STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225326	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reservoir Center for Health & Rehabilitation, The	400 Bolton Street Marlborough, MA 01752

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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. 44337 Based on observation, interview, and policy review, the facility failed to provide a dignified dining experience for one Resident (#79), out of a total sample of 27 residents. Specifically, the facility staff remained standing and stood over Resident #79 while assisting the Resident during a breakfast meal. Findngs include: Resident #79 was admitted to the facility in April 2024, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment) and Malnutrition (condition caused by not getting enough calories or the right amount of key nutrients, such as vitamins and minerals, that are needed for health). Review of Resident #79's MDS Assessment, dated 7/30/24, indicated that the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of a total 15. On 9/26/24 at 9:13 A.M., the surveyor observed Resident #79 lying in bed with the head of the bed elevated. The surveyor also observed Certified Nurses Aide (CNA) #6 standing over Resident #79 while assisting him/her with the breakfast meal. During an interview and observation at the time, Unit Manager (UM) #2 said that CNA #6 should be seated next to the Resident and not standing over him/her while assisting with the breakfast meal. Review of the facility document titled CNA Standard of Care Information Sheet, updated March 2023, indicated the following: -Each resident is always treated with dignity and respect. -Allow ample time for feeding - sit at eye level to feed if assistance is needed. During an interview on 9/30/24 at 1:40 P.M., the Director of Nursing (DON) said that the facility provided training to the CNAs using the CNA Standard of Care Information Sheet. The DON said that CNAs should be seated while assisting Residents with meals and not standing over the Residents while assisting with meals.

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42761 Based on observation, interview, record and policy reviewed, the facility failed to notify the Physician/Nurse Practitioner (NP) of the need to alter treatments, based on specialist medical practitioners' recommendations for two Residents (#84 and #79), out of a total sample of 27 residents. Specifically, the facility failed to notify the Physician/NP of: 1. a recommended change in treatment from Resident #84's Wound Care Consultant to cleanse two Stage Four pressure ulcers (PUs: full-thickness skin and tissue loss, usually over a bony prominence, with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer), which increased the Resident's risk for infection and delayed healing. 2. a recommended change in treatment from Resident #79's Urologist (Physician who specializes in treatment of the urinary tract) relative to the size change of the Resident's indwelling urinary catheter, increasing the Resident's risk for indwelling urinary catheter associated complications. Findings include: 1. Resident #84 was admitted to the facility in March 2021, with diagnoses including Other Paralytic Syndrome (complete or partial weakness of the body or part of the body, which can occur suddenly or gradually as a result of conditions that affect the brain, spinal cord, or nerves) following Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area). Review of Resident #84's Chronic Wound Care Plan, initiated 4/10/24, indicated the following: -The Resident required Enhanced Barrier Precautions (EBPs: risk-based approach of personal protective equipment [PPE] use to reduce the spread of organisms during high contact resident care, including wound care) due to chronic wound - pressure ulcer. Review of Resident #84's Pressure Ulcer Care Plan, initiated 11/2/23, indicated the following: -The Resident had Stage Four PUs to his/her right and left buttocks. -Staff were to monitor for signs and symptoms of wound infection. -Staff were to update the Physician with changes. Review of Resident #84's Bowel Incontinence Care Plan, initiated 8/6/21, indicated the following: -The Resident had bowel incontinence related to paraplegia (paralysis of legs and lower body). -The Resident used disposable briefs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident required facility staff to provide bowel incontinence care. Review of two active Physician orders, dated 3/5/24, indicated the following relative to Resident #84's PU care: -Treatment to left buttock wound: 1. NS (Normal Saline: sterile solution) wash. 2. Pat dry . -Treatment to right buttock wound: 1. NS wash. 2. Pat dry . Review of Resident #84's Wound Center Consult Report, dated 8/6/24, indicated the following: -The Physician Assistant (PA) Wound Care Specialist assessed Resident #84 that same day relative to care of right and left ischial (lower back region of the hip bone) ulcers. -A recommendation was made by the PA Wound Care Specialist to cleanse the ulcers by washing them daily with soap and water. Review of Resident #84's clinical record indicated no evidence that the facility notified the Physician/NP of the PA Wound Care Specialist's recommendation to wash the Resident's right and left ischial ulcers daily with soap and water (a change from the NS). On 10/1/24 at 10:45 A.M., Surveyor #2 observed the following during PU care provided by Nurse #2 to Resident #84: -Nurse #2 removed the dressings from each of the Resident's ischial regions. -Two open ulcers were present, one on each of the Resident's ischial regions. -Nurse #2 cleansed both open ulcers using NS before patting them dry and applying the new dressings. Surveyor #2 did not observe Nurse #2 use soap and water to cleanse either open ulcers during the PU care observation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/2/24 at 11:38 A.M., the PA Wound Care Specialist said she assessed Resident #84 at the Wound Center on 8/6/24, and recommended daily soap and water cleansing to the Resident's right and left ischial ulcers. The PA Wound Care Specialist said she recommended soap and water cleansing versus the use of wound cleanser because soap and water decreases the bacterial load (quantity of bacteria present in a wound that may delay healing) in a wound more than a NS wash. The PA Wound Care Specialist said sometimes wound dressings needed to be changed more than once a day, in order to keep the wounds clean for Residents due to incontinence or a significant amount of wound drainage. The PA Wound Care Specialist further said if Resident #84 required dressing changes more frequently than once a day, that was fine, and that each time the dressing was changed, the ulcers should be cleansed with soap and water to decrease the bacterial load. During an interview on 10/2/24 at 11:56 A.M. with NP #1 and NP #2, NP #1 said she worked at the facility three days per week and NP #2 said she worked at the facility two days per week. NP #1 said when specialist consultants made treatment recommendations for residents, she usually agreed with the recommendations because the area of consultation was that consultant's specialty. NP #1 said when Residents returned to the facility from a specialty consultation, the Nurse receiving the consultation recommendations would notify her or NP #2 of the treatment recommendations so that orders could be obtained. NP #1 also said if she was in the facility when a Resident returned with consultation recommendations, the Nurse would show her the consult report form so she could review it, she would sign the consult report form, and then provide instruction to the Nurse on any new orders. At the time, NP #2 said that if the NPs were not in the facility when wound consultation recommendations came back, the Nurse was to notify them by telephone to obtain orders. The surveyor reviewed Resident #84's Wound Center Consult Report, dated 8/6/24, including the recommendation for cleansing the Resident's PUs with soap and water with NP #1 and NP #2. NP #1 and NP #2 both said they did not recall being notified of the PA Wound Care Specialist's recommendation to cleanse the Resident's PUs with soap and water. NP #2 said the PA Wound Care Specialist's recommendation should have been communicated by the facility so that orders could have been obtained to implement the recommendation into the Resident's PU treatment. During an interview on 10/2/24 at 1:00 P.M. Unit Manager (UM) #1 said she was the designated Wound Nurse for the facility and would always talk to NP #1 about Residents' wound care treatment recommendations. UM #1 said Resident #84 was assessed at the Wound Center on 8/6/24, and that she was aware of the PA Wound Care Specialist's recommendation to cleanse the Resident's PUs with soap and water, but that the Nurses always just used wound cleanser instead at the facility. UM #1 said that Resident #84 required dressing changes more frequently than once a day due to significant wound drainage and fecal incontinence. UM #1 said she did not consider Resident #84 as at risk for acquiring wound infections. No evidence that either of the facility's NPs were notified of the Wound Center's PA Wound Care Specialist recommendation to cleanse Resident #84's PUs with soap and water was provided to the surveyor by the end of the survey period. 44337 2. Resident #79 was admitted to the facility in April of 2024 with diagnoses including Urinary Retention (difficulty urinating and completely emptying the bladder), and Obstructive and Reflux Uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Change of Condition Notification last revised in April 2023, indicated the following: -The facility will inform the Resident, the Resident's healthcare provider, and the Resident's family/legal representative when there is a change in condition. Review of the active Physician's orders indicated the following: -Indwelling urinary catheter 20 French with a 10 cc (cubic centimeter) balloon to straight drainage for urinary retention, initiated 8/24/24. Review of the Resident's medical record indicated a Urology Consult Form dated 9/12/24, that indicated: -a new 16 French (Fr) 10 cc balloon indwelling catheter had been placed. -the Resident was to return to the Urologist in four weeks for a catheter change. Further review of the Urology Consult Form did not indicate that the Physician had been notified of the change in Resident #75's treatment plan. Review of the Nurses Progress Notes for September 2024, indicated no evidence that the Physician had been notified of the change in Resident #75's treatment plan relative to the Urology consult. On 9/26/24 at 8:47 A.M., the surveyor, Certified Nurses Aide (CNA) #6 and Unit Manager (UM) #2 observed that Resident #75 had a 16 Fr/ 10 cc balloon indwelling urinary catheter in place. During an interview and record review with UM #2 on 9/26/24 at 1:45 P.M., UM #2 said that when a Resident goes to an outside Provider for an appointment, a Consult Form is sent with the Resident so that the outside Provider can communicate any treatment changes back to the facility. UM #2 said that usually the Consult Form or the information documented on the Consult Form is provided to the Resident's Physician and a notation is made on the Consult Form indicating the information had been communicated to the Physician. UM #2 said that Resident #75 had gone out to a Urology appointment on 9/12/24. UM #2 said that she was not sure if the Physician had been made aware of Resident #75's treatment change because there was no notation made on the Consult Form and the Physician orders for Resident #75 had not been updated. UM #2 also said that there was no evidence documented in the Nursing Progress Notes that indicated the Physician had been notified of the change in treatment for Resident #75. UM #2 said that she would notify Resident #75's Physician of the Urology Consult Form and obtain a Physician's order for the correct treatment plan for the Resident.

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F 0646 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on policy and record review, and interview, the facility failed to notify the state mental health authority for a resident review after a significant change in mental condition occurred for one Resident (#104) out of a total sample of 27 residents. Specifically, the facility failed to request a Preadmission Screening and Resident Review Level II screen (PASRR- an evaluation done to determine if a resident has an intellectual or developmental disability and/or serious mental illness and is in need of additional specialized support services at the facility) after Resident #104 received a diagnosis of Psychosis and experienced limitations in major life activities due to mental illness. Findings include: Resident #104 was admitted to the facility in June 2022, with diagnoses of Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Unspecified Psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #104: -was severely cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15. -had not been evaluated by a Level II PASRR. -has active diagnoses of Anxiety, Depression, and Psychotic Disorder. Review of the Resident #104's PASRR Level I (initial pre-screening completed prior to admission to a Nursing Facility) screen, dated 6/13/22, indicated: -No diagnosis of mental illness or disorder. -No treatment history for mental illness in the past two years (such as association with a mental health agency) -No limitations in major life activities (i.e. interpersonal functioning such as hallucinations) due to mental illness in the past six months. -Negative SMI screen was indicated. Review of the Psychiatric Evaluation and Consultation note dated 6/21/23, indicated: -Resident experienced depression, anxiety, and psychosis (continued on next page)

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F 0646 Level of Harm - Potential for minimal harm Residents Affected - Some	-Staff report delusions (false beliefs)/hallucinations (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) persist -Recommendation to increase antipsychotic medication and initiate an antidepressant medication Review of Resident #104's clinical record indicated a diagnosis of Unspecified Psychosis was initiated 6/21/23. During an interview on 9/26/24 at 11:53 A.M., the Social Worker (SW) said she was new to the facility since September 2023 and the PASRR was completed for Resident #104 before her time of employment. The SW said Resident #104's diagnosis of Psychosis was dated 6/21/23 which came from the Psychiatric Evaluation done on 6/21/23. The SW said that if she were to complete the PASRR form now, she would indicate a positive screen due to the mental health diagnosis and treatment history, and request a Level II evaluation, which had not been done and should have been done.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44337 Based on interview, record and policy review, the facility failed to ensure its staff implement the plan of care for one Resident (#75) relative to weight measurements, out of a total sample of 27 residents. Specifically, the facility staff failed to perform weight measurements for Resident #75 when the Resident had been readmitted to the facility with a gastrostomy tube (G-tube: a small flexible tube surgically inserted into the stomach through the abdomen to provide nutrition, fluids, and medicine), a diagnosis of Malnutrition and a significant change in condition. Findings include: Resident #75 was admitted to the facility in August 2024, with diagnoses of G-tube placement and Malnutrition (condition caused by not getting enough calories or the right amount of key nutrients, such as vitamins and minerals, that are needed for health). Review of the facility policy titled Weight Policy and Procedure last revised January 2023, indicated the following: -Each resident's weight will be obtained and documented upon admission, re-admission, monthly, or significant change in condition, and documented in the electronic medical record. On 9/25/24 at 9:40 A.M. the surveyor observed Resident #75 lying in bed with enteral (through a G-tube to the stomach) nutrition infusing through the Resident's G-tube. Review of the Nursing Progress Note, dated 8/30/24, indicated: -Resident #75 returned to the facility after a 28-day hospital admission -G-tube was placed during hospitalization -Resident experienced a significant change in status due to decline in activities of daily living (ADL: a term used to describe fundamental skills needed to care for oneself such as bathing, dressing, eating, and grooming) status, weight loss, and a new pressure ulcer. Review of the Nutritional Evaluation effective 9/4/24 indicated the following recommendations: -Monitor/evaluate weight changes -Notify Registered Dietitian and Physician of significant weight changes -Obtain/record weights as indicated Review of the active Physician orders 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 - Few	-Weekly weight every day shift, every Tuesday. Notify Physician/Nurse Practitioner if weight fluctuates by -5 pounds in one week, initiated 8/31/24 Review of the facility weight record indicated the facility had obtained weight measurements for the weeks of 8/30/24, 9/6/24, and 9/14/24 for Resident #75. Further review of the facility weight record indicated no evidence that Resident #75 had been weighed weekly on 9/20/24 and 9/27/24 as ordered. During an interview on 10/1/24 at 10:35 A.M., Certified Nurse Aide (CNA) #6 said that he worked at the facility full time and often provided care for Resident #75. CNA #6 said that he was not sure how often Resident #75 should have been weighed. CNA #6 said that at the beginning of each month a weight list is posted at the nurses station that lists all of the residents on the unit and when the residents are supposed to be weighed. CNA #6 also said that the CNAs are responsible for obtaining the weight measurements for the residents. During an interview on 10/1/24 at 12:12 P.M., Nurse #6 said that Resident #75 had a Physician's order to be weighed weekly. Nurse #6 also said that the Resident had not been weighed on 9/20/24 and 9/27/24 as ordered, but should have been weighed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on record review, and interview, the facility failed to ensure that comprehensive care plans were reviewed and revised by the interdisciplinary team (IDT) for two Residents (#40 and #9), out of a total sample of 27 residents. Specifically, facility staff failed to review and revise comprehensive care plans following: 1. one comprehensive and one quarterly review assessment for Resident #40. 2. one comprehensive review assessment for Resident #9. Findings include: 1. Resident #40 was admitted to the facility in June 2023, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD: group of lung diseases that worsen over time and prevent air flow to the lungs causing difficulty breathing). Review of Resident #40's clinical record indicated the following: -A comprehensive review assessment, dated 5/24/24, had been completed. -A quarterly review assessment, dated 8/17/24, had been completed. Further review of Resident #40's clinical record included no evidence the Resident's comprehensive care plan had been reviewed and revised by the IDT following either the 5/24/24 and 8/17/24 assessments. During an interview on 10/2/24 at 1:45 P.M., the Social Worker (SW) said that Resident #40 had been scheduled for an IDT meeting to review and revise his/her care plan following the comprehensive review assessment, but that the IDT meeting did not occur because the SW was unavailable and the meeting was not rescheduled. The SW also said that an IDT meeting to review and revise Resident #40's comprehensive care plan following the quarterly review assessment had not been scheduled, so it was never done. 48206 2. Resident #9 was admitted to the facility in July 2024, with diagnoses including Schizoaffective Disorder (chronic mental health condition characterized primarily by symptoms of Schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), and Congenital Hydrocephalus (a birth defect that causes a buildup of cerebrospinal fluid (CSF) in the brain). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #9: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible total 15, -had a Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) but it was not activated (evaluation of capacity by a Physician that a Resident is unable to make medical decisions). Review of Resident #9's medical record indicated the following: -A comprehensive MDS Assessment, dated 7/8/24, had been completed. -Resident #9 was transferred to the hospital on 7/8/24. -Resident #9 returned to the facility on [DATE]. Review of Resident #9's Plan of Care indicated that the care plans were initiated on 7/8/24. During an interview on 9/25/24 at 1:51 P.M., Resident #9 said that he/she wanted to explore options for discharge to the community, but he/she had not spoken with anyone in the facility about his/her options and had not met with the SW, but would like to. Further review of Resident #9's medical record did not indicate evidence of the plan of care being reviewed with the Resident after his/her re-admission to the facility on [DATE]. During an interview on 9/26/24 at 4:05 P.M., the SW said that there was no evidence that Resident #9 participated in any care plan meetings or that a discussion about his/her plan of care occurred. Please Refer to F660

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on interview, policy and record review, the facility failed to develop and implement an effective discharge planning process for one Resident (#9), out of a total sample of 27 residents. Specifically, for Resident #9, the facility failed to identify the discharge needs and involve the Resident in the development of a discharge plan. Findings include: Review of the facility policy titled Team Based Assessment (TBA), revised February 2023, indicated: -Within two to three business days of admission, an Interdisciplinary Team (IDT) meeting will be scheduled . -Together with the residents, their family or responsible party, the following members of the IDT will be present: Licensed Rehab Therapist, Licensed Nursing Manager Designee, MDS (Minimum Data Set) Coordinator, Social Worker, Business Office Manager . -The meeting will address the following: >Resident input: Expectation of their stay, anticipation of discharge, and Resident's goals for discharge >Social Service needs: anticipation of need for community services, VNA (Visiting Nurse Association), assessment of prior living conditions and plan for equipment needs following discharge; assessment of caregiver involvement following discharge, initiation of a working discharge plan -At the culmination of the meeting, the resident/point-person/responsible party and the IDT will: >Have a clear understanding of the goals needed to reach a successful discharge >Have been given an estimated length of stay -Summary of the TBA will be documented in the Weekly Skilled Review/Discharge Plan and Prep Guide in PCC (Point Click Care- electronic health record). Resident #9 was admitted to the facility in July 2024, with diagnoses including Schizoaffective Disorder (chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression) and Congenital Hydrocephalus (a birth defect that causes building of cerebrospinal fluid in the brain). Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated the following: -Resident participated in the assessment. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible total 15. -Resident's goal was to discharge to the community. -Active discharge planning was occurring. -A referral had been made to the Local Contact Agency. During an interview on 9/25/24 at 1:51 P.M., Resident #9 said that he/she wanted to explore options for discharge to the community and previously had an apartment he/she wanted to return to with nursing and counseling support services. Resident #9 further said that he/she had not spoken with anyone in the facility about his/her discharge options and had not met with the Social Worker (SW), but would like to. Review of the SW Initial assessment dated [DATE], indicated: -Resident #9 was their own responsible party. -Resident supplied answers for the assessment. -Resident's overall goal was to discharge to the community. -Referral had previously been made to the Local Contact Agency. -Discharge plan with goal to discharge to the community was initiated. Review of the Plan of Care relative to the need for safe and appropriate discharge, initiated 7/8/24 and last revised 9/4/24, indicated the following: -Resident's goal to discharge to the community was initiated 7/8/24 -Resident goal was revised to remain in the facility on 9/4/24. -Intervention to assess discharge needs beginning on day of admission, at initial care plan meeting, and through the stay was currently active. -Intervention to assess the need for home health services and community resources as appropriate was resolved on 9/4/24. -Intervention to assess learning needs and barriers toward discharge planning was resolved on 9/4/24. Review of the SW Social Determinants of Health Note dated 9/4/24, did not indicate any discussion regarding return to the community with Resident #9 or why the Plan of Care for need of safe and appropriate discharge had been revised for the Resident to remain in the nursing facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Behavioral Healthcare Note dated 9/11/24, indicated the Resident continues to wish he/she could be living independently with wrap around support again. During an interview on 9/26/24 at 8:20 A.M., the Social Worker (SW) said that Resident #9 was previously living in a setting where he/she needed to be able to ambulate and perform ADLs (activities of daily living, i.e. bathing, dressing, toileting) to safely return to the community. The SW said the Resident had homecare services in the community setting and had an involved and supportive family member who was a Health Care Proxy. The SW said that Resident #9 was his/her own responsible party and the HCP was not invoked. During a follow-up interview with the Director of Nursing (DON) and the SW on 9/26/24 at 4:05 P.M., the DON said that when Resident #9 admitted to the facility, the Resident was likely to require long term care as the Resident lived in a group home for many years, but the group home was not able to take the Resident back because the group home could not care for him/her. The SW said that there was no evidence that Resident #9 participated in any meetings relative to discharge planning or that a Team Based Assessment had occurred. Further review of Resident #9's medical record did not indicate evidence of evaluation for discharge planning, inclusion of Resident #9 in discussion about goals of discharge, establishment of a working discharge plan, discussion with the Resident's prior group home, what Local Contact Agency to which a referral had been made, or why return to the community was not feasible. The facility did not provide any further information related to discharge planning for Resident #9 to the survey team at the time of survey exit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, interview, and record review, the facility failed to provide care and services according to professional standards of practice for two Residents (#124 and #84), out of a total sample of 27 residents, with an indwelling urinary catheter (Foley Catheter/Foley - a tube placed through the urethra into the bladder to drain urine) increasing the Residents' risk for indwelling urinary catheter complications. Specifically, the facility staff failed to: 1. For Resident #124, follow Physician orders to insert the Foley catheter with the correct balloon size and switch the Foley catheter bag from straight drainage to leg bag upon the Resident getting out of bed in the morning. 2. For Resident #84, obtain a Physician order to include indications, the type and amount of solution required to flush (manual injection with normal saline to clean or clear the catheter) and irrigate the Resident's indwelling urinary catheter. Findings include: Review of the facility's policy titled Urinary Catheterization, revised April 2024, indicated: -Urinary catheterizations are the aseptic process of inserting a sterile hollow pliable tube into the urethra to facilitate urine drainage into a closed drainage system. -Urinary catheters should be placed only under direction of a Physician order. -Physician order to include catheter type, size, diagnoses for use, irrigation if indicated, and drainage collection type. 1. Resident #124 was admitted to the facility in September 2024 with diagnoses of Benign Prostatic Hyperplasia (BPH - enlargement of the prostate gland that can block the flow of urine out of the bladder), Chronic Kidney Disease (CKD - long standing disease of the kidneys leading to renal failure), and Retention of Urine (inability to completely empty the bladder of urine). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #124 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out a total score of 15. On 9/25/24 at 8:54 A.M., the surveyor observed Resident #124 ambulating in the hallway with a walker. The surveyor observed that the Resident had a Foley catheter and the catheter tubing was visible through his/her pants. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 1:55 P.M., the surveyor observed Resident #124 ambulating in the hallway with the Physical Therapist (PT). The surveyor observed the Resident had a catheter tubing that went down through his/her pants and hung on the base of the walker while ambulating. Review of Resident #124's September 2024 Physician's orders indicated: -Change catheter drainage bag from straight drainage to leg bag upon Resident getting out of bed in the morning, initiated 9/6/24. -Change from leg bag to straight drainage at hour of sleep and document in the Point of Care, initiated 9/6/24. -Indwelling catheter 16 French (Fr) with 10 ml (milliliters) of balloon to straight drainage for Urinary Retention, initiated 9/9/24. Review of Resident #124's Care Plan dated 9/9/24, indicated Foley catheter related to BPH, Urinary Retention, Obstructive Uropathy 16 Fr (French) with 10 ml balloon. During an interview on 9/26/24 at 7:59 A.M., Resident #124 said the facility staff had not offered him/her a leg bag. During an interview on 9/26/24 at 10:01 A.M., Nurse #2 said he had not offered Resident #124 a leg bag and that a leg bag would provide dignity and independence. Nurse #2 observed Resident #124's Foley catheter with the surveyor and Nurse #2 said Resident #124's Foley catheter size was 16 French and 5 ml balloon. Nurse #2 said the balloon was not what the Physician had ordered and that the balloon size should have been a 10 ml balloon. During an interview on 9/26/24 at 11:10 A.M., Unit Manager (UM) #1 said she had no idea why the leg bag was ordered for Resident #124. UM #2 further said facility staff should have followed Physician's orders and offered the leg bag to the Resident, but they had not. 42761 2. Review of Lippincott Nursing Procedures - 9th Edition (2023) guidelines titled, Indwelling Urinary Catheter Irrigation indicated the following: -Indwelling urinary (Foley) catheter obstructions sometimes occur and require irrigation. -To relieve an obstruction resulting from clots, mucus, or other causes, an intermittent method of irrigation may be used. -Supplies needed include prescribed irrigating solution . 30 to 60 ml (milliliter) syringes . -Verify the Practitioner's order. -Gather and prepare the appropriate equipment . - . pour the prescribed amount of sterile irrigating solution into a sterile basin. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Place the tip of the syringe into the solution and fill the syringe with the appropriate amount. -Instill the irrigating solution into the catheter. -If necessary, repeat the procedure until you've instilled the prescribed amount of irrigating solution. -Document the date and time of irrigation as well as the type and volume of irrigating solution instilled. Review of the facility policy titled Urinary Catheterization, dated April 2024, indicated the following: -Urinary catheters were to be placed only under the direction of a Physician order. -Physician order to include . irrigation (flush: procedure to open a blocked urinary catheter) if indicated . Resident #84 was admitted to the facility in March 2021, with diagnoses including Retention of Urine. Review of Resident #84's clinical record indicated that the use of an indwelling urinary catheter had been initiated on 12/21/23. Review of Resident #84's July 2024 Treatment Administration Record (TAR) indicated Nurse #1 flushed the Resident's indwelling urinary catheter on 7/4/24. Review of Resident #84's July 2024 Progress Notes included no information relative to indications and the procedure used for flushing the Resident's indwelling urinary catheter on 7/4/24. Review of Resident #84's August 2024 TAR indicated Nurse #1 flushed the Resident's indwelling urinary catheter on 8/29/24. Review of Resident #84's August 2024 Progress Notes included no information relative to indications and the procedure used for flushing the Resident's indwelling urinary catheter on 8/29/24. Review of Resident #84's September 2024 active Physician's orders indicated the following: -Catheter flushes (PRN [as needed] schedule) Document: color of urine . resistance . sediment . as needed for catheter flush, initiated 12/21/23. -Indwelling catheter 16 French with 10 cc[or ml] balloon to straight drainage, initiated 5/17/24. Further review of the Physician's orders included no instructions relative to indications for flushing the catheter and no instructions relative to what solution and how much of the solution should be used to flush the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #84's Indwelling Urinary Catheter Care Plan, initiated 9/25/24, indicated the following: -The Resident had an indwelling urinary catheter. -No interventions relative to indications to flush the catheter. -No interventions relative to what solution and how much of the solution would be used to flush the catheter. On 9/25/24 at 12:00 P.M., the surveyor observed Resident #84 sitting partially upright in bed. The surveyor observed a clear plastic tube, extending out from under the bed sheet on the right side of the bed, that led to a privacy bag which was connected to the bed frame. During an interview at the time, Resident #84 said that the tube observed by the surveyor was his/her indwelling urinary catheter tube. During an interview on 9/27/24 a 11:59 A.M., the Staff Development Coordinator (SDC) said that she provided training to Licensed Nurses relative to indwelling urinary catheter care. The SDC said that a Physician order was required in order for Nurses to flush Residents' indwelling urinary catheters and that the order needed to include instructions relative to indications for flushing the catheter as well as what solution, and how much of that solution, was to be used to flush the urinary catheter. The SDC said that the indications and solution/amount of solution used to flush a catheter needed to be determined by the Physician based on the individual needs of the Resident. During a telephone interview on 10/2/25 at 9:25 A.M., Nurse #1 said that Residents with indwelling urinary catheters required a Physician order to flush their catheters and that the Physician order would include the information relative to indications for flushing as well as what solution, and how much of that solution, should be used to flush the catheter. Nurse #1 said she could not recall the details of how the Resident presented that indicated Resident #84's indwelling urinary catheter needed to be flushed nor could she recall the instructions included in the Physician order for flushing the Resident's indwelling urinary catheter when Nurse #1 flushed the catheter on 7/4/24 and 8/29/24.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, interview, and record review, the facility failed to provide appropriate pain management for one Resident (#84), out of a total sample of 27 residents, when Physician ordered pain medications were not administered in a timely manner. Specifically, for Resident #84, the facility staff failed to administer three pain medications as scheduled during the morning medication pass, resulting in the Resident experiencing unrelieved pain. Findings include: Review of the facility's policy titled Pain Management, revised April 2023, indicated: -Qualified staff will monitor the resident's response to pain management according to CMS, State, specific rules and regulations and facility practice guidelines. -To improve the resident's wellbeing by increasing comfort and reducing depression and anxiety. -To monitor treatment efficacy and side effects. -Administer pain relief medications when needed and monitor for effect. -To evaluate pain status and treatment effects on a regular basis, example during routine medication pass. Resident #84 was admitted to the facility in November 2021, with diagnoses including Paralytic Syndrome (a medical condition that cause neuromuscular weakness and paralysis), Headache (painful sensation in any part of the head), Osteoporosis (weak and brittle bones), Chronic Pain (persistent pain) and Diabetic Neuropathy (nerve pain that occur with diabetes). Review of Resident #84's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. -The Resident had impairment on both upper and lower extremities. -The Resident had frequent pain that affects sleep. -The Resident was on scheduled pain medications. -The Resident was dependent on staff for activities of daily living (ADLs - bathing, dressing, grooming). Review of Resident #84's Physician's orders, dated 9/2/24, indicated: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Acetaminophen Oral Syrup (pain reliever/fever reducer medication) give 30 milliliters (ml) via g-tube (gastrostomy) three times a day for pain, ordered 8/15/24. -Gabapentin (anticonvulsant medication used to treat neuropathic pain) Oral Capsule 300 milligrams (mg) give via g-tube two times a day for neuropathic pain to be administered at 8:00 A.M. and 2:00 P.M. for neuropathic pain, ordered 2/20/24. -Gabapentin Oral Capsule 400 mg, give via g-tube one time a day for neuropathic pain, ordered 2/20/24. -Lidocaine (anesthetic medication) External Patch 4%, apply to lower back topically two times a day for back pain and remove per schedule, ordered 3/13/23. -Tramadol (narcotic analgesic medication) HCL oral tablet 50 mg, give 0.5 tablet via g-tube four times a day for moderate to severe pain, ordered 5/22/24. Review of Resident #84's September 2024 Medication Administration Record (MAR) indicated: -Acetaminophen oral syrup 30 ml via g-tube three times a day, scheduled for 8:00 A.M., 2:00 P.M., and 8:00 P.M. -Tramadol 50 mg oral tablet via g-tube four times a day scheduled for 9:00 A.M., 12:00 P.M., 5:00 P.M., 9:00 P.M. -Gabapentin Oral Capsule 300 mg via g-tube two times a day, scheduled for 8:00 A.M. and 2:00 P.M. -Gabapentin Oral Capsule 400 mg via g-tube one time a day, scheduled for 8:00 P.M. -Lidocaine External Patch 4% apply to lower back topically two times a day for back pain, scheduled to remove old patch at 8:00 A.M. and 8:00 P.M. Review of Resident #84's MAR on 9/27/24 at 12:00 P.M. indicated the following medications had been signed off as being administered: -Acetaminophen medication - 8:00 A.M. -Tramadol medication - 9:00 A.M. -Gabapentin medication 8:00 A.M. During an interview on 9/27/24 at 12:05 P.M., Nurse #1 said she had signed off the medications as given, but she had not given them as yet and was preparing to administer the medications at the time (3 and 4 hours late). During a medication administration observation on 9/27/24 at 12:16 P.M., the surveyor observed Nurse #1 administer medications that were crushed in liquid to Resident #84. The Resident told Nurse #1 that he/she had a headache of 6 out 10 on the pain numeric scale. During an interview at the time, Nurse #1 said she had administered the Tramadol medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 9/27/24 at 12:38 P.M., Nurse #1 said she had not administered the 8:00 A.M. Acetaminophen, the 9:00 A.M. Tramadol and the 8:00 A.M. Gabapentin medication (at the scheduled time) because she had been late. During an interview on 9/27/24 at 1:10 P.M., with Nurse Practitioner (NP) #1, NP #1 said she received a call from the facility at 12:06 P.M., informing her that Resident #84 had missed his/her morning medications. NP #1 said she was not aware that the Resident's morning medications were his/her pain medications. NP #1 said Resident #84 had been very particular about not receiving opioid medications and the Resident and the NP had agreed on taking the Acetaminophen, Tramadol, and Gabapentin medications on schedule to avoid any unrelieved pain. NP #1 said facility staff had not made her aware of Resident #84's pain level being 6 out of 10 on the numerical pain scale. Please Refer to F760.

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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. 42761 Based on observation, record review, and interview, the facility failed to provide services consistent with professional standards of practice relative to hemodialysis (a procedure where a machine with a special filter called a dialyzer is used to remove waste from the blood) treatment schedule coordination, for one Resident (#34) out of two residents receiving dialysis services, out of a total sample of 27 residents. Specifically, for Resident #34, the facility staff failed to: -coordinate meal and medication times with the dialysis treatment schedule when the Resident was not offered breakfast or food to take with him/her on dialysis days, increasing the Resident's risk for malnutrition and weight loss. -administer a dialysis support medication as scheduled and with food as required. Findings include: Review of the facility's policy titled Hemodialysis, dated February 2002 and revised May 2014, indicated the following: -A resident admitted to the facility requiring hemodialysis will have their dialysis needs met. -After initial assessment, the Care Planning Team develops a care plan for hemodialysis. Review of the Food and Drug Administration (FDA) label for Renvela (Sevelamer Carbonate: medication in powder form used for the control of serum phosphorus [measure of phosphorous level in one's blood] in adults . on dialysis), dated November 2014, indicated: -Sevelamer Carbonate was a phosphate binder indicated for use to control serum phosphate in patients on dialysis. -Sevelamer Carbonate was to be administered three times a day with meals. Review of the Dialysis Services Coordination Agreement between the facility and the dialysis facility, effective July 2017, indicated the following: -The Long Term Care (LTC) Facility shall ensure that ESRD (End Stage Renal Disease: last stage of kidney failure when the kidneys can no longer filter waste and excess fluids from the blood) residents are prepared to spend an extended length of time at the ESRD Dialysis Unit. -The LTC Facility shall ensure that ESRD residents have received proper nourishment and any medications prescribed, as appropriate, . before coming to the ESRD Dialysis Unit. Review of the National Kidney Foundation's guidance titled, Kidney Failure at https://www.kidney.org/kidney-topics/kidney-failure, dated 9/5/23, indicated the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-People with kidney failure may need to take medicines or supplements to manage certain complications. -Therapies can include . medicines that lower phosphorous or potassium in the blood. -The dose or timing of certain medicines may need to be adjusted for people on dialysis. -Nutrition . are important parts of your health. Resident #34 was admitted to the facility in March 2023, with diagnoses including: Dependence on Renal (kidney) Dialysis, ESRD, Type Two Diabetes Mellitus (DM II - condition in which the body does not produce enough insulin hormone and has trouble controlling blood sugar levels), and Moderate Protein-Calorie Malnutrition (not consuming enough protein and calories which can lead to muscle loss, fat loss, and the body not working as it usually would). Review of Resident #34's active Nutrition Care Plan, initiated 4/11/23, indicated: -The Resident was at risk for malnutrition and had a history of significant weight loss. -Provide, serve diet as ordered. -Super Cereal with breakfast. Review of Resident #34's active Dialysis Care Plan, initiated 11/24/23, indicated: -The Resident required dialysis related to renal failure. -The Resident required dialysis three times weekly. -Medications were to be scheduled with dialysis times consideration. Review of Resident #34's Minimum Data Set (MDS) Assessment, dated 8/30/24, indicated: -The Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15 total possible points. -The Resident received dialysis treatments. Review of Resident #34's September 2024 Physician's orders indicated the following: -Sevelamer Carbonate Oral Packet 0.8 GM (grams); give one packet by mouth three times a day for decrease phosphorous levels, initiated 6/21/24. -Dialysis Tuesday, Thursday, Saturday. Pick up 0500 (5:00 A.M.), chair time (dialysis treatment time) 0600 (6:00 A.M.) every shift for dialysis, initiated 7/11/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 1:15 P.M., Resident #34 said he/she went to dialysis three times per week. Resident #34 said he/she took no food or medications to dialysis treatments and that he/she did not usually get any breakfast before going to dialysis. Review of Resident #34's September 2024 Medication Administration Record (MAR) indicated the following: -The Resident attended dialysis on: 9/3/24, 9/5/24, 9/7/24, 9/10/24, 9/14/24, 9/17/24, 9/19/24, 9/21/24, and 9/24/24. -Sevelamer Carbonate Oral Packet 0.8 GM was scheduled to be administered to the Resident daily at 8:00 A. M. -The Sevelamer Carbonate Oral Packet was not administered to the Resident as ordered, on 9/5/24, 9/12/24, 9/19/24, and 9/21/24. Review of Resident #34's September 2024 Meal Intake Record indicated the Resident was unavailable for breakfast on: 9/3/24, 9/5/24, 9/7/24, 9/12/24, 9/14/24, 9/17/24, and 9/19/24. On 9/26/24 at 10:58 A.M., the surveyor observed Resident #34 sitting in the hallway across from the nurses station. During an interview at the time, the Resident said he/she had not eaten yet for the day and had just returned from dialysis. When the surveyor asked whether anyone had offered him/her breakfast that day, the Resident said he/she wasn't given anything. The surveyor observed Nurse #3 approach Resident #34 and ask if she could administer some medications to the Resident and then assisted the Resident to his/her room. During an interview on 9/26/24 at 11:15 A.M., Nurse #3 said she had just administered the Sevelamer Carbonate Oral Packet to Resident #34. During a follow-up interview on 9/26/24 at 11:45 A.M., Nurse #3 said she had administered one dose of the Sevelamer Carbonate Oral Packet to Resident #34 around 11:00 A.M. that same morning because the Resident was at dialysis at 8:00 A.M., when the medication was ordered to be administered. Nurse #3 further said the dose she administered around 11:00 A.M. was considered the Resident's 8:00 A.M. dose, because the Resident had missed the dose, and that another dose was due at 12:00 P.M. Nurse #3 said she would administer the next dose of Sevelamer Carbonate Oral Packet to Resident #34 toward the end of the Resident's meal, which would arrive to the Unit around 12:00 P.M Nurse #3 said that as far as she knew, the Resident had not had a meal yet that day, but may have had some snacks at dialysis and that the Resident would have lunch soon. During an interview on 9/26/24 at 12:00 P.M., the Food Service Director (FSD) said if Residents on dialysis were not at the facility during a mealtime due to being at a dialysis treatment session, dietary staff would prepare the meal for the Residents and store them in the kitchen until the Residents returned to the facility. The FSD said that it was the responsibility of the nursing staff on the resident units to alert the dietary staff when the residents returned from dialysis so that the prepared meals could be warmed and sent to the residents. The FSD said he was aware that Resident #34 went to dialysis on Tuesdays, Thursdays, and Saturdays, but that nursing staff had not alerted dietary staff the Resident had returned from dialysis. The FSD also said that at the time, lunch meals were being served. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 12:15 P.M., the Director of Nursing (DON) said Sevelamer Carbonate was supposed to be administered to Residents with meals as it was a medicine used to manage phosphorous levels. The DON said dietary staff were supposed to prepare meals and provide them to Residents on dialysis prior to the Residents leaving the facility for dialysis and that Residents requiring Sevelamer Carbonate should receive that medication with the meal. The DON said dietary staff should have prepared and provided breakfast meals for Resident #34 on each dialysis treatment day and that the Resident's Sevelamer Carbonate administration time should have been adjusted in accordance with meals on dialysis treatment days. The DON further said that the dose of Sevelamer Carbonate Oral Packet administered to Resident #34 around 11:00 A.M. that same morning should have been considered the ordered noon time dose and that the 8:00 A.M. dose should have been considered a missed dose. During a telephone interview on 9/27/24 at 9:43 A.M., the Dialysis Nurse said Resident #34 attended dialysis treatments three days per week and that he/she did not bring any food to dialysis treatments, nor did he/she eat at the dialysis center. During an interview on 9/27/24 at 2:15 P.M., Nurse Practitioner (NP) #1 said she did not know Resident #34 had not been receiving breakfast prior to dialysis treatments and that the Resident was not provided with any food to bring with him/her. The NP further said that the facility should have been providing Resident #34 with food on an adjusted schedule on dialysis treatment days. The NP also said the Sevelamer Carbonate Oral Packet was supposed to be administered with food.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on interview, policy and record review, the facility failed to provide appropriate treatment and services to attain the highest practicable mental and psychosocial well-being for one Resident (#9) with a known history of Suicidal Ideation (SI- verbal expressions of thoughts of harming oneself that may or may not lack specific intent) and Post-Traumatic Stress Disorder (PTSD- a mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety), out of a total sample of 27 residents. Specifically, for Resident #9, the facility failed to provide behavioral health services timely putting the Resident at risk for further psychosocial decline when he/she continued to express SI. Finding include: Review of the facility policy titled Suicide Ideation, revised May 2023, indicated: -Should there be a determination that there is a potential threat of harm to the resident's well being or others, the following will occur: >Licensed Nurse will notify Psychiatry Services and request an evaluation be done on the resident as soon as possible. If Psychiatry services cannot evaluate the Resident within 24 hours .then the resident should be sent to the E.R. (emergency room) for evaluation. Review of the facility policy titled Behavior Management Program, revised October 2022, indicated: -Program will .provide Behavioral and Psychiatric Services to assess and assist with the development of treatment plans and offer emotional support and education to the residents and families/responsible parties. -Prior to admission, the facility will review the resident's diagnosis, history of behaviors, and any events such as trauma or substance use disorder that may contribute to the resident's behaviors in order to be prepared to assist in minimizing any stress to the resident that an admission to a new environment may cause. -The intradisciplinary [sic] team will develop a resident centered base line care plan within 48 hours of admission that identifies the challenging behaviors that warrant strategies and interventions for behavior management. Revisions to the plan of care will be implemented as needed based on identified patterns of the resident's behavior throughout the resident's stay. Resident #9 was admitted to the facility in July 2024, with diagnoses including Schizoaffective Disorder (chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), Post Traumatic Stress Disorder, Major Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Suicidal Ideation. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Assessment, dated 9/7/24, indicated Resident #9: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. -reported symptoms of Depression including loss of interest, trouble falling asleep, and fatigue for several days in addition to feeling depressed and trouble concentrating half or more of the days. Review of Resident #9's Physician's Encounter Note, dated 7/8/24, indicated the following: -[Resident] is presenting with acute change in mental status today. -Resident is at extreme risk for patient's safety is verbalizing suicidal ideations with a plan and auditory hallucinations (the perception of the presence of something that is not actually there). -Placed on one-to-one to maintain safety and see if patient could be kept in with in-house Psychiatry to evaluate/assess and treat as indicated. -Psychiatric medical professional currently unavailable in this facility. -MD order to send patient via Section 12 (emergency restraint and hospitalization of persons posing risk of serious harm by reason of mental illness) for significant elevated risk for self injury due to verbalization of S/I (Suicidal Ideation) with a plan, auditory hallucinations. Review of the Physician's Encounter Note, dated 7/24/24, indicated: -Resident readmitted to facility after inpatient Psychiatric stay on 7/23/24. -Resident had a history of multiple psychiatric hospitalization s and suicide attempts. -Resident had moments of perseveration related to past medical history and longstanding history of sexual abuse. -Inpatient psychiatric stay resulted in medication updates, improvement in mood, and decrease in auditory hallucinations. Review of the Physician's Encounter Note, dated 7/25/24, indicated: -[Resident] presented with acute changes in mental status per nursing report. -Resident expressed to the Provider about ending it all. -Resident demonstrated increased agitation and presenting with suicidal thoughts. -[Resident] endorses positive affect when having cognitive behavioral therapy and received services previously. -Psychiatric medical professional unavailable in this facility at this time. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Discussing with nursing, nursing supervisor, director of nursing as patient failed 1:1 to maintain safety and requires higher level of assessment. -Order to send [Resident] via Section 12. Review of the Physician's Encounter Note, dated 7/28/24, indicated: -At emergency roiagnom on [DATE] [Resident] seen for Depression and expressing suicidal thoughts and seen by Specialist who did not believe [Resident] needed inpatient psychiatric care at that time. -Recommendations from emergency room indicated to follow-up with Psychiatrist in 1-2 days. Further review of the clinical record and Progress Notes indicated: -on 8/9/24, Resident #9 reported to Physical Therapy that he/she wanted to die. -on 8/9/24, Resident was followed by Psychiatry services. Review of the Physician's Encounter Note, dated 8/10/24, indicated: -Mood and behavior stable at this time with current meds. -Psychiatry follow-up in the facility for management and monitoring of psych [diagnoses] and med adjustment if indicated. Review of the clinical record and Physician's orders did not indicate any orders for Behavioral Health Services. Review of Resident #9's Psychosocial Well-Being Plan of Care, initiated 7/8/24 and last revised 9/4/24, indicated: -Resident had an identified problem of behavioral concerns with history of suicide attempt with plan and negative statements during hospitalization and admission and mental health needs with long history of Schizophrenia with psychosis, depression, and PTSD. -Interventions include: > Provide Resident opportunities to express feelings related to limited/restricted communications/visits with friends and family and inability to participate in group activities, initiated 7/8/24 >Provide behavioral interventions: refer to psych for medication, mood and behavior monitoring, and 1:1 supportive therapy, initiated 7/8/24 >Consult with Psychiatric/psychological services as needed, initiated 7/8/24 Review of Resident #9's Mood Plan of Care, initiated 7/8/24 and revised 7/24/24, indicated: -Resident has a diagnosis of Schizoaffective Disorder with psychosis and depression . (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions include: >Arrange for psych consult, follow-up as indicated, initiated 7/8/24 Review of Resident #9's Preadmission Screening and Resident Referral (PASRR) Plan of Care, initiated 7/8/24 and revised 7/24/24, indicated: -PASRR process has recommended services while Resident is residing in the facility .diagnosis of Schizoaffective Disorder and Depression -Interventions include: >Mental Health counseling as needed, initiated 7/8/24 >Behavioral Health (psych) evaluation as needed, initiated 7/8/24 >Resident specific psychotherapy as needed, initiated 7/8/24 Review of Resident #9's Trauma Care Plan, initiated 7/8/24 and revised 9/26/24, indicated: - Resident had history of being a victim of a traumatic event; PTSD related to sexually abused during childhood - Interventions include: > Encourage Resident to express feelings, initiated 7/8/24 > Encourage Resident to discuss areas of enjoyment (activities, pets), initiated 7/8/24 Review of Resident #9's Behavior Care Plan, initiated 8/9/24 and revised 8/15/24, indicated: -Resident has a behavior problem; reports to staff he/she is going to kill him/herself and has a plan when transferred for emergency psych services he/she tells hospital staff he/she doesn't remember saying it. Interventions include: >Encourage the resident to express feelings appropriately, initiated 8/9/24 >Monitor behavior episodes and attempt to determine underlying cause, initiated 8/9/24 >Psych services as indicated, initiated 8/9/24 Review of the Psychology Services Progress Note, dated 8/14/24 (three weeks after return from inpatient psychiatric hospitalization) indicated: -Visit was an initial psychological evaluation. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident had chronic PTSD -Current symptoms of distress or worry appear related to long standing mental illness, trauma history, personal difficulties, and medical concerns/her physical condition. -Auditory hallucinations are connected to trauma history as they are often critical or self-abusive in nature. -Resident reported thoughts that he/she would be better off dead more than half the days. -It is recommended when providing care to be aware that patient has a history of trauma and to utilize a trauma informed lens. -Resident appears to positively benefit from socialization with others and engagement in facility. -Psychologist will continue to follow up with Resident every week. Further review of the medical record failed to provide evidence that Psychiatric/Psychological services and 1:1 supportive therapy were provided to Resident #9 prior to 8/14/24 as indicated in the plan of care when he/she indicated positive effect when having cognitive behavioral therapy and received behavioral health services previously. During an interview on 9/26/24 at 8:20 A.M., the Social Worker (SW) said Resident #9 had instances of suicidal ideation in July 2024 and since his/her return from inpatient psychiatry stay, Resident #9 had changed rooms with a positive impact on his/her mood. The SW said that the Resident had expressed depressive symptoms at times. The SW also said that she did check-ins with the Resident to monitor behaviors, these are short visits for 1:1 support, and said that she will have to review the documentation of those visits and get back to the surveyor. During an interview on 9/26/24 at 9:25 A.M., Unit Manager (UM) #2 said when a Resident needs to be seen by psych services, she would speak to the Physician, obtain an order for Psych Consult. UM #2 then discusses with the Director of Nursing (DON) the reason for the Psych Consult, and the DON manages the request for Psych Services. The surveyor and UM #2 reviewed Resident #9's Physician's Encounter Note dated 7/25/24, indicating recommendation for psych follow up within 1-2 days and UM #2 said she would get back to the surveyor. During an interview on 9/26/24 at 11:11 A.M., the Director of Nursing (DON) said that Resident #9 was referred to psychiatry services on 7/8/24, and he/she had been registered with the Behavioral Healthcare group on 7/8/24. When the surveyor requested evidence of the Resident being seen prior to 8/14/24, the DON said she would get back to the surveyor. During a follow-up interview on 9/26/24 at 4:05 P.M., the DON said that she did not have evidence of a Behavioral Healthcare visit prior to 8/14/24. The DON further said that Resident #9 had a long history of psychiatric issues and she would have expected that Behavioral Healthcare would have seen the Resident prior to 8/14/24 to review medications and assess for non-pharmacological interventions. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide any additional evidence to the survey team at time of survey exit relative to 1:1 supportive visits facilitated by the Social Worker.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on interview, policy and record review, the facility failed to ensure that one Resident (#84), out of a total sample of 27 residents, was from significant medication error. Specifically, the facility staff failed to adhere to the time and the administration of ordered pain medications for Resident #84 when he/she was having pain. Findings include: Review of the facility's policy titled Medication Pass, revised May 2023, indicated: -All medications are administered safely and timely per the Physician's orders. -Acceptable medication pass time is one hour before and one hour after the scheduled time. -Remember the ten rights of the medication pass: *Right Resident, *Right Drug, *Right Dose, *Right Route, *Right Time, *Right Education, *Right to Refuse, *Right Documentation, *Right Drug-Drug interaction, *Right Evaluation. Review of the facility's policy titled Pain Management, revised April 2023, indicated: -Qualified staff will monitor the resident's response to pain management according to CMS, State, specific rules and regulations and facility practice guidelines. -To improve the resident's well being by increasing comfort and reducing depression and anxiety. -To monitor treatment efficacy and side effects. -Administer pain relief medications when needed and monitor for effect. Resident #84 was admitted to the facility in November 2021, with diagnoses including Paralytic Syndrome (a medical condition that cause neuromuscular weakness and paralysis), Headache (painful sensation in any part of the head), Osteoporosis (weak and brittle bones), Chronic Pain (persistent pain), and Diabetic Neuropathy (nerve pain that occur with diabetes). Review of Resident #84's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. -The Resident had impairment on both upper and lower extremities -The Resident had frequent pain that affects sleep. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident was on scheduled pain medications. -The Resident was dependent on staff for activities of daily living (ADL- bathing, dressing, grooming). Review of Resident #84's Physician's orders, dated 9/2/24, indicated: -Acetaminophen Oral Syrup give 30 milliliters (ml) via g-tube (gastrostomy) three times a day for pain, ordered 8/15/24. -Gabapentin Oral Capsule 300 milligrams (mg) give via g-tube two times a day for neuropathic pain to be administered at 8:00 A.M. and 2:00 P.M. for neuropathic pain, ordered 2/20/24. -Gabapentin Oral Capsule 400 mg, give via g-tube one time a day for neuropathic pain, ordered 2/20/24. -Lidocaine External Patch 4%, apply to lower back topically two times a day for Back pain and remove per schedule, ordered 3/13/23. -Tramadol HCL oral tablet 50 mg, give 0.5 tablet via g-tube four times a day for moderate to severe pain, ordered 5/22/24. Review of Resident #84's September 2024 Medication Administration Record (MAR) indicated: -Acetaminophen Oral Syrup 30 ml via g-tube three times a day, scheduled for 8:00 A.M., 2:00P.M., and 8:00 P.M. -Tramadol 50 mg Oral Tablet via g-tube four times a day scheduled for 9:00 A.M., 12:00 P.M., 5:00 P.M., 9:00 P.M. -Gabapentin Oral Capsule 300 mg via g-tube two times a day, scheduled for 8:00 A.M. and 2:00 P.M. -Gabapentin Oral Capsule 400 mg via g-tube one time a day scheduled for 8:00 P.M. -Lidocaine External Patch 4% apply to lower back topically two times a day for back pain, scheduled to remove old patch at 8:00 A.M. and 8:00 P.M. Review of Resident #84's MAR on 9/27/24 at 12:00 P.M., indicated the following medications were signed off as being given: -Acetaminophen medication - 8:00 A.M. -Tramadol medication - 9:00 A.M. -Gabapentin medication 8:00 A.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/27/24 at 12:05 P.M., Nurse #1 said she had signed off the Acetaminophen, Tramadol, and Gabapentin as given but the medication had not been administered to the Resident as yet. During a medication administration pass on 9/27/24 at 12:16 P.M., the surveyor observed Nurse #1 administer medications crushed in liquid to Resident #84. The Resident told Nurse #1 that he/she had a headache with a pain scale of 6 out 10. During an interview at the time, Nurse #1 said she had administered Tramadol medication. During a follow-up interview on 9/27/24 at 12:38 P.M., Nurse #1 said she had not administered the 8:00 A.M. Acetaminophen, the 9:00 A.M. Tramadol and the 8:00 A.M. Gabapentin medications, that she would go back and document not administered and had notified the Nurse Practitioner (NP) because she had been late administering the medications. During an interview on 9/27/24 at 2:15 P.M., the Director of Nursing (DON) said it was not the practice of the facility to sign off medications as given when they were not administered. The DON said Nurse #1 should not have signed off the medications and that Nurse #1 should have implemented the facility's medication administration policy of an hour before and an hour after the scheduled dose of medication administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44337 Based on observation, interview, and policy review, the facility failed to remove expired medications from one medication cart, out of a sample of four medication carts. Specifically, the facility failed to remove and dispose expired Famotidine (acid reducer) medication, increasing the risk of non-therapeutic benefit when the medication is administered. Findings include: Review of the facility policy titled Medication Storage in the Facility, undated, indicated the following: -Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. On 9/30/2024 at 10:20 A.M., the surveyor and Nurse #6 observed the [NAME] 2A medication cart on the second floor nursing unit. The surveyor and Nurse #6 found 13 individually packaged Famotidine tablets (a medication used to treat gastrointestinal [stomach and intestine] conditions by reducing acid production in the stomach) stored in a plastic container in the top drawer of the medication cart to have an expiration date of 9/23. Nurse #6 said that the Famotidine medication had expired and that it should not have been in the medication cart. Nurse #6 said that the expired medication should have been removed from the cart, and given to the Unit Manager (UM), and not dispensed to any residents.

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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** 42761 Based on observation, interview, record and policy review, the facility failed to implement infection control measures according to professional standards of practice on one Unit (East One Unit) out of four resident units, and for two Residents (#65 and #84) out of a total sample of 27 residents. Specifically, the facility failed to: 1. Ensure that staff who worked on the East One Unit and considered as exposed to COVID-19, completed initial and requisite outbreak testing when the facility was experiencing an outbreak of COVID-19 on the East One Unit, increasing the risk for transmission of infection to residents and staff. 2. Ensure timely and effective implementation of interventions to prevent the transmission of Clostridium Difficile (C. Diff: bacterium that causes diarrhea and colitis [an inflammation of the colon] and can be life-threatening) when Resident #65 was actively being treated for C.diff and required the use of Contact Precautions (use of proper hand hygiene, gloves, and gown upon entering/exiting the environment of the infected individual). 3. Ensure that nursing staff dispensed medications in a safe and sanitary manner and according to professional standards of practice. 4. Ensure that staff followed the PPE requirement for the Droplet Precautions, where a door sign outlined the required personal protective equipment (PPE) needed to be worn before staff entered the room. 5. Ensure that proper cleaning and disinfection of a glucometer machine was conducted after the glucometer machine was used to check Resident #84's blood sugar level, increasing the risk of contamination and transmission of infection. Findings include: 1. Review of the facility's policy titled Clinical Guide for Operations During COVID-19 Health Emergency, dated 3/13/23, indicated the following: -To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the Department of Public Health (DPH). -An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. -Once a new case is identified in a facility, following the requisite outbreak testing, long-term care facilities should test exposed residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case . unless a DPH epidemiologist directs otherwise. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Massachusetts (MA) DPH guidelines titled Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents, including Visitation Conditions, Communal Dining, and Congregate Activities, dated 5/10/23 indicated the following: - . Long-term care facilities are required to perform outbreak testing of residents and staff as soon as possible when a case is identified. -If the long-term care facility identifies that the resident or staff member's first exposure occurred less than 24 hours ago, then they should wait to test until 24 hours after any exposure, if known. -Once a new case is identified in a facility, following outbreak testing, long-term care facilities should test exposed residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case unless a DPH epidemiologist directs otherwise. During an interview on 9/25/24 at 8:09 A.M., the Administrator said there were currently residents in the building with facility transmission of COVID-19. During an interview on 9/26/24 at 12:20 P.M., the Infection Preventionist (IP) said the facility was experiencing an outbreak of COVID-19 on the East One Unit. The IP said the outbreak began on 9/11/24, when one resident was symptomatic, and tested positive for COVID-19. The IP said the Unit One Unit Manager (UM) became symptomatic and tested positive for COVID-19 on 9/12/24. The IP said that outbreak testing indicated for resident positive tests on 9/13/24, that outbreak testing continued every 48 hours for residents on the Unit, and that the most recent positive case of COVID-19 on the Unit was identified on 9/25/24. The IP said staff who worked on the East One Unit were not required to perform outbreak testing and were only required to test if they became symptomatic. The IP further said the facility followed MA DPH guidance for COVID-19 testing and that she did not realize staff on the affected Unit were required to perform outbreak testing. 2. Review of the Centers for Disease Control and Prevention (CDC) Guidelines titled About C. diff, dated March 6, 2024, indicated the following: -C. Diff can affect anyone. Most cases of C. Diff occur when you've been taking antibiotics for something else or not long after you've finished. -About 1 in 6 patients who get C. Diff will get it again in the subsequent 2-8 weeks. -Symptoms include diarrhea, fever, stomach tenderness or pain, loss of appetite, and nausea. -C. Diff germs spread from person to person in poop (stool), but the bacteria are often found in the environment. -When C. Diff germs are outside the body, they become spores (an inactive form of the germ and have a protective coating allowing them to live for months or years on surfaces .). -The germs become active again when you swallow these spores and they reach the intestines. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Reduce the spread of C. Diff by washing your hands with soap and water after using the bathroom and always before you eat. Resident #65 was admitted to the facility in February 2024, with a diagnosis of Crohn's Disease (chronic nflammatory bowel disease that affects the lining of the difestive tract) and Dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Review of Resident #65's Minimum Data Set (MDS) Assessment, dated 7/31/24, indicated the following: -The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total points. -The Resident required supervision or touching assistance from staff for toilet transfers. -The Resident required partial/moderate assistance (helper does less than half the effort) for toilet hygiene. -The Resident was frequently incontinent of bowel. Review of Resident #65's clinical record indicated the Resident was transferred from the facility to the hospital on 8/30/24. Review of Resident #65's Hospital Discharge Summary, dated 9/6/24, indicated the following: -The Resident had a history of C. Diff and recurrent C. Diff. -The Resident had been diagnosed with Active Colitis (inflammation of the colon) due to C. Diff. -Vancomycin (antibiotic) treatment had been initiated for the Resident while in the hospital for treatment of C. Diff. -The Resident was to continue the use of Vancomycin taper (gradual reduction of medication dosage) for treatment of C. Diff upon return to the facility. Review of Resident #65's Physician Progress Note dated 9/20/24, indicated the Resident continued on the Vancomycin taper. Review of Resident #65's clinical record indicated the Resident was transferred to the hospital again on 9/20/24 and returned to the facility on [DATE]. Review of Resident #65's Nurse Practitioner (NP) Progress Note dated 9/23/24, indicated the following: -The NP visit with the Resident was for readmission to the facility from the hospital. -The Resident's diarrhea had improved over the previous 48 hours at the hospital. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Resident required continued treatment for C. Diff with oral Vancomycin. Review of Resident #65's September 2024 Physician's orders indicated the following: -Vancomycin Oral Capsule 125 mg by mouth two times a day for C. Diff for seven days, start date 9/21/24 and discontinue date 9/22/24. -Vancomycin Oral Capsule 125 mg (milligrams). Give one capsule by mouth two times a day for C. Diff for five days, start date 9/22/24. -Maintain Contact Precautions related to C. Diff every shift, start date 9/25/24. Review of Resident #65's September 2024 Activity of Daily Living (ADL) flowsheets indicated the following: -The Resident used the toilet with supervision/touch assist from staff on 9/22/24 at 8:34 P.M. -The Resident used the toilet independently and was incontinent of a large sized bowel movement on 9/24/24 at 12:43 P.M. -The Resident used the toilet independently and was incontinent of a medium sized bowel movement on 9/25/24 at 12:10 P.M. During an observation and interview on 9/25/24 between 1:39 P.M. and 1:55 P.M., the surveyor observed the following from outside of Resident #65's room: -A Contact Precaution sign was posted on the outer doorframe to the Resident's room. -The name plate outside the door indicated three residents resided in the room. -Resident was #65 lying on his/her bed which was the bed on the door side of the room. At the time, the surveyor donned a gown and gloves and entered Resident #65's room. The Resident said he/she had not been feeling well and that he/she had been having loose stools and fecal incontinence. Resident #65 said that staff assisted him/her to the bathroom when he/she had to have a bowel movement, but that the bathroom was shared between two resident rooms so sometimes he/she would have to wait to use the bathroom. Resident #65 also said that he/she had an infection that was causing the loose stools and that he/she did not want to get anyone else sick. The surveyor observed that the bathroom in Resident #65's room adjoined with another resident room that also housed three residents. Upon preparing to exit Resident #65's room, the surveyor entered the bathroom and washed their hands with soap and water, then observed there were no paper towels or paper towel dispenser in the bathroom so had to carefully air dry their hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 4:30 P.M., the surveyor observed Resident #65 lying in bed and observed Certified Nurses Aide (CNA) #7 don a gown and gloves and enter Resident #65's room. The surveyor observed CNA #7 handle the Resident's bed linens that were already in the bed and in contact with the Resident, then provide the Resident with an additional blanket. CNA #7 then removed her gown and gloves and exited the room, performing hand hygiene with an alcohol based hand rub (not soap and water). Another resident in the room then requested a snack and CNA #7 responded that she would get him/her some cookies. The surveyor observed CNA #7 walk down the hallway toward the nurses station and when she reached the nurses station, leaned forward placing her arms and hands on the nurses station countertop while talking to another staff member. The surveyor observed a resident walk toward the nurses station and approach CNA #7, they engaged in brief conversation, and the surveyor observed CNA #7 place her hand on the resident's shoulder. The surveyor then observed CNA #7 turn toward the Unit Nourishment Kitchen, use her hand to enter the code to enter the Unit Nourishment Kitchen and open the door. The surveyor did not observe CNA #7 wash her hands with soap and water at any time between exiting Resident #65's room and entering the Unit Nourishment Kitchen. During an interview on 9/25/24 at 5:00 P.M., CNA #7 said she was aware that hand hygiene using soap and water was required after working in Resident #65's room. CNA #7 also said there were no paper towels in the bathroom in the Resident's room for staff to dry their hands after handwashing. During an interview on 9/25/24 at 5:20 P.M., the Director of Nursing (DON) said that all staff who worked in Resident #65's room were required to perform hand hygiene using soap and water when exiting the room because the Resident had C. Diff. The DON also said she was unaware that the shared bathroom in the Resident's room had no paper towel holder and no paper towels. The DON said that a paper towel holder with paper towels needed to be accessible for staff to wash their hands. During an observation and interview on 9/26/24 at 9:00 A.M., the surveyor observed a commode positioned next to Resident #65's bed. At the time, the Resident said he/she did not know why the commode was brought into the room, but someone had brought it in room the previous evening. Resident #65 said he/she had not used it yet and was unsure whether he/she was supposed to use it independently. Resident #65 said prior to the placement of the commode at his/her bedside, he/she had been using the shared resident bathroom that was in the room. During an interview on 9/26/24 at 9:32 A.M., Nurse #3 said she did not know why Resident #65 now had a commode at his/her bedside. Nurse #3 said she knew that Resident #65 was being treated for C. Diff, but that in her experience, Residents with C. Diff would use the toilet and the other Residents would be supplied with a commode. Nurse #3 said she thought Resident #65 may have had the commode because there wasn't enough space in the rooms for five other Residents to have commodes. Nurse #3 further said no matter what, a Resident with C Diff. should not be sharing the same toileting surface as other Residents. Nurse #3 also said she had learned that C. Diff spores can live on surfaces in the environment for months and that a Resident sharing a toileting surface with other Residents would increase the risk for transmission of C. Diff to the other Residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/24 at 12:20 P.M., the Infection Preventionist (IP) said any Resident identified with C. Diff would be provided a commode at the bedside by the facility. The IP said Resident #65 had been undergoing treatment for C. Diff prior to his/her transfer to the hospital on 9/20/24 and that treatment for C. Diff continued upon his/her return from the hospital on 9/22/24. The IP said she realized when she reviewed Resident #65's record and spoke with the Resident and staff the previous day that no commode had been provided for the Resident, so she provided one at that time. The IP said the commode should have been in place when Resident #65 returned from the hospital, but it was not. The IP also said that staff were required to wash their hands with soap and water every time they exited the Resident's room, rather than use alcohol based hand rub, to reduce the risk for transmitting C.Diff. 44337 3. On 9/30/24 at 9:13 A.M., the surveyor observed the medication administration pass with Nurse #1 and a Nurse orientee (a Nurse in orientation to the facility under Nurse #1's supervision) on the East Nursing Unit on the first floor. The surveyor and Nurse #1 observed the Nurse orientee spill a medication tablet onto a piece of paper on top of the medication cart while pouring medications into a medicine cup to dispense to a resident. The surveyor observed Nurse #1 instruct the Nurse orientee to put on gloves, pick up the medication tablet from the paper and place it into the medicine cup with other prepared medications. During an interview at the time, Nurse #1 said she should not have instructed the Nurse orientee to place the spilled medication tablet into the medicine cup because the medication might have been contaminated. Nurse #1 said the medication should have been discarded and a new tablet should have been dispensed. 47901 4. On 9/26/24 at 8:26 A.M., the surveyor observed CNA #2 enter a room with Droplet Precautions sign at the door, outlining the required personal protective equipment (PPE) needed to be worn before staff entered the room. The sign indicated the appropriate PPE to be used when providing care included gloves, gown, mask, and goggles/face shield. The surveyor observed CNA #2 don (put on) a gown, gloves, and mask but he did not wear goggles or a face shield. The surveyor observed Unit Manager (UM) #2 stood at the room entrance and handed CNA #2 a breakfast tray, and the CNA was observed without eye protection. During an interview on 9/26/24 at 8:28 A.M., CNA #2 said he did not have eye protection on, and he should have. During an interview at the same time, UM #2 said CNA #2 should have had eye protection on but he did not. On 9/26/24 at 9:01 A.M., the surveyor observed CNA #1 ambulate a resident to the bathroom and then make the resident's bed. The surveyor observed signage outside the Resident's room indicating Enhanced Barrier Precautions (EBP- protective barrier gowns and gloves used as an infection control intervention designed to reduce transmission of multi-drug-resistant organisms [MDRO] during high contact resident care) and the appropriate PPE to be used for resident care included gown and gloves. CNA #1 was not observed wearing a gown or gloves. During an interview at the time CNA #1 said she was not aware she needed to wear any PPE for walking the Resident and for making his/her bed. The surveyor and CNA #1 reviewed the Enhanced Barrier Precaution sign at the Resident's door and CNA #1 said she should have worn a gown and gloves, but she did not. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #84 was admitted to the facility in November 2021 with diagnosis of Diabetes (disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood). Review of Resident #84's September 2024 Physician's orders indicated: -Resident was on Enhanced Barrier Precautions related to Stage 4 pressure ulcers. On 9/27/24 at 12:16 P.M., the surveyor observed Nurse #1 perform blood glucose testing on Resident #84 in the Resident's room. The Nurse removed the used test strip from the glucometer machine, then placed the machine in the case. The surveyor did not observe Nurse #1 clean or sanitize the glucometer machine before storing it in the case. During an interview on 9/27/24 at 12:38 P.M., Nurse #1 said she did not have a bleach wipe while she was in the Precautions room. Nurse #1 said she should have wiped off the glucometer machine with a facility approved bleach wipe after performing the finger stick blood glucose test, but she did not.