/24, new cushion in place. -1/20/24, ROHO cushion in place and staff educated on inflation. Review of the Physical Therapy Evaluation and Plan of Treatment, dated 1/11/24, indicated Resident Goals were to receive ROHO management education. Additionally, Rehab Staff #3 noted the ROHO needed to be checked daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Physical Therapy Progress note, dated 1/18/24, indicated staff education was complete and Resident was being discharged from therapy. Review of the Physical Therapy Discharge Summary, dated 1/18/24, indicated goals were met and staff education was completed on 1/18/24. Review of the Staff Education titled ROHO Training, undated, provided to the Surveyor by Rehab Staff #3 indicated the Director of Nurses (DON) and two Certified Nursing Assistants (CNAs) (CNA #1 and CNA #2). None of the nurses caring for Resident #33 were educated on the inflation of the ROHO, placement of the cushion, and how to fill the cushion. During an interview on 2/6/24 at 9:10 A.M., Rehab staff #3 said the floor nurses were responsible for maintaining the cushion and they were not part of this education, and they should have been. During an interview on 2/5/24 at 12:30 P.M., the ADON said Resident #33 has a ROHO cushion and it took a while to get it, but she has nothing to do with ordering and does not know who has been educated on how to use the cushion. During an interview on 2/5/24 at 1:05 P.M., Nurse #4 said Resident #33 has a ROHO cushion and she just makes sure it is intact, sanitizes it if it gets soiled, and it does not have any settings, it is inflated and does its own thing. Additionally, she said she doesn't have to do anything special, just visualize it, and she thinks the aides can put more air in it if needed but she has never seen it done. During an interview on 2/6/24 at 10:30 A.M., CNA #2 said Resident #33 has a cushion in his/her chair that has an air pump, but she doesn't know anything about it. During an interview on 2/6/24 at 10:46 A.M., CNA #1 said he checks the cushion for air, then after we get him/her in the chair if he/she says they are good we don't do anything, but if it needs air, there is a pump. CNA #1 said he doesn't check anything; he just goes by what the Resident says. During an interview on 2/6/24 at 2:25 P.M., Nurse #3 said she didn't know anything about the chair cushion. Then she said he/she has an air cushion, so we just check to make sure it has air in it, but that is all, nothing special. 48362 3. Resident #73 was admitted to the facility in December 2023 with diagnoses including Stage 3 pressure injury of the left buttock, weakness, and rhabdomyolysis (breakdown of skeletal muscle due to direct or indirect muscle injury). Review of the MDS assessment, dated 12/23/23, indicated Resident #73 had a BIMS score of 14 of 15, indicating he/she was cognitively intact. Review of Section M: Skin Conditions of the MDS assessment indicated the Resident had two stage 3 pressure ulcers/injuries on admission. The assessment also indicated Resident #73 was receiving pressure ulcer/injury care including the application of non-surgical dressings and ointments. Review of Resident #73's December 2023 Physician's Orders indicated the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Start Date 12/18/23: Left Buttock - Normal Saline Wash (NSW) + Calcium Alginate + Cover with Border Gauze Dressing every day shift and as needed (PRN). Review of the consultant Wound Physician's documentation, dated 12/26/23, indicated the following: - Stage 3 pressure ulcer of the left buttock measuring 4.0 x 0.5 x 0.1 cm. - Stage 3 pressure ulcer of the right buttock measuring 2.5 x 1.0 x 0.1 cm. - Treatment recommendations for both pressure wounds included Calcium Alginate, Santyl, and a super absorbent gelling fiber with silicone border and faced dressing once a day x 30 days. - Further recommendations included: off-load area and reposition per facility protocol. Review of the Nursing Skin Assessment, dated 12/27/23, indicated the following: - Resident #73 was seen on 12/26/23 during wound rounds. - The assessment indicated the right upper sacrum area had been resolved. - The assessment indicated the left buttock pressure area had a size of 4.0 x 0.5 x 0.1 cm and was to be treated with Calcium Alginate followed by superabsorbent gelling fiber with silicone border and faced dressing. Further review of the Nursing Skin Assessment, dated 12/27/23, failed to indicate the consultant Wound Physician's recommendation for Santyl to the left buttock. The assessment also failed to indicate the Stage III pressure wound to the right buttock as indicated by the consultant Wound Physician. Review of Resident #73's December 2023 TAR indicated an order for the left buttock to have a treatment of NSW, Calcium Alginate, cover with border gauze dressing. The TAR indicated this was the only dressing treatment completed from 12/18/23 through 12/28/23 daily. The TAR failed to indicate orders for Calcium Alginate, Santyl, and super absorbent gelling fiber with silicone border and faced apply once daily for 30 days which was recommended by the consultant Wound Physician on 12/26/23. Review of Resident #73's medical record indicated a change in medical status resulting in rehospitalization on [DATE]. The medical record indicated Resident #73 returned to the facility on [DATE]. Review of Resident #73's current Physician's Orders indicated the following: - Start Date 12/18/23: Left Buttock - Normal Saline Wash (NSW) + Calcium Alginate + Cover with Border Gauze Dressing every day shift and as needed (PRN). - Start Date 1/21/24: Calcium Alginate apply once daily for 30 days on left buttock; superabsorbent gelling fiber with silicone border faced apply once daily for 30 days. - Start Date 1/21/24: Santyl apply once daily for 30 days on left buttock. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #73's consultant Wound Physician's documentation, dated 1/19/24, indicated the following: - Resident was being evaluated for wound on his/her left and right buttock. - The stage 3 pressure ulcer of the right buttock had resolved on 1/19/24. - The stage 3 pressure ulcer of the left buttock measuring 1.2 x 0.9 x 0.1 cm. - The area was noted to be improving as evidenced by decreased surface area. - Treatment recommendation: Calcium Alginate, Santyl, and super absorbent gelling fiber with silicone border and faced dressing once daily for 30 days. - Further recommendations indicated: off-load the area and reposition per facility protocol. Review of Resident #73's Nursing Skin Assessment, dated 1/21/24, indicated the following: - Resident #73 was seen on 1/19/24 during wound rounds. - The left buttock pressure ulcer had a size of 1.2 x 0.9 x 0.1 cm and was improving. - The assessment indicated the area was to be treated with Calcium Alginate, Santyl and super absorbent gelling fiber with silicone border and faced dressing once daily for 30 days. - The assessment indicated recommendations for the area to be off-loaded and for the Resident to reposition per facility protocol. Review of Resident #73's consultant Wound Physician documentation, dated 1/26/24, indicated the following: - Resident was being evaluated for wound on his/her left and right buttock. - The stage 3 pressure ulcer of the left buttock measuring 1.0 x 0.8 x 0.1 cm. - The area was noted to be improving as evidenced by decreased surface area. - Treatment recommendation: Calcium Alginate, Santyl and super absorbent gelling fiber with silicone border and faced dressing once daily for 30 days. - Further recommendations in [TRUNCATED]

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 43935 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to manage a contracture and prevent further potential complications in one Resident (#9) with muscular sclerosis, out of a total resident sample of 21 residents. Findings include: Resident #9 was admitted to the facility in July 2019 with diagnoses which included: multiple sclerosis (MS), dementia, and cognitive communication deficit. On 1/30/24 at 9:02 A.M., the surveyor observed Resident #9 sitting in a Broda chair (positioning chair) in his/her room with a closed left hand. The surveyor did not observe any brace or assistive device in the room or on the Resident. During an interview with observation on 1/31/24 at 8:09 A.M., the surveyor observed Nurse #9 assisting the Resident with his/her breakfast meal. The Resident's left hand was observed to be tightly closed with the arm lying across his/her upper abdomen. Nurse #9 said the Resident's left hand is contracted closed and is not usable. She said the Resident used to wear a splint on that hand but she is unsure of where it went or why the Resident no longer has one. On 1/31/24 at 11:54 A.M., the surveyor observed the Resident sitting in a Broda chair in his/her room watching television. The left arm was resting over the upper portion of the Resident's abdomen and the left hand was closed with no hand roll, cloth, splint, or device in place or observed in the room. Review of the medical record for Resident #9 indicated but was not limited to the following: - Two licensed monthly summaries completed on 1/8/23 and 3/3/23 respectively that indicated functional limitation related to contractures and limited range of motion (ROM). - Two healthcare Nurse Practitioner (NP) notes, dated 2/6/23 and 4/3/23, indicated Resident had muscle rigidity, extremity stiffness, and contractures. - An Occupational Therapy (OT) evaluation on 4/4/23 failed to indicate the Resident had any upper extremity contractures and indicated the ROM and strength in the Resident's upper extremities was not tested during this evaluation. - Review of the Certified Nurse Assistant (CNA) care card Kardex on 1/31/24 failed to indicate the Resident had a contracture or any interventions were in place or necessary for the care and management of the Resident related to the left-hand contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of the facility's NP and Attending Physician's Progress Notes from 1/30/23 through 1/31/24 failed to indicate the Resident was being monitored for continued progression of her MS, had contractures or had any treatment or management in place to prevent complications of the left-hand contracture. - Review of the Nurse Progress Notes from 1/1/2023 through 1/31/24 failed to indicate the Resident had a left-hand contracture or any treatment or management in place to prevent potential complications from a left-hand contracture. - Review of Resident #9's diagnosis list failed to indicate a contracture was present. - Current physician's orders from 2/1/24 failed to indicate the Resident had any orders for a device to prevent further complications of the left-hand contracture. Review of Resident #9's Minimum Data Set (MDS) assessments on file indicated but were not limited to the following: - Assessment reference date (ARD) 1/10/24; Section G, functional status question G0400, limitation in ROM: upper extremity (shoulder, elbow, wrist, hand) = no impairment The four prior MDS assessments with ARD's 10/11/23, 7/12/23, 4/1/23, and 2/22/23 also failed to indicate under Section G that the Resident had limited upper extremity ROM. During an observation with interview on 1/31/24 at 12:48 P.M., the surveyor observed Hospice Staff #3 sitting in the Resident's room and the Resident was sitting in his/her Broda chair and the television was on. The surveyor observed the Resident to have a closed left hand with his/her arm resting over his/her lap. Hospice Staff #3 said the Resident has been on and off hospice over the last few years and she knows the Resident well. She said the left hand cannot be opened and has been contracted for as long as she can remember. She said she does not recall the Resident ever having any type of brace or device placed in his/her hand since he/she has been on hospice. She attempted to open the Resident's left hand and said it was very tight and did not want to force the hand open and cause the Resident any pain or discomfort. Review of the Resident's current care plans, as of 1/31/24, failed to indicate the Resident had a left-hand contracture or any interventions in place to prevent potential complications related to the left-hand contracture. During an observation with interview on 2/1/24 at 7:32 A.M., Nurse #10 observed the Resident in bed with a closed left hand and no device in place with the surveyor present. She said the Resident's left hand had been contracted closed for a long time and the Resident does not use any type of splint or device to prevent complication of the contracture, although she believed the Resident did at one time prior to being on hospice services. She attempted to open the Resident's left hand for a skin inspection, the hand was tightly closed with the fingers lying straight down across the lower part of the palm and the thumb over the fingers. She said she could not manipulate the hand further than approximately a one finger width open without causing the Resident discomfort. She said pressure, moisture, and pain would be a potential concern for this Resident and management of the contracture to prevent these complications. She said the Resident is on hospice and could not be seen by skilled rehab until hospice was contacted for approval. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/1/24 at 1:18 P.M., CNA #6 said she knows the Resident and the Resident had a known left-hand contracture. She said the Resident does not have any type of brace or hand roll or towel placed in her left hand and she does not recall seeing anyone do that. She said the Resident doesn't use the left hand and it is closed all the time and the Resident has almost always been dependent on the staff for care. During an interview on 2/1/24 at 1:27 P.M., Nurse #9 said the Resident's left hand is contracted and cannot even be opened fully for skin checks but they can open it slightly to look inside. She said the Resident had a pillow like hand roll splint that he/she used to use, but she has not seen that device since the Resident has been on hospice this last time. She said she is not sure why the Resident doesn't have it or where it went but it has been a long time since the Resident has had it. She said typically if the staff identified an issue like this, they would write a note, inform management and notify skilled rehab to look at the patient for something, but rehab typically does not see people on hospice without prior approval, she said she would notify management of this concern for further guidance on what she should do. During an interview on 2/1/24 at 4:07 P.M., the Director of Rehab said he was contacted by nursing to perform a rehab screen on Resident #9 for the left-hand contracture and there is a scheduled OT evaluation for the Resident on 2/2/24. He said the hand contracture does not appear new but he would need to wait for a full OT evaluation. He reviewed the April 2023 OT evaluation and said that evaluation was not completed to the standard since the upper extremities were not evaluated and the evaluation scheduled would be more complete. During an interview on 2/1/24 at 4:34 P.M., the Director of Nurses (DON) said Resident #9 had been known to have the left-hand contracture since at least October of 2023 when she started working at the facility. On review of the medical record, she said she does not know why there is no mention of the contracture or why there was no care plan in place to manage the contracture and prevent complications. On 2/2/24 at 9:39 A.M., the surveyor observed the Resident out of bed sitting in a Broda chair in his/her room with an unrolled flat face cloth placed in between the palm and fingers of the left-hand contracture. The Resident appeared comfortable and smiled at the surveyor but was unable to answer any questions. During an interview on 2/2/24 at 9:54 A.M., CNA #4 said she provides care to the Resident every day she is at the facility and knows Resident #9 very well. She said the left hand of Resident #9 has been contracted for a very long time. She said when you open the hand it is very minimally and only to clean it. She said the Resident used to have a roll that was pillow like and held in place with an elastic on the back that was worn in the Resident's left hand and that the Resident would sometimes remove the roll but she does not know what happened to it and doesn't believe she has seen it since maybe around last spring, when the Resident went back on hospice services. Review of the most recent Hospice certification and plan of care dated: 12/18/23 for certification period: 12/29/23 - 2/26/24, failed to indicate Resident #9 had a left-hand contracture or any treatments or management in place to prevent potential complications of the contracture.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on observations, interviews, record review, and policy review, the facility failed to identify a significant weight loss of over 10% in one month and provide treatment and interventions to prevent further unprescribed, unplanned weight loss for one Resident (#71), out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Weight Measurement, dated as revised February 2022, included but was not limited to: - All residents will be weighed at a minimum monthly - Residents with a weight variance of 5% or more or less than the previous month will be re-weighed. - The charge nurse will notify the physician, responsible party and dietician when a 5% more or less variance is noted. - The dietician will review the resident weight and make recommendations accordingly. - When a significant weight fluctuation of 5% more or less is noted, the resident will be weighed based on determination of the Interdisciplinary Team (IDT). - The resident plan of care will be updated accordingly. Resident #71 was admitted to the facility in June 2023 with diagnoses including: dysphagia (difficulty swallowing), hemiparesis, hypertension, and diabetes type II. Review of the Minimum Data Set (MDS) assessment, dated 12/19/23, included but was not limited to the following: - Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident is cognitively intact. - Section K of the MDS, which indicated swallowing/nutritional status, and triggered for weight loss of 5% or more in the last month or 10% or more in the last 6 months. - Section K also indicated that Resident #71 was not on a prescribed weight loss regimen. Review of Resident #71's current Physician's Orders indicated the Resident was on a 2 gm (gram) Na+(sodium) diet with regular consistency texture and thin liquids, and small portions. Review of Resident #71's Nutritional Quarterly Assessment, dated 11/29/23, indicated but was not limited to the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nutritional plan: discontinue super cereal and super pudding (high calorie, high nutrient food) due to good intake and to encourage gradual weight loss On 1/31/24 at 8:06 A.M., the surveyor observed Resident #71, sitting upright in bed, consuming 100% of his/her breakfast, feeding himself/herself, with a Certified Nursing Assistant (CNA) present in the room. On 2/1/24 at 7:33 A.M., the surveyor observed Resident #71, sitting upright in bed, consuming 100% of his/her breakfast, feeding himself/herself. Review of Resident #71's weights in the medical record indicated the following: - 11/07/23: 210 pounds (lbs.) - 12/05/23: 187 lbs. - 12/06/23: 187 lbs. - 12/07/23: 187 lbs. (loss of 10.95% in one month) - 12/08/23: 188.2 lbs. - 01/07/24: 184.8 lbs. Review of Resident #71's weights from 11/07/23 to 12/07/23 indicated a significant weight loss of 10.95%. Review of Resident #71's Progress Notes by nursing, Primary Physician, Nurse Practitioner or the Registered Dietitian, dated 12/1/23 through 2/2/24, failed to indicate any documentation of the significant weight loss. During an interview on 2/2/24 at 11:16 A.M., CNA#3 said she reports any changes in a resident's weight to the nurse and was not aware of Resident #71's weight loss. During an interview on 2/2/24 at 11:11 A.M., Nurse #9 said if there are any changes in a resident's weight of three pounds they will obtain daily weights for three days. If the three weights demonstrate the loss or gain is accurate, it is reported to the MD or Nurse Practitioner and the Director of Nursing (DON). Nurse #9 reviewed the record and was unable to locate any documentation the weight loss had been reported to the MD, Nurse Practitioner, HCP or DON. Nurse #9 said she doesn't know why Resident #71's super cereal and super pudding had been discontinued. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/24 at 3:41 P.M., the Registered Dietitian said he was aware of the significant weight loss, but said he was not sure how or why the weight loss occurred. He said when the Resident was admitted he/she weighed around 210 pounds, and now the Resident weighed around 180 pounds. He said the super cereal and super pudding were discontinued because the Resident was starting to eat better. The Dietitian said the process for when a significant weight loss was identified was for the Dietitian to speak with the nursing staff and the resident regarding food preferences for extra calories, make recommendations and notify the provider. The Dietitian said he had not made recommendations (to address the weight loss) or notified the provider of Resident #71's significant weight loss. During an interview on 2/6/24 at 4:02 P.M., the MDS nurse said the quarterly MDS, dated [DATE], indicated a weight loss of greater than 5% without a prescribed weight loss regimen and was completed by the dietitian. She said the dietitian sends a report to the DON and the resident is followed by the IDT at the weekly risk meeting. She said the dietitian is responsible for creating the nutritional care plan. The MDS nurse reviewed the record and said there was no nutritional care plan for Resident #71. During an interview on 2/6/24 at 4:27 P.M., the DON said her expectation for residents with weight loss is to obtain three re-weights, notify the MD or Nurse Practitioner, HCP and dietitian, and update the care plan accordingly. Residents with significant weight loss are followed by the IDT weekly in the Risk meeting. She said she was not aware of Resident #71's significant weight loss and the resident is not followed at the weekly risk meeting. She said the dietitian creates the initial nutritional care plan, and her expectation is for the resident to have one in the medical record, but there was not one.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sachem Center for Health and Rehabilitation	66 Central Street East Bridgewater, MA 02333

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F 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.

48362

Based on observation, interview, and record review, the facility failed to ensure enteral nutrition and fluids provided via a percutaneous endoscopic gastrostomy tube (PEG, an opening into the stomach for delivery of nutrition and hydration) or gastrostomy tube (G-tube, a tube inserted into the stomach through which nutrition is provided) were provided in accordance with professional standards of practice and facility policy for two Residents (#74 and #48), out of a total sample of 21 residents. Specifically, the facility failed:

1. For Resident #74, to ensure enteral feedings were provided via PEG tube in accordance with physician orders; and

2. For Resident #48, to ensure enteral formula containers and water flush bags were labeled with the Resident's name, date and time hung, and initialed by staff members.

Findings include:

Review of the facility's policy titled Enteral Tube Feeding via Continuous Pump, undated, included but was not limited to:

- The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings.

- Preparation: Verify that there is a physician's order for this procedure.

- General Guidelines: Check the enteral nutrition label against the order before administration. Check the following information: Resident name, ID, and room number; type of formula; date and time formula was prepared; route of delivery; access site; method (pump, gravity, syringe); and rate of administration (milliliters (mL)/hour).

- Initiate Feeding: On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.

1. Resident #74 was admitted to the facility in January 2024 with diagnoses including quadriplegia, tracheostomy (a small surgical opening made through the neck to assist with breathing), dysphagia (difficulty swallowing liquid or food), and paralysis of the vocal cords.

Review of the Minimum Data Set (MDS) assessment, dated 1/11/24, indicated Resident #74 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating he/she was cognitively intact. Review of Section K: Swallowing/Nutritional Status of the MDS assessment indicated Resident #74 was receiving nutritional support through a feeding tube and he/she received 51% or more of total calories through the feeding tube. The assessment also indicated the Resident was averaging 501 cubic centimeters (cc) per day or more of fluid intake.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/24 at 1:23 P.M., the surveyor observed Resident #74 was resting in bed without a tube feeding running. Prior to the observation, Resident #74's Medical Administration Record (MAR) was reviewed and indicated the tube feeding was hung on this date. On 1/31/24 at 2:23 P.M., the surveyor observed Resident #74 was resting in bed without a tube feeding running. During an interview at this time, Resident #74 said he/she was at therapy but no one had put up feeding since he/she returned. On 1/31/24 at 2:45 P.M., the surveyor observed Unit Manager #1 (who was working a shift as nurse on the unit) went into Resident #74's room with a feeding bottle and water bag. Unit Manager #1 hung the tube feed with a rate of 100 mL(milliliters)/hour and a flush rate of 250 mL/hour at every four hours. The Unit Manager dated the tube feeding as 1/31/24 at 2:35 P.M. and started the tube feeding prior to exiting the Resident's room. Review of Resident #74's current Physician's Orders indicated but were not limited to: - Start Date 1/5/24: NPO (nothing by mouth) - tube feeding only diet: NPO texture, NPO consistency - Start Date 1/5/24: Elevate head of bed (HOB) 30-45 degrees during feeding and at least one hour post feeding every shift - Start Date 1/27/24: Enteral Feed Order in the evening Glucerna 1.2 at 80 mL/hour x 20 hours = up at 1 P. M. and down at 9 A.M. - Start Date 1/6/24: Glucerna 1.2 at 100 mL/hour x 16 hours 4 P.M. - 8 A.M., H2O (water) flush at 250 mL/hour every four hours Review of Resident #74's January MAR indicated the following: - Glucerna 1.2 at 100 mL/hour x 16 hours (4 P.M. - 8 A.M.) order was administered daily from 1/6/24 through 1/31/24. - Glucerna 1.2 at 80 mL/hour x 20 hours (1 P.M. - 9 A.M.) order was administered daily from 1/27/24 through 1/31/24. Review of Resident #74's Dietitian documentation, dated 1/26/24, indicated the Resident was receiving tube feeding through PEG placement. The Dietitian documentation indicated recommendations were made to adjust the tube feeding to 80 mL/hour x 20 hours due to a desirable weight gain of six pounds (lbs.) since admission. During an interview on 1/31/24 at 2:24 P.M., Unit Manager #1 said the tube feeding for Resident #74 is administered daily. Unit Manager #1 said the feeding should be hung at 1:00 P.M. each day. She said she indicated on the MAR the tube feeding was administered prior to hanging the feeding. Unit Manager #1 said she intended to the hang the feed after marking it off as administered on the MAR but got distracted. Unit Manager #1 said she should mark off the tube feeding as administered after it was hung up in the Resident's room. She said the feeding was overdue to be administered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/24 at 2:54 P.M., Unit Manager #1 reviewed the MAR for Resident #74. Unit Manager #1 said there were two tube feeding orders present on the MAR. She said there was an original order from admission on 1/6/24 and an order was updated on 1/27/24. Unit Manager #1 said she was not sure of the correct order for the tube feedings since there were two orders in the system. Unit Manager #1 said she knew the feeding was to be hung at 1:00 P.M. but was not certain of the correct tube feeding rate and water flushes per hour. During an interview on 1/31/24 at 2:57 P.M., Nurse #1 said she was in the process of clarifying Resident #74's feeding orders. Nurse #1 said there was a duplication of orders for Resident #74's tube feedings. Nurse #1 said the Resident was seen by the Dietitian on 1/26/24 and the recommendation for a rate change was completed. Nurse #1 said the recommendations were confirmed with the Resident's physician and the order was updated. Nurse #1 said the old order for tube feeding was never discontinued. Nurse #1 said the current feeding running in Resident #74's room was incorrect. Nurse #1 said orders for tube feedings should have a water flush rate. Nurse #1 said the orders were clarified and the feeding should be running at a rate of 80 mL/hour and water flushes at a rate of 100 mL/hour every four hours as recommended by the Dietitian and accepted by the Physician. Nurse #1 said she was going to reset the feeding to indicate the proper orders. During an interview on 1/31/24 at 3:24 P.M., the Director of Nurses (DON) said when the Dietitian sees a resident they will make recommendations for changes to tube feedings. The DON said these recommendations need to be accepted or declined by the resident's physician. The DON said once the physician accepts the recommendation, they are updated in the computer. The DON said the expectation is that old orders are discontinued. The DON and the surveyor reviewed the observations for Resident #74's feeding. The DON said she would expect nurses to clarify duplicate orders with the physician prior to hanging tube feedings and not check off that both orders were administered on the TAR. The DON said tube feedings should be hung according to the order. 2. Resident #48 was admitted to the facility in December 2023 with diagnoses including dysphagia, cerebrovascular disease, and pneumonia. Resident #48 had an activated Health Care Proxy (HCP) established on 12/18/23. Review of the MDS assessment, dated 1/16/24, indicated Resident #48 had a BIMS score of 6 of 15, indicating he/she had severe cognitive impairment. Review of Section K: Swallowing/Nutritional Status of the MDS assessment indicated Resident #48 was receiving nutritional support through a feeding tube and he/she received 51% or more of total calories through the feeding tube. The assessment also indicated the Resident was averaging 501 cc per day or more of fluid intake. On 1/31/24 at 11:31 A.M., the surveyor observed the Resident resting in bed with enteral feed running. The surveyor observed the feed bag to be undated, no rate of feed listed, no initials of the nurse who hung the feeding, and no time indicating when the feed was started. The water bag hung adjacent to the enteral feeding for water flushes was also undated and without a time indicating when the water bag was started. On 1/31/24 at 1:20 P.M., the surveyor observed the Resident resting in bed with enteral feed running. The surveyor observed the feed bag to be undated, no rate of feed listed, no initials of the nurse who hung the feeding, and no time indicating when the feed was started. The water bag hung adjacent to the enteral feeding for water flushes was also undated and without a time indicating when the water bag was started. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/1/24 at 7:37 A.M., the surveyor observed the Resident resting in bed with enteral feed running. The surveyor observed the feed bag to be undated, no rate of feed listed, no initials of the nurse who hung the feeding, and no time indicating when the feed was started. The water bag hung adjacent to the enteral feeding for water flushes was also undated and without a time indicating when the water bag was started. On 2/1/24 at 12:16 P.M., the surveyor observed the Resident resting in bed with enteral feed running. The surveyor observed the feed bag to be undated, no rate of feed listed, no initials of the nurse who hung the feeding, and no time indicating when the feed was started. The water bag hung adjacent to the enteral feeding for water flushes was also undated and without a time indicating when the water bag was started. Review of Resident #48's current Physician's Orders indicated but were not limited to: - Start Date 12/18/23: NPO-tube feeding only diet; NPO texture, NPO consistency. - Start Date 1/25/24: IsoSource 1.5 at 80 mL/hour x 22 hours (up at 10 A.M. and down at 8 A.M.) with 100 mL G-tube pre/post tube feed every shift. - Start Date 1/25/24: Flush G-tube with 160 mL water every four hours and continue additional hydration flush PRN (as needed). Review of Resident #48's December and January MARs indicated treatments were administered per physician's orders. During an interview on 2/5/24 at 1:05 P.M., Unit Manager #1 said enteral feeding bottles or bags are hung daily per physician's orders. She said she was uncertain of the facility policy, but expected enteral feeding bottles or bags to be dated and timed when they were hung by the nurse administering them. Unit Manager #1 said bottles and bags were only good for 24 hours. She said if a bottle was found undated and not timed, the expectation would be for the feeding to be stopped and a new bag or bottle to be hung because you would be unable to determine when the bag was hung up. Unit Manager #1 and the surveyor reviewed the observations made regarding undated, untimed enteral feedings hung in Resident #48's room. Unit Manager #1 said she believed one of those days she had hung the enteral feeding for Resident #48. She said the enteral feeding bag should have been dated, initialed and time stamped prior to administering. During an interview on 2/6/24 at 8:08 A.M., the DON said her expectation was for nurses to check orders prior to administering enteral feedings. The DON said enteral feeding bags or bottles should be labeled with the nurse's initials, date, and time. The DON said the enteral tube feeding bottles can only be up for 24 hours. The DON said she expects unlabeled or undated enteral feeding to be taken down and rehung because you could not be certain when it was hung. The DON and the surveyor reviewed the observations of Resident #48's enteral feedings. The DON said the enteral feeding bottles and bag should have been dated, timed and initialed by the nurse administering them.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48084 Based on observation, record review, policy review, and interview, the facility failed to ensure staff provided respiratory care in accordance with professional standards for one Resident (#16), out of a total sample of 21 residents. Specifically, the facility failed to ensure nebulizer equipment was changed weekly and stored in a sanitary manner. Findings include: Review of the facility's policy titled Administering Medications through a small volume (Handheld) Nebulizer, undated, indicated but was not limited to the following: -The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. -When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. -Change equipment and tubing every seven days. Resident #16 was admitted to the facility in August 2022 with diagnoses which included chronic respiratory failure with hypoxia, pleural effusion, and chronic obstructive pulmonary disease (COPD). Review of the most recent Minimum Data Set (MDS) assessment, dated 11/8/23, indicated Resident #16 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS) and needed maximum assistance and/or was dependent with activities of daily living (ADLs). The surveyor made the following observations: -1/30/24 at 11:36 A.M., Resident #16 was in bed, nebulizer machine was on the bedside table, facemask and tubing (undated) were opened, attached to the machine on the bedside table uncovered, next to and touching personal items on the table, and a clear plastic storage bag was under the machine (undated). -1/31/24 at 9:53 A.M., Resident #16 was in bed, nebulizer machine was on the bedside table, facemask and tubing (undated) were opened, attached to the machine on the bedside table uncovered, next to and touching personal items on the table, and a clear plastic storage bag was under the machine (undated). -1/31/24 at 12:46 P.M., Resident #16 was in bed, facemask and tubing (undated) were in a clear plastic storage bag (undated), hanging from the machine. -2/1/24 at 12:36 P.M., Resident #16 was in bed, facemask and tubing (undated) were in a clear plastic storage bag (undated), hanging from the machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/5/24 at 12:00 P.M., Resident #16 was in bed, nebulizer machine was on the bedside table, facemask and tubing (undated) were opened attached to the machine on the bedside table uncovered, next to and touching personal items on the table, and a clear plastic storage bag was hanging from the machine (undated). -2/5/24 at 1:25 P.M., Resident #16 was in bed, nebulizer machine was on the bedside table, facemask and tubing (undated) were opened attached to the machine on the bedside table uncovered, next to and touching personal items on the table, and a clear plastic storage bag was hanging from the machine (undated). -2/6/24 at 9:20 A.M., Resident #16 was in bed, nebulizer machine was on the bedside table, facemask and tubing (undated) were opened, attached to the machine on the bedside table uncovered, next to and touching personal items on the table, and a clear plastic storage bag was hanging from the machine (undated). Review of Resident #16's current Physician's Orders indicated but was not limited to the following: -Albuterol Sulfate Nebulizer Solution (2.5 milligram (mg) / 3 milliliter (ml)) 0.083% one-unit inhale orally via nebulizer every six hours as needed for shortness of breath. (8/21/2023) Further review of the Physician's Orders failed to indicate an order to change equipment and tubing every seven days. Review of the Care Plan failed to indicate the equipment needed to be changed every seven days. During an interview on 1/30/24 at 11:36 A.M., Resident #16 said he/she does not use the nebulizer all the time. During an interview on 2/5/24 at 1:05 P.M., Nurse #4 said nebulizer equipment and tubing is changed as needed, there is no schedule or order to change it. Additionally, she said it is nursing judgment, if it is dirty etc. then we change it, but it should be dated when it is changed. During an interview on 2/5/24 at 12:30 P.M., the Assistant Director of Nurses (ADON) said she was not sure of the policy and would check with the Director of Nurses (DON) regarding the policy. During an interview on 2/5/24 at 4:30 P.M., the ADON said the DON was still looking for the policy and she could not speak to the process. During an interview on 2/5/24 at 4:53 P.M., the DON said nebulizer equipment should be cleaned and tubing replaced and dated weekly on the night shift. She said it was not an order in the computer, there was a book/binder on each unit to alert the night nurse who had a nebulizer and needed equipment and tubing changed. The DON was unable to locate the book on the Sachem unit. During an interview on 2/5/24 at 5:10 P.M., Nurse #2, who was on the Passport unit, was unable to locate the binder when the surveyor asked. Additionally, he was unable to speak to the process or if there was a book, however he said the tubing should be dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/24 at 5:15 P.M., the DON said the Respiratory Therapist had the books to update them and that was why she couldn't find them. During an interview on 2/5/24 at 5:20 P.M., the Respiratory Therapist said she keeps a worksheet to update who is on nebulizer treatments, inhalers, and other respiratory treatments. She said the list is all inclusive and uses it as her worksheet when she does rounds. Additionally, she said the nurses don't sign off anywhere when they change the equipment, but it should be dated when they change it. The Respiratory Therapist provided copies of the worksheets and the nebulizer change calendars from the binders. The surveyor requested historical logs, worksheets, and/or change calendar for the last 3 months. Review of the documents provided indicated five residents were on the calendars for nebulizer equipment changes and only three of the five were on the worksheet for having nebulizer orders. The worksheet had five additional residents with nebulizer treatment orders listed and Resident #16 was not on either of the documents. During an interview on 2/6/24 at 11:15 A.M., Unit Manager (UM) #1 said the nebulizer change order should populate on the treatment record in the computer for the night nurse and everyone knows it needs to be changed weekly and dated. UM #1 approached the surveyor at 11:30 A.M., and said the DON told her there was a nebulizer change binder. UM #1 said she was unaware of the binder. During an interview on 2/6/24 at 2:30 P.M., UM #2 said the tubing is changed nightly on the night shift and they don't date it stating, I don't know why, maybe for privacy or something. Additionally, she said she thinks the order populates in the computer but was unsure. UM #2 had worked the night shift the week prior and when asked about the nebulizer equipment changes UM #2 said she did not do them as she was not on the medication cart that night, so she did not do the treatments. During an interview on 2/6/24 at 11:00 A.M., the Respiratory Therapist said she was unable to provide the surveyor with historical worksheets as it was a shared document that she updates in the computer and does not save them. She said she uses them for her own tracking, and it is more of a worksheet. Additionally, she said she does not update the nebulizer change binder, the nurses on the floor do, and she has nothing to do with it, but if the book isn't accurate and the staff don't know the process then the process needs to be changed, because all the equipment isn't getting changed as it should if the list is not accurate.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49424 Based on record review, interviews, and observations, the facility failed to manage and effectively treat two Residents (#33 and #69), out of a total sample of 21 residents for pain. Specifically, the facility failed: 1. For Resident #33, to ensure staff provided requested as needed pain medication timely when the Resident had a 9 out of 10 pain level (based on a pain scale of 1-10 with 10 being the worst pain); and 2. For Resident #69, to implement Benzocaine spray (a topical anesthetic) when recommended to assist with pain during wound dressing changes of a Stage 4 pressure injury (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone) to the coccyx and a Deep Tissue Injury (DTI- pressure related injury to subcutaneous tissue under intact skin) to the left buttock. Findings include: Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to the following: -Medications are administered in a safe and timely manner, and as prescribed. -Medication administration times are determined by the resident need and benefit, not staff convenience. Factors that are considered include: enhancing optimal therapeutic effect of medication; preventing potential medication or food interactions; and honoring resident choices and preferences consistent with his or her care plan. Review of the facility's policy titled Pain-Clinical Protocol, undated, indicated but was not limited to: -The nursing staff will assess everyone for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new or worsening existing pain. -The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. -The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example wound care, ambulation, or repositioning. -The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances, social isolation, and falls. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-The staff will evaluate and report the resident's use of standing and PRN (as needed) analgesics (medications used to treat and manage pain); if there are more than occasional analgesic requests, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose of an existing analgesic, switching to another analgesic, and/or adding non-pharmacological measures. Resident #33 was admitted to the facility in April 2022 with diagnoses of osteomyelitis (infection of the bone), a stage 4 pressure ulcer of sacral region, and spinal stenosis. Review of the Minimum Data Set (MDS) assessment, dated 1/17/24, indicated Resident #33 had intact cognitive function as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of the Comprehensive Care Plans included but was not limited to: Focus: Resident has actual pain relating to pressure ulcer of sacral region, history of osteomyelitis, and spinal stenosis. Goal: Resident will not have an interruption in normal activities due to pain throughout the review date (date-initiated April 2022) Interventions: Administer medications Tylenol, Dilaudid per orders; evaluate the effectiveness of pain interventions routinely; anticipate resident's need for pain relief and respond immediately to any complaint of pain; identify and record previous pain history and management of that pain and impact of function; identify previous response to analgesia including pain relief, side effects, and impact on function. Review of the January 2024 Physician's Orders indicated the following pain medications: -Acetaminophen Tablet 325 milligrams (MG) give two tablets by mouth every 6 hours as needed for pain -Acetaminophen Extra Strength Tablet 500 MG give two tablets by mouth three times a day for pain -Dilaudid (an opioid) Oral Tablet 2 MG give 1 tablet by mouth every 12 hours as needed for pain Review of Resident #33's Pain Assessment Interview, dated 1/16/24, indicated over the past five days, pain had made it hard to sleep at night; had limited day to day activities over the past five days due to pain and had shown evidence of pain daily. On 1/31/24 at 7:10 A.M., the surveyor observed Resident #33 request pain medication from Nurse #4. The surveyor observed Nurse #4 tell Resident #33 that he/she would have to wait because the breakfast meal was on the way up from the kitchen. The surveyor observed the Resident shifting his/her weight in the wheelchair, had a furrowed brow, and was grimacing. The surveyor observed the Resident tell Nurse #4 that he/she was in a lot of pain. On 1/31/24 at 7:18 A.M., the surveyor observed Unit Manager #2 tell Nurse #4 to give Resident #33 his/her pain medication. Nurse #4 responded that the breakfast trays were going to be on the unit shortly. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 1/31/24 at 7:18 A.M. through 7:58 A.M., the surveyor observed Nurse #4 distribute breakfast trays, feed a resident breakfast, and provide cigarettes to the maintenance assistant for residents who were going out to smoke. On 1/31/24 from 7:59 A.M. through 8:03 A.M., the surveyor observed Nurse # 4 engage in non-resident related conversation with her coworkers and assist another resident by bringing them a beverage. During an interview on 1/31/24 at 8:09 A.M., Nurse #4 said Resident #33 had requested pain medications before breakfast, and she was going to give the requested medication with his/her morning medication. She said she was not supposed to give medications or take vital signs during breakfast. On 1/31/24 at 8:17 A.M., the surveyor heard Resident #33 yell out from his/her room, What is taking so long? I'm in so much pain and so sore; I asked for pain medication a while ago. Nurse #4 responded, I know, I'm coming. On 1/31/24 at 8:23 A.M., the surveyor heard Resident #33 yelling out Please, I'm in pain! On 1/31/24 at 8:25 A.M., the surveyor observed Nurse #4 give Resident #33 the requested pain medication. The surveyor observed Resident #33 wait at least 75 minutes for the requested pain medication (Dilaudid). During an interview on 1/31/24 at 8:49 A.M., Resident #33 said his/her pain was a 9 out of 10 and if the pain was any worse, he/she would have to go to the hospital. Resident #33 said he/she felt that the pain was severe and said he/she did not know why he/she waited so long in pain before the nurse came with his/her medication. Resident said he/she was waiting for the small pain pill not the Acetaminophen. Resident #33 said that he/she received the as needed pain medication last night around 7:30 P.M. and the medication did not last 12 hours. During the interview, the surveyor observed Resident #33 fidget in his/her wheelchair, attempt to weight shift, and grimace with a furrowed brow. Review of the Medication Administration Record (MAR) indicated Resident #33 received the as needed Dilaudid administered on 1/30/24 at 7:37 P.M. During an interview on 1/31/24 at 3:18 P.M., Unit Manager #2 said she did hear Resident #33 request pain medication before breakfast and she told Nurse #4 to give the medication since the Resident was saying he/she was in pain. She said that if a patient is requesting pain medication and has a physician's order it needs to be given when requested regardless of the time. During an interview on 1/31/24 at 3:27 P.M., the Director of Nurses (DON) said that her expectation was that the Resident would have received his/her medication when they asked and not have to wait until after breakfast to receive his/her requested pain medication since Resident #33 was in pain. Review of the January 2024 MAR indicated Resident #33 received the as needed Dilaudid 16 times during the month and each medication administration was coded as E for effective. (continued on next page)

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F 0697

Level of Harm - Actual harm

Residents Affected - Few

During an interview on 2/1/24 at 7:15 A.M., Resident #33 said that he/she was in pain and was waiting for pain medication that was requested an hour ago and that he/she did not know why it was taking so long.

On 2/1/24 at 7:25 A.M., the surveyor observed Nurse #5 tell the Assistant Director of Nurses (ADON) that she was waiting for the next nurse to come relieve her and only one additional resident needed medication and indicated which resident (not Resident #33).

On 2/1/24 at 7:39 A.M., the surveyor observed Nurse #5 give Resident #33 the requested pain medication (Dilaudid) at least 24 minutes after he/she asked for it.

During an interview on 2/1/24 at 10:15 A.M., the Resident said that his/her pain was often a 9 (out of 10) in the morning and that he/she had to ask for medication because the pain comes back. He/she said the medication helps for only a few hours.

Review of the Medication Administration Record (MAR) for January 2024 indicated Resident #33 received Dilaudid oral tablet 2 MG on 1/31/24 at 8:25 A.M., and on 2/1/24 at 7:31 A.M. (observed to be given at 7:39 A.M.)

On 2/1/24 at 12:40 P.M., the surveyor observed the Resident tell the DON that he/she had over an hour wait again today for pain medication.

During an interview on 2/1/24 at 2:33 P.M., the Nurse Practitioner said that she was not aware that Resident #33 has had complaints of pain and she had not been contacted by staff regarding Resident #33's pain.

During an interview on 2/1/24 at 4:36 P.M., the DON said that she met with Resident #33 who did tell her he/she had a lengthy delay for pain medication administration on 1/31/24 and 2/1/24 and on 1/31/24 the Resident said he/she was told to wait for the medication until after breakfast. The DON said the Resident should not have to wait for pain medication.

36542

2. Resident #69 was admitted to the facility in January 2024 with diagnoses of rectal cancer, Stage 4 pressure injury to the coccyx, and Deep Tissue Injury (DTI) to the left buttock.

Review of the MDS assessment, dated 1/18/24, indicated Resident #69 was cognitively intact as evidenced by a BIMS score of 13 out of 15.

Review of the care plans for Resident #69 indicated the Resident was at risk for pain related to rectal cancer with mets (metastasis- spreading of a pathogenic agent from one site in the body to another) to the bone and liver and wounds to the coccyx and left buttock. The pain interventions included: administering analgesics as per orders, anticipate need for pain relief, observe resident during care for signs of pain.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the Wound Evaluation and Management Summary, dated 1/23/24, from the Wound Physician indicated Resident #33 had an unstageable DTI of the left buttock measuring 4 centimeters (cm) in length by 2.5 cm in width by 0.5 cm in depth, with 7.5 cm of undermining at 3 o'clock and a Stage 4 pressure injury on the coccyx measuring 4 cm in length by 2 cm in width by 3.5 cm in depth. Review of the Wound Physician's treatment plan indicated to add Benzocaine spray to both wound treatments. Review of the Physician's Progress Note, dated 1/23/24, indicated Resident #33 was being followed by the Wound Physician, continued on Morphine and Oxycodone for pain management, and the Wound Physician was trialing a topical Lidocaine (a local anesthetic used to prevent pain by blocking the signals at the nerve endings in the skin) prior to dressing changes. During an interview on 2/6/24 at 10:21 A.M., Resident #69 said the wounds were very painful, crawl out of my skin painful, when treatments were performed. The Resident said the Wound Physician was supposed to order some spray to help with pain, but the staff had not been using it. He/she said the nurses knew how bad the treatments hurt and were giving an oral medication prior to the dressing change, which helped a little, but it was still very painful. During an interview on 2/6/24 at 12:34 P.M., Unit Manager #2 said Resident #69 experienced pain with the dressing changes and the nurses knew to give an as needed opioid medication prior to the treatments, but no other interventions had been initiated. She said she did not use Benzocaine spray that morning when completing the dressing changes. Review of the January and February 2024 MARs and TARs failed to indicate the Benzocaine spray was added to the treatment. During an interview on 2/6/24 at 1:20 P.M., the Assistant Director of Nurses said she regularly conducted wound rounds with the Wound Physician. She said the Wound Physician had recommended Benzocaine spray to both the coccyx and the left buttock wounds on the most recent visit and had suggested that the staff obtain it from a local store instead of waiting for the item to be ordered. She said Benzocaine spray was used to make the Resident more comfortable during a dressing change and had not been implemented for Resident #69 and the Resident continued to experience pain during dressing changes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on observation, interview, and policy review, the facility failed to ensure medications with a shortened expiration date upon opening were properly labeled once opened to prevent potential use of an expired medication in one medication cart out of five medication carts in use by the facility. Findings include: Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to the following: - The expiration/beyond use date on the medication label is checked prior to administering. - When opening a multi-dose container, the date opened is recorded on the container. On [DATE] at 11:45 A.M., the surveyor inspected the medication cart side A on the Joppa unit and made the following observations: -Four tubes of Erythromycin (antibiotic) eye ointment opened, and in use, for different residents with no opened date. During an interview on [DATE] at 11:47 A.M., Nurse #9 said the eye drops are only good for 30 days once opened and has no way of knowing if the medication has expired without an open date on the tube. During an interview on [DATE] at 4:32 P.M., the Director of Nursing (DON) was made aware of the surveyor's observations and said her expectation is that medications such as eye drops and eye ointments are dated upon opening and discarded after 30 days from the open date. She said medications are to be removed from the cart if they do not have an open date, so they cannot be used beyond the expiration date.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 36542 Based on record review and interview, the facility failed to maintain in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid program. Findings include: On 2/6/24, the surveyor requested written documentation for a transfer agreement with a hospital from the Administrator. During an interview on 2/6/24 at 11:29 A.M., the Administrator said he did not have a transfer agreement and the facility is not affiliated with any hospital. He said emergency medical services would bring a resident to the nearest hospital. At the time of exit, the facility had failed to produce a written transfer agreement between the facility and a hospital. 49424

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 36542 49424 Based on interviews and review of the Health Care Facility Reporting System (HCFRS-State agency reporting system), the facility failed to provide written notice to the State agency when a change in the facility's Director of Nursing (DON) occurred. Findings include: During an interview on 2/6/24 at 11:21 A.M., the Infection Preventionist said she was the DON from September to October 2023 and the current DON started in October 2023. The Infection Preventionist said the former administrator should have reported the changes in the DONs. Review of HCFRS indicated the last reported change in facility DON occurred on 6/26/23 but no changes indicated that that DON no longer worked for the facility beginning in September. Further review of HCFRS failed to indicate the State Agency was notified when the change took place for the previous DON in September 2023 and the current DON in October 2023. During an interview on 2/6/24 at 10:11 A.M., the Administrator said the changes in DON should have been reported in HCFRS when the changes occurred.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations, interviews, policy review, and record review, the facility failed to ensure staff implemented infection prevention and control practices and policies. Specifically, the facility failed to: 1. Implement COVID-19 testing every 48 hours for all staff during a COVID-19 outbreak for 1 out of 5 sampled staff members; 2. Follow infection control standards during a medication pass, for Resident #66 and Resident #75; 3. Follow infection control practices during a wound dressing change for Resident #73; and 4. Appropriately utilize personal protective equipment (PPE) for residents on enhanced barrier precautions and transmission-based precautions for Resident #33. Findings include: 1. Review of the facility's policy titled Coronavirus Prevention and Control, dated as revised in January 2023, indicated if the facility identifies that the resident or staff member's first exposure occurred less than 2 days ago, then they should wait to test until 24 hours after any exposure and then test residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case. Review of the facility's LTC (Long Term Care) Respiratory Surveillance Line List indicated a resident tested positive for COVID-19 on 12/25/23. During an interview on 2/2/24 at 2:00 P.M., the Infection Control Preventionist said the facility was in a COVID-19 outbreak from 12/25/23 through 1/31/24, affecting all three units. She said during this time the facility had initiated broad-based testing and was testing all staff and residents every 48 hours. She said she had not been physically present in the facility when the outbreak initiated and had instructed the Director of Nurses to conduct broad-based testing of all staff every 48 hours until the facility had gone 10 days without a new case. During an interview on 2/2/24 at 2:50 P.M., the Director of Nurses said she had documented the nursing floor staff testing on the handwritten nursing schedule and testing was conducted every other day. Review of the testing log indicated staff testing was initiated on 12/26/23 and then conducted every other day following that date. Review of time sheets indicated Nurse #4 worked on 12/27/23, 12/28/23, and 12/29/23. Review of the COVID-19 testing logs did not indicate Nurse #4 was tested during that time. During an interview on 2/6/24 at 12:23 P.M., Human Resources said Nurse #4 did not work between 1/3/24 and 1/9/24 as she was out sick. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the LTC Respiratory Surveillance Line List for staff did not indicate Nurse #4 had COVID-19. During an interview on 2/6/24 at 1:00 P.M., the Director of Nurses and the Infection Control Preventionist said Nurse #4 did not have COVID-19 when she was out sick. Review of time sheets indicated Nurse #4 returned to work on 1/10/24. Review of the COVID-19 testing logs indicated testing was conducted on 1/9/24 and 1/11/24 and did not include Nurse #4. Review of time sheets indicated Nurse #4 worked on 1/15/24 and 1/17/24 (scheduled COVID-19 testing day) and tested negative for COVID-19. Review of time sheets indicated Nurse #4 worked on 1/20/24. Review of the COVID-19 testing log indicated Nurse #4 had not been tested since 1/17/24, 3 days prior. During an interview on 2/6/24 at 1:00 P.M., the Director of Nurses said she tracked staff by having them test every other day and utilizing the nursing schedule. She said she was not sure why Nurse #4 had not tested for COVID-19 on 12/28/23 as the Nurse had been working at the facility but was not listed on the handwritten schedule as tested . The Director of Nurses said she was not sure why Nurse #4 had not been tested when she returned to the facility on [DATE]. 49425 2. Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to the following: -The Director of Nursing (DON) supervises and directs all personnel who administer medications and/or have related functions. -Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) Resident #66 was admitted to the facility in June 2023 with a diagnosis of Parkinson's disease. Review of the Physician's Orders, active as of 1/31/24, for Resident #66, indicated but were not limited to the following: -Carbidopa/Levodopa 25/100 milligrams (mg) (treats Parkinson's disease) one tablet by mouth (PO) four times a day -Multivitamin with minerals (supplement) one tablet PO daily -Amlodipine (treats high blood pressure) 5 mg one tablet PO daily -Sertraline 50 mg tablet with 25 mg tablet to equal 75 mg (treats depression) PO daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/31/24 at 10:00 A.M., the surveyor observed Nurse #4 remove the medications from a pouch and place them into a medication cup. The Sertraline 25 mg tablet missed the cup and landed on top of the medication cart. Nurse #4 put on gloves, picked up the Sertraline 25 mg tablet and placed it into the medication cup with the other medications. She then removed her gloves and performed hand hygiene. Nurse #4 then transferred the medication tablets into a pill crusher pouch and crushed them. She then took a scoop of applesauce and placed it into the medication cup and sprinkled the crushed medications on top of the applesauce. She then administered the medications to Resident #66. Resident #75 was admitted to the facility in November 2023 with diagnoses of urinary tract infection, anxiety, and anemia. Review of the Physician's Orders, active as of 1/31/24, for Resident #75, indicated but were not limited to the following: -Baclofen 10 mg one tablet (treats muscle spasms) PO twice a day -Multivitamin with minerals one tablet PO daily -Buspirone 7.5 mg one tablet (treats anxiety) PO every 12 hours On 1/31/24 at 10:06 A.M., the surveyor observed Nurse #4 remove the medications from a pouch and place them into a cup. The Buspirone 7.5 mg missed the cup and landed on top of the medication cart. Nurse #4 put on gloves, picked up the Buspirone 7.5 mg tablet and placed it in the medication cup with the other medications. Nurse #4 then removed gloves and performed hand hygiene. She then took the medication cup and administered the medications to Resident #75. During an interview on 1/31/24 at 2:22P.M., Nurse #4 said she had cleaned her medication cart in the morning, however she should not have administered the medication that fell on top of the cart to Resident #66 and Resident #75. She said she should have discarded that medication and administered a new one. During an interview on 1/31/24 at 3:50 P.M., the Director of Nurses said the top of the medication cart is considered dirty and medications that come in contact with the top of the mediation cart should not be administered because they could potentially be contaminated with germs, and it is an infection control breech. She said the expectation is that the nurse would and should have destroyed the medication and provided a new clean pill. 48362 3. Review of the facility's policy titled Dressings, Dry/Clean, undated, indicated but was not limited to the following: -Verify that there is a physician's order for this procedure. -Assemble the equipment and supplies as needed. -The following equipment and supplies will be necessary when performing this procedure: Personal protective equipment (e.g. gowns, gloves, mask etc., as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Steps in the procedure include: a. Wash and dry your hands thoroughly. b. Put on clean gloves. Loosen tape and remove soiled dressing. c. Pull glove over dressing and discard into plastic or biohazard bag. d. Wash and dry your hands thoroughly. e. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. f. Label tape or dressing with date, time, and initials. Place in clean field. g. Wash and dry your hands thoroughly. h. Put on clean gloves. i. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. j. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward). k. Use dry gauze to pat the wound dry. l. Apply the ordered dressing and secure with tape or bordered dressing per note. Label with date and initial top of dressing. m. Discard disposable gloves and designated container. Wash and dry your hands thoroughly. Resident #73 was admitted to the facility in December 2023 with diagnoses including Stage III pressure ulcer of the left buttock, weakness, and rhabdomyolysis (breakdown of skeletal muscle due to direct or indirect muscle injury). Review of the Minimum Data Set (MDS) assessment, dated 1/21/24, indicated Resident #73 had a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating he/she was cognitively intact. Further review of Section M: Skin Conditions of the MDS assessment indicated the Resident had one Stage III pressure ulcers/injuries on admission and was receiving care and treatment for the areas. Review of Resident #73's current Physician's Orders indicated the following: - Start Date 12/18/23: Left Buttock - Normal Saline Wash (NSW) + Calcium Alginate + Cover with Border Gauze Dressing every day shift and as needed (PRN). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Start Date 1/21/24: Calcium Alginate apply once daily for 30 days on left buttock; superabsorbent gelling fiber with silicone border faced apply once daily for 30 days. - Start Date 1/21/24: Santyl apply once daily for 30 days on left buttock On 2/6/24 at 11:40 A.M., the surveyor observed the following: - Nurse #8 entered the room to dress the wound. Nurse #8 completed hand hygiene prior to entering the Resident's room. Nurse #8 donned (put on) PPE including gown, gloves, and a mask prior to entering the Resident's room. - Nurse #8 gathered wound supplies from the treatment cart (including barrier paper, non-sterile 4x4 gauze pads, 4x4 drain sponge, bordered gauze and 2x2 calcium alginate) at the door of the Resident's room and set up on the overbed table after wiping it down with bleach. - Nurse #8 had the Resident roll to their side, removed the Resident's brief and undressed the left buttock wound. She then removed her gloves, returned to the treatment cart outside of the room to retrieve saline wash. - Nurse #8 returned to the Resident's bedside. Nurse #8 indicated she did not have enough gloves and started to untie her gown. The Resident indicated a box of gloves on his/her nightstand. - Nurse #8 retrieved the box of gloves from the nightstand and retied the bottom of her gown, leaving the top untied. - Nurse #8 put on a new pair of gloves and opened all the supplies on the bedside table. - Nurse #8 sprayed cleanser on the wound and patted it dry with gauze. - Nurse #8 ripped calcium alginate square in half to the approximate size of 2.0 x 1.0 cm. - Nurse #8 then stretched the calcium alginate dressing to be slightly larger than 2.0 x 1.0 cm. - Nurse #8 placed the calcium alginate over the wound and extended it onto healthy skin. - Nurse #8 covered the area with border gauze, then removed her gloves. - Nurse #8 without gloves donned re-attached the brief and repositioned the Resident, covering him/her with bed sheets. - Nurse #8 opened a biohazard bag and placed the trash bag containing used supplies inside. She then gathered up remaining supplies and threw them away. - Nurse #8 removed her gown, without gloves donned, placed it in the trash before removing her mask and completing hand hygiene. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Sachem Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 66 Central Street East Bridgewater, MA 02333	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/24 at 12:00 P.M., Nurse #8 said she performed hand hygiene at the start and end of the dressing change. Nurse #8 said she did not perform hand hygiene between glove changes. Nurse #8 said she did believe she needed to perform hand hygiene between glove changes because she was putting on a clean pair of gloves. During an interview on 2/6/24 at 12:51 P.M., the surveyor reviewed the observations made during Resident #73's dressing change with the Assistant Director of Nurses (ADON). The ADON said hand hygiene should be performed prior to starting the dressing change, as well as in between each glove change and at the end of the treatment. During an interview on 2/6/24 at 1:40 P.M., the surveyor reviewed the observations made during Resident #73's dressing change with the Director of Nurses (DON). The DON said hand hygiene should be completed at the start and end of dressing changes, as well as between any changes of gloves. 48084 4. Review of the facility's policy titled Clinical Services: Subject: Precautions to Prevent Infections, dated as last revised January 2020, indicated but was not limited to the following: -Transmission Based Precautions (TBP) are for patients who are known or suspected to be infected or colonized with an infectious agent, which require additional control measures to effectively prevent transmission. -Enhanced Barrier Precautions (EBP), which falls between standard and contact, require gown and glove use for certain residents during specific high-contact resident care activities. -High Risk Activities are identified as: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use of a device, and wound care. -Contact Precautions are intended to prevent transmission of infectious agents. -Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. -Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens. -Contact Precautions: gloves and gown (don before room entry, doff (take off) before room exit. Resident #33 was admitted to the facility in April 2022 with diagnoses which included pressure ulcer of the sacral region stage 4 and osteomyelitis. Review of the current Physician's Orders indicated but was not limited to the following: -EBP when providing high contact care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Maintain Extended-Spectrum beta-lactamase (ESBL) precautions in urine every shift (ESBL is an antibiotic resistant bacteria). Review of the Care Plan for Resident #33 indicated but was not limited to the following: -Resident is on EBP; follow facility protocol on EBP -Resident has an actual Infection ESBL Urinary Tract Infection (UTI); TBP Required; Contact ESBL Urine. On 2/1/24 at 9:06 A.M., the surveyor observed wound care for Resident #33 and made the following observations: -Nurse #1 and Certified Nurses Assistant (CNA) #1 were in Resident #33's room when the surveyor entered the room. -Nurse #1 had a gown on, the gown was tied at the waist, the top/neck tie was not tied; gloves and facemask were on. -CNA #1 had a gown with both ties tied, gloved and facemask on. -Wound care was provided by Nurse #1 and CNA #1 assisted as needed with care, including turning. -CNA #1 exited the room with the gown, gloves, and facemask that were used during care still on and walked down the hallway. -CNA #1 re-entered the room pushing the Hoyer Lift (mechanical lift to transfer resident) with his dirty gloves and gown on. -CNA #1 left the Hoyer Lift in the doorway of the room and approached the Resident in bed. -CNA #1 put Resident #33's pants on, without changing gloves or performing hand hygiene, while Nurse #1 put wound care supplies away. -CNA #1 looked in the room for the Hoyer lift pad and was unable to locate one. -CNA #1 exited the room and walked down the hallway to retrieve a Hoyer pad, still with the same dirty gown, gloves and facemask on. -CNA #1 re-entered the room with a Hoyer pad and proceeded to put the pad under the Resident, without changing gloves or performing hand hygiene. -Nurse #1's gown was noted to be falling over her shoulders while providing care. -Nurse #1 adjusted the top of her gown several times, however, did not tie the top/neck tie. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/1/24 at 9:38 A.M., Nurse #1 said the gown should have been tied at the top and bottom. Additionally, she said CNA #1 should have removed his PPE (gown, gloves and facemask) when he exited the room and put on clean PPE when he re-entered the room both times. During an interview on 2/1/24 at 12:50 P.M., CNA #1 said he should not have worn the gown and gloves in the hallway. During an interview on 2/5/24 at 12:30 P.M., the ADON said Resident #33 was on EBP because of the wound and catheter and TBP because of the ESBL in his/her urine. She said PPE should be removed in the room and disposed of and the CNA should not have gone into the hallway with the gown and gloves on. During an interview on 2/6/24 at 2:30 P.M., Unit Manager #2 said staff should not have PPE on in the hallway and it should have been removed in the resident's room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on document review and interview, the facility failed to maintain an effective training program, as indicated in their facility assessment. Findings include: Review of the Facility Assessment, dated as updated in May 2023, indicated but was not limited to the following: -Throughout the year all employees receive training and education on topics related to patient care and services. -Some training provided during general orientation is repeated at least annually. -Other topics are provided during the year based on Quality Assurance Performance Improvement (QAPI) initiatives, ensuring regulatory compliance, best practices, clinical competencies, program development, etc. Review of annual mandatory training content titled: Round [NAME] Annual Education, dated 9/21/23, indicated the following trainings were provided during the 9/21/23 mandatory in-service: -Abuse and Neglect; Resident Rights; Advance directives; Health Insurance Portability and Accountability Act (HIPAA) -ADL Training; Assisting with care; Medication errors; Controlled substance count; Pain assessment; Peri-Care -Antibiotic Stewardship; Blood Borne Pathogens; Infection Control; Covid symptoms -Dementia: Overview of Mild Cognitive Impairment; Understanding the early stage of Dementia; Management of common medical conditions during middle and late stages of Dementia; Medical treatments of Dementia; and Palliative end of life care of persons with Dementia -Change in condition; How to deal with difficult behaviors; Documentation -Safety training; Elopement; Falls Prevention; Fire Safety; Hazard Communication; Preventing Workplace Violence -Person-Centered Care Plan; Skin tears and Pressure Ulcers; Trauma Informed Care; Wound Assessment -Communication; Corporate compliance; cultural competency; Lesbian, Gay, Bisexual, Transgender, Queer, and more (LGBTQ+) -Quality Assurance Performance Improvement (QAPI); and Survey Prep (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the in-service education attendance record titled Mandatory In-services, dated 9/21/23, indicated 17 out of 93 employees on the pre-printed attendance list attended and completed the trainings. During an interview with the Assistant Director of Nurses (ADON) and Regional Nurse on 2/6/24 at 11:35 A. M., the ADON said she is responsible for staff training and has only been in the facility since October 2023. The Regional Nurse said she would provide a list of what specific content was covered in the mandatory in-services and they use a Round [NAME] annual education guide for mandatory education. The Regional Nurse reviewed the educational sign-in sheets and said, based on the number of people who appeared to have attended, the trainings were ineffective because not enough staff participated. The ADON said she would double check to see if any other in-services were provided prior to her start at the facility. During a follow up interview on 2/6/24 at 4:33 P.M., the ADON said there were no other in-service sign-in sheets or trainings available for the surveyors to review.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on documentation review and interview, the facility failed to provide their staff training in effective communication, as indicated by the Facility Assessment. Findings include: Review of the Facility Assessment, dated May 2023, indicated but was not limited to the following: Staff training/education and competencies: -Throughout the year employees receive training and education on topics related to patient care and services. -Some trainings provided during general orientation is repeated at least annually. -Other topics are provided during the year based on Quality assurance performance improvement initiatives, ensuring regulatory compliance, best practices, clinical competencies and program development. List of staff training, and competencies needed by staff type: Nurses and Certified Nurse Assistants (CNAs) and other: Communication - effective communications for direct care staff Review of annual mandatory training content titled: Round [NAME] Annual Education, dated 9/21/23, indicated but was not limited to the following mandatory trainings were provided during the 9/21/23 in-service: -Communication Review of the In-service Education Attendance Record for the Round [NAME] training, dated 9/21/23, indicated 17 of 93 employees attended the required trainings. Review of the 2023 and 2024 staff education and in-service sign-in sheets provided by the facility failed to indicate further trainings had been completed on effective communication. During an interview with the Assistant Director of Nurses (ADON) and Regional Nurse on 2/6/24 at 11:35 A. M., the ADON said she is responsible for staff training and has only been in the facility since October 2023. The Regional Nurse said she would provide a list of what specific content was covered in the mandatory in-services and they use a Round [NAME] annual education guide for mandatory education. The Regional Nurse reviewed the educational sign-in sheets and said, based on the number of people who appeared to have attended, the trainings were ineffective because not enough staff participated. The ADON said she would double check to see if any other in-services were provided prior to her start at the facility. (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/24 at 4:33 P.M., the ADON said there were no other in-service sign-in sheets or trainings available for the surveyors to review.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on document review and interview, the facility failed to ensure staff attended and received education on the facility Quality Assurance and Performance Improvement (QAPI) program, as indicated in the Facility Assessment. Findings include: Review of the Facility Assessment, dated as updated in May 2023, indicated but was not limited to the following: -Throughout the year all employees receive training and education on related topics to patient care and services. -Some training provided during general orientation is repeated at least annually. -Other topics are provided during the year based on Quality Assurance Performance Improvement (QAPI) initiatives, ensuring regulatory compliance, best practices, clinical competencies, program development, etc. -List of staff training and competencies needed by staff type: -Nurses and Certified Nurse Assistants (CNAs), and Others: Quality Assurance Performance Improvement (QAPI). Staff educator or designee will educate facility staff on QAPI on hire Review of annual mandatory training content titled: Round [NAME] Annual Education, dated 9/21/23, indicated the following mandatory trainings were provided during the 9/21/23 in-service: -Quality Assurance Performance Improvement (QAPI) Review of the Inservice Education Attendance Record for the Round [NAME] training, dated 9/21/23, indicated 17 of 93 employees attended the required trainings. Review of the 2023 and 2024 staff education and in-service sign-in sheets provided by the facility failed to indicate further trainings had been completed. During an interview with the Assistant Director of Nurses (ADON) and Regional Nurse on 2/6/24 at 11:35 A. M., the ADON said she is responsible for staff training and has only been in the facility since October 2023. The Regional Nurse said she would provide a list of what specific content was covered in the mandatory in-services and they use a Round [NAME] annual education guide for mandatory education. The Regional Nurse reviewed the educational sign-in sheets and said, based on the number of people who appeared to have attended, the trainings were ineffective because not enough staff participated. The ADON said she would double check to see if any other in-services were provided prior to her start at the facility. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 2/6/24 at 4:33 P.M., the ADON said there were no other in-service sign-in sheets or trainings available for the surveyors to review.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on documentation review and interview, the facility failed to ensure their staff were educated on infection control and prevention which included, training on standards, policies, and procedures for the facility's infection prevention and control program. Findings include: Review of the Facility Assessment, dated May 2023, indicated but was not limited to the following: Staff training/education and competencies: - Throughout the year employees receive training and education on topics related to patient care and services. - Some trainings provided during general orientation is repeated at least annually. - Other topics are provided during the year based on Quality assurance performance improvement initiatives, ensuring regulatory compliance, best practices, clinical competencies and program development. List of staff training, and competencies needed by staff type: Nurses and Certified Nurse Assistants (CNAs), and other: -Infection control - a facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies and procedures for the program. -Orientation, in-service use of personal protective equipment (PPE), Infection control and hand washing, environmental rounds, Covid signs and symptoms, Outbreak and surveillance policy/procedures, Vaccine (influenza, Covid, Pneumonia, Hepatitis B) policy and Methicillin drug resistant organism policy and procedures. Review of annual mandatory training content titled Round [NAME] Annual Education, dated 9/21/23, indicated the following trainings were mandatory for staff and provided during the 9/21/23 mandatory in-service: -Antibiotic Stewardship; Blood Borne Pathogens; Infection Control; Covid symptoms Review of the In-service Education Attendance Record for the Round [NAME] training, dated 9/21/23, indicated 17 of 93 employees attended the required infection control and prevention trainings. Review of the 2023 and 2024 staff education and in-service sign-in sheets provided by the facility failed to indicate further trainings had been completed on all the facility required pieces of infection control and prevention as indicated in the Annual Round [NAME] education guidelines. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Assistant Director of Nurses (ADON) and Regional Nurse on 2/6/24 at 11:35 A. M., the ADON said she is responsible for staff training and has only been in the facility since October 2023. The Regional Nurse said she would provide a list of what specific content was covered in the mandatory in-services and they use a Round [NAME] annual education guide for mandatory education. The Regional Nurse reviewed the educational sign-in sheets and said, based on the number of people who appeared to have attended, the trainings were ineffective because not enough staff participated. The ADON said she would double check to see if any other in-services were provided prior to her start at the facility. During a follow up interview on 2/6/24 at 4:33 P.M., the ADON said there were no other in-service sign-in sheets or trainings available for the surveyors to review.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on document review and interview, the facility failed to provide their staff training on facility ethic standards, policies, and procedures. Findings include: Review of the Facility Assessment, dated May 2023, indicated but was not limited to the following: Staff training/education and competencies: - Throughout the year employees receive training and education on topics related to patient care and services. - Some trainings provided during general orientation is repeated at least annually. - Other topics are provided during the year based on Quality assurance performance improvement initiatives, ensuring regulatory compliance, best practices, clinical competencies and program development. The Facility Assessment failed to indicate ethics and compliance training were required in accordance with the regulations. Review of annual mandatory training content titled Round [NAME] Annual Education, dated 9/21/23, indicated the following trainings were mandatory for staff, included but were not limited to the following and were provided during the 9/21/23 in-service: -Corporate compliance Review of the In-service Education Attendance Record for the Round [NAME] training, dated 9/21/23, failed to indicate ethics as a topic of education. Review of the 2023 and 2024 staff education and in-service sign-in sheets provided by the facility failed to indicate any trainings had been completed on the topic of ethics. During an interview on 2/6/24 at 4:33 P.M., the Assistant Director of Nurses said there were no other in-service sign-in sheets or trainings available for the surveyors to review.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on document review and interview the facility failed to provide behavioral health trainings as required in accordance with their facility assessment. Findings include: Review of the Facility Assessment, dated May 2023, indicated but was not limited to the following: Staff training/education and competencies: - Throughout the year employees receive training and education on topics related to patient care and services. - Some trainings provided during general orientation is repeated at least annually. - Other topics are provided during the year based on Quality assurance performance improvement initiatives, ensuring regulatory compliance, best practices, clinical competencies and program development. List of staff training and competencies needed by staff type: Nurses and Certified Nurse Assistants (CNAs): Behavioral Health, including: Aggressive behaviors, Intrusive wandering, Self-destructive/self-injurious behaviors, coping mechanisms for unhealthy behaviors Nurses, CNAs, Activities and Social services: How to deal with difficult behaviors/mental health, Substance abuse (SUD) trainings Review of the in-service education attendance record titled Behavioral Health / SUD, dated 4/17/23, indicated but was not limited to the following: 45 of 107 employees on the pre-printed employee sign-in roster completed the training Review of the in-service education attendance record titled: Behavioral Residents, dated 4/26/23, indicated but was not limited to the following: 52 of 70 employees on the pre-printed employee sign-in roster completed the training Review of annual mandatory training content titled Round [NAME] Annual Education, dated 9/21/23, indicated but was not limited to the following trainings provided during the 9/21/23 mandatory in-service: (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dementia: Overview of Mild Cognitive Impairment; Understanding the early stage of Dementia; Management of common medical conditions during middle and late stages of Dementia; Medical treatments of Dementia; and Palliative end of life care of persons with Dementia -Change in condition; How to deal with difficult behaviors; Lesbian, Gay, Bisexual, Transgender, Queer, and more (LGBTQ+) Review of the in-service education attendance record titled Mandatory In-services (Round [NAME] Annual Education), dated 9/21/23, indicated but was not limited to the following: An additional four staff members completed Behavioral health/SUD training for a completion rate of 45.79% An additional seven staff members completed Behavioral Residents training for a completion rate of 84.28% During an interview with the Assistant Director of Nurses (ADON) and Regional Nurse on 2/6/24 at 11:35 A. M., the ADON said she is responsible for staff training and has only been in the facility since October 2023. The Regional Nurse said she would provide a list of what specific content was covered in the mandatory in-services and they use a Round [NAME] annual education guide for mandatory education. The Regional Nurse reviewed the educational sign-in sheets and said, based on the number of people who appeared to have attended, the trainings were ineffective because not enough staff participated. The ADON said she would double check to see if any other in-services were provided prior to her start at the facility. During an interview on 2/6/24 at 4:33 P.M., the ADON said there were no other in-service sign-in sheets or trainings available for the surveyors to review.