

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Melrose Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 40 Martin Street Melrose, MA 02176	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on record review and interviews, the facility failed to obtain consents for psychotropic medications explaining the risks and benefits of treatment, prior to administering psychotropic medication for two Residents (#47 and #76) out of a sample of 20 Residents.</p> <p>Findings include:</p> <p>A review of the facility's policy titled Psychotropic Medication, dated July 2023, indicated the following:</p> <p>-To administer and monitor the effects of psychotropic medications when prescribed. The interdisciplinary team assesses and monitors the appropriateness, effectiveness, and side effects associated with psychotropic medications for each resident via resident care plan review. The resident, and when indicated, the family or responsible person, will be included in this process prior to the administration of dose. Psychotropic medication management includes:</p> <ol style="list-style-type: none"> a. a physician's order and an appropriate diagnosis is required for psychotropic medications. b. a written informed consent from the resident (or legally authorized individual in the case of resident incompetence) is required for administration of psychotropic medication. <p>1. Resident #47 was admitted to the facility in October 2022 with diagnoses that included legal blindness, anxiety, dementia, and depression.</p> <p>Review of Resident #47's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of one out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #47 was dependent on staff for all care and mobility.</p> <p>Review of Resident #47's physician orders indicated the following psychotropic medication orders:</p> <p>-Mirtazapine (an anti-depressant medication) Tablet 15 mg. Give 1 tablet by at bedtime for increased appetite. Dated 1/4/24.</p> <p>Review of the medical record failed to include signed consent for the administration of Mirtazapine.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/1/24 at 2:21 P.M., the Director of Nursing #1 said consent for use of psychotropic medications needs to be obtained from the resident or his/her representative prior to the administration of the medication.</p> <p>49880</p> <p>2. Resident #76 was admitted to the facility in March 2024 with diagnoses that included end stage renal disease, anxiety and left leg above the knee amputation.</p> <p>Review of Resident #76 most recent Minimum Data Set (MDS) assessment, dated 3/10/24, indicated he/she was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff as being severely cognitively impaired.</p> <p>Review of active physician's orders indicated the following psychotropic medication orders:</p> <p>-Ativan (a medication used to treat anxiety) 0.5 milligrams every 4 hours as needed, dated 3/19/24.</p> <p>-Ativan 0.5 milligrams two times a day, dated 3/19/24.</p> <p>Review of the March 2024 and April 2024 Medication Administration Record indicated that Resident #76 had been receiving Ativan as ordered.</p> <p>Review of Resident #76's medical record failed to indicate signed consent for the administration of Ativan.</p> <p>During an interview on 4/1/24 at 2:21 P.M., the Director of Nursing #1 said that consent for the use of psychotropic medications needs to be obtained from the resident or the resident's representative prior to the administration of psychotropic medications.</p> <p>During an interview on 4/3/24 at 9:24 A.M., Nurse #6 said that consent for the use of psychotropic medications should be obtained prior to the administration of any psychotropic medication. Nurse #6 reviewed Resident #76's medical record and said that Resident #76 did not have a consent for the administration of Ativan.</p>

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>36876</p> <p>Based on observation and interview, the facility failed to ensure residents on 3 of 3 units had access to the use of a telephone where calls can be made without being overheard.</p> <p>Findings include:</p> <p>During the Resident Group Interview on 4/2/24 at 2:00 P.M., all participating residents said that staff are unable to provide a telephone in private for Residents to make calls. Residents reported that the facility used to have a portable phone but now any residents who do not own their own cell phone, can only use the phone at the nurses station, where anyone can hear their conversations. Residents said this occurs on all units.</p> <p>On 4/3/24 at 8:18 A.M., the surveyors observed Resident #16 at the nurses station on the 2nd floor making a phone call. Resident #16 said that he/she used to be able to have the conversations with his/her family on a portable phone in his/her room but did not know where the portable phone went.</p> <p>On 4/3/24 at 10:13 A.M. the surveyor observed a resident at the nurses station on the 2nd floor making a phone call while staff and residents were in the area and could overhear his/her conversation.</p> <p>During an interview on 4/3/24 at 8:22 A.M., CNA #1 said that if a resident needs to use the phone, they need to use the phone at the nursing station. CNA #1 said that the residents used to have a cordless phone, but was not sure what happened to it.</p> <p>During an interview on 4/3/24 at 8:29 A.M., the Activity Director said that residents have to use the phone at the nurses station if they want to make a phone call on the 1st and 2nd floor nursing units. The Activity Director said that the facility used to have a cordless phone they could use but it's no longer available.</p> <p>During an interview on 4/3/24 at 10:21 A.M., Director of Nursing (DON) #1 said that there is an office residents can use to make a private call. The DON was not aware staff were not assisting residents to the private office to make private phone calls.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on record review and interview the facility failed to ensure advanced directives related to guardianships were valid and in place for two Residents, (#16 and #12) out of a total of 20 sampled Residents. Specifically:</p> <p>1.) For Resident #16, the facility failed to ensure an established Guardianship was reviewed and renewed annually per court order, and;</p> <p>2.) For Resident #12, the facility failed to establish a health care agent/representative when his/her activated health care proxy was no longer reachable or involved in his/her care.</p> <p>Findings include:</p> <p>1. Resident #16 was admitted to the facility in June 2009 with diagnoses including schizoaffective disorder, syncope, and bipolar disorder.</p> <p>Review of his/her most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #16 scored 9 out of a possible 15 on the Brief Interview for Mental Status Exam, (BIMS), indicating moderate cognitive impairment.</p> <p>Review of the clinical record indicated Resident #16 had an established [NAME] Guardianship, (a Guardianship specifically related to the authorizing treatment with anti-psychotic medication), dated 2/2/23. The Guardianship indicated: Authorization treatment with anti-psychotic medication shall be reviewed on or before 2/2/24.</p> <p>The clinical record failed to indicate the [NAME] Guardian was reviewed and renewed by the courts in 2024.</p> <p>During an interview on 4/2/24 at 10:05 A.M., the Social Worker said that Resident #16's [NAME] Guardian was not renewed or reviewed by the courts as ordered.</p> <p>2. Resident #12 was admitted to the facility in February 2016 with diagnoses including Wernicke's encephalopathy, chronic obstructive pulmonary disease, and alcohol dependence.</p> <p>Review of Resident #12's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she scored 8 out of a possible 15 on the Brief Interview for Mental Status Exam, indicating moderate cognitive impairment.</p> <p>Review of the clinical record indicated Resident #12 had an activated healthcare proxy.</p> <p>Review of Resident #12's clinical progress note dated 1/29/24 indicated: Attempted to contact [health care agent] multiple times to obtain Covid-19 consent or refusal. Phone is no longer in service. Resident was unaware phone was no longer in service and has no contact information for [health care agent]. Certified letter was sent to [healthcare agent] using address on file.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The clinical record failed to indicate any further information regarding Resident #12's health care agent or possible guardianship.</p> <p>During an interview on 4/3/24 at 10:16 A.M., Director of Nursing (DON) #1 said that the facility had difficulty in contacting Resident #12's health care agent. DON #1 said it's been a long time. We sent a certified letter but was unable to say when the last time Resident #12's health care agent had been reachable or involved in Resident #12's care or medical related decisions. DON #1 said that Resident #12 had no other family or friends involved and that the facility would need to pursue Guardianship. DON #1 could not say why the facility did not proceed with establishing Guardianship for Resident #12 prior to the surveyor's inquiry.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, record review, policy review and interviews, the facility failed to ensure one Resident (#31) was free from involuntary seclusion, out of a total sample of 20 Residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Abuse: Prohibition, dated December 2017, indicated the following:</p> <p>-Each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property. Every resident in the facility will be treated with respect and dignity at all times.</p> <p>-Involuntary seclusion: the separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative.</p> <p>Resident #31 was admitted to the facility in February 2024 with diagnoses including stroke with paralysis on right side and abnormalities of gait and mobility.</p> <p>Review of Resident #31's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15, which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #31 required maximum assistance from staff for bed mobility tasks.</p> <p>On 4/1/24 at 12:24 P.M., Resident #31 was observed lying in bed in a dark room behind a closed door. There was a pillow placed under the fitted sheet on the left side of the mattress preventing the Resident from moving his/her legs to that side of the bed. Resident #31 said he/she did not know why the pillow was there and he/she was not able to move his/her arms to the pillow to remove it. Resident #31 said he/she would like to get out of bed. There was no chair in the Resident's room for him/her to get into if he/she desired to get out of bed.</p> <p>Resident #31 was not observed out of bed for the entirety of the 7:00 A.M. to 3:00 P.M. shift on 4/1/24. His/her door to his/her room was always closed and his/her light in the room was never on.</p> <p>On 4/2/24 at 7:45 A.M., Resident #31 was observed lying in bed in a dark room behind a closed door. There was a pillow placed under the fitted sheet on the left side of the mattress preventing the Resident from moving his/her legs to that side of the bed.</p> <p>On 4/2/24 at 8:37 A.M., Resident #31 was observed attempting to get out of bed by placing his/her legs over the side of the bed. Resident #31 said he/she would like to get out of bed. There was no chair in the Resident's room for him/her to get into if he/she desired to get out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/24 at 12:00 P.M., Resident #31 was still observed lying in bed in a dark room behind a closed door. Resident #31 said he/she would love to get out of bed to eat lunch and said he/she could not remember the last time he/she was out of bed.</p> <p>Review of Resident #31's activity of daily living care plan initiated on 2/23/24, indicated the following:</p> <ul style="list-style-type: none"> -Transfer: assist to dependent. -Locomotion: assist with wc (wheelchair). <p>Further review of Resident #31's complete care plans failed to indicate the Resident prefers to stay in his/her bed or room and refuses to get out of bed.</p> <p>Review of all nursing progress notes since Resident #31's admission to the facility failed to indicate the Resident refused to get out of bed.</p> <p>Review of the Physical Therapy evaluation dated 2/24/24 indicated the following:</p> <ul style="list-style-type: none"> -Patient goals: I want to walk better but I have no energy. -Potential for achieving goals: Patient demonstrates good rehab potential as evidenced by decreased need for task segmentation, active participation with plan of treatment, motivated to participate and motivated to return to prior level of living. -Reason for referral: Pt. (patient) has been non ambulatory x 1 yr (year) since CVA (stroke) and needs further rehab to enable greater (I) (independence) with mobility. -Resident #31 was able to complete a stand pivot transfer with maximal assistance from the therapist. -Clinical Impressions: Skilled PT (physical therapy) required to return to PLOF (prior level of function) or develop compensatory methods of mobility such as WC mobility. -The plan of care was for therapy to treat the Resident 5 times a week for 4 weeks. <p>Review of the physical therapy notes indicated Resident #31 only received two treatments on 2/27/24 and 3/7/24. The physical therapy notes failed to indicate the physical therapist assistant attempted dynamic sitting training or transfers out of bed. The notes also failed to indicate the therapist provided a chair for the Resident if he/she chose to get out of bed with the nursing staff.</p> <p>During an interview on 4/2/24 at 11:32 A.M., Nurses #3 and #4 said they work consistently at the building and know Resident #31. Both Nurse #3 and Nurse #4 said they have never observed Resident #31 out of bed. Both nurses said the Resident stays in bed daily and were unaware how the Resident transferred or what type of chair he/she would sit in if out of bed.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/24 at 11:40 A.M., Certified Nursing Assistant (CNA) #1 said she is the primary CNA for Resident #31. CNA #1 said she does not transfer Resident #31 out of bed because the Resident is a high falls risk. CNA #1 said she makes the choice to keep the Resident in bed and does not ask the Resident if he/she would like to get out of bed. CNA #1 said physical therapy is working with the Resident and the therapists are the only staff members who can transfer the Resident out of bed. CNA #1 said safety comes first and it is safer to have to Resident stay in bed.</p> <p>During interviews on 4/2/24 at 11:18 A.M., and 4/2/24 at 12:46 A.M., the Regional Director of Rehabilitation (DOR) said Resident #31 was only on physical therapy for two treatment sessions and is not currently receiving therapy services. The Regional DOR said Resident #31 did not have a chair to transfer into if he/she wanted to get out of bed and the therapy staff should have provided a chair to the Resident.</p> <p>During an interview on 4/2/24 at 12:39 P.M., the Regional Nurse said nursing is able to obtain a wheelchair for a resident and is able to get a resident out of bed without waiting for therapy.</p> <p>During an interview on 4/2/24 at 12:16 P.M., Director of Nursing (DON) #1 said all residents should be asked if they would like to get out of bed daily and throughout the day as needed. DON #1 said all residents should be provided with a chair/method of getting out of bed. DON #1 said nursing can assist residents with transferring out of bed and it is not the responsibility of therapy to get residents out of bed. DON #1 said she is unaware of Resident #31's schedule and if he/she gets out of bed. DON #1 said she was unaware Resident #31 had not been offered to get out of bed.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, record review, policy review and interviews, the facility failed to ensure one Resident (#31) was free from restraints out of a total sample of 20 residents. Specifically, the facility failed to identify and assess the use of a pillow under a fitted sheet as a potential restraint for Resident #31.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Use of Restraints, dated 1/2024, indicated the following:</p> <ul style="list-style-type: none"> -Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. -Physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot move remove a device in the same manner in which the staff applied it given that resident's physical condition and this restricts his/her typical ability to change position or place, that device may be considered a restraint. <p>Resident #31 was admitted to the facility in February 2024 with diagnoses including stroke with paralysis on right side and abnormalities of gait and mobility.</p> <p>Review of Resident #31's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15, which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #31 required maximal assistance from staff for bed mobility tasks.</p> <p>On 4/1/24 at 12:24 P.M., Resident #31 was observed lying in bed. There was a pillow placed under the fitted sheet on the right side of the mattress preventing the Resident from moving his/her legs to that side of the bed. Resident #31 said he/she did not know why the pillow was there and he/she was not able to move his/her arms to the pillow to remove it.</p> <p>On 4/2/24 at 7:45 A.M., Resident #31 was observed lying in bed. There was a pillow placed under the fitted sheet on the right side of the mattress preventing the Resident from moving his/her legs to that side of the bed.</p> <p>On 4/2/24 at 8:37 A.M., Resident #31 was observed attempting to get out of bed by placing his/her legs over the side of the bed. Resident #31 said he/she would like to get out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on record review, observations and interviews, the facility failed to ensure resident centered care plans were developed and/or implemented for two Residents (#47, and #53) out of a total sample of 20 Residents. Specifically the facility failed to;</p> <ol style="list-style-type: none"> 1.) develop a vision, communication and fall risk care plan for Resident #47, 2.) develop a pacemaker care plan for Resident #53. <p>Findings include:</p> <p>A review of the facility's policy titled Care Plans, comprehensive Person-centered dated January 2024, indicated the following:</p> <p>-A comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial, and functional needs is developed for each resident. Comprehensive care plan development includes:</p> <ol style="list-style-type: none"> a. the Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, may assist with the development of a comprehensive care plan for each resident. b. the care plan interventions are derived from the information gathered as part of the comprehensive assessment. c. the resident comprehensive care plan will identify problem areas and their causes as warranted and developing interventions that are targeted and meaningful to the resident. <p>1. Resident #47 was admitted to the facility in October 2022 with diagnoses including legal blindness, anxiety, dementia, and depression.</p> <p>Review of Resident #47's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #47 required dependence for all care and mobility.</p> <p>On 4/1/24 at 8:06 A.M., Resident #47 was observed lying in bed. Certified Nursing Assistant (CNA) #1 entered the room while the surveyors were attempting to interview the Resident. CNA #1 said Resident #47 only speak French-Creole and would not be able to understand the interview and the CNA proceeded to interpret for the surveyor. CNA #1 also said Resident #47 is legally blind and requires assistance for all tasks due to the Resident's physical status.</p> <p>Review of Resident #47's care plans failed to indicate a care plan for communication, vision status or falls risk.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #47's last comprehensive MDS dated [DATE], indicated the Care Area Assessment (CAA) was triggered for visual function and falls which indicated to proceed to care plan to create a care plan for these areas. Further review of the MDS, in the communication section of the MDS (B0700 and B0800) was not assessed.</p> <p>During an interview on 4/2/24 at 2:42 P.M., the MDS nurse said if a Care Area Assessment is triggered on a comprehensive MDS than a care plan should be developed for any Care Area Assessments triggered. The MDS nurse said she would expect care plans for vision, communication and fall risk to have been developed for Resident #47 since these Care Area Assessments triggered.</p> <p>43846</p> <p>2. Review of the facility policy titled Care of a Resident with a Pacemaker, dated March 2018, indicated</p> <p>1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission:</p> <ul style="list-style-type: none"> a. The name, address, and telephone number of the cardiologist. b. Type of pacemaker. c. Type of leads. d. Manufacturer and model. e. Serial number. f. Date of implant; and g. Paced rate. <p>2. When the resident's pacemaker is monitored by the Physician, document the date and results of the pacemaker surveillance, including:</p> <ul style="list-style-type: none"> a. How the resident's pacemaker was monitored (phone, office, internet); b. Type of the heart rhythm. c. Functioning of the leads. d. Frequency of utilization; and e. Battery life. <p>Resident #53 was admitted to the facility in September 2023 with diagnoses that included type 2 diabetes, depression, hyperlipidemia, and chronic kidney disease.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #53's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 13 out of 15 on the Brief Interview of Mental Status indicating he/she is cognitively intact.</p> <p>On 4/1/24 at 8:41 A.M., the surveyor observed a Medtronic device plugged in with a green light on. The device was on the floor next to Resident #53's bed. Resident #53 said he/she has a pacemaker in his/her chest.</p> <p>On 4/2/24 at 9:00 A.M., the surveyor observed a Medtronic device plugged in with a green light on. The device was on the floor next to Resident #53's bed.</p> <p>Review of Resident #53's medical record failed to indicate a plan of care for his/her pacemaker.</p> <p>During an interview on 4/2/24 at 12:24 P.M., the Director of Nurses (DON) said Resident #53 does have a pacemaker Medtronic device plugged in and functioning. The DON said the Resident should have orders in place and a care plan but does not.</p> <p>During an interview on 4/3/24 at 9:09 A.M., Nurse #6 said Resident #53 has said in the past that he/she does have a pace maker. Nurse #6 said she has noticed the Medtronic device plugged in and said that is used to transmit data to a cardiology office but is unaware of the Resident's cardiology office to contact. Nurse #6 said there should be orders in place for pacemaker checks and identify the Resident's cardiology office.</p> <p>36876</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48990</p> <p>Based on observations, interviews, record review, and policy review, the facility to ensure that services provided met professional standards for one Resident (#13), out of 20 total sampled Residents. Specifically, the facility failed to implement a daily wound dressing according to the physician's order for five days.</p> <p>Findings include:</p> <p>Review of the facility policy titled Medication and Treatment Orders, last revised April 2018, indicated:</p> <p>-Orders for medications and treatments will be consistent with regulatory standards.</p> <p>Review of the facility policy titled Dressings, Dry/Clean, revised April 2018, indicated:</p> <p>-Verify that there is a physician's order for this procedure.</p> <p>Resident #13 was admitted to the facility in December 2022 with diagnoses that included peripheral vascular disease and obesity.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/21/24, indicated that Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. This MDS indicated Resident #13 had an open lesion on his/her foot.</p> <p>On 4/1/24 at 8:06 A.M., the surveyor observed Resident #13 lying in bed. Resident #13 said the nurses do not change my foot dressing very often. Resident #13 had a dressing on his/her right foot, dated 3/27/24 (5 days prior).</p> <p>Review of the Resident #13's physician's order, 3/12/24, indicated:</p> <p>-Clean right distal plantar lateral foot with normal saline, apply A & D ointment, then cover with dry dressing, change daily and PRN.</p> <p>Review of the March 2024 Treatment Administration Record (TAR), dated 3/27/24, 3/28/24, 3/29/24, 3/30/24, and 3/31/24, indicated the physician's treatment order was documented as completed, (contradicting the surveyors observation).</p> <p>During an interview on 4/1/24 at 8:52 A.M., the surveyor and Nurse #2 observed Resident #13 lying in bed with a dressing on his/her right foot dated 3/27/24. Nurse #2 said the dressing was not changed since 3/27/24; five days prior. Nurse #2 said that Resident #13's right foot dressing is ordered to be changed daily and wound dressings should be changed at the frequency frequency the physician ordered.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care related to non-pressure wound of the right distal plantar lateral foot and potential for skin breakdown, dated 1/3/24, failed to indicate Resident #13 refuses dressing changes.</p> <p>Review of the nursing progress notes, dated 3/5/24 to 4/1/24, failed to indicate Resident #13 refused any dressing changes.</p> <p>During an interview on 4/2/24 at , the Wound Physician said she was not notified that Resident #13 refused or did not have his/her right foot dressing changed from 3/27/24 until 4/1/24. The Wound Physician said Resident #13 does not usually refuse dressing changes.</p> <p>During an interview on 4/3/24 at 8:46 A.M., Director of Nursing (DON) #2 said dressings should be changed at the frequency the physician ordered and if refused than the physician should be notified. DON #2 said if a dressing change is not done or refused, the rationale should be documented in the TAR or in a nursing note. DON #2 said if a dressing change is not completed, it should not be documented as completed in the TAR.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, record review, policy review and interviews, the facility failed to provide assistance with meals for two Residents (#379 and #30) out of a total sample of 20 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, dated September 2019, indicated the following:</p> <ul style="list-style-type: none"> -Residents will be provided with care, treatment and services as appropriate to maintain or improve as able their ability to carry out activities of daily living (ADLs). -Residents who are unable to carry out activities of daily living independently will receive the services necessary for activities of daily living. -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with dining (meals and snacks). <p>1. Resident #379 was admitted to the facility in October 2023 with diagnoses including pneumonitis due to inhalation of food and vomit and dementia.</p> <p>Review of Resident #379's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15, which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #379 required supervision or touching assistance during meals.</p> <p>On 4/1/24 at 8:40 A.M., Resident #379 was observed eating breakfast while lying in bed. The privacy curtain was drawn, and the Resident was not visible from the hallway. The Resident was observed to have food on his/her chest.</p> <p>On 4/2/24 at 8:43 A.M., Resident #379 was observed eating breakfast in his/her room alone. The privacy curtain was drawn, and the Resident was not visible from the hallway.</p> <p>On 4/2/24 at 12:36 P.M., Resident #379 was observed eating lunch in his/her room alone. The privacy curtain was drawn, and the Resident was not visible from the hallway.</p> <p>Review of Resident #379's activity of daily living care plan, last revised 1/22/24, indicated the following:</p> <ul style="list-style-type: none"> -Eating: setup and cue, provide continual supervision/assist prn (as needed). <p>Review of Resident #379's Kardex (a form indicating the level of care required) indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Eating: setup and cue, provide continual supervision/assist prn.</p> <p>During an interview on 4/2/24 at 2:00 P.M., Certified Nursing Assistant #1 said Resident #379 requires supervision while eating.</p> <p>During an interview on 4/2/24 at 2:18 P.M., Director of Nursing #1 said she would expect the staff would supervise the Resident per his/her activity of daily living care plan.</p> <p>49880</p> <p>2. Resident #30 was admitted to the facility in June 2015 with diagnoses that include cerebral infarction (stroke), dysphagia (difficulty swallowing), dementia and paraplegia.</p> <p>Review of Resident #30's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #30 is cognitively intact. The MDS further indicated that Resident #30 required supervision or touching assistance for eating.</p> <p>On 4/1/24 at 9:16 A.M. the surveyor observed Resident #30 in bed eating breakfast, sliding down and leaning towards the left. There were no staff present in Resident #30's room.</p> <p>On 4/2/24 at 8:47 A.M., the surveyor observed a Certified Nurses Aid (CNA) bring Resident #30 his/her breakfast tray, set his/her tray up and leave the room. Resident #30 was observed in bed with the head of the bed elevated at approximately 45 degrees and leaning to the left. The tray table was elevated, and Resident #30 had to reach up and over it to feed his/herself.</p> <p>On 4/2/24 at 8:53 A.M., the surveyor and Director of Nursing #2 (DON) observed Resident #2 in bed eating alone. DON #2 said that Resident #30 was not in a safe position to eat.</p> <p>Review of Resident #30's activities of daily living care plan, revised on 3/24/23, indicated eating assistance varies from supervision to total assist.</p> <p>Review of Resident #30's nutrition care plan, revised on 2/8/24, indicated that Resident #30 has swallowing difficulty due to dysphagia as evidenced by need for mechanically altered diet and to monitor for signs and symptoms of aspiration.</p> <p>During an interview on 4/2/24 at 2:18 P.M., DON #1 said that she would expect CNA's to supervise Resident #30 as per his/her plan of care with meals.</p> <p>During an interview on 4/3/24 at 9:11 A.M., CNA #3 said that Resident #30 needs supervision with meals and said someone should always be in the room with him/her while eating.</p> <p>During an interview on 4/3/24 at 9:15 A.M., CNA #4 said that Resident #30 needs to be supervised with meals because he/she coughs a lot when eating.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, record review, policy review and interviews, the facility failed to provide an activity program for three Residents (#31, #38 and #47) out of a total sample of 20 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Activity Evaluation, dated April 2019, indicated the following:</p> <ul style="list-style-type: none"> -In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities. -Each residence activities care plan relates to his/her comprehensive assessment and reflects his/her individual needs. -The activity evaluation is used to develop individual activities care plan (Separate from or as part of the comprehensive care plan) that will allow the resident to participate in activities of his/her choice and interest. <p>1. Resident #31 was admitted to the facility in February 2024 with diagnoses including stroke with paralysis on right side and abnormalities of gait and mobility.</p> <p>Review of Resident #31's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15, which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #31 required maximal assistance from staff for bed mobility tasks.</p> <p>On 4/1/24 Resident #31 was observed in his/her room for the entirety of the 7:00 A.M. to 3:00 P.M. shift. During all observations, the Resident was lying in bed and there was no television or music playing in the room. There were no activity materials observed in the Resident's room.</p> <p>Activities listed on the activity calendar on this day were: coffee cart and morning greetings, crossword puzzle and Never Have I Ever Game.</p> <p>On 4/2/24 Resident #31 was observed in his/her room from 7:00 A.M. to approximately 1:30 P.M. During observations made at this time, the Resident was lying in bed and there was no television or music playing in the room. There were no activity materials observed in the Resident's room.</p> <p>Activities listed on the activity calendar during these hours were: It's Coffee Time, Chit Chat Group, Crossword Puzzle, and You're the Judge.</p> <p>Review of Resident #31's Recreation Admission Assessment, dated 2/23/24, indicated the following:</p> <ul style="list-style-type: none"> -Activities of preference: music, reading/writing, spiritual, TV, and talking to others. <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #31 is alert and able to make his/her needs known.</p> <p>-Resident #31 participates in coffee hour in his/her room and enjoys spending time watching television.</p> <p>-It is very important to the Resident to have books, newspapers, magazine, music, and religion activities.</p> <p>-It is somewhat important to the Resident to do things with groups of people.</p> <p>Review of Resident #31's care plans failed to indicate an activity care plan was developed for the Resident.</p> <p>Review of Resident #31's Activity of Daily Living care plan initiated on 2/23/24, indicated the following intervention:</p> <p>-Invite, encourage, remind, escort to activity programs consistent with the resident's interests.</p> <p>Review of the Documentation Survey Report dated March 2024 and April 2024 failed to indicate the Resident had participated in any activities since admission to the facility.</p> <p>During an interview on 4/3/24 at 9:02 A.M., the Activities Director said the activity department consists of her and one assistant. The Activities Director said she is often pulled away by other building business and this at times takes away from her ability to complete activities with the residents. The Activities Director said the activity calendar is made based on the residents' preferences and she had the residents fill out a survey of their preferences. The Activities Director said the residents who primarily stay in their rooms depend on visits from the activity staff. The Activities Director said there are activity materials on the floor and nursing should be passing the materials out to the residents throughout the day. The Activities Director said Resident #31 is a tough resident to provide activities for because he/she does not want to be in the facility and stays in his/her room. The Activities Director said she visits Resident #31 in his/her room, and he/she likes to listen to music and watch television. She said the Resident is also very religious and enjoys reading the bible, as he/she used to be a minister. The Activity Director was unaware Resident #31 did not have a radio in his/her room or that the television had not been on for two days. She said she would have expected nursing to put on the television for the Resident. The Activities Director said if the Resident had participated in activities, she would have documented the participation the electronic medical record.</p> <p>2. Resident #38 was admitted to the facility in June 2019 with diagnoses including Alzheimer's Disease and depression.</p> <p>Review of Resident #38's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15 which indicated he/she had severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/1/24 at 7:39 A.M., Resident #38 said he/she was bored. The Resident said he/she used to play cards with other residents in the facility and that no longer happens. Resident #38 said he/she likes to listen to music and would like a radio. There were no activity materials observed in the room and the Resident did not have a radio in the room.</p> <p>On 4/1/24 and 4/2/24 throughout 7:00 A.M. through 3:00 P.M. shift, Resident #38 was not observed participating in any activities.</p> <p>The activities listed on the activity calendar on 4/1/24 were: coffee cart and morning greetings, crossword puzzle and Never Have I Ever Game.</p> <p>The activities listed on the activity calendar on 4/2/24 were: It's Coffee Time, Chit Chat Group, Crossword Puzzle, and You're the Judge.</p> <p>Review of Resident #38's most recent activity assessment dated [DATE] indicated the Resident prefers the radio and television, trivia and coffee social. The assessment indicated the Resident also enjoys reminiscing.</p> <p>Review of Resident #38's activity care plan last revised 5/15/23 indicated the following interventions:</p> <ul style="list-style-type: none"> -Explain importance of activities. -Introduce to other residents. -Invite to scheduled activities. <p>Review of section F of the comprehensive MDS dated [DATE] indicated the following:</p> <ul style="list-style-type: none"> -Activities very important to the Resident are listening to music, dingo things with groups of people. -Activities somewhat important to the Resident are being around animals, and religious services. <p>Review of the Documentation Survey Report dated March 2024 and April 2024 failed to indicate Resident #38 had participated in any activities since March 1, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/3/24 at 9:02 A.M., the Activities Director said the activity department consists of her and one assistant. The Activities Director said she is often pulled away by other building business and this at times takes away from her ability to complete activities with the residents. The Activities Director said the activity calendar is made based on the residents' preferences and she had the residents fill out a survey of their preferences. The Activities Director said the residents who primarily stay in their rooms depend on visits from the activity staff. The Activities Director said there are activity materials on the floor and nursing should be passing the materials out to the residents throughout the day. The Activities Director said Resident #38 used to participate in a poker game group, but she had to stop this group because the residents were gambling. The Activities Director said she did not replace this group with a different type of card game other than poker. The Activities Director said Resident #38 does like to stay in his/her room and listen to music and was unaware there was no radio in the Resident's room. The Activities Director said if the Resident had participated in activities, she would have documented the participation the electronic medical record.</p> <p>3. Resident #47 was admitted to the facility in October 2022 with diagnoses including dementia, anxiety, and depression.</p> <p>Review of Resident #47's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 1 out of a possible 15, which indicated he/she had severe cognitive impairment.</p> <p>On 4/1/24, Resident #47 was not observed participating in any activities on the 7:00 A.M. to 3:00 P.M. shift.</p> <p>The activities listed on the activity calendar on 4/1/24 were: coffee cart and morning greetings, crossword puzzle and Never Have I Ever Game.</p> <p>On 4/2/24, Resident #47 was not observed participating in any activities on the 7:00 A.M. to 3:00 P.M. shift.</p> <p>The activities listed on the activity calendar on 4/2/24 were: It's Coffee Time, Chit Chat Group, Crossword Puzzle, and You're the Judge.</p> <p>Review of Resident #47's most recent activity assessment date 1/27/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident participated in self-directed activities and one on one activities. -The Resident likes radio and is supposed to have a radio/cd player to play music and church music at his/her request. The Resident also likes to pray. <p>Review of the most recent comprehensive MDS indicated the staff did not assess the Resident for his/her preferences.</p> <p>Review of Resident #47's activity care plan last revised 10/21/23, indicated the following interventions:</p> <ul style="list-style-type: none"> -Arrange one on one contacts with resident. <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Offer ongoing structured activity program for intellectual stimulation.</p> <p>-Offer reality orientation on all possible occasions and contacts.</p> <p>-Offer schedule of activities for resident to select choices.</p> <p>-Post personal activity schedule in resident's room.</p> <p>-Transport resident to activities. Assist in transporting any health-related equipment to activities.</p> <p>Review of the Documentation Survey Report dated March 2024 and April 2024 indicated Resident #47 had participated in activities twice since March 1, 2024.</p> <p>During an interview on 4/3/24 at 9:02 A.M., the Activities Director said the activity department consists of her and one assistant. The Activities Director said she is often pulled away by other building business and that at times takes away from her ability to complete activities with the residents. The Activities Director said the activity calendar is made based on the residents' preferences and she had the residents fill out a survey of their preferences. The Activities Director said the residents who primarily stay in their rooms depend on visits from the activity staff. The Activities Director said there are activity materials on the floor and nursing should be passing the materials out to the residents throughout the day. The Activity Director said Resident #47 is very religious and spends most of his/her time in the dining room. The Activity Director said staff should be making music available to him/her but staff often hide his/her radio.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on record review an interview, the facility failed to follow up on a referral for ophthalmology services for one Resident (#12) out of a total of 20 sampled Residents.</p> <p>Findings include:</p> <p>Resident #12 was admitted to the facility in February 2016 with diagnoses including Wernicke's encephalon, chronic obstructive pulmonary disease, and alcohol dependence.</p> <p>Review of Resident #12's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she scored 8 out of a possible 15 on the Brief Interview for Mental Status Exam, indicating severe cognitive impairment. The MDS also indicated he/she requires physical assistance from staff with bathing, dressing and toileting.</p> <p>During an interview on 4/1/24 at 7:59 A.M., Resident #12 said he/she wants to be seen by an eye doctor and wants glasses.</p> <p>Review of Resident #12's optometry notes indicated:</p> <ul style="list-style-type: none"> - 11/8/23: Assessment: Glaucoma suspect, Cataract nuclear, [right] eye. Plan: Cataract surgery recommended. Referral: ophthalmology consult. - 3/8/24: Assessment: Glaucoma suspect. Open angle with borderline findings. Cataract, mixed, [right] eye. Patient wants to proceed with surgery. Referral: cataract ophthalmology; please make appointment for initial cataract consultation. Please arrange transportation to and from appointment. <p>Review of clinical record failed to indicate a referral was placed to ophthalmology or an appointment was made for Resident #12, or the recommendation was reviewed with his/her activated health care agent.</p> <p>During an interview on 4/3/24 at 8:52 A.M., Corporate Nurse #1 said that Resident #12's eye appointment was not made.</p> <p>During an interview on 4/3/24 at 10:16 A.M., Director of Nursing (DON) #1 said that the facility would have needed to get approval from Resident #12's activated health care proxy to proceed with the referral, but the facility has been unable to get in touch with his/her health care agent for many months. DON #1 said that the facility sent out a certified letter to Resident #12's health care agent.</p> <p>The clinical record indicated a certified letter was sent to Resident #12's health care agent on 1/29/24 after staff could not reach them regarding vaccination consent or declination. There was no evidence in the clinical record indicating the facility attempted to reach the health care agent regarding vision services for Resident #12.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49880</p> <p>Based on observations, record review and interviews, the facility failed to ensure respiratory care was provided consistent with professional standards of care for one Resident (#4) out of a sample of 20 residents. Specifically for Resident #4, the facility to ensure oxygen was administered in accordance with the physician's orders.</p> <p>Findings Include:</p> <p>Review of facility policy titled Oxygen Administration, revised January 2024, indicated to review the physician's orders for oxygen administration and to evaluate oxygen saturation.</p> <p>Resident #4 was admitted to the facility in March 2018 with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and weakness.</p> <p>Review of Resident #4's most recent Minimum Data Set (MDS) assessment, dated 3/7/24, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating that Resident #4 is cognitively intact. The MDS assessment failed to indicate the use of oxygen.</p> <p>On 4/1/24 at 7:52 A.M., the surveyor observed Resident #4 lying in bed, oxygen was not being administered.</p> <p>On 4/1/24 at 1:06 P.M., the surveyor observed Resident #4 sitting on the side of his/her bed. Resident #4 was not utilizing oxygen and there was no portable oxygen concentrator observed in the room.</p> <p>On 4/1/24 at 2:20 P.M., the surveyor observed Resident #4 lying in bed, oxygen was not being administered and there was no portable oxygen concentrator in the room.</p> <p>On 4/2/24 at 7:49 A.M. and 11:34 A.M., the surveyor observed Resident #4 sleeping in bed, oxygen was not being administered and there was no portable oxygen concentrator in the room.</p> <p>Review of Resident #4's active physician's orders, dated 2/23/24, indicated O2 [oxygen] 1-4 liters to maintain [oxygen saturation] >90%, ordered for all shifts.</p> <p>Review of Resident #4's April 2024 Treatment Administration Record indicated that oxygen was administered on 4/1/24 and 4/2/24.</p> <p>Review of Resident #4's medical record indicated that the last recorded oxygen saturation was on 3/27/24.</p> <p>Review of Resident #4's progress notes from March 2024 and April 2024 failed to indicate any assessment of oxygen saturation.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/24 at 2:11 P.M., Nurse #7 said that she had not assessed Resident #4's oxygen saturation on her shift. Nurse #7 reviewed Resident #4's physician's orders and said that the oxygen order would be a continuous order and oxygen saturation should be assessed. Nurse #7 said the last documented oxygen saturation was on 3/27/24. Nurse #7 said that Resident #4 was not currently utilizing oxygen.</p> <p>During an interview on 4/2/24 at 2:16 P.M., the Director of Nursing (DON) said that Resident #4's oxygen order is a continuous oxygen order. The DON said that she would expect that nurses are assessing oxygen saturation every shift for Resident #4.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880</p> <p>Based on observations, record review and interviews, the facility failed to ensure services consistent with professional standards of practice related to hemodialysis (the process of cleansing the blood by passing it through a special machine, necessary when the kidneys are unable to filter the blood) were provided for one Resident (#65) out of a total sample of 20 residents.</p> <p>Specifically, for Resident #65 the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. That a plan of care was developed for his/her AV (arterio-venous) Fistula (dialysis access site). 2. That emergency supplies were at the bedside in accordance with the physician's orders. <p>Findings Include:</p> <p>Review of facility policy titled Hemodialysis Access Care, revised November 2017, indicated: care of an AV Fistula includes but is not limited to checking the patency of the site at regular intervals by checking for bruit and thrill (to ensure blood flow through the access site), and monitoring the site for bleeding.</p> <p>Resident #65 was admitted to the facility in November 2023 with diagnoses that included end stage renal disease requiring hemodialysis and anemia.</p> <p>Review of Resident #65's most recent Minimum Data Set (MDS) Assessment, dated 1/9/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #65 is cognitively intact. The MDS assessment further indicated that Resident #65 received dialysis treatment.</p> <ol style="list-style-type: none"> 1. On 4/1/24 at 8:30 A.M. Resident #65 said that he/she received hemodialysis treatments three times a week. Resident #65 said that he/she has access in his/her chest through a catheter and through an AV Fistula in his/her left arm. Resident #65 said that at the current time he/she is receiving dialysis treatments through the AV Fistula. The surveyor observed both sites were present. <p>Review of Resident #65's active physician's orders failed to indicate an order to monitor the AV fistula access site.</p> <p>Review of Resident #65's dialysis care plan, revised 2/12/24, failed to indicate that Resident #65 has an AV fistula.</p> <p>Review of Resident #65's nursing progress notes from February 2024 through April 2024 failed to indicate any monitoring of left arm AV Fistula.</p> <p>During an interview on 4/2/24 at 2:05 P.M., Nurse #7 said that Resident #65 received dialysis through a chest wall catheter.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/24 at 2:26 P.M., DON #1 said that she would expect staff to assess an AV Fistula for bruit and thrill and for staff to know how Resident #65 receives dialysis treatments.</p> <p>During an interview on 4/3/24 at 8:16 A.M., the Dialysis Nurse said that Resident #65 received dialysis through a left arm AV Fistula.</p> <p>2. On 4/1/24 at 8:30 A.M., the surveyor observed there was no emergency kit at the bedside or observed anywhere in Resident #65's room.</p> <p>On 4/2/24 at 7:53 A.M., the surveyor did not observe an emergency kit at Resident #65's bedside or in Resident #65's room.</p> <p>Review of Resident #65's physician's orders, dated 2/12/24, indicated: emergency kit on wall, if bleeding occurs use [NAME] clamp, apply pressure and call 911.</p> <p>Review of Resident #65's dialysis care plan, revised 2/12/24, indicated: maintain emergency kit at bedside.</p> <p>During an interview on 4/2/24 at 2:05 P.M., Nurse #7 said there should be an emergency kit at the bedside in the event of bleeding from Resident #65's dialysis access. Nurse #7 checked Resident #65's room and said that there was no emergency kit present.</p> <p>During an interview on 4/2/24 at 2:26 P.M., the Director of Nurses #1 (DON) said that Resident #65 should have an emergency kit in his/her room. DON #1 checked Resident #65's room and said that there was no emergency kit present.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>49880</p> <p>Based on Record review and interviews the facility failed to act upon irregularities identified in the pharmacist's Medication Regimen Review (MRR) for one Resident (#76) out of a sample of 20 residents.</p> <p>Findings include:</p> <p>Resident #76 was admitted to the facility in March 2024 with diagnoses that included end stage renal disease, anxiety and left leg above the knee amputation.</p> <p>Review of Resident #76 most recent Minimum Data Set (MDS) assessment, dated 3/10/24, indicated he/she was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff as being severely cognitively impaired.</p> <p>Review of Resident #76's physician's orders, dated 3/19/24, indicated Ativan (a psychotropic medication used to treat anxiety) 0.5 milligrams every four hours as needed.</p> <p>Review of Resident #76's medical record indicated a pharmacist recommendation dated 3/18/24 with the following recommendation regarding physician's orders for Ativan as needed: PRN [as needed] orders for psychotropic medications are limited to 14 days. If the prescribing practitioner believes it is appropriate for the PRN order to be extended beyond the 14 days, they must document their rationale in the resident's medical record and indicate the duration for the PRN order and give order for a specific stop date. PRN orders cannot be open ended. The physician/ prescriber response was to agree with the recommendations, signed and dated 3/26/24.</p> <p>Review of physician's orders failed to indicate that nursing staff followed through with the pharmacist's recommendations in the MRR after the practitioner agreed to the recommendation.</p> <p>Review of the most recent practitioner progress note, dated 3/21/24, indicated that the Ativan order should have a 14 day stop date.</p> <p>During an interview on 4/2/24 at 2:23 P.M., the Director of Nursing #1 (DON) said that she would expect that the recommendations from the pharmacist's MRR were followed.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>49880</p> <p>Based on record review and interviews the facility failed to ensure that PRN [as needed] ordered psychotropic drugs were limited to 14 days for one Resident (#76) out of a total sample of 20 residents. Specifically, for Resident #76 the facility failed to ensure a 14 day stop date for a PRN Ativan (a psychotropic medication used to treat anxiety) order.</p> <p>Findings Include:</p> <p>Resident #76 was admitted to the facility in March 2024 with diagnoses that included end stage renal disease, anxiety and left leg above the knee amputation.</p> <p>Review of Resident #76 most recent Minimum Data Set (MDS) assessment, dated 3/10/24, indicated he/she was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff as being severely cognitively impaired.</p> <p>Review of Resident #76's physician's orders, dated 3/19/24, indicated: Ativan 0.5 milligrams every four hours as needed. The Ativan order failed to indicate a stop date for the medication.</p> <p>Review of Resident #76's March and April 2024 Medication Administration Record indicated that PRN Ativan had been administered on 3/22/24.</p> <p>During an interview on 4/2/24 at 2:23 P.M., the Director of Nursing #1 (DON) said that she would expect that a PRN order for Ativan would have a 14 day stop date and then be re-evaluated.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48990</p> <p>Based on observations, interviews, and policy review, the facility failed to ensure staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically,</p> <ol style="list-style-type: none"> 1. The facility failed to properly secure medications and medication carts on two of four units. 2. The facility failed to ensure medications were labeled and stored according to manufacturer's guidelines in two of four medication carts. <p>Findings include:</p> <p>Review of facility policy titled Storage of Medications, revised 1/2024, indicated:</p> <ul style="list-style-type: none"> -The facility shall store drugs and biologicals in a safe, secure, and orderly manner. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use. <p>1.) The surveyor made the following observations of medication carts left unlocked, unattended, and out of line of vision:</p> <ul style="list-style-type: none"> -On 4/1/24 at 8:39 A.M., the surveyor observed the second floor medication cart #2 unlocked and unattended. Nurse #5 said medication carts should be locked when unattended. -On 4/2/24 at 8:47 A.M. to 8:52 A.M., Nurse #1 left medication cart unlocked while she was in a resident's room. Nurse #1 said medication carts should be locked when unattended. -On 4/3/24 at 8:15 A.M., the surveyor observed the second floor medication cart #1 unlocked and unattended. Nurse #8 said medication carts should be locked when unattended. <p>During an interview on 4/3/24 at 8:46 A.M., the Director of Nursing (DON) said medication carts should be locked when unattended.</p> <p>2a.) During medication administration pass, on 4/2/24, with Nurse #1 assigned to the second floor medication cart #1, the surveyor observed the following:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-At 8:41 A.M., Nurse #1 removed an unlabeled, undated inhaler that was in vital sign machine, which was stored in the hallway. The inhaler was not in a box. This inhaler has 54 doses remaining. Nurse #1 said she was not sure who's inhaler it was. Nurse #1 said she did not put the inhaler in the vital sign machine and that it should not be in the vital sign machine.</p> <p>-At 8:43 A.M., Nurse #1 placed the inhaler on the top of the medication cart #1 and walked down the hall and around the corner, out of her line of vision.</p> <p>-From 8:47 A.M., Nurse #1 left medication cart again with the inhaler left on top of medication cart #1 and was in a resident's room. The inhaler was not within Nurse #1's line of vision.</p> <p>During an interview on 4/2/24 at 8:52 A.M., Nurse #1 said the inhaler should have been locked in the medication drawer, instead of on top of the medication cart.</p> <p>During an interview on 4/3/24 at 8:46 A.M., Director of Nursing (DON) #2 said inhalers should be labeled with the resident name, the date opened, and stored in the manufacturer box. DON #2 said inhalers should always be locked in the medication cart.</p> <p>43846</p> <p>2b. On 4/2/24 at 1:21 P.M., the surveyor observed the following in the A Unit Medication Cart:</p> <ul style="list-style-type: none"> - one Combivent inhaler, opened and undated. - one Albuterol inhaler, opened and undated. - one Ventolin inhaler, opened and undated. - one Fluticasone Propionate inhaler, opened and undated. - one Spiriva inhaler, opened and undated. - one Solostar Lantus insulin pen, opened and undated. <p>During an interview and observation on 4/2/24 at 1:22 P.M., Nurse #9 said inhalers and insulin should be dated when they are opened by the nurse and were not.</p> <p>During an interview on 4/3/24 at 8:46 A.M., Director of Nursing #2 said inhalers should be labeled with the resident name, the date opened, and stored in the manufacturer box.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41456</p> <p>Based on observation, policy review, and interview, the facility failed to store and prepare food in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Food and Supply Storage, dated June 2018, indicated the following:</p> <ul style="list-style-type: none"> - Food, non-food items, and supplies used in food preparation and service shall be stored in such a manner as to maintain safety and sanitation of food or supply for human consumption as outlined in the Federal Drug Administration Food Code, state regulations, and city county/health codes. - Discard food that exceeds their use by date or expiration date, is damaged, is spoiled, has the time and temperature danger zone requirements, or incorrectly stored such that it is unsafe or its safety is uncertain. <p>During an initial tour of the kitchen on 4/1/24 at 7:05 A.M., the following was observed:</p> <ul style="list-style-type: none"> *A container of cool whip that was opened and undated. The Top of the container was not fully secured and was loosely on the container. *A container of coleslaw with a discard date of 3/27/24. *A container of tuna salad with a discard date of 3/31/24. *A container of cold cuts, undated. *A prepared salad, undated. *Three slices of pizza wrapped in tin foil, undated. <p>During an observation and interview on 4/2/24 at 11:11 A.M., the surveyor perceived a strong musty odor in the basement food storage area. The surveyor observed a white wispy substance consistent with mold and standing water in the bottom of a chest refrigerator containing multiple cases of milk. The surveyor observed two dented cans in the basement food storage area. The Regional Food Service Director said she would expect staff to notify management if the chest refrigerator needs to be drained and cleaned whenever staff use the refrigerator, and that staff use the refrigerator on a regular basis. The Regional Food Service Director said she was not notified but that the refrigerator needs to be drained and cleaned. The Regional Food Service Director said cans will be inspected when they are received, and any dented cans will be set aside in the office to be returned to the vendor. The Regional Food Service Director also said that cans will be checked before they are brought upstairs to the kitchen on the can rack to be used for cooking.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Melrose Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 40 Martin Street Melrose, MA 02176	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 4/2/24 at 11:22 A.M., the surveyor observed two significantly dented cans of chili con carne stored on the can rack in the kitchen. The Regional Food Service Director said the two cans are dented and should have been set aside to be returned, not stored on the can rack.		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, record reviews, policy review and interviews, the facility failed to maintain accurate medical records for three Residents (#31, #13, and #76) out of a total sample of 20 Residents. Specifically: 1) For Resident #31, the facility inaccurately documented the Resident had been transferred out of bed. 2) For Resident #13, the facility documented a daily wound dressing as completed, when it was not completed according to the physician's order for five days; and 3) For Resident #76 the facility failed to accurately document skin assessments on the weekly skin evaluation.</p> <p>Findings include:</p> <p>1. Resident #31 was admitted to the facility in February 2024 with diagnoses including stroke with paralysis on right side and abnormalities of gait and mobility.</p> <p>Review of Resident #31's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15, which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #31 required maximal assistance from staff for bed mobility tasks.</p> <p>On 4/1/24 and 4/2/24, Resident #31 was observed in bed throughout the 7:00 A.M. to 3:00 P.M. shift.</p> <p>During an interview on 4/2/24 at 11:40 A.M., Certified Nursing Assistant (CNA) #1 said Resident #1 stays in bed for safety reasons and the staff do not transfer him/her out of bed.</p> <p>Review of the document titled, Documentation Survey Report, dated April 2024, indicated the CNAs documented Resident #31 had been transferred out of bed on 4/1/24 and 4/2/24 during the 7:00 A.M. to 3:00 P.M. shift.</p> <p>During an interview on 4/2/24 at 1:48 P.M., Director of Nursing #1 said the CNAs should not document an activity that did not occur.</p> <p>48990</p> <p>2. Resident #13 was admitted to the facility in December 2022 with diagnoses including peripheral vascular disease and obesity.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/21/24, indicated that Resident #13 had moderate cognitive impairment evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. This MDS indicated Resident #13 had an open lesion on his/her foot.</p> <p>On 4/1/24 at 8:06 A.M., the surveyor observed Resident #13 lying in bed. Resident #13 said, the nurses don't change my foot dressing very often. Resident #13 had a dressing on his/her right foot, dated 3/27/24.</p> <p>Review of the Resident #13's physician's order, 3/12/24, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Clean right distal plantar lateral foot with normal saline, apply A & D ointment, then cover with dry dressing, change daily and PRN.</p> <p>Review of the Treatment Administration Record (TAR), dated 3/27/24, 3/28/24, 3/29/24, 3/30/24, and 3/31/24, indicated physician's treatment order was documented as completed to Resident #13's ankle.</p> <p>During an interview on 4/1/24 at 8:52 A.M., the surveyor and Nurse #2 observed Resident #13 lying in bed with a dressing on his/her right foot dated 3/27/24. Nurse #2 said the dressing was not changed since 3/27/24; five days before the observation. Nurse #2 said that Resident #13's right foot dressing is ordered to be changed daily and wound dressings should be changed at the frequency the physician ordered. Nurse #2 said if a dressing change is not completed than it should not be documented as completed on the TAR.</p> <p>During an interview on 4/3/24 at 8:46 A.M., Director of Nursing (DON) #2 said dressings should be changed at the frequency the physician ordered. DON #2 said if a dressing change is not completed than it should not be documented as completed on the TAR.</p> <p>49880</p> <p>3. Review of facility policy titled Prevention of Pressure Ulcer/ Injuries, dated November 2017, indicated to conduct a comprehensive skin assessment upon admission and to inspect the skin on a daily basis when performing or assisting with personal care.</p> <p>Resident #76 was admitted to the facility in March 2024 with diagnoses that included end stage renal disease and left leg above the knee amputation.</p> <p>Review of Resident #76 most recent Minimum Data Set (MDS) assessment, dated 3/10/24, indicated he/she was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff as being severely cognitively impaired. The MDS assessment further indicated that Resident #76 had one or more unhealed pressure injuries and is at risk for further pressure injuries. The MDS indicated that Resident #76 has one stage 2 pressure injury (a shallow, open wound that has broken through both the top and bottom layers of the skin) that was present on admission, and that Resident #76 has a surgical wound.</p> <p>Review of Resident #76's admission skin evaluation, dated 3/5/24, indicated that Resident #76 had a pressure area to the right heel and non-pressure areas to the left knee surgical site with staples, right buttock, and a right knee scabbed area.</p> <p>Review of weekly skin evaluations indicated the following:</p> <ul style="list-style-type: none"> -On 3/11/24 Resident #76 had a stage IV pressure ulcer (an opening in the skin extending into the muscle, tendon, ligament, cartilage or even bone) to his/her coccyx and a right heel pressure ulcer, -On 3/18/24 Resident #76 had a stage IV pressure ulcer to his/her coccyx, a right heel pressure ulcer and a right heel scabbed wound. -On 3/25/24 Resident #76 had no skin areas; skin was documented as clean and intact. <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 4/1/24 Resident #76 had a right heel scab with surrounding non blanchable area, and a sacrum stage 2 pressure ulcer.</p> <p>Review of Resident #76's skin care plan dated 3/5/24, indicated actual alterations in skin integrity: left thigh surgical site, right buttock denuded area (loss of the top layer of skin), stage 2 right heel, and surgical wound left above the knee amputation.</p> <p>Review of Resident #76 progress notes since admission failed to indicate documentation on the condition of Resident #76's coccyx wound, sacrum wound or right heel wound.</p> <p>During an interview and observation on 4/3/24 at 8:01 A.M., the Director of Nurses #1 (DON) and surveyor reviewed the weekly skin evaluations with DON #1, and the DON said that the evaluations were inaccurate as Resident #4 never had a stage 4 pressure ulcer on his/her buttocks.</p>