STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225324	A. Building B. Wing	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Newton Healthcare	25 Armory Street West Newton, MA 02465

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review and interview the facility failed to ensure a dignified existence for four Residents (#30, #49, #74 and #35) out of a total sample of 40 residents. Specifically for 1. Residents #30 and #49 the facility failed to assist with the removal of unwanted chin hair, 2. For Resident #74 the facility removed the Resident's socks in the dining room to cut his/her toenails and 3. For Resident # 35 the facility failed to provide clean sheets. Findings include: Review of the facility policy titled Resident Rights, dated revised 11/2017 indicated that employees shall treat residents with kindness, respect and dignity. Review of the facility policy titled Activities of Daily Living (ADL's), Supporting, dated revised 9/2019 indicated that residents who are unable to carry out activities of daily living independently will receive the services necessary for activities of daily living. 1a). Resident #30 was admitted to the facility in December 2012 with diagnoses including dementia, depression and psychotic disorder. Review of the Minimum Data Set assessment dated [DATE], failed to indicate the level of assistance needed to complete personal hygiene, including shaving. The area was left blank. Further review indicated that Resident #30 requires assistance from staff to complete ADL's. Further review indicated that Resident #30 scored a 7 out of 15 on the Brief Interview for Cognitive Status exam indicating severe cognitive impairment. Review of the care plan indicated that Resident #30 requires an extensive assist for grooming. On 1/30/24, at 7:38 A.M., 11:13 A.M., 2:22 P.M., on 1/31/24, at 10:29 A.M., and on 2/01/24, at 8:42 A.M. the surveyor observed Resident #30 to have a significant amount of chin hair. During in interview on 1/30/24, at 7:38 A.M. Resident #30 said that he/she doesn't like the chin hair and wants it removed. Resident #30 then said that nobody helps to remove the chin hair. 1b).Resident #49 was admitted to the facility in June 2016 with diagnoses including dementia, depression and anxiety. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan indicated Resident #49 requires an assist to totally dependent on staff for grooming. On 1/30/24, at 7:35 A.M., at 11:13 A.M., 2:22 P.M., on 1/31/24, at 10:30 A.M., and on 2/01/24, at 9:52 A.M. the surveyor observed Resident #49 to have a significant amount of chin hair. During an interview on 1/30/24, at 7:35 A.M., Resident #49 said that he/she didn't like the chin hair and wanted help to remove it. During an interview on 2/01/24, at 9:52 A.M. Certified Nurse's Aide (CNA) #7 said that it is the responsibility of the CNAs to assist a resident with removing unwanted chin hair with daily care if they require assistance. 2. Resident #74 was admitted to the facility in November 2019 with diagnoses including schizophrenia, depression and psychotic disorder. Review of the Minimum Data Set assessment dated [DATE], indicated Resident #74 is severely cognitively impaired. Review of the care plan for activities of daily living (ADL) dated initiated 12/13/2019, indicated that Resident #74 has an ADL deficit and needs assistance with all aspects of care. During an interview on 1/30/24 at 2:29 P.M., Resident #74 asked the surveyor if someone could cut his/her toe nails. Resident #74 said that his/her toes hurt. The surveyor then informed nursing about Resident #74's request to have his/her toe nails cut and that his/her toes hurt. On 1/30/24, at 2:30 P.M. the surveyor observed Certified Nurse's Aide (CNA) #10 sit down in the dining room and remove Resident #74's socks, to attempt to cut Resident #74's toe nails. The surveyor also observed nine other residents in the dining room. During an interview on 1/30/24, at 2:45 P.M. Nurse #10 said that CNA #10 should not have attempted to cut Resident #74's toenails in the dining room. 41019 3. Resident #35 was admitted in June 2014 with diagnoses including hypertension and cognitive impairment. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #35 scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. During an observation on 1/31/24, at 8:14 A.M., Resident #35's bed contained a stained set of sheets and stained pillow case. There was an open package of brownies scattered on the sheets. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/1/24, at 9:00 A.M., Resident #35 still had the same stained sheets and pillow case. During an interview on 2/1/24, at 9:15 A.M., Certified Nursing Aide #10 said that Resident #35's sheets need to be changed daily and after the Resident eats breakfast because he/she will wipe chocolate all over the sheets. CNA #10 said that the aides should be replacing the sheets.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to 1. complete admission consents and 2. invoke the health care proxy for 1 Resident (#255) out of a total sample of 40 residents. Findings include: Resident #255 was admitted in December 2023 with diagnoses including depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #255 was moderately impaired. Review of the MDS indicated that Resident #255 needs and wants an interpreter to communicate with staff or a doctor. 1. Review of the clinical record indicated the following consents were not completed for Resident #255: - Consent to admission and treatment - Side Rail Consent form - Immunization consent - Consent for ancillary services - Consent for supportive care for routine diagnosis and treatment Resident #255 had side rails on his/her bed despite the consent not being signed. 2. Review of the Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) indicated that Resident #255's daughter, as the Resident's designated Health Care Proxy, signed the MOLST form. Review of the clinical record indicated that Resident #255's daughter completed the designation as the Resident's Health Care Proxy, but the invocation of the Health Care Proxy did not get signed or ordered by a physician. During an interview on 2/1/24 at 7:54 A.M., the Director of Nursing said that the health care proxy has to be invoked to sign the MOLST and that she will review the consents to get them signed.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46339 Based on observation, record review and interviews, the facility failed to ensure one Resident (#2C) had a physician order in place and was assessed for the ability to self-administer medications independently, out of a total sample of 32 Residents. Findings include: Review of the facility policy titled 'Safety and Supervision of Residents', dated April 2018, indicated the following: *Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. *If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medication. Resident #2C was admitted to the facility in February 2024 with diagnoses including bilateral age-related nuclear cataract and glaucoma. On 3/14/24 at 8:45 A.M., the surveyor and Nurse #5 were in Resident #2C's room for medication administration. Resident #2C said he/she had his/her eye drops in the drawer. Nurse #5 asked the Resident to show him the eye drops. Resident #2C gave Nurse #5 two bottles of eye drops, they were as follows: -Cosopt -Latanoprost During an interview on 3/14/24 at 8:47 A.M., Resident #2C said he/she keeps eye drops in his/her room and does self-administration. One eye drop is to both eyes and one goes to right eye, both eye drops twice a day. Review of current physician orders failed to indicate an order for self-administration of medication. Review of the self-medication evaluation form-V2 dated 2/15/24 indicated the Resident was safe to administer medications with supervision. Review of the current physician order indicated the following order for eye drops: -Latanoprost ophthalmic solution 0.005% instill one drop in both eyes at bedtime for glaucoma change bottle in four weeks. -Polyvinyl alcohol ophthalmic solution 1.4% instill one drop in both eyes four times a day for dry eye therapy. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/24 at 12:00 P.M., Nurse #5 said for Resident #2C to self-administer medication, an assessment needs to be completed for self-administration, a physician order is required, and medications should much the current physician orders. He further said nurses have been administering Resident #2C medications and the Resident should not have any medications kept in his/her room. During an interview on 3/14/24 at 11:55 A.M., the Director of Nursing said self-medication administration assessment should be completed to determine if residents can self-administer their own medications, she further said a physician order is required for self-administration and medications should be kept securely.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45343 Based on observation, interview, and record review, the facility staff failed to provide a choice of smoking was honored for two Resident's (#15) and (#79), out of a total sample of 40 residents. Findings include: During an interview on 2/1/24 at 11:28 A.M., the Administrator said there was no set policy or alternative plan for smokers at this time and the facility was currently figuring out a final plan. 1.Resident #15 was admitted to the facility in October 2020 with diagnoses including chronic obstructive pulmonary disease (COPD), cardiomyopathy and chronic ischemic heart disease. Review of Resident 15's facility medical record indicated a quarterly Minimum Data Set (MDS) Assessment, dated 1/15/20, indicated that the Resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the Resident was cognitively intact. During an interview on 1/31/24 at 8:03 A.M., Resident 15 said he/she would like to smoke and has been told no the past three days. Resident #15 said he/she normally is allowed to go out twice a day to smoke but has been told he/she is not allowed and that he/she needs to stay in his/her room because the current Covid outbreak. During an interview on 1/31/24 at 9:32 A.M., Nurse #3 said there was a Covid outbreak over the weekend and the residents who smoke were told everyone is on quarantine and not allowed to go out to smoke. Nurse #3 said she was not aware what the alternate plan for smokers is when there is a Covid outbreak but would ask the Assistant Director of Nursing (ADON). During an interview on 1/31/24 at 9:45 A.M., the ADON said he was unsure how the smokers are managed during a Covid outbreak and would check with the Director of Nursing (DON) and the Administrator regarding how the smokers are to be managed. During an interview on 1/31/24 at 9:58 A.M., the ADON said he spoke with the DON and the Administrator and said the plan was to put N95 masks on the residents who smoke and have a Certified Nursing Assistant (CNA) bring them out to smoke. Review of Resident #15's care plan, last revised 10/22/22, indicated the follow: SMOKING: Resident wishes to smoke and is assessed for supervision level: Supervised. During an interview on 2/2/24 at 8:44 A.M., Resident #15 said that no one came to bring him/her out to smoke yesterday during the scheduled smoking times. The facility failed to provide Resident #15 alternative supportive measures for smoking during the current Covid outbreak. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Resident #79 was admitted to the facility in May 2021 with diagnoses including cerebral infarction, dysphagia (difficulty swallowing), and hemiplegia (paralysis of one side of the body). Review of Resident 79's facility medical record indicated a quarterly Minimum Data Set (MDS) Assessment, dated 11/11/23, showed that the resident scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. During an interview on 1/31/24 at 4:12 P.M., Resident #79 said he/she had not been out for a cigarette since last Saturday. Resident #79 asked if he/she could go out to smoke and was told he/she wasn't allowed to go out because of the Covid outbreak on the unit. During an interview on 1/31/24 at 4:17 P.M., Nurse #11 said because of the Covid outbreak she was unaware of any alternate plan to take the resident out to smoke this afternoon. Review of Resident #79's care plan, last revised 5/30/23, indicated the follow: SMOKING: Resident wishes to smoke and is assessed for supervision level: Supervised. During an interview on 2/1/24 at 11:28 A.M., the Administrator said there was no set policy or alternative plan for smokers at this time and the facility was currently figuring out a final plan. During an interview on 2/2/24 at 10:22 A.M., Resident #79 said he/she did not go out to smoke yesterday at all and is frustrated at the current situation. The facility failed to provide Resident #79 alternative supportive measures for smoking during the current Covid outbreak.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review and interview the facility failed to 1. Ensure resident wheelchairs were maintained in a safe, clean condition on two out of three units observed and specifically for two Residents (#30 and #63) out of a total of 40 residents. 2. Ensure residents were provided with a homelike dining experience. Findings include: 1. On 2/1/24, at 1:45 P.M., the surveyor observed the following: A. On the first floor unit, one out of six wheelchairs had broken/cracked wheelchair arms. B. On the second floor unit, two out of four wheelchairs had broken/cracked wheelchair arms. C. On the third floor unit, five out of ten wheelchairs had broken/cracked wheelchair arms. 2a. Resident #30 was admitted to the facility in December 2012 with diagnoses including dementia, depression and psychotic disorder. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #30 requires assistance from staff to complete Activities of Daily Living (ADL's). Further review indicated that Resident #30 scored a 7 out of 15 on the Brief Interview for Mental Status exam indicating severe cognitive impairment. On 1/30/24, at 7:38 A.M., 11:13 A.M., 2:22 P.M., on 1/31/24, at 10:29 A.M., and on 2/01/24, at 8:42 A.M. the surveyor observed Resident #30 sitting in a wheelchair with cracked, broken wheelchair arm pads. 2b. Resident #63 was admitted to the facility in March 2019 with diagnoses including Parkinson's disease and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident # 63 required substantial assistance, when in the wheelchair, with the mobility of the wheelchair. Review of the MDS dated [DATE], indicated Resident #63 scored a 3 out of 14 on the Brief Interview for Mental Status exam indicating severe cognitive impairment. On 1/30/24, at 7:45 A.M., 3:25 P.M., and on 2/01/24, at 12:30 P.M. the surveyor observed Resident #63 sitting in a wheelchair with the left arm pad missing, Resident #63 was leaning forward and over the the left side of the wheelchair with Resident #63's arm dangling and his/her armpit resting on the metal bar of the arm rest. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/01/24, at 1:00 P.M., the Maintenance Director said that he cleans the wheelchairs on one unit per month, so that every wheelchair is cleaned and repaired if needed every three months. The Maintenance Director then said that more frequent rounds are not completed and he depends on the nursing staff to inform him if repairs are needed in the interim. 3. During all days of the survey conducted on 1/30/24 through 2/2/24, the surveyors identified the facility did not have a home-like environment on two of three nursing units as evidenced by meals served on trays in an institutional manner in the dining rooms. During an interview on 2/1/24, at 2:10 P.M., the Director of Nursing and the Administrator said that they were not aware that meals were to be served off the trays.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on interview and record review, the facility failed to file a grievance for one Resident (#72) out of a total sample of 40 residents. Findings Include: Review of the facility policy titled Grievances, dated as revised 12/18, indicated the following: Policy: The facility will support each resident's right to voice grievances and to ensure that after a grievance has been received, the Grievance Official (Administrator or designee) will collaboratively work with team members to resolve the issue and provide written grievance decisions to the resident and or resident's family. Guideline: The Administrator is identified as the Grievance Official responsible for oversight of the grievance process in the facility. This includes responsibility for reviewing and tracking grievances, leading any investigations, ensuring that grievances and/or complaints are confirmed or not confirmed, and that a written grievance decision has been provided to the person filing the grievance. Procedure: 2. Grievances and complaints may be submitted orally or in writing. -Note: If a grievance is submitted orally, the facility employee taking the grievance must write up on the grievance report form. Documentation: 1. Grievances will be documented on the Grievance/Complaint Report and the Grievance Log. 2. The Administrator or designee will keep completed grievance forms in a separate file or binder. Resident #72 was admitted in October 2022 with diagnoses including Muscular Dystrophy and Type 2 Diabetes Mellitus. Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated that Resident #72 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/24 at 11:00 A.M., Resident #72 said he/she has been missing five pairs of sweat pants, and five long and short sleeve T-shirts since he/she moved from the first floor. Resident #72 said he/she did not file a grievance form but spoke to the Administrator about the missing clothing but never heard back from the Administrator or any other staff if the items were located. Resident #72 said he/she spoke to one of the social workers last week about his/her missing clothing, but never heard back from her. Record review on 1/31/24 at 3:34 P.M., indicated the resident moved from the first floor to his/her current room in June 2023. Review of the Grievance Log failed to indicate a grievance was filed for Resident #72. During an interview on 2/1/24 at 10:25 A.M., Social Worker #1 said she did speak with Resident #72 regarding his/her missing clothing. She said she spoke with laundry services about Resident #72's missing clothing but never heard back from them. Social Worker #1 was asked if she followed up with laundry services about the missing clothing, she said no. She was asked what the current policy is if a resident reports missing clothing, she said she was unsure but would check with the Administrator. During an interview on 2/1/24 at 11:23 A.M., The Administrator said he did speak to Resident #72 about his/her missing clothing and reported the missing items to laundry services. The Administrator said Resident #72 did not mention the missing clothing again since the initial report, so he assumed the items had been located. He was asked if he followed up with laundry services regarding the missing clothing, he said no. He said the expectation for missing clothing would be that a grievance would be filled out and investigated. During an interview on 2/2/24 at 10:15 A.M., Resident #72 said the Administrator, nor the Social Worker have updated him/her on the missing clothing. During an interview on 2/2/24 at 11:30 A.M., the Administrator said he has not followed up with laundry services about Resident #72's missing clothing.

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F 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review, and interview, the facility failed to ensure podiatry services were offered and toenails were kept trimmed and free of infection for 1 Resident (#74) out of a total sample of 40 residents. Findings include: Resident #74 was admitted to the facility in November 2019 with diagnoses including schizophrenia, depression and psychotic disorder. Review of the Minimum Data Set assessment dated [DATE], indicated Resident #74 was unable to complete the Brief Interview for Mental Status exam and is severely cognitively impaired. Review of the care plan for activities of daily living (ADL) dated as initiated 12/13/2019, indicated that Resident #74 has an ADL deficit and needs assistance with all aspects of care. During an interview on 1/30/24 at 2:29 P.M., Resident #74 asked the surveyor if someone could cut his/her toe nails. Resident #74 said that her/his toes hurt. The surveyor then informed nursing about Resident #74's request to have his/her toe nails cut. On 1/30/24, at 2:30 P.M. the surveyor observed Certified Nurse's Aide (CNA) #10 sit down in the dining room and remove Resident #74's socks, to attempt to cut Resident #74's toe nails. When CNA #10 saw the condition of the toe nails, CNA #10 told the surveyor that she was not able to cut them because they were to thick and long. On 1/30/24, at 2:30 P.M., the surveyor and Nurse #10 observed Resident #74's toe nails to be excessively thick and long with the 5th toe nails on both feet to be approximately 2 inches long. The surveyor and Nurse #10 also observed the bases of several of the toenails were reddened. Review of the medical record on 1/30/24, at 2:30 P.M., Nurse #10 and the surveyor were not able to locate any documentation that Resident #74 had been seen by a podiatrist or that nursing was aware of the condition of Resident #74's toe nails. Further review failed to indicate that Resident #74 had refused podiatry services or refused to have his/her toe nails cut. During an interview on 1/30/24, at 2:30 P.M. Nurse #10 said that she was aware that Resident #74 often refused care but she was unaware of the condition of Resident #74's toe nails. Nurse #10 then said that she would expect that if a resident continually refused to be seen by podiatry to have toe nails trimmed, an appointment with the podiatrist would still be made for evaluation to determine if the condition of the toe nails was causing any adverse medical problems. Nurse #10 also said that she would expect that Resident #74's responsible party would be notified. (continued on next page)

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West Newton Healthcare	25 Armory Street West Newton, MA 02465

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/24, at 2:48 P.M. the Director of Nursing (DON) said that every 3-4 months residents should be evaluated by podiatry regardless if a resident refuses or not. The DON then said that she was made aware that Resident #74 was refusing care but she was not aware Resident #74's toe nails had deteriorated to that extent. The DON also said that the guardian had not been notified about the condition of Resident #74's feet or her/his continual refusals of care. The DON then said that she would expect that if a resident continually refused to be seen by podiatry to have toe nails trimmed, an appointment with the podiatrist would still be made for evaluation to determine if the condition of the toe nails was causing any adverse medical problems. Review of the medical record failed to indicate that Resident #74's responsible party had been given the opportunity to sign on for podiatry services.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to provide a copy of the transfer/discharge notice upon transfer to the hospital for four Residents (#3, #16, #42 and #48) out of a total of 40 sampled Residents. Findings include: Review of facility policy titled 'Bed Holds/Return' last revised May 2018, indicated the following but not limited to: *Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. *Prior to a transfer, written information will be given to the residents and/or the resident representatives that explain in details: -The rights and limitations of the resident regarding bed-holds. -The details of the transfer (per the Notice of Transfer) 1. Resident #3 was admitted to the facility in July 2018 with diagnoses including bipolar disorder, borderline personality disorder and post traumatic stress disorder. Review of Resident #3's Minimum Data Set Assessment (MDS) dated [DATE], indicated Resident #3 is moderately cognitively impaired and requires assistance with bathing and dressing. Review of Resident #3's clinical record indicated Resident #3 was transferred to the hospital on 12/1/23. The clinical record failed to indicate Resident #3 was provided with the intent to transfer notice as required upon his/her transfer to the hospital. During an interview on 2/2/24 at 7:20 A.M., the Director of Nursing said the nurses are responsible for sending the notice of intent to transfer and discharge. She said the facility was not providing this document to the residents upon transfers. 2. Resident #16 was admitted to the facility in January 2018 with diagnoses including Multiple Sclerosis and hypertension. Review of Resident #16's Minimum Data Set Assessment (MDS) dated [DATE], indicated he/she is cognitively intact and requires assistance with bathing, dressing and transfers. Review of the clinical record indicated that Resident #16 was hospitalized on [DATE] and 12/20/23. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	The clinical record failed to indicate that Resident #16 was provided with the transfer/discharge notice as required upon transfer to the hospital. During an interview on 2/2/24 at 7:20 A.M., the Director of Nursing said the nurses are responsible for sending the notice of intent to transfer and discharge. She said the facility was not providing this document to the residents upon transfer. 46339 3. Resident #42 was admitted to the facility in November 2022 with diagnoses including anoxic brain damage. Review of Resident #42's Minimum Data Set (MDS) dated [DATE], indicated he/she is rarely/never understood. Review of the clinical record indicated that Resident #42 was hospitalized on [DATE], 8/19/23, 9/5/23 and 10/2/23. The clinical record failed to indicate that Resident #42 or his/her representative was provided with the transfer/discharge notice as required upon transfer to the hospital. During an interview on 2/2/24 at 7:20 A.M., the Director of Nursing said the nurses are responsible for sending the notice of intent to transfer and discharge. She said the facility was not providing this document to the residents upon transfer. 4. Resident #48 was admitted to the facility in November 2022 with diagnoses including chronic obstruction pulmonary disorder. Review of Resident #48's Minimum Data Set (MDS) dated [DATE], indicated he/she scored a 15 out of a possible 15 on the Brief interview of Mental status indicating intact cognition. Review of the clinical record indicated that Resident #48 was hospitalized on [DATE] and 11/21/23. The clinical record failed to indicate that Resident #48 was provided with the transfer/ discharge notice as required upon transfer to the hospital. During an interview on 2/2/24 at 7:20 A.M., the Director of Nursing said the nurses are responsible for sending the notice of intent to transfer and discharge. She said the facility was not providing this document to the residents upon transfers.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to provide a copy of the bed hold notice upon transfer to the hospital for four Residents (#3, #16, #42, and #48) out of a total of 40 sampled Residents. Findings include: Review of facility policy titled 'Bed Holds/Return' last revised May 2018, indicated the following but not limited to: *Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. *Prior to a transfer, written information will be given to the residents and/or the resident representatives that explain in details: -The rights and limitations of the resident regarding bed-holds. -The details of the transfer (per the Notice of Transfer) 1. Resident #3 was admitted to the facility in July 2018 with diagnoses including bipolar disorder, borderline personality disorder and post traumatic stress disorder. Review of Resident #3's Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #3 is moderately cognitively impaired and requires assistance with bathing and dressing. Review of Resident #3's clinical record indicated Resident #3 was transferred to the hospital on 12/1/23. The clinical record failed to indicate Resident #3 was provided with the bed hold notice as required upon his/her transfer to the hospital. During an interview on 2/2/24 at 7:20 A.M., the Director of Nursing said nurses are responsible for sending the the bed hold notice when residents are transferred to the hospital. She said prior to her arrival at the facility in December 2023, the staff were not providing this document to the residents during transfer. 2. Resident #16 was admitted to the facility in January 2018 with diagnoses including Multiple Sclerosis and hypertension. Review of Resident #16's Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she is cognitively intact and requires assistance with bathing, dressing and transfers. Review of the clinical record indicated that Resident #16 was hospitalized on [DATE] and 12/20/23. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	The clinical record failed to indicate that Resident #16 was provided with the bed hold policy as required upon transfer to the hospital. During an interview on 2/2/24 at 7:20 A.M., the Director of Nursing said nurses are responsible for sending the bed hold notice when residents are transferred to the hospital. She said prior to her arrival at the facility in December 2023, the staff were not providing this document to the residents during transfer. 46339 3. Resident #42 was admitted to the facility in November 2022 with diagnoses including anoxic brain damage. Review of Resident #42's Minimum Data Set (MDS) dated [DATE] indicated he/she is rarely/never understood. Review of the clinical record indicated that Resident #42 was hospitalized on [DATE], 8/19/23, 9/5/23 and 10/2/23. The clinical record failed to indicate that Resident #42 nor his/her representative was provided with the bed hold notice as required upon transfer to the hospital. During an interview on 2/2/24 at 7:20 A.M., the Director of Nursing said the nurses are responsible for sending the notice of intent to transfer and discharge. She said the facility was not providing this document to the residents upon transfers. 4. Resident #48 was admitted to the facility in November 2022 with diagnoses including chronic obstruction pulmonary disorder. Review of Resident #48's Minimum Data Set (MDS) dated [DATE], indicated he/she scored a 15 out of a possible 15 on the Brief interview of Mental status. Review of the clinical record indicated that Resident #48 was hospitalized on [DATE] and 11/21/23. The clinical record failed to indicate that Resident #48 was provided with the bed hold notice as required upon transfer to the hospital. During an interview on 2/2/24 at 7:20 A.M., the Director of Nursing said the nurses are responsible for sending the bed hold notice. She said the facility was not providing this document to the residents upon transfers prior to her arrival at the facility.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on record review, policy review, and interview, the facility failed to complete a Level I Preadmission Screening and Resident Review (PASARR- screen to determine if a resident had an intellectual or developmental disability and/or serious mental illness and needed further evaluation) for two Residents (#44 and #404), out of a total sample of 40 residents. Findings include: 1. For Resident #44 the facility failed to complete a level 1 preadmission screening and Resident Review. Resident #44 was admitted to the facility on [DATE] with diagnoses including bipolar disorder and schizophrenia. Review of Resident #44's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 indicating he/she was moderately cognitively impaired. Review of Resident #44's medical record failed to indicate a Level 1 Preadmission Screening and Resident Review (PASARR) had been completed prior to admission to the facility. During an interview on 2/1/24 at 10:34 A.M., the Social Worker said the hospital does the PASARR screening and the administrator has access to them. She further said all residents should have PASARR done under the law regardless of their diagnosis prior to admission to the facility. 36797 2. Resident #404 was admitted to the facility in January 2024 with diagnoses including schizophrenia, bipolar disorder and dependence on dialysis with an indwelling central line catheter. Review of the medical record failed to indicate that a Preadmission Screening and Resident Review (PASARR) was completed prior to admission. During an interview on 2/1/24, at 12:47 P.M., the Social Worker said that when a PASARR is completed it should be maintained as part of a resident's medical record. During an interview on 2/1/24, at 12:49 P.M., the Administrator said that when a PASARR is completed it should be maintained as part of a resident's medical record. He then said that a company liaison could have completed it but forgot to upload it into the medical record. By the end of the survey the facility failed to provide the surveyors the completed PASARR.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record record review and interview the facility failed to create a baseline plan of care within the required 48 hours of admission for one Resident (#404) out of a total sample of 40 residents. Findings include: The facility failed to provide a policy for the development of a baseline care plan. Resident #404 was admitted to the facility on [DATE], with diagnoses including dependence on dialysis with an indwelling central line catheter, schizophrenia and bipolar disorder. Review of the medical record on 1/31/24, failed to indicate a baseline care plan. During an interview on 1/31/24, at 9:00 A.M., the Director of Nursing (DON) said that a baseline care plan should be developed immediately but at a minimum of 72 hours after admission. During an interview on 1/31/24, at 9:01 A.M., Nurse #5 said that a care plan is supposed to be developed on admission. Nurse #5 said that nurses look to the care plan for information on what the residents need. Nurse #5 then said it was really important because a resident admitted with a central line, nursing should measure the length of the central line catheter exiting the body so that a nurse can determine if the line has accidentally been pulled further out.

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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** 45343 Based on observations, record review and interviews, the facility failed to develop and implement care plans for three Residents, (#20, #70 and #255). Specifically: 1. For Resident #20, the facility failed to implement supervision during meals as part of a nutritional care plan 2. For Resident #70, the facility failed to implement a scoop mattress as part of a fall care plan, and 3. For Resident #255, the facility failed to develop a care plan related to suicidal ideation, out of a total of 40 sampled residents. Findings include: 1. Resident #20 was admitted to the facility in March 2016 with diagnoses including transient chronic obstructive pulmonary disease (COPD), cerebral ischemic attack, dysphagia (difficulty swallowing) and adult failure to thrive. Review of Resident #20's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15, indicating he/she has severe cognitive impairments. On 1/31/24 at 12:43 P.M., 1/31/24 at 1:05 P.M., 2/1/24 at 8:24 A.M., and 2/2/24 at 8:40 A.M., Resident #20 was observed eating alone in his/her room .There was no staff present providing supervision, cueing or encouragement for the Resident to eat his/her meal. Record review on 1/31/24 at 10:40 A.M., Resident #20's last nutrition assessment on 12/28/23 indicated the Resident is at potential nutrition risk related to a history of inadequate intake, dementia and depression, history of muscle and fat wasting. Underweight r/t decreased oral intake, COPD, dementia, dysphagia as evidence by history of weight loss, body mass index (BMI) less than 18 even with nutritional supplements. Further review indicated a nutritional care plan initiated on 9/28/23 indicated the following: Diet a/o, continuous supervision 1:8, cue to complete meals. During an interview on 2/2/24 at 8:44 A.M., Nurse #3 said Resident #20 can eat on his/her own but is a picky eater and does not eat much. Nurse #3 said he/she does not require supervision for meals. During an interview on 2/2/24 at 9:31 A.M., the Director of Nursing (DON) said if a resident is on continuous supervision for meals, they should be supervised by staff any time they are eating. 46339 2. Resident #70 was admitted to the facility in June, 2023 with diagnoses including fracture of right leg and orthostatic hypotension. Review of Resident #70's Minimum Data Set (MDS) dated [DATE], indicated the Resident scored 11 out of possible 15 on the Brief Interview for Mental Status (BIMS) score indicating that he/she was moderately cognitively impaired. The MDS further indicated the Resident required partial to moderate assistance for bed mobility and transfers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/24 at 8:19 A.M., the surveyor observed Resident #70 lying in his/her bed with a cast on his/her left arm. The bed was in the low position with a regular mattress. On 1/31/24 at 6:34 A.M., the surveyor observed Resident #70 lying in his/her bed and the Resident had a cast on his/her left arm. The bed was low with a regular mattress. On 2/2/24 at 8:41 A.M., the surveyor observed Resident #70 lying in his/her bed and the Resident had a cast on his/her left arm. The bed was in the low position with a regular mattress. Review of the fall incident report completed on 1/23/24 indicated the Resident had reported he/she had fallen out of bed during the night. The Resident sustained a 4th-5th left hand metacarpal (hand bones) fracture with mild displacement. Review of the final investigation report that was submitted to the Commonwealth of Ma Health Care Facility Reporting System (Virtual Gateway) indicated the facility was going to implement a scoop mattress as an intervention. Review of the falls care plan date initiated 1/23/24 failed to indicate a scoop mattress as an intervention. During an interview on 2/2/24 at 10:56 A.M., the Director of Nursing (DON) said that Resident #70's healthcare proxy had declined the use of a scoop mattress as an intervention for the fall. When asked if the Resident's health care proxy had been invoked the DON said it had not been and that the Resident should have been offered the scoop mattress and it be his/her decision as to whether he/she wanted it or not. Review of Resident #70's medical record failed to indicate that the healthcare proxy had been invoked (the resident has been determined in writing by thier attending physician that they don't have the temporary or permanent capacity to make their own health care decisions). 41019 3. For Resident #255 the facility failed to develop a care plan related to suicidal ideation. Resident #255 was admitted in December 2023 with diagnoses including depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #255 was moderately cognitively impaired. Further review indicated that Resident #255 needs and wants an interpreter to communicate with staff or a doctor. Review of the clinical record indicated that Resident #255 was sent out to the hospital in November 2023. Review of the hospital discharge paperwork, dated 11/22/23, indicated that Resident #255 expressed suicidal ideation. The hospital note indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Daughter also mentioned that in the past two weeks on multiple occasions when the Resident was not confused has mentioned that he/she wants to end his/her life. Resident #255 sometimes wishes that he/she could just jump off of the building and kill self. No prior history of SI or HI. Resident #255 has never had any suicide attempt. Daughter notes that the patient is just tired of old age and his/her disability. Patient was last hospitalized from 10/21 through 10/27. Review of the clinical record did not indicate that there was a care plan developed for Resident #255's suicidal ideation or mental health. During an interview on 2/1/24 at 10:13 A.M., Social Worker #1 said that she would expect a care plan to be completed for anyone expressing suicidal ideation.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview the facility failed to ensure four Residents (#404, #68, #255 and #90), out of a total sample of 40 residents, received care and treatment in accordance with professional standards. Specifically, the facility failed 1. for Resident (#404), to take a baseline measurement of a peripherally inserted central catheter (PICC) on admission and monitor the condition of the insertion site as well as the length of the catheter exiting the body, 2. For Resident #68 the facility failed to follow a physician recommendation for a hand surgeon consult, 3. For Resident #255 the facility failed to review and implement hospice recommendations, and 4. For Resident #90 the facility failed to ensure that a diabetic resident received the correct supplement during a medication pass. Findings include: 1. Resident #404 was admitted to the facility in January 2024 with diagnoses including dependence on dialysis with an indwelling peripherally inserted central catheter, schizophrenia and bipolar disorder. Review of the medical record on 1/31/24, failed to indicate a baseline care plan. Further review failed to indicate that a care plan of a PICC line was developed. Review of the doctor's orders dated January and February 2024 failed to indicate orders for the care of a PICC line. During an interview on 1/31/24, at 9:00 A.M., the Director of Nursing (DON) said that a baseline care plan should be developed immediately but at a minimum of 72 hours after admission. The DON said that should include the care of a PICC line. During an interview on 1/31/24, at 9:01 A.M., Nurse #5 said that said it was really important to measure the external length of a PICC line because a resident admitted with a central line, nursing should measure the length of the central line catheter exiting the body so that a nurse can determine if the line has accidentally been pulled further out. During an interview on 1/31/23, at 12:34 P.M., both the DON and the Corporate Nurse said that she was not able to locate a policy on PICC line insertion site monitoring. The Corporate Nurse then said that it was a standard of practice that PICC lines are measured upon admission and every shift if the dressing allows visualization and if not, measurements should at least be done with dressing changes. The Corporate Nurse also said that the insertion site should be monitored for infection at least with dressing changes as well. 41019 2. For Resident #68 the facility failed to follow a physician recommendation for a hand surgeon consult. Resident #68 was admitted in October 2022 with diagnoses including dysphagia and reduced mobility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #68 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Further review indicated that Resident #68 is totally dependent with bathing, transfers, personal hygiene, and upper and lower body dressing. During an observation on 1/30/24 at 11:08 A.M., Resident #68 had two contracted hands. Review of the physician progress note, dated 6/13/23, indicated that the patient reports intermittent pain. Patient reports minimal ROM (range of motion) of hands. Patient would like to explore treatment options, consult hand surgeon for possible intervention. Review of the physician note, dated 9/19/23, indicated a recommendation to consult a hand surgeon regarding hand contractures. Review of the clinical record failed to indicate that Resident #68 had ever been seen by a hand surgeon. During an interview on 2/2/24 at 9:39 A.M., Resident #68 said that he/she would like to see a hand surgeon for treatment options. During an interview on 2/2/24 at 7:38 A.M., the Director of Nursing said that she would look into the consult for the hand surgeon for Resident #68. 3. For Resident #255, the facility failed to review hospice recommendations. Resident #255 was admitted in December 2023 with diagnoses including depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #255 was moderately impaired. Review of the MDS indicated that Resident #255 needs and wants an interpreter to communicate with staff or a doctor. Review of the medical record indicated that Resident #255 received hospice services. Review of the record indicated that on 1/12/24, the hospice Nurse Practitioner recommended the following: -Ativan (a medication used to treat anxiety) 1 milligram by mouth every 4 hours as needed for restlessness -Morphine (a medication used to treat pain) 10 milligrams by mouth every 4 hours as needed for pain Review of the clinical record and physician's orders did not indicate that the recommendation was reviewed or put into place. During an interview on 2/2/24 at 7:32 A.M., the Director of Nursing said that there is a binder that recommendations are put into and the doctor is supposed to review those recommendations. The Director of Nursing was not aware that the hospice recommendation was not reviewed. (continued on next page)

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West Newton Healthcare	25 Armory Street West Newton, MA 02465

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46339 4. Resident #90 was admitted to the facility in May 2023 with diagnoses including diabetes mellitus due to underlying condition with hyperglycemia. Review of Resident #90's physician orders indicated the following: -Glucerna Thera shake (a diabetic meal supplement) after meals for weight gain, dated 6/8/2023. During a medication pass observation on the third-floor unit on 1/31/24 at 10:30 A.M., the surveyor observed Nurse #6 prepare and administer medication to Resident #90. Nurse #6 prepared and administered Resident #90's medication and gave the supplement Med pass 2.0 120 milliliters (ml) with the medication. The Med Pass 2.0 had 18 grams of added sugar per eight ounces. During an interview on 1/31/24 at 2:38 P.M., Nurse #6 said the facility had run out of Glucerna and he decided to give the Resident Med pass 2.0 as it was readily available. When Nurse $6 was asked if the Med pass 2.0 would have an impact on a diabetic resident, Nurse #6 said it could increase their blood sugar level. During an interview on 2/1/24 at 8:22 A.M., the Director of Nursing said the facility did not have Glucerna and that the nurses should consult with the dietician for an alternate. During an interview on 2/1/24 at 11:42 A.M., the Dietician said they had an issue with the supply chain for Glucerna and that the substitute for the Glucerna was the unsweetened mighty shake which the nurses should have been giving to the residents.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, record review and interview, the facility failed to: 1. assess and treat one Resident (#68) after a decline in functional status, 2. provide appropriate communication services for one Resident (#255) resulting in agitation and frustration with his/her ongoing inability to communicate with staff, 3. provide assistance with meals for two Residents (#28 and #81), out of a total sample of 40 residents. Findings include: 1. Resident #68 was admitted in October 2022 with diagnoses including dysphagia and reduced mobility. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #68 scored a 14 out of 15 on the Brief Interview of Mental Status (BIMS), indicating intact cognition. Further review indicated that Resident #68 is totally dependent for bathing, transfers, personal hygiene, and upper and lower body dressing. During an interview on 1/30/24 at 11:08 A.M., Resident #68 said that he/she never gets rehab services and would like rehab. Review of the clinical record indicated that Resident #68 last received occupational therapy and physical therapy services in November 2023. Review of the occupational therapy discharge summary, dated 11/13/23, indicated that Resident #68 required the following assistance with activities of daily living: - Bed mobility- Supervision or touching assistance - Upper body dressing- partial or moderate assistance - Bathing- partial or moderate assistance - Lower body dressing- partial or moderate assistance Review of the physical therapy discharge summary, dated 11/9/23, indicated that Resident #68 required partial to moderate assistance with sitting to standing and toilet transfers and required supervision when lying to sitting on the side of the bed. During an interview on 2/1/24 at 8:34 A.M., Certified Nursing Aide #9 said that Resident #68 is dependent with every activity of daily living task except for rolling over onto his/her side. Review of the CNA task sheets for January 2024 indicated that Resident #68 is totally dependent for bathing, bed mobility, and dressing; indicating a functional decline in Resident #68's status since his/her discharge from therapy. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/1/24 at 11:24 A.M., the Rehab Director said that she is sent an email with anyone who needs therapy services and then OT and PT services are put in place as needed. The Rehab Director said that she would expect an evaluation to be completed if a resident had a decline in functional status and that she would evaluate Resident #68. The Rehab Director was not aware that Resident #68 had a decline in functional status. 2. Resident #255 was admitted in December 2023 with diagnoses including depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #255 was moderately impaired cognition. Review of the MDS indicated that Resident #255 needs and wants an interpreter to communicate with staff or a doctor. Review of the care plan for communication indicated that Resident #255 has a language barrier and that Resident #255's primary language is Mandarin. The care plan indicated that Resident #255 requires an interpreter to communicate with staff. The care plan did not indicate the use of any other means of communicating Mandarin with Resident #255. During an observation on 1/31/24 at 9:04 A.M., Resident #255 was found in his/her room in distress, yelling out in Mandarin. During an interview on 1/31/24 at 9:06 A.M., Certified Nurse Aide (CNA) #9 said that communication is very difficult and that staff can only communicate with the Resident if they call the daughter. CNA #9 could not say what to do in an emergency other than tell the nurse. CNA #9 said that there were no communication cards or any other way to communicate other than call the daughter. CNA#9 said that she does not use the language line and that Resident #255's phone is in Mandarin so cannot be opened to call his/her daughter. During an interview on 1/31/24 at 9:40 A.M., Resident #255's daughter said that Resident #255 is only confused when he/she has an infection, but can communicate fine and is not normally confused. Resident #255's daughter said that it is confusing for her because staff tell her one thing and Resident #255 tells her another thing. Resident #255's daughter said that the Resident is mentally intact, but finds it difficult to communicate with staff due to the language barrier. She said that Resident #255 will call her for a glass of water and that she has to call the nurses at the desk to ask for the water. Review of the record and hospital discharge paperwork did not indicate that Resident #255 had a history of dementia or impaired cognitive function. During an observation on 2/1/24 at 7:35 A.M., Resident #255 was in his/her room and agitated, yelling out and pointing to the dresser. CNA #9 said that she tried everything to make the Resident comfortable, but Resident #255 was still upset. CNA #9 did not use the language line to communicate with the Resident. During an observation on 2/1/24 at 8:11 A.M., the surveyor observed Resident #255 was continuing to yell out and in emotional distress. The surveyor notified the Administrator. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/2/24 at 9:42 A.M, Resident #255 was continuing to yell out and pointing to his/her dresser. CNA #9 said that communication is frustrating and she has to rely on the nurses to call the daughter to communicate anything with the Resident. Nurse #4 came in the room and for several minutes, both the CNA and Nurse tried to communicate with Resident #255. Nurse #4 eventually left the room to call the daughter. During an interview on 2/2/24 at 9:50 A.M., Nurse #4 said that she has to call the Resident's daughter anytime something is going on with Resident #255. Nurse #4 said that the daughter usually answers. During an interview on 2/1/24 at 7:48 A.M., the Director of Nursing the surveyor informed her that Resident #255 was upset and she said that staff are supposed to use the language line to communicate with Resident #255. The Director of Nursing pointed to a piece of paper in her office that contained the language line. The Director of Nursing did not say if staff were trained on the use of the language line. 3a. Resident #28 was admitted in November 2022 with diagnoses including dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #28 could not participate in the cognitive assessment and is severely cognitively impaired. Review of the MDS indicated that Resident #28 requires substantial to maximal assistance with eating. Review of the care plan for activities of daily living indicated that Resident #28 requires continued supervision 1:8, cue to encourage self-feeding to start meal, needs assistance to finish meal due to decreased attention span and fatigue. Review of the certified nursing aide task sheet indicated that Resident #28 requires limited assistance with most meals. During an observation on 1/31/24 at 9:12 A.M., Resident #28 was in his/her room eating breakfast alone. There were no staff present in the room or hallway. During an observation on 1/31/24 at 12:22 P.M., Resident #28 was in his/her room eating lunch alone. During an observation on 2/2/24 at 8:43 A.M., Resident #28 was in his/her room eating breakfast alone. During an interview on 2/2/24 at 9:39 A.M., Nurse #6 said that if a resident needs supervision or assistance then the care plan should accurately reflect that. Nurse #6 said that most residents on that unit need some sort of assistance. 3b. Resident #81 was admitted in October 2022 with diagnoses including dysphagia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #81 scored a 13 out of a possible 15 on the Brief Interview for Mental status (BIMS), indicating intact cognition. Review of the MDS indicated that Resident #81 requires substantial to maximal assistance with eating. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan indicated that Resident #81 is able to eat his/her meals with limited assist of one and set up (last revised 8/27/23). Review of the progress note, dated 9/14/23 indicated that Resident #81 was sent out to the hospital after choking on food stuck in his/her throat. Resident #81 returned to the facility on a downgraded diet. Review of the active physician's orders for Resident #81 indicated the following diet order: Regular diet, Mechanical Soft texture, thin liquids. Review of the physician's orders indicated Resident #81 requires Aspiration precautions with the head of the bed elevated to at least 45 degrees at all times (a measure to prevent choking). Review of the Activities of Daily living task sheet indicated that Resident #81 ranged from independent to total dependence at meals. Review of the Speech Therapy Discharge summary, dated 10/9/23, indicated that Resident #81 required soft and bite sized textured food with set up and supervision during meals due to impaired vision. During an observation on 1/31/24 at 9:09 A.M., Resident #81 was laying in bed, at 45 degrees, alone in his/her room with his/her tray in front of him/her with the curtain drawn. Resident #81 left the tray untouched. There were no staff present in the room. During an observation on 2/1/24 at 8:48 A.M., Resident #81 was eating in his/her room alone, at 45 degrees, with the curtain drawn. There were no staff present in the room. During an interview on 2/1/24 at 8:50 A.M., Nurse #4 said that Resident #81 refuses assistance at meals even if staff try to help him/her. During an interview on 2/2/24 at 7:39 A.M., the Director of Nursing said that if a Resident refuses assistance then staff should, at minimum, supervise the Resident in their room.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. 36876 Based on observation and interview, the facility failed to provide an ongoing program of individual and group activities designed to meet the interests of and support the physical, mental and psychosocial well-being for Residents on three of three nursing units. Findings include: The facility failed to provide the surveyors of a policy for the provision of activities. During initial interviews multiple residents said that there were no activities available to residents. One resident reported that there have not been activities, except on some Sundays. Review of the posted Activity Calendar for January 2024 indicated the following activities scheduled for 1/30/24: 10:00 A.M., Chair Zumba 11:00 A.M. Reminiscing 12:00 P.M. Dining Social (lunch) 2:00 P.M. Room Visits 3:00 P.M. Name Tune 4:00 P.M. Meet and Greet During observations on the 1st, 2nd and 3rd floor units on 1/30/24 at the schedule activity times (10:00, 11:00, 2:00, 3:00 and 4:00), there were no activities being held as indicated on the calendar. During an interview on 1/31/24 at approximately 10:30 A.M., the Administrator said that facility did not have activity staff and that Certified Nursing Aids (CNAs) are asked to provide activities occasionally. The Administrator said that the Activity Director left in December 2023 but occasionally comes in to help. Review of the former Activity Director's time sheet for January 2024 indicated he/she worked a total of five days for the month (1/11/24, 1/14/24, 1/21/24, 1/24/24 and 1/25/24) for a total of 22.5 hours. A sticky note on the time sheet indicated the former Activity Assistant volunteered at the facility on 1/5/24 for a total of four hours. Review of the posted Activity Calendar for January 2024 indicated the following activities scheduled for 1/31/24: 10:00 Art and Craft (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11:00 Ball Toss 12:00 D. Social 2:00 Dancing with the Stars 3:00 Music Trivia 4:00 Bingo Games During observations on the 1st, 2nd and 3rd floor units on 1/31/24 at the schedule activity times (10:00, 11:00, 2:00, 3:00 and 4:00), there were no activities being held as indicated on the calendar. During an interview on 1/31/24 at 12:27 P.M., CNA #4 said that she had been asked to assist with activities today on the 2nd floor. CNA #4 said that she had gone from room to room with an activity cart, but due to a Covid-19 outbreak, many of the Residents do not feel well. CNA #4 said that she had been asked twice to assist with activities, but only for the 2nd floor unit. CNA #4 said that the facility does not have activities since the two activity staff left last month. During an interview on 1/31/24 at 1:50 P.M., CNA #7 said that there are no activities for residents in the facility. CNA #7 said that sometimes the retired activity director will come to do an activity, but otherwise, there was nothing available. During an interview on 1/31/24, at 4:05 P.M., Nurse #9 said she was the nurse working on the 3rd floor unit since 7:00 A.M., and had not seen any activities taking place for the residents all day except for having the television on in the dining room. During an interview on 2/1/24 at 10:33 A.M. Social Worker #1 said that she had been full time at the facility for a few weeks. Social Worker #1 said, I can't make a comment on activities in the building. Review of the February 2024 Activity Calendar indicated the following activities for 2/1/24: 10:00 A.M. Chair Yoga 11:00 A.M. Nail Care 12:00 P.M. Dining Social 2:00 Cookies and Coffee Social 3:00 P.M. Black History 4:00 P.M. Meet and Greet (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations on the 1st, 2nd, and 3rd floor units on 2/1/24 during the schedule activity times (10:00, 11:00, 2:00, 3:00 and 4:00), there were no activities being held as indicated on the calendar. Review of the working schedule dated 2/1/24 indicated CNA #4 was assigned to perform activities on the 2nd floor unit. There were no other staff assigned to perform activities on the 1st or 3rd floor. On 2/1/24 at approximately 2:00 P.M., the surveyor observed CNA #4 seated in the common room of the 2nd floor unit next to another CNA. CNA #4 was reading a book and there were no residents in the common room. 36797 During an interview on 2/1/24, at 2:10 P.M., the Administrator said that the Activity Director had resigned over two months ago, (the Activity Director had resigned in December 2023 while the Activity Assistant had resigned in November 2023). The Administrator said that he had attempted to have a CNA provide some activities but he had not put a specific Quality Assurance Performance Improvement (QAPI) plan in place too ensure that the activity program continued to provide activities to the residents.

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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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, record reviews and interviews, the facility failed to ensure physician's orders were followed for prevention of pressure ulcer development for one Resident (#91) out of a total sample of 40 residents. Specifically, the facility failed to implement heel booties as ordered resulting in a reddened area on the Resident's left heel and a deep tissue pressure injury on the right heel and failed to implement the correct setting for an air mattress. Findings include: Review of facility policy titled 'Pressure Ulcer/Injury Risk Assessment', last revised April 2018, indicated the following but not limited to: *Risk factors that increase a resident's susceptibility to develop, or to not heal, a pressure ulcer or pressure injuries include: a. Under nutrition, malnutrition, and dehydration deficits. b. Impaired/decrease mobility and decreased functional ability. Review of facility policy titled Support Surface Guidelines, last revised May 2018, indicated the following but not limited to: *Support surfaces are modifiable. Individual resident needs differ. *Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed. Resident #91 was admitted to the facility in September 2023 with diagnoses including adult failure to thrive and severe protein-calorie malnutrition. Review of Resident #91's Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) indicating Resident #91 is cognitively intact. The MDS further indicated that the Resident was at a higher risk for developing pressure ulcers and was totally dependent for all activities of daily living.The Resident did not have any open pressure ulcer noted on the MDS. Review of Resident #91's physician's orders dated 12/27/23, indicated the following: *Bilateral heels booties on at 8 am and off at 8 pm. Every morning and at bedtime for pressure ulcer prevention related to unspecified severe protein calorie malnutrition. *Pressure redistribution mattress every shift for sacral wound care check for correct settings and function, dated 1/11/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/30/24 at 8:12 A.M., the surveyor observed the Resident lying in bed he/she did not have heels booties on, the air mattress was set at 200 lbs. (pounds). On 1/30/24 at 1:26 P.M., the surveyor observed the Resident lying in bed he/she did not have heels booties on, the air mattress was set at 200 lbs. On 1/31/24 at 6:34 A.M., the surveyor observed the Resident lying in bed he/she did not have have heel booties on, the air mattress was set at 200 lbs. On 1/31/24 at 11:10 A.M., the surveyor observed the Resident lying in bed he/she did not have heels booties on, the air mattress was set at 200 lbs. During an interview on 1/31/24 at 11:10 A.M., the Resident told the surveyor that he/she has been having ongoing heel pain to both feet and no one had done anything about it. The Resident further said that he/she has not worn any type of boots to his/her heels when in bed. Review of the weekly skin evaluation dated 1/16/24, indicated the skin intergrity was clean and intact. Healed stage three on coccyx no longer open. Review of the weekly skin evaluation dated 1/24/24, indicated the skin integrity was not clean and intact. Skin alteration noted, redness to sacrum. Review of the Norton Scale for predicating risk of pressure ulcer-V2 dated 1/16/24, indicated the Resident scored a 10 which indicated high risk for developing pressure ulcer. Review of the pressure ulcer care plan date revised 12/22/23, had the following interventions: -Follow facility policies/protocol for the prevention/treatment of skin breakdown. Review of the most recent documented weight for Resident #91 dated 1/4/24 was 120.4 lbs. During an interview on 1/31/24 at 11:30 A.M., Certified Nursing Assistant (CNA) #9 said she takes care of Resident #91 and that he/she has not had any heel booties. The surveyor asked if the CNAs were allowed to change the air mattress setting. CNA #9 said only nurses are allowed to touch the settings. She further said the Resident did not have any issues on his/her feet that she was aware of. During an interview and observation on 1/31/24 at 11:33 A.M., the surveyor and Nurse #7 observed Resident #91's heels, the left heel was red non blanchable (discoloration of the skin that does not turn white when pressed, indicating pressure injury). The right heel had a deep purple discoloration indicating a deep tissue pressure injury. Nurse #7 said she was not aware that the Resident had developed pressure injuries to the heels. Nurse #7 said the Resident should have the heel booties as ordered and she further said that Resident #91's air mattress was on the correct setting because the normal light indicator was on. When asked if she knew how much the Resident weighed and if the setting of 200 lbs. was correct. Nurse #7 said she believed the Resident weighed 160 lbs. when he/she was initially admitted to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/1/24 at 8:39 A.M., the Director of Nursing said the air mattress setting is set to residents' weight, physician orders should be followed for heel booties as ordered, she further said the red area to the Resident's left heel and the deep purple to the right heel were pressure injury areas.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to update the falls care plan with appropriate interventions to prevent further falls for one Resident (#97) out of a total of 40 sampled Residents. Findings include: Review of the facility's policy titled Assessing Falls and Their Causes, dated January 2018, indicated: *When a resident falls, the following documentation should be recorded in the following should be recorded in the resident's record: Completion of a falls risk assessment. Appropriate interventions taken to prevent future falls. Resident #97 was admitted to the facility in September 2023 with diagnoses including traumatic brain injury, chronic obstructive pulmonary disease and dementia. Review of Resident #97's Minimum Data Set assessment dated [DATE] indicated he/she is moderately cognitively impaired and requires assistance with bathing and dressing. Review of Resident #97's fall risk assessment dated [DATE], indicated he/she was at moderate risk for falls. Review of Resident #97's fall care plan initiated 9/13/23, indicated the following: Focus: The Resident is at high risk for falls r/t TBI (traumatic brain injury) and dementia. Interventions: Educate the resident/family caregivers about safety reminders and what to do if a fall occurs. Ensure that the resident is wearing proper nonslip footwear when ambulating or mobilizing in w/c. Follow facility fall protocol. PT evaluate and treat as ordered or PRN. Review of Resident #97's incident reports indicated the following falls: 1/18/24 at 11:02 A.M.: S/P witnessed fall. Resident noted falling forward from WC in day room. Staff present and assisted pt to knees in community room. (The incident report failed to indicate any measures taken to prevent future falls and there were no updates made to Resident #97's fall care plan.) 1/23/24 at 1:30 P.M.: Resident slid out of his/her chair while watching TV in the lounge room. Resident assisted back to his/her chair by 3 nursing staff, no injuries sustained. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/1/24 at 9:07 A.M., the Director of Nursing (DON) said that after a resident sustains a fall, the expectation is for an investigation to be conducted and care plans to be updated with new interventions addressing the fall to prevent re-occurrence. The DON said that she had updated Resident #97's fall care plan after his/her fall on 1/23/24.

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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** 36876 Based on observation, record review and interview, the facility failed to identify and address a significant weight loss timely and implement interventions addressing his/her weight loss for one Resident (#97), out of a total sample of 40 residents, resulting in an 11.7% loss of his/her total body weight in three months. Findings include: Review of the facility's Weight Measurement Policy, dated as revised 4/4/2019, indicated: *Weights will be obtained weekly X 4 after admission. Subsequent weights will be monthly, unless physicians orders or the resident's condition [NAME] more frequent as determined by the Interdisciplinary Team (IDT). *All residents with significant weight changes will have verification of weight measurement for accuracy and documentation purposes. If verification of weight indicates significant weight change (suggested parameters for evaluating significance of unplanned and undesired weight loss are: 5% in 30 days, 7.5% in 90 days and 10% in 180 days) the resident and/or representative and IDT will be notified and the plan of care will be revised as appropriate. *Residents with significant unintended weight changes will be added to weekly weights or until weight stabilizes. *The registered dietitian will be responsible for determining the desirable body weight range. This will be documented on the initial medical nutrition therapy assessments and re-assessments. Resident #97 was admitted to the facility in September 2023 with diagnoses including traumatic brain injury, diabetes and dementia. Review of Resident #97's Minimum Data Set assessment dated [DATE], indicated he/she is moderately cognitively impaired and is supervised for meals. On 1/30/24 at 8:05 A.M., the surveyor observed Resident #97 in his/her room eating breakfast. Resident #97 was pleasantly confused and feeding himself/herself independently. Review of Resident #97's dietary evaluation dated 9/18/23 indicated he/she weighed 225.2 lbs (pounds) upon admission with an IBW (ideal body weight) of 166 lbs and was on a NAS (no added salt) diet. The evaluation indicated that Resident #97 could benefit from some weight loss, but due to his/her altered mental status, education regarding weight loss was not recommended. Review of Resident #97's weights indicated: 9/13/23: 225.2 lbs 10/10/23: 210.6 lbs (a loss of 6.44% of his/her total body weight since 9/13/23) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/10/23: 207 lbs (a loss of 8% of his/her total body weight since 9/13/23) 12/12/23: 198.6 lbs (a loss of 11.7 % of his/her total body weight since 9/13/23) 1/8/24: 194.6 lbs Weekly weights for Resident #97 were not obtained upon admission, verifying weights to confirm significant weight loss were not obtained, and weekly weights were not completed after his/her significant weight loss was documented, per the facility's policy. Review of Resident #97's nutrition care plan initiated 9/13/23 and revised 12/14/23 indicated: Focus: Unintentional weight loss due to adjusting to new facility, [altered mental status], psychosis. 11% weight loss since admission. Goals: Will consume >75% meals and fluids; No sig (significant) wt (weight) changes. Interventions: Diet as ordered. Diet liberalized to optimize intake. Encourage intake. Offer nutrient dense food as tolerated, 12/14/23. Monitor for signs/symptoms of dehydration. Monitor labs as ordered. Monitor PO intake. Monitor skin assessment. Monitor weight per facility policy as ordered. Vitamins/minerals as ordered, 9/18/23. Diet consult PRN (as needed). Monitor diet texture tolerance and refer to SLP (speech pathology) PRN, 9/13/23. Review of Resident #97's physicians orders indicated: Glucerna Thera Shake, two times a day, initiated 12/13/23. Review of Resident #97's clinical record and nutritional care plan indicated that interventions were not implemented in response to his/her significant weight loss until 12/13/23: 64 days after an initial significant weight loss in October 2023 was first documented in the clinical record. Review of the Dietitian's assessment dated [DATE] indicated: PO (by mouth) intake and appetite is good, primarily 75-100% but occasionally 50-75%. Eating independently but sometimes requires supervision or assistance. No chewing/swallowing issues on current texture.Regardless of good intake, pt (patient) has experienced a 11% wt loss since admission.[Recommend] adding Glucerna (a sugar free nutritional supplement used for people with diabetes) BID [twice daily]. During an interview on 2/1/24 at 9:07 A.M., the Director of Nursing said that if a resident is losing weight, staff should investigate the weight loss, notify the family, physician and Dietitian to review the resident status. The DON was not aware that Resident #97 had an initial significant weight loss in October 2023 that was not identified or addressed until December 2023. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 1/31/24 at 10:25 A.M., and 2/6/24 at 12:36 P.M., the Dietitian said that new admissions to the facility should be weighed weekly per policy. The Dietitian said that it has been difficult to obtain regular weights or re-weighs for residents with significant weight loss. The Dietitian says she does not always document her requests for confirmation weights because they are very frequent requests. The Dietitian said that she is in the facility for approximately 16-20 hours a week and reviews resident's weights in the electronic records and staff do not notify her if resident's have sustained a weight loss. The Dietitian said that the physicians or nurse practitioners do not regularly become involved in the evaluation of residents when there is a significant weight loss and to her knowledge, the physician or nurse practitioner was not involved in evaluating Resident #97's weight loss. The Dietitian said that the measurement of an ideal body weight documented in the dietary evaluations are used as an indicator similar to the Body Mass Index (BMI) related to height and weight, and are not meant to be goal weights. The Dietitian said that there was no goal The Dietitian said that 166 lbs is not a goal weight for Resident #97. The Dietitian said in response to Resident #97's weight loss she recommended implementing Glucerna supplements. The Dietitian said that there no goals in place for Resident #97 to lose weight. Resident #97's weight loss was unintentional, concerning and he/she should have been evaluated before December.

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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. 46339 Based on observation, record review and interview, the facility failed to ensure staff provided appropriate care and services for one Resident (#42) with a Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medications), out of 40 sampled residents. Specifically, the facility failed to: a. ensure staff labeled the enteral formula container and water flush bag with the Resident's name, date and time hung, the administration rate, duration, and initials of the staff member hanging them. b. ensure staff programmed the Resident's enteral feeding pump (device used to deliver nutrition to patients who cannot consume food and drink by swallowing) properly with the ordered frequency of feeding (used to maintain patency and provide hydration) causing the Resident to not receive the total volume ordered of 1680 milliliters (ml) of enteral feed in a 16- hour period (2 pm-6am) on 2/1/24. Findings include: Review of facility policy titled 'Enteral Nutrition' Last revised 2018, indicated the following but not limited to: *When the resident is fed by tube, nursing staff are assigned to specific enteral feeding responsibilities. These may include but may not be limited to: a. Administration of feeding b. Providing appropriate care of the tube and site. *Dieticians will give recommendations as needed for alternative formulas and rates or amounts of administration of the formula or water to meet the resident's needs. Resident #42 was admitted to the facility in November 2022 with diagnoses including anoxic brain injury, dysphagia and dependent on tube feed for nutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/9/23, indicated the Resident was rarely/never understood. The MDS further indicated that he/she was dependent on feeding tube. Review of the most current physician orders indicated the following: *Enteral feed order two times a day Glucerna 1.2 cal at 105 ml x 16 hours. Up at 2 PM and down at 6 am for a total volume of 1680 ml with free water flush every six hours. Dated 8/23/23. *Enteral feed order, as needed, for if formula bags are unavailable, give 215 ml bolus of Glucerna 1.5 and 130 ml of free water every 3 hours starting at 2pm and ending at 5 am for a total of 15 hours. (2pm, 5pm, 8pm,11pm, 2am, 5am). Dated 10/23/23. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/24 at 7:48 A.M., the surveyor observed Resident #42 lying in bed. An enteral formula bag and water flush were both hanging from an Intravenous pole (IV). The bags were not labeled with the Resident's name, date, and time the formula was hung. The bag did not have the initials of the nurse that hung the bags. The rate on the pump was noted at 105 ml (Milliliter) per hour for formula and 200 ml of water flush every six hours. During an interview on 1/30/24 at 7:50 A.M., Nurse #5 said the bags should be labeled and dated whenever they were hung. On 2/1/24 at 2:30 P.M., the surveyor observed Resident #42 lying in bed, his/her enteral feeding was not hung. On 2/1/24 at 4:06 P.M., the surveyor observed Resident #42 lying in bed, his/her enteral feeding was not hung. On 2/1/24 at 4:36 P.M., the surveyor observed Resident #42 lying in bed with his/her enteral feeding and water bags hanging from an IV pole. The bags were not dated, labeled, or initialed. During an interview on 2/1/24 at 4:38 P.M., when asked by the surveyor why the enteral feed was not hung at 2 pm, Nurse #2 said she was waiting for formula clarification before hanging the enteral feed as they did not have the Glucerna 1.2 on hand. On 2/2/24 at 6:28 A.M., the surveyor observed Resident #42 lying in his/her bed, the enteral formula bag was infusing with 300 ml left in it. On 2/2/24 at 7:00 A.M., the surveyor observed Resident #42 lying in his/her bed with the enteral feeding off and bags removed from the room. During an interview on 2/2/24 at 7:05 A.M., Nurse #5 said she took the feeding down at 6:30 am, when asked if she had received report from the previous nurse of what time the enteral feeding was hung, she said she did not. Nurse #5 said she was following the orders and knew the feeding hung from 2pm - 6am. When the surveyor asked Nurse #5 if she knew what formula had been hung, she said she assumed it was Glucerna 1.2 as that was the physician order. The surveyor asked Nurse #5 if the formula had been hung at 4.30 P.M. and was taken down at 6.30 A.M., if the Resident had received the ordered volume, Nurse #5 said the Resident would not have received the correct total volume of 1680 milliliters. During an interview on 2/2/24 at 10:37 A.M., the Director of Nursing (DON) said that Resident #42 did not get his/her formula hung at 2 P.M., as the nurse was waiting for clarification order from the dietician as they were out of Glucerna 1.2. When the DON was asked if she knew there was an alternative order for formula to hang, she said she wasn't sure. When asked if Resident #42 had received the ordered total volume if the formula went up at 4.30 P.M., and came down at 6.30 A.M., she said the Resident would not have received the total volume ordered. When the DON was asked of the expectations of the nurses with hanging the enteral feed, she said the bags should be labeled, timed, dated, and initial. (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 2/2/24 at 11:31 A.M., the Dietician said nurses should not be waiting for any order clarification as they already have a standing order for alternative formula per the orders. She further said the Resident should receive a total volume of 1680 ml as ordered regardless of what time the feeding was hung.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, record review, and interview, the facility failed to 1. change oxygen tubing according to a physician's order for three Residents (#31, #20 and #48), and 2. failed to change an oxygen concentrator filter for one Resident (#48), out of a total sample of 40 residents. Findings include: Review of the facility policy titled Oxygen Administration, dated 02/2023, indicated the following: Preparation - Verify that there is a physician's order in place. Review the physician's orders or facility protocol for oxygen administration. 1a. Resident #31 was admitted in October 2022 with diagnoses including chronic respiratory failure and emphysema. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #31 scored a 14 out of a possible 15 on the Brief Interview for Mental status (BIMS), indicating intact cognition. Review of the MDS also indicates that Resident #31 requires oxygen therapy. Review of the physician's orders indicated the following order: -Change nebulizer and O2 tubing weekly and PRN (as needed). Every night shift every Wednesday for O2 therapy change weekly and PRN. During an observation on 1/30/24 at 10:04 A.M., Resident #31 was laying in bed utilizing his/her oxygen. The oxygen tubing was dated 1/9/24, which was 3 weeks prior. Review of the Medication Administration Record for January 2024 indicated that the oxygen tubing was changed on 1/17/24 and on 1/24/24. During an interview on 2/2/24 at 7:39 A.M., the Director of Nursing said that if the physician's order says to change oxygen tubing weekly then she expects it to be changed weekly. 45343 1b. Resident #20 was admitted to the facility in March 2016 with diagnoses including chronic obstructive pulmonary disease, transient cerebral ischemic attack, and Covid. Review of Resident #20's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15, indicating he/she has severe cognitive impairments. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #20's physician orders indicated the following: *Administer oxygen via nasal cannula at 2 liters/minute continuously, check saturation % q (every) shift related to Chronic Obstructive Pulmonary Disease. *Change oxygen tubing and bottle weekly and PRN (as needed). Rinse oxygen filter with H2O (water), pat dry and replace. Initial tubing and bottle at time of change. Place tubing in dated plastic bag when not in use, every night shift, every Wednesday. On 1/31/24 at 8:05 A.M., 1/31/24 at 3:05 P.M.,1/31/24 at 4:20 P.M., 2/1/24 at 8:05 A.M., 2/2/24 at 8:42 A.M., and 2/2/24 at 9:15 A.M. Resident #20 was observed lying in bed with oxygen at 2 liters per minute (L/min) via nasal cannula. The oxygen tubing was labeled 1/25/24. Review of the Medication Administration Record for January 2024 indicated that the oxygen tubing was changed on 1/24/24 and on 1/31/24. During an interview on 2/2/24 at 8:46 A.M., Nurse #2 said the oxygen tubing should be changed but she was unsure on how often or who was responsible for changing the tubing. Nurse #2 said she would check with the Director of Nursing and get back to the surveyor. During an interview on 2/2/24 at 9:2:28 A.M., the Director of Nursing said they recently changed the orders for all tubing to be changed and dated every Wednesday on the night shift. The Director of Nursing said nurses should follow the physician's orders for cleaning and labeling tubing. 46339 2. Resident #48 was admitted to the facility in November 2023 with diagnoses including chronic obstructive pulmonary disease, interstitial pulmonary disease, and malignant neoplasm of oropharynx (middle of throat). Review of Resident #48's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated the Resident was cognitively intact. Review of Resident #48's physician orders indicated the following: *Oxygen via nasal cannula at 2 liters/minute continuously every shift for oxygenation. *Change oxygen tubing every night shift every Sunday. *Wipe down concentrator and clean filter weekly every night shift every night shift every Sunday. On 1/30/24 at 11:29 A.M., the surveyor observed Resident #48's wearing oxygen tubing in his/her nares, the oxygen concentrator filter was coated with a thick layer of dust, the oxygen tubing was undated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/31/24 at 11:16 A.M., the surveyor observed Resident #48's wearing oxygen tubing in his/her nares, the oxygen concentrator filter was coated with a thick layer of dust, the oxygen tubing was dated 1/30/24. During an interview on 1/31/24 at 11:48 A.M., Nurse #7 said the oxygen concentrator filter should be wiped down weekly per physician's orders. She said the tubing should be changed every Sunday night and should be labeled and dated. During an interview on 2/1/24 at 8:47 A.M., the Director of Nursing said nurses should follow the physician's orders for cleaning and labeling oxygen tubing and concentrators.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46339 Based on record review, policy review and interview, the facility failed to provide care and services consistent with professional standards for one Resident (#404) who required renal dialysis (a life sustaining treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) out of a total sample of 40 residents. Specifically, the facility failed to ensure that clamps and pressure dressings were kept with the Resident (#404) for emergency related to a tunneled hemodialysis catheter (a plastic tube used for exchanging blood between a patient and a hemodialysis machine). Findings Include: Review of the facility policy titled 'End-Stage Renal Disease, Care of a Resident with (sic)' last revised July 2023, indicated the following but not limited to: Policy: The facility assures that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. Resident #404 was admitted to the facility in January 2024 with diagnoses including end stage renal disease, dependence on renal dialysis. Review of Resident #404's medical record indicated the following order: *Central line to right subclavian for hemodialysis. Do not access, monitor for infection, bleeding at site. Notify MD with any signs or symptoms. On 1/30/24 at 8:17 A.M., the surveyor observed Resident #404 lying in his/her bed. The surveyor did not locate emergency clamps or pressure dressing with the Resident or in the Resident's room. On 1/30/24 at 1:20 P.M., the surveyor observed Resident #404 lying in his/her bed. The surveyor did not locate emergency clamps or pressure dressing with the Resident or in the Resident's room. On 1/31/24 at 6:35 A.M., the surveyor observed Resident #404 lying in his/her bed. The surveyor did not locate emergency clamps or pressure dressing with the Resident or in the Resident's room. On 2/2/24 at 8:41 A.M., the surveyor observed Resident #404 lying in his/her bed. The surveyor did not locate emergency clamps or pressure dressing with the Resident or in the Resident's room. During an interview on 2/2/24 at 8:59 A.M., Nurse #4 said they should have a clamp, Vaseline gauze dressing and pressure dressing set up in the Resident's room.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observation record review and interview, the facility failed to ensure a plan of care was developed for Trauma-Informed Care for one Resident (#91), who was admitted with the diagnosis of Post-Traumatic Stress Disorder (PTSD), out of a total sample of 40 residents. Findings include: Review of the facility policy titled 'Trauma Informed Care' revised October 2019, indicated the following but not limited to: *To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. *Include trauma-informed care as part of the QAPI (quality assurance performance improvement) plan, so that needs and problems areas are identified and addressed, Resident #91 was admitted to the facility in September 2023 with diagnoses including post-traumatic stress disorder. Review of Resident #91's Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) indicating Resident #91 was cognitively intact. The MDS further indicated the Resident had an active diagnosis of PTSD. Review of Resident #91 medical record failed to indicate a care plan had been developed or implemented. During an interview on 2/1/24 at 8:46 A.M., the Director of Nursing said the social workers, nurses and herself are responsible to ensure residents admitted to the facility with diagnosis of PTSD had a care plan in place. During an interview on 2/1/24 at 10:31 A.M., the Social Worker said that normally the MDS (minimum data set) nurse and the social workers were responsible for ensuring the care plans were developed for trauma informed care.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on interview, facility assessment review, and in-service documentation review, the facility failed to ensure that the nursing staff received the appropriate competencies and skill sets necessary for the care and treatment of residents. Specifically, the facility failed to ensure annual competencies were completed and documented for six out of six certified nursing assistants (CNAs), and six out of six licensed nurses whose education records were reviewed. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board of Nursing and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Review of the Facility Assessment Tool, last revised on [DATE] (sic), indicated the following: General orientation, monthly in-services calendars, care related clinical competencies annually and as needed based on case load. Relias training and specialized training offered by agencies that we partner with. Some examples of annual competencies include but are not limited to the following: -Code Blue -Elopement -Dementia -Abuse -CPR/Mock Code -Infection Control The Administrator provided the surveyor with the education files for the CNAs and nurses. Review of the education records for six of six CNAs, and six of six licensed nurses failed to indicate that annual competencies were completed in 2023. During an interview on [DATE] at 11:16 A.M., the Administrator said that the Facility Assessment was last revised on [DATE], and the date of [DATE] was a typo. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:45 A.M., the Assistant Director of Nursing (ADON) said he assumed all staff education when he started in [DATE], he is aware staff education and competencies are not up to date and is in the process getting all required staff competencies completed. The ADON said it would be the expectation that competencies would be completed yearly.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 45343 Based on record review and interview, the facility failed to complete annual Certified Nurse Aide (CNA) performance reviews for six of six sampled Certified Nurses Assistants (CNAs). Findings include: During the review of six CNA employee records on 2/1/24 at 3:25 P.M. and 2/2/24 at 9:00 A.M., the Surveyor noted that six of six sampled CNAs did not receive annual performance reviews. During an interview with the Director of Nursing (DON) and the Administrator on 2/2/24 at 11:45 A.M., the above concerns were reviewed. The Administrator said Corporate is responsible for annual performance reviews and is unsure who is currently completing them. The Director of Nursing said she would check with Corporate regarding the annual performance reviews.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to provide behavioral health services for 1 Resident (#255) out of a total sample of 40 residents. Findings include: Review of the facility policy titled Behavioral Health Services, dated 09/2019, indicated the following: -Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care. -Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. -Staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress. Resident #255 was admitted in December 2023 with diagnoses including depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #255 had moderately impaired cognition. the MDS did not contain a Brief Interview for Mental Status (BIMS) score (cognitive assessment). Review of the MDS indicated that Resident #255 needs and wants an interpreter to communicate with staff or a doctor. Review of the clinical record indicated that Resident #255 was admitted back to the facility from the hospital in November 2023. Review of the hospital discharge paperwork, dated 11/22/23, indicated that, during the hospitalization , Resident #255 expressed suicidal ideation. The hospital note indicated the following: Daughter also mentioned that in the past two weeks on multiple occasions when the Resident was not confused has mentioned that he/she wants to end his/her life. Resident #255 sometimes wishes that he/she could just jump off of the building and kill self. No prior history of SI or HI. Resident #255 has never had any suicide attempt. Daughter notes that the patient is just tired of old age and his/her disability. Review of the clinical record did not indicate that anyone followed up with Resident #255 regarding his/her suicidal ideation. Review of the clinical record did not indicate that Resident #255 had not been referred to or seen by psych services upon return. Review of the physician notes did not indicate that the physician was aware of Resident #255's suicidal ideation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the social work notes did not indicate that social services had followed up with Resident #255. Review of the behavioral health visit request/follow-up log did not indicate that Resident #255 was ever put on the list to be evaluated or seen regarding behavioral health services. Review of the care plan did not indicate that Resident #255 was care planned for any suicidal ideation or mental health concerns. During an interview on 1/31/24 at 12:26 P.M., Nurse #4 said that when she reviews the hospital paperwork, if she sees anything regarding suicidal ideation, that she would let the physician know and consult psych services. During an interview on 2/1/24 at 7:50 A.M., the Director of Nursing said that nurses are supposed to review the discharge paperwork and that psych services and the social worker should be notified if a resident is having suicidal ideation. The Director of Nursing said that the first step would be to make sure that the Resident is safe, the social worker would do an evaluation, and that psych services would be consulted. The Director of Nursing was unaware that psych services had not been put in place for Resident #255. The Director of Nursing said that she would have expected psych services to be put into place for Resident #255.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, record review, and interview, the facility failed to provide medically related social services to attain the highest practicable physical, mental, and psychosocial well-being, for one Resident (#255) specifically, providing or arranging for needed mental and psychosocial counseling services after verbalizing suicidal ideation Findings include: Review of the facility policy titled Behavioral Health Services, dated 09/2019, indicated the following: -Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care. -Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. -Staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress. 1. Resident #255 was admitted in December 2023 with diagnoses including depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #255 was moderately cognitively impaired. Review of the MDS indicated that Resident #255 needs and wants an interpreter to communicate with staff or a doctor. Review of the clinical record indicated that Resident #255 was sent out to the hospital in November 2023. Review of the hospital discharge paperwork, dated 11/22/23, indicated that Resident #255 expressed suicidal ideation. The hospital note indicated the following: -Daughter also mentioned that in the past two weeks on multiple occasions when the Resident was not confused has mentioned that he/she wants to end his/her life. Resident #255 sometimes wishes that he/she could just jump off of the building and kill self. No prior history of SI or HI. Resident #255 has never had any suicide attempt. Daughter notes that the patient is just tired of old age and his/her disability. Review of the social services notes did not indicate that anyone from social services followed up with Resident #255 regarding his/her suicidal ideation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/1/24 at 7:50 A.M., the Director of Nursing said that nurses are supposed to review the discharge paperwork and that psych services and the social worker should be notified if a resident is having suicidal ideation. The Director of Nursing said that the first step would be to make sure that the Resident is safe, the social worker would do an evaluation, and that psych services would be consulted. During an interview on 2/1/24 at 10:13 A.M., Social Worker #1 said that she would expect someone who expresses suicidal ideation to be care planned for that. Social Worker #1 was not aware that Resident #255 had expressed any suicidal ideation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observation, record review and interviews, the facility failed to ensure it provided a physician ordered medication for one Resident (#64) out of a total sample of 40 residents. Specifically, on 1/31/24 Nurse #1 did not have Resident #64's physician ordered Trazadone (medication used to treat depression) and Nurse #1 failed to obtain the medication from the emergency medication supply. Findings Include: Review of the facility policy titled 'Administering Medications', dated February 2020, indicated the following and is not limited to: *Medications are administered in a safe and timely manner and as prescribed. Resident #64 was admitted to the facility in October 2022 with diagnoses including anxiety and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #60 has a Brief Interview for Mental Status (BIMS) score of 14 out of possible 15 indicating he/she was cognitively intact. The MDS further indicated that he/she had anxiety and depression. Review of the physician's order, dated 6/20/23 indicated the following: -Trazodone HCL 50 mg oral tablet give one tablet by mouth one time a day for agitation. On 1/31/24 at 9:11 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #64. Nurse #1 said she did not have Trazodone to administer to Resident #64 and she was going to contact the pharmacy. Nurse #1 said when medications were not available, she would document them as unavailable and contact pharmacy for delivery. Review of the emergency medication supply indicated the following was available in the kit: - Trazodone 50 milligram (mg) tablet, quantity 10 tablets. Review of the pharmacy delivery manifest dated 1/24/24 indicated the following medication had been delivered to the facility: -Resident #64: Trazodone 50 mg, quantity 30 tablets. During an interview on 1/31/24 at 2:38 P.M., Nurse #1 said she should have checked the emergency kit for the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/2/24 at 9:29 A.M., the Director of Nursing (DON) said the medication was available in the emergency kit and that Nurse #1 should have checked the kit. The DON also said she was going to look for the medication as it had been delivered to the facility recently according to the pharmacy delivery manifest.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 46339 Based on observations, record reviews, policy reviews and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5 percent. Three out of four nurses observed made four errors in 38 opportunities on two of three units resulting in a medication error rate of 10.53%. These errors impacted three Residents (#90, #27 and #64), out of five residents observed. Findings include: Review of the facility policy titled 'Administering Medications', revised 2/2020, indicated the following but not limited to: *Medications are administered in a safe and timely manner, and as prescribed. 1.During a medication pass on 1/30/24 at 10:07 A.M., the surveyor observed Nurse #6 prepare and administer the following medication to Resident #90: -metformin 500mg one tablet by mouth Review of current physician's orders indicated the following: -Metformin HCL oral tablet 500 mg (milligram) give two tablets by mouth one tome a day related to diabetes mellitus due to underlying condition with hyperglycemia. During an interview on 1/30/24 at 2:38 P.M., Nurse #6 said he should have given two tablets of the metformin according to the physician's orders. 2. During a medication pass on 1/31/24 at 8:43 A.M., the surveyor observed Nurse #9 prepare and administer the following medication to Resident #27: -Multivitamin with mineral one tablet by mouth. Review of current physician's orders indicated the following: -Multivitamin tablet give one tablet by mouth one time a day for vitamins. During an interview on 1/31/24 at 2:44 P.M., Nurse #9 said she was supposed to give the regular multivitamin and not the one with minerals. 3. During a medication pass on 1/31/24 at 9:11 A.M., the surveyor observed Nurse #8 prepare and administer the following medication to Resident #64. -Midodrine 10mg one tablet by mouth, Nurse #8 checked the Resident's blood pressure and documented 125/71. Review of current physician's orders indicated the following: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Midodrine HCL tablet 10 mg (milligram) give 10 mg by mouth two times a day for low blood pressure hold for systolic blood pressure greater than 110 - Thiamine HCL tablet 100 mg give one tablet by mouth one time a day related to alcohol abuse. During an interview on 1/31/24 at 2:38 P.M., Nurse #8 said she thought she gave the thiamine and for midodrine she should have read the directions clearly and should have not given it. During an interview on 2/1/24 at 8:22 A.M., the Director of Nursing said the nurses are expected to read the orders thoroughly and administer medications correctly.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 46339 Based on observations, record reviews and interviews, the facility failed to ensure that a resident was free from significant medication error. Specifically, the facility failed to ensure blood pressure increasing medication was held per physician orders parameters for one Resident (#64) out of a total sample of 40 residents. Findings include: Review of facility policy titled 'Administering Medications' last revised February 2020, indicated the following but not limited to: *Medications are administered in a safe and timely manner, and as prescribed. *Medications are administered in accordance with prescriber orders, including any required time frame. Resident #64 was admitted to the facility in October 2022 with diagnoses including history of falling and anemia. Review of Resident #64 medical record active physician's orders indicated the following: *Midodrine HCL tablet 10 mg (milligrams) give 10 mg by mouth two times a day for low blood pressure hold if systolic blood pressure greater than 110. On 1/31/24 at 9:11 A.M., the surveyor observed a medication pass with Nurse #8, Nurse #8 prepared medications and checked Resident #64's blood pressure using a wrist blood pressure reading machine, she then proceeded to administer the medications including midodrine. Nurse #8 then documented the blood pressure readings in the electronic medical record. The readings were as follows: 125/71. Review of the medical record Medication administration record (MAR) for the month of January 2024 indicated the Resident received the midodrine for 28 out of 31 days in spite of blood pressures being recorded as outside of the administration parameters per the physician's order. During an interview on 1/31/24 at 2:38 P.M., Nurse #8 said the Resident should not have received the medication as it was outside of the parameters per physician orders. During an interview on 2/1/24 at 8:22 A.M., the Director of Nursing said the expectation is that nurses are following the physician orders accurately and that the midodrine should not have been administered.

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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** 46339 Based on observations, policy review and interviews, the facility failed to ensure medications with short expiration dates were dated when opened, failed to ensure medication carts were securely locked when unattended and medications were securely locked. Findings include: Review of the facility policy titled 'Storage of Medication' last revised in [DATE], indicated the following but not limited to: *Medications and biologicals are stored safely securely and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. *Medication storage areas are kept clean, well lit and free of clutter and extreme temperatures and humidity. *When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. *The nurse shall place a 'date opened' sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening unless the manufacturer recommends another date or regulations/guidelines require different dating. On [DATE] at 1:22 P.M., the surveyor observed the medication cart on the first floor unlocked and unattended. Nurse # 7 returned to the medication after a awhile and said that medication carts should be locked at all times when unattended. On [DATE] at 6:30 A.M., the surveyor inspected the first-floor medication cart the following was observed: -Fluticasone propionate and salmeterol ,d+[DATE] mcg (micrograms) with an opened date of [DATE] and a use by [DATE]. During an interview on [DATE] at 6:45 A.M., Nurse #5 said medication should have been discarded after 30 days. During an inspection of the medication room on the third-floor unit on [DATE] at 7:10 A.M., the following was observed in one of the medication cabinets: -Food container -Toilet paper (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bags of resident medications -plastic container with coffee, sugar, cereal and a container of resident specific medication -On one shelf there was raid bug spray, nystatin (antifungal) powders, a container full of sugar packets and topical ointments. During an interview on [DATE] at 7:28 A.M., Nurse #12 said that she is from the agency and does not touch that cabinet as it belongs to the regular staff. She further said the medication room should only have medications for the residents and not any other things. During an interview on [DATE] at 8:31 A.M., the Director of Nursing said nurses are responsible to ensure no expired or outdated medications are available for administration, medication carts are always secured, medications are always secured properly, and that medication storage room is kept clean and should not have any other items in it. She further said the medication room had been worse before with excessive clutter. 36876 2. The facility failed to properly secure medications and medication carts. On [DATE] at 7:59 A.M., the surveyors observed a medication cart unlocked in front of the nurses station on the 2nd floor nursing unit. The nurses were behind the nurses station and unable to visualize the cart. The nurses were giving report and were not aware the medication cart was unlocked. The surveyor notified the nurse who then immediately secured the med cart. On [DATE] at 11:07 A.M., the surveyor observed a bottle of Vitamin D on top of the medication carton the 1st floor nursing unit. There was no staff in the area.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to provide dental services to replace missing dentures for 1 Resident (#78) out of a total sample of 40 residents. Findings include: The facility failed to provide the surveyors of a policy for the provision of routine/emergent dental services. Resident #78 was admitted in August 2022 with diagnoses including type 2 diabetes and hypertension. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #78 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the MDS indicated that Resident #78 requires partial to moderate assistance with meals. Review of the progress note, dated 9/28/23, indicated that Resident #78 reported to the Dietitian that he/she lost his/her lower denture making chewing difficult. Review of the physician's orders indicate that Resident #78's diet was downgraded on 9/28/23 to mechanical soft texture with thin liquids. Review of the clinical record indicated that Resident #78 was last seen by the dentist on 4/3/23. There was no indication in the clinical record that a dental consult was ever done after the Resident reported missing dentures. Review of the paper chart indicated a flagged recommendation for dental services, which was dated 12/21/23. During an interview on 2/1/24 at 11:13 A.M., Nurse #5 said that residents that need dental services are put on a list for the dentist to be seen and if the Resident has a flagged consult form in his/her chart then he/she should be seen by the dentist.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41019 Based on observation and policy review the facility failed to maintain proper sanitation practices in the kitchen, specifically related to glove use when serving the tray line. Findings include: Review of the facility policy titled Hand washing, Bare Hand Contact, and Glove use, dated 06/2018, indicated the following: Single use disposable gloves -Only use gloves approved for food service. -Glove use in itself does not guarantee food safety. Gloves are a food contact surface; they are just like hands and cause and spread pathogens if not used properly. -Disposable gloves are task specific and should be changed when switching to a new task. During an observation on 2/2/24 at 7:52 A.M. to 8:10 A.M., the cook serving the line was wearing single use gloves and was serving the tray line. The breakfast line included pancakes, muffins, and toast, which all were served without the use of utensils. During the serving line, the cook would grab the handle of one serving utensil and then, with the same potentially contaminated single use gloves, would serve toast with the same gloved hands. The cook would then use the same gloved hands to place a jelly container on the tray and then would grab a muffin with the same gloved hands. The cook did not change his gloves during the observed line, despite touching non-food objects.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 36797 Based on observations and interviews the facility failed to ensure it was administered in a manner that enabled the facility to use its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident and provide a homelike environment. Specifically, the facility administration failed to ensure the governance and leadership members sustained a sufficient activities program and a sufficient Quality Assurance Performance Improvement (QAPI) program during transitions in staffing and the serving of meals in a homelike manner. Findings include: During the recertification survey conducted on 1/30/24, through 2/2/24, the survey team observed concerns with a lack of activities programming for all residents. During the recertification survey conducted on 1/30/24, through 2/2/24, the surveyors identified the building did not have a home-like environment on 3 of 3 nursing units evidenced by, meals served on trays in an institutional manner. During an interview on 2/1/24, at 2:10 P.M. with the Director of Nursing and the Administrator, the Administrator said that he was aware that there was no one in the activities department providing activities for all of the residents. He then said that he tries to have the Certified Nurse's Aides provide activities. The Administrator also said that the activities director position has been open for more than two months and activities for the residents have been directly impacted by the lack of an activity director. The Administrator and the Director of Nursing then said that they were not aware that staff were to remove the food trays and serve meals by placing plates and cups on directly on the table for a homelike dining experience. Despite having the knowledge of the aforementioned concerns, the facility's administrative team and governing body did not provide the services necessary to provide for the needs of residents. See F925

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 36797 Based on interview and record review, including review of the Quality Assurance and Performance Improvement program (QAPI) facility policy, the facility failed to ensure that the governing body provided oversight and accountability for: 1. The maintenance of an effective QAPI program. 2. The provision of a sufficient activity program. Findings include: Review of the facility policy titled Quality Assurance Performance Improvement (QAPI) revised June 2019 indicated the following: The [NAME] President Of Operations will periodically review the QAPI process. The facility will identify areas of improvement and rank them by factors such as prevalence, risk, cost, relevance, responsiveness, feasibility and continuity. From this we will develop our Performance Improvement Projects (PIP). PIP projects are developed based on a prioritizing process . Further review indicated that the facility will use a Plan-Do-Study-Act (PDSA) process and Root Cause Analysis (RCA) to identify improvement opportunities and to understand how to improve them. 1. Review of the QAPI meeting minutes for 2023 failed to indicate the [NAME] President of Operations had reviewed the QAPI process in the facility. Further review failed to indicate that the facility was following the QAPI policy by failing to investigate the root cause of a concern, develop a specific plan of action, implement the plan, evaluate the effectiveness of the plan and revise the plan as necessary. Further review indicated that the medical director did not attend three out of the four quarterly QAPI meetings. During an interview on 2/1/24, at 2:10 P.M., the Administrator said that the governing body has not discussed the QAPI meeting minutes he provides them and they have not informed him that sections of the QAPI are not being completed per the policy, or that the medical director has not attended three of the four quarterly QAPI meetings. 2. During all days of the survey, from 1/30/24 through 2/2/24, the surveyors observed that no activities were taking place on three of the three resident units. During an interview on 2/1/24, at 2:10 P.M., The Administrator said that there has not been an activity director for over two months. The Administrator said that he tries to have a Certified Nurse's Aide help out in the activity department when possible. The Administrator then said that the governing body was not aware of the lack of activities in the facility.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on interviews and review of the facility assessment, the facility failed to accurately evaluate their resident population and identify the resources needed to provide the necessary care and services of the resident population related to activities programming. Findings include: During observations throughout the survey from 1/30/24 through 2/2/24 the surveyors identified concerns related to Activity Programming. Review of the Facility assessment dated [DATE] indicated: Provide Person-Centered Directed care Psycho/Social/Spiritual support: Note; some of these preferences are not able to be met at this time due to existing Covid-19 protocols relating to cohorting, limited visitation, communal activities, communal dining, etc. Activities are scheduled for residents on a one-to-one basis in resident rooms, offering puzzles, games, nail cleaning and conversation. Residents are also encouraged in virtual visitation with families and friends. During an interview on 2/2/24 at 11:16 A.M., the Administrator said that the Facility Assessment was last revised on 12/28/23, and the date of 12/28/24 was a typo. The Administrator and Assistant Director of Nursing (ADON) said that there had been no Covid-19 outbreak in the facility in December 2023. The Administrator said that the information in the assessment about not being able to provide communal activities was an error and he would look into it.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 36797 Based on record review and interview the facility failed to ensure that the medical director attended the Quality Assurance and Performance Improvement (QAPI) meetings at least quarterly. Findings include: Review of the facility policy titled Quality Assurance Performance Improvement (QAPI) dated revised June 2019 indicated the following: The facility will form a QAPI steering committee designed to meet monthly. The Steering Committee must include the Medical Director (attendance required quarterly). Review of the QAPI meeting minutes sign in logs for 2023 indicated that the medical director attended one QAPI meeting (July 2023) for the year 2023. During an interview on 2/1/24, at 2:10 P.M., the Administrator said that the medical director is supposed to attend the QAPI meetings at least quarterly. The Administrator was unable to say why the medical director had not attended three of the four quarterly meetings in 2023.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview the facility failed to accurately document in the medical record for three Residents (#404, #97 and #91) out of a total sample of 40 residents. Specifically for 1. For Resident #404 the doctor's orders indicated that dialysis was on hold when the Resident was receiving dialysis. 2. For Resident #97 nursing was documenting the Resident was receiving Glucerna when it was not available. 3. For Resident #91 nursing documented the Resident was wearing booties when they were not available. Findings include: The facility failed to provide a policy for accurate documentation in the clinical record that was requested by the surveyors. 1. Resident #404 was admitted to the facility in January 2024 with diagnoses including dependence on dialysis with an indwelling peripherally inserted central catheter, schizophrenia and bipolar disorder. Review of the doctor's orders dated 1/24/24, indicated a doctor's order for Dialysis in the morning every Mon, Wed, Fri for Hemo Dialysis, status on hold. During an interview on 1/31/24, at 11:30 A.M., Nurse #10 said that Resident #404 had gone out of the facility to dialysis. Nurse #10 then said that she was not aware the doctor's order for dialysis was on hold and that it was incorrect. Review of the nurse's notes dated 1/31/24, written at 3:46 P.M. indicated that Resident alert and oriented to self, no acute distress observed or reported. Resident left for dialysis today accompanied by two EMTs (Emergency Medical Technicians). 36876 2. Resident #97 was admitted to the facility in September 2023 with diagnoses including traumatic brain injury, diabetes and dementia. Review of Resident #97's Minimum Data Set assessment dated [DATE], indicated he/she is moderately cognitively impaired and requires assistance with bathing and dressing. Review of Resident #97's physicians orders indicated: Glucerna Thera Shake after meals, initiated 1/9/24 On 2/1/24 at approximately 11:05 A.M. the surveyor observed the medication room on the 2nd floor unit. There was no glucerna available. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/1/24 at 11:08 A.M. Nurse #2 took the surveyor to the supply room to look for Glucerna. At that time, another nurse was exiting the supply room and said that there was no Glucerna shake in house, but she had found a box of Ensure. Nurse #2 said that if an ordered supplement was not available, the expectation would be for staff to alert the physician and determine an alternate option. During an interview on 2/1/24 at 11:14 A.M., Nurse #1 said she did not give Glucerna to any residents on the unit. Review of Resident #97's Medication Administration Record (MAR) indicated Nurse #1 had signed off that he/she had received his/her scheduled Glucerna shake at 9:00 A.M. During an interview on 2/1/24 at approximately 12:15 P.M. the Administrator and Corporate Nurse #1 said that if a supplement is not available, the expectation is for staff to document in the medical record and alert the physician and ask for an appropriate replacement. 46339 3. Resident #91 was admitted to the facility in September 2023 with diagnoses including, adult failure to thrive and weakness. Review of Resident #91's Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) indicating Resident #91 was cognitively intact. The MDS further indicated that the Resident was at a higher risk for developing pressure ulcers and required total dependent for all activities of daily living. Review of Resident #91's physician orders dated 12/27/2023, indicated the following: *Bilateral heels booties on at 8 am and off at 8pm. Every morning and at bedtime for pressure ulcer prevention related to unspecified severe protein calorie malnutrition. On 1/30/24 at 8:12 A.M., the surveyor observed the Resident lying in bed he/she did not have heels booties on. On 1/30/24 at 1:26 P.M., the surveyor observed the Resident lying in bed he/she did not have heels booties on. On 1/31/24 at 11:10 A.M., the surveyor observed the Resident lying in bed he/she did not have heels booties on. Review of the medical record for Resident #91 Treatment Administration Record (TAR) indicated that Nurse #7 had signed that the Resident was wearing heels booties. During an interview on 1/31/24 at 11:30 A.M., Certified Nursing Assistant (CNA) #9 said she always takes care of the Resident and that he/she does not have heel booties in place. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/31/24 at 11:33 A.M., Nurse #7 said the Resident does not have heel booties in place, when asked why she had signed the TAR record indicating the booties were in place. She said the physician was aware the heel booties were not available, and that Resident's heel were offloaded with pillows. During an interview on 2/1/24 at 8:39 A.M., the Director of Nursing said the nurses should be following physician's orders and should not document in the TAR if a task has not been performed.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 36797 Based on interview and review of the Quality Assurance Performance Improvement (QAPI) meeting minutes for 2023, the facility staff failed to ensure an effective QAPI plan was in place. Findings include: Review of the facility policy titled Quality Assurance Performance Improvement (QAPI) revised June 2019 indicated the following: We will identify areas of improvement and rank them by factors such as prevalence, risk, cost, relevance, responsiveness, feasibility and continuity. From this we will develop our Performance Improvement Projects (PIP). PIP projects are developed based on a prioritizing process . Further review indicated that the facility will use a Plan-Do-Study-Act (PDSA) process and Root Cause Analysis (RCA) to identify improvement opportunities and to understand how to improve them. Review of all the 12 months of meeting minutes for 2023 failed to indicate that there were benchmarks developed, failed to indicate a prioritizing process was implemented, failed to indicate that a root cause analysis was completed for identified problems and failed to indicate the tracking of outcomes for any interventions put in place. Review of the Quarterly December 2023 QAPI meeting minutes failed to indicate that a performance improvement plan was implemented to ensure the continuation of an effective activities program. Further review failed to indicate that any new QAPI plans were implemented or that the results of any QAPI plans previously put in place were discussed. During an interview on 2/1/24, at 2:10 P.M., the Administrator said that the activity director had resigned two months ago. The Administrator said that he had attempted to have a Certified Nurse's Aide (CNA) provide some activities but he had not put a specific QAPI plan in place to ensure that the activity program continued to provide activities to the residents. The Administrator the said that QAPI was not being followed as directed by the corporate QAPI resource guide he was directed to use to drive the QAPI program. The Administrator said that issues are discussed at QAPI but root cause analysis and the tracking of outcomes of interventions is not completed.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 36797 Based on observation and interview the facility failed to ensure that the Medical Director or an appropriate designee attended Quality Assurance and Performance Improvement Plan (QAPI) Committee meetings at least quarterly. Findings include: Review of the Facility policy titled Quality Assurance Performance Improvement (QAPI) dated revised June 2019 indicated that the QAPI steering committee must include the medical director (attendance required quarterly). Review of the Facility documents titled Quality Assurance Performance Improvement Committee Attendees indicated that three of the last four quarters the Medical Director or an appropriate designee did not attend the meeting. During an interview on 2/1/24, at 2:10 P.M., the Administrator said that the medical director is supposed to attend the QAPI meetings at least quarterly. The Administrator was unable to say why the medical director had not attended three of the four quarterly meetings in 2023.

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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** 36876 Based on observation and policy review, the facility failed to ensure staff followed infection control standards on one of three nursing units. Specifically: 1. The facility failed to ensure staff followed isolation precautions while providing care and housekeeping services during a Covid-19 outbreak. Additionally, 2. the facility failed to ensure that professional standards of practice were upheld during a medication pass to prevent the spread of infection. Findings include: Upon entrance to the facility on [DATE], the surveyors were notified that there was a Covid-19 outbreak on the second floor unit. A total of 20 out of 40 residents on the unit had tested positive for Covid-19. On 1/31/24, an additional three residents tested positive. Review of the facility's Infection Prevention for Covid-19 dated as revised May 2020, indicated: Process: To mitigate risk for the spread of Covid-19 to residents and staff. 1. The facility will follow transmission based policies and procedures and Centers for Medicare and Medicaid services guidance for residents suspected or confirmed coronavirus disease (Covid-19) in healthcare settings. 2. The facility staff will follow outbreak policies and procedures and infection control guidelines policies. 3. Employees will follow hand hygiene per hand hygiene policy and procedures. 1. On 1/30/24 at 7:45 A.M. the surveyors observed signs on the doors of multiple rooms on the 2nd floor unit with signs indicating the resident in the rooms were on Isolation Precautions. The signs indicated: Clean hands when entering and exiting. Gown: change between each resident. N95 Respirator: Facemask acceptable if N95 not available. Eye protection: Goggles/face shield. Gloves: change between each resident. Keep door closed (unless safety concerns or not on physically separate unit). Use patient dedicated or disposable equipment. Clean and disinfect shared equipment. On 1/30/24 at 7:54 A.M., the surveyor observed CNA #1 in the hallway wearing a surgical mask gown, gloves and a face shield. There was a box of N95 respirators on top of a precaution cart outside the door. CNA #1 entered a resident room with an Isolation Precaution sign hanging on the door. CNA #1 exited the room without removing his/her PPE, holding a bag of soiled linen, and entered another resident room that also had an isolation precaution sign. Upon seeing the surveyor, CNA #1 removed his gown and gloves and placed them in the soiled linen bag. CNA #1 then walked across the hall and obtained a new pair of gloves without performing hand hygiene. CNA #1 then retrieved the bag of soiled linen and walked down the hall to the laundry chute while dragging the bag of soiled linen on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/24 at 8:01 A.M., the surveyor observed CNA #3 wearing a face shield and surgical mask passing meal trays. CNA #3 entered an Isolation Precaution room without performing hand hygiene, and delivered the breakfast meal. CNA #3 then exited the room, without performing hand hygiene, and while walking past another Isolation Precaution room, reached her arm inside the doorway to turn the light on. CNA #3 then walked to the food truck to get another tray to deliver to another resident without performing hand hygiene. On 1/31/24 at 7:53 A.M. the surveyor observed CNA #2 providing care to a resident who was on Isolation Precautions. CNA #2 was wearing a gown, surgical mask, gloves and face shield. CNA #2 exited the room while wearing his contaminated PPE, walked to the clean linen cart and removed fresh linens while wearing his contaminated gloves. CNA #2 then re-entered the room to continue to provide care to the Resident. At that time, CNA #3 was observed exiting an Isolation Precaution room while wearing a surgical mask and a face shield, wearing gloves and holding a bag of soiled linen. Without removing her gloves or performing hand hygiene, CNA #3 then began to walk down the hall dragging the bag of soiled linen on the floor. The Assistant Director of Nursing (ADON) observed this and approached CNA #3 and told her she could not wear gloves in the hallway. The ADON then proceeded down the hallway to speak with CNA #2 and CNA #3 continued to drag the bag of soiled linen, while wearing her contaminated gloves to the laundry chute. On 1/31/24 at 11:00 A.M. the surveyor observed a housekeeper wearing a gown, gloves an N95 mask and no eye protection, cleaning an Isolation Precaution room. The Housekeeper exited the room just outside the door, removed his gloves and obtained a new pair without performing hand hygiene. The Housekeeper then returned to the room and mopped the floor. At 11:06 A.M. the Housekeeper exited the room again, removed the mop head and his contaminated gloves. Then, without performing hand hygiene or removing his gown, the Housekeeper walked down the hallway with his cart, adjusted his mask with his hand, then entered another Isolation Precaution room to clean. On 2/1/24 at 8:44 A.M. the surveyor observed three used face-shields placed on chairs and shelves in the common room. On 2/1/24 at 8:46 A.M., the surveyor observed CNA #8 inside an Isolation Precaution room wearing a face shield and surgical mask. CNA #8 exited the room and opened the PPE cart to obtain a gown, re-entered the room without performing hand hygiene and shut the door. On 2/1/24 at 8:47 A.M., the surveyor observed CNA #6 wearing a face shield, N95 mask and donning a gown and gloves and enter an Isolation Precaution room without performing hand hygiene. On 2/1/24 at 8:48 A.M., the surveyor observed a surgical mask placed inside of an open box of un-used N95 masks on a precaution cart in the hallway. On 2/2/24 at 8:31 A.M. the surveyor observed one used face shield on the floor and another used face shield on a bookshelf in the common room. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/2/24 the surveyor requested a copy of the Isolation Precaution policy and the facility provided a copy of an Enhanced PPE precaution sign which indicated the use of N95 masks for aerosol generating procedures or ongoing transmissions on the unit. The Enhanced PPE signs were not the same signs that were observed on the 2nd floor unit on Covid-19 positive resident rooms. During an interview on 2/2/24 at 9:16 A.M., the ADON said he is the Infection Preventionist at the facility. The ADON said that staff entering Isolation Precaution rooms were expected to perform hand hygiene, wear gloves, gowns, eye protection and an N95 mask. When the surveyor shared the observations made on the 2nd floor unit, the ADON said that there were issues with staff following precaution protocols. 46339 2. Review of facility policy titled 'Medication Administration' date 2/2023 indicated the following but not limited to: *Staff follow established facility infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility policy titled 'Infection control guidelines for all nursing procedures' dated 2/2023, indicated the following but not limited to: *The nurse should clean multi-use equipment between patients with the appropriate cleaning solution based on manufacture guidelines. During a medication pass observation with Nurse #6 on 1/30/24 at 9:56 A.M., Nurse #6 was observed preparing medication for administration, Nurse #6 punched medication from the medication card which fell on top of the medication cart, Nurse #6 picked up the pill with his bare hand and continued preparing medication for administration. Nurse #6 was then observed checking a resident's blood pressure with a blood pressure cuff which he then placed on his medication cart without cleaning it, contaminating the top of the medication cart. On 1/30/24 at 10:14 A.M., Nurse #6 then proceeded to use the blood pressure cuff on another resident without disinfecting the blood pressure cuff. During an interview on 1/30/24 at 2:40 P.M., Nurse #6 said he should not have picked up the dropped pill with his bare hand and should have sanitized the blood pressure cuff between each use. During an interview on 2/1/24 at 8:39 A.M., the Director of Nursing said nurses should follow infection control practices during medication administration and with the use of shared medical equipment should be disinfected after each use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225324	A. Building B. Wing	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Newton Healthcare	25 Armory Street West Newton, MA 02465

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 36876 Based on record review and interview, the facility failed to offer and provide influenza immunization for one Resident (#64) out of five residents reviewed. Findings include: Resident #64 was admitted to the facility in October 2022. Review of Resident #64's clinical record, and the facility's immunization logs failed to indicate he/she had been offered or received the influenza vaccine. During an interview on 2/2/24 at 10:40 A.M., the Assistant Director of Nursing (ADON) provided the surveyor with a signed consent form for influenza immunization which was dated for 2022. The ADON said that he was unable to locate evidence Resident #64 had received or been offered the influenza vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 36876 Based on record review and interview, the facility failed to offer and provide Covid-19 immunization for one Resident (#64) out of five residents reviewed. Findings include: Resident #64 was admitted to the facility in October 2022. Review of Resident #64's clinical record, and the facility's immunization logs failed to indicate he/she had been offered or received the Covid-19 vaccine. During an interview on 2/2/24 at 10:40 A.M., the Assistant Director of Nursing (ADON) provided the surveyor with a signed consent form for Covid-19 immunization which was dated for 2022. The ADON said that he was unable to locate evidence Resident #64 had received or been offered the Covid-19 vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225324	A. Building B. Wing	02/02/2024

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 45343 Based on record review, policy review, and interview the facility failed to ensure that at least 12 hours of in-service training was completed for six of six Certified Nurse Aides (CNAs). Findings include: Review of the policy titled, In-service Training Program, Nurse Assistance, last revised 10/2019 indicated the following: Policy statement: *Nurse Assistance personnel shall participate in regular in-service training classes. Policy Interpretation and Implementation: *3. Annual in-services: a. Ensure the continuing competence of nurse assistants. b. Be no less than 12 hours per employment year. During the review of employee education files on 2/2/24 at 9:00 A.M., the Surveyor noted six out of six Certified Nursing Aides did not receive 12 hours of required in-service education within 12 months. During an interview on 2/2/24 at 11:45 A.M., the Assistant Director of Nursing (ADON) said he assumed all staff education when he started in December 2023, he is aware staff education is not up to date. The ADON said it would be the expectation that mandatory education would be completed yearly.