STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225332	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Newburyport	180 Low Street Newburyport, MA 01950

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49880 Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) Assessments were accurately completed to reflect the status of one Resident (#25) out of a total sample of 27 residents. Specifically, the facility failed to document that Resident #25 is receiving antipsychotic medication. Findings Include: Resident #25 was admitted to the facility in September 2022 with diagnoses that include Major Depressive Disorder and Anxiety Disorder. Review of Resident #25's most recent Minimum Data Set (MDS) Assessment, dated 8/16/24, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating that Resident #25 has moderate cognitive impairment. The MDS failed to indicate receiving antipsychotic medication. Review of Resident #25's physician's orders indicated the following order dated 7/18/24: -Abilify (an antipsychotic medication) oral tablet 5 milligrams (mg) by mouth one time a day for mood depression. Review of Resident #25's August 2024 Medication Administration Record (MAR) indicated that the Resident received abilify once daily from 8/1/24 through 8/31/24. Review of Resident #52's plan of care dated as initiated 7/18/24 indicated that the Resident uses antipsychotic medications related to behavior management. Review of Resident #25's Psychiatric Evaluation and Consultation, dated 7/18/24, indicated he/she will start abilify tomorrow. Monitor for any adverse reactions of this antipsychotic. During an interview on 10/9/24 at 11:38 A.M., the MDS Nurse reviewed Resident #25's medical record and said that the MDS is coded incorrectly because the Resident has been receiving antipsychotic medication since July.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to develop a comprehensive person-centered care plan for two Residents (#36 and #18) out of a sample of 27 residents. Specifically, 1(a) For Resident #36, the facility failed to develop comprehensive person-centered care plans for a history of alcohol abuse and, (b) a history of suicidal ideation. 2. For Resident #18, the facility failed to develop a comprehensive person-centered care plan for a history of alcohol abuse on admission. Findings include: Review of the facility policy titled 'Care Plan-Comprehensive' with a revision date of October 2022 indicated the following: -A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -The Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 1 (a) Resident #36 was admitted to the facility in February 2023 with diagnoses including major depressive disorder and anxiety disorder. Review of the Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating that Resident #36 is cognitively intact. Review of Resident #36's Admission Social History Evaluation, dated 2/8/23, indicated the following: -D. Smoking/Alcohol use Does the resident use any of the following (check all that apply): Alcohol-checked off. Does not currently use but has a known history of use-checked off. Review of the behavioral health group therapy progress notes, dated 4/30/24, indicated the following: -Substance Abuse/Addiction History: ETOH (alcohol) per chart-not currently. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the behavioral health group medication management progress notes dated 4/10/24 indicated the following: -Substance Abuse/Addiction History: ETOH (alcohol) per chart-not currently. A review of Resident #36's care plan failed to indicate that a comprehensive person-centered care plan was in place for a history of alcohol abuse. During an interview on 10/9/24 at 11:12 A.M., Resident #36 denied he/she has a history of alcohol abuse. During an interview on 10/9/24 at 4:51 P.M., Social Worker (SW) #1 said she would not be expected to develop a personalized care plan for Resident #36 because the history was not identified in his/her hospital discharge paperwork. During an interview on 10/9/24 at 6:02 P.M., the Regional Director of Clinical said Resident #36 does not need a personalized history of alcohol abuse care plan because he/she does not have a documented diagnosis of alcohol abuse. During a telephone interview on 10/11/24 at 1:34 P.M., Licensed Clinical Social Worker (LCSW) #2 said some residents with a history of alcohol abuse are very forthcoming with their alcohol abuse history, however, some of them are very cautious and will not reveal their alcohol abuse history easily. She said this could be based on first impressions, approach and how much rapport the person inquiring about the alcohol abuse history has with the Resident. LCSW #2 said residents with a history of alcohol abuse can be sober for years, but they can get triggered to start drinking alcohol again based on their mood at any point in time, therefore a personalized plan of care should be in place. (b) Resident #36 was admitted to the facility in February 2023 with diagnoses including major depressive disorder and anxiety disorder. Review of the Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating that Resident #36 is cognitively intact. Review of the hospital discharge clinical paperwork that accompanied Resident #36 at admission, dated 7/29/22, indicated the following: -[NAME] suicide severity/suicide rating scale: Wish to be dead (past month)-Yes Suicidal thoughts (past month)-Yes Suicidal thoughts with method without plan (past month)-Yes Review of the Resident #36's care plan failed to indicate that a comprehensive person- centered care plan was in place for a history of suicidal ideation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and chart review on 10/9/24 at 4:51 P.M., SW #1 and the Surveyor reviewed the clinical paperwork. SW #1 said she would not be expected to develop personalized care plans identifying Resident #36's history of suicidal ideation because the Resident eventually denied making those suicidal ideation statements. During an interview on 10/9/24 at 6:02 P.M., the Regional Director of clinical said Resident #36 did not need a personalized history of suicidal ideation care plan because the statements were a history and not happening in the present moment. During a telephone interview on 10/11/24 at 1:34 P.M., LCSW #2 said residents with a history of suicidal ideation can be re-triggered to have further suicidal ideations based on their mood at any point in time therefore a personalized plan of care should be in place. 2. Resident #18 was admitted to the facility in August 2024 with diagnoses including alcohol dependence with withdrawal delirium and cognitive communication deficit. Review of the Minimum Data Set (MDS) Assessment, dated 8/5/24, did not indicate a Brief Interview for Mental Status (BIMS) score. Review of Resident #18's care plan indicated a substance abuse care plan was initiated on 10/9/24. During an interview on 10/10/24 at 9:47 A.M., SW #1 said Resident #18 did not have a personalized substance abuse care plan, so she developed it on 10/9/24.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, interview, and record review, the facility failed to meet professional standards of quality for one Resident (#52), out of a total sample of 27 residents. Specifically for Resident #52, the facility failed to assess the diet texture for Resident #52 after swallowing incident. Findings include: Resident #52 was admitted to the facility in October 2021 with diagnoses including major depressive disorder, diabetes, traumatic brain injury, and vitamin D deficiency. In June 2023, Resident #52 was diagnosed with dysphagia (difficulty chewing and swallowing). Review of the most recent Minimum Data Set (MDS) assessment, dated 9/24/24, indicated Resident #52 had a Brief Interview for Mental Status (BIMS) exam score of 3 out of a possible 15, which indicated he/she had severely impaired cognition. The MDS further indicated Resident #52 requires partial/moderate physical assistance with eating and is on a therapeutic diet. Review of Resident #52's medical record indicated he/she choked while eating chicken in July 2022, requiring the Heimlich maneuver (a first aid procedure to treat airway obstructions by a foreign object) and, at that time, physician orders were obtained to downgrade the Resident's diet to a Mechanical Soft Diet (an altered textured diet for individuals with difficulty chewing and swallowing). Further review of the medial record indicated a second choking incident that occurred in July 2023, resulting in Resident #52 being transferred to the hospital, and a third swallowing incident that occurred in August 2024. Review of Resident #52's Speech Therapy Discharge Summary dated 2/2/24 indicated the following recommendations: -Mechanical soft, thin liquids. To facilitate safety and efficiency, it is recommended the patient use the following strategies during oral intake: bolus size modifications including taking small bites. Review of Resident #52's Occupational Therapy Discharge Summary dated 1/24/24 indicated the following recommendations: -Patient is SU (set-up) and supervision for self-feeding. Supervision or touching assistance. -Assistance with ADL's. Dining / Swallowing Program. -Staff trained and 100% compliant with pt (patient) self-feeding supervised and SU. Review of Resident #52's Nurse Practitioner note dated 8/16/24, indicated: -Reason for appointment - Swallowing Issue. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Being seen today related to nursing with reports of pt with trouble swallowing during his/her lunch. Upon encounter pt is sitting upright in wheelchair in the day room, awake and alert in NAD, pleasantly conversant. Pt verbalizes he/she was eating too fast and pasta got stuck in his/her throat. Currently denies any issues swallowing. Treatment: Choking sensation. Monitor for new or worsening s/sx (signs and symptoms). Speech therapy follow up, nursing aware. Review of Resident #52's Dietician Nutritional assessment dated [DATE], indicated: Regular diet, mechanical soft, thin liquids. recent choking sensation eating pasta noted, NP aware. Eating skills: Independent with set up, Supervision, Limited Assist and eating devices - lipped plate, sippy cup. -New/recent indications or complaints: Constipation, Swallowing. Review of Resident #52's Activities of Daily Living Care Plan last revised on 5/20/24, indicated the following: -Eating: Requires feeding assist at times, cueing. Lip Plate and sippy cups with meals. Cut up food to bite size, No bread products. -Supervision/touching. Review of the nutritional risk care plan dated 10/25/21 indicated the following interventions: - Increase initiation cues to help promote independence. Dated 10/27/23. -Resident to use lip plate and sippy cups to promote independence. Revised 2/16/24. -Supervised with meals. Dated 10/27/23. Review of the facility nutritional care manual indicate the following: Dental Soft (Mechanical Soft) Diet. This consistency modified diet is for individuals with limited or difficulty in chewing regular textured foods. This diet follows the Regular Diet planned and provides foods that can be easily chewed. The diet consists of food of nearly regular textures but eliminates very hard, sticky, crunchy or hard to chew foods. Foods should be moist and fork tender. This diet may also be used by a Speech Language Pathologist (SLP) in the treatment of dysphagia with individualization per recommendations by the SLP. This diet may be used for those experiencing mouth irritation and dentition problems including lack of teeth or poor fitting dentures. Individualization for specific food tolerances is required. For individuals that have any swallowing problems or dysphagia, it is recommended that a SLP be consulted and one of the Dysphagia Level Diets may need to be implemented. The diet consists of food of nearly regular textures but excludes very hard, sticky, crunchy or hard to chew foods. Foods should be moist and fork tender. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dry, hard crusty breads are excluded. Popcorn; dry, hard crusty breads. Breads, cereals and crackers with nuts or seeds; dried fruits; granola Nuts, pretzels, snack chips, potato chips; chewy candy (caramels, licorice). Review of Resident #52's active physician orders indicated the following: -Regular diet Mechanical soft with Ground meat texture, Thin Liquids consistency. Dated 2/29/24. - Diet Recommendations: 3 sippy cups with lids on her tray with meals. Dated 1/11/24. - pt (patient) issued lip plate with meals. Dated 10/3/23. Review of the medical record failed to indicate Resident #52 was assessed by speech therapy after Resident #52 had a swallowing incident as documented by the Nurse Practitioner on 8/16/24. On 10/8/24 at 8:20 A.M., the surveyor observed Resident #52 sitting in the dining room, in a wheelchair leaning forward with his/her head down on the table sleeping. There were no staff present. On 10/8/24 at 8:28 A.M., the surveyor observed Resident #52 sitting in the dining room eating whole French toast, oatmeal, and yogurt. Two sippy cups without lids were observed on the breakfast tray. The Resident was observed drinking from one sippy cup containing red liquid. The sippy cup did not have a lid. There were no staff members assisting or supervising the Resident during the meal. The Resident was observed placing a large piece of French toast into his/her mouth. The Resident began to choke and was leaning forward in his/her wheelchair. The Resident's facial color turned red, and the Resident could be heard making gargling and coughing sounds. Two staff members could hear the sounds from the nurses' station, and both came over to check on the Resident. The Resident continued to lean forward and was able to expectorate the French toast from his/her mouth. The Resident could be heard saying I choke a lot all the time to a staff member as the staff member assisted Resident #52 back to the table. The surveyor observed Nurse #1 checking the oxygenation saturation of the Resident and said to the Resident 98% you're good. On 10/8/24 at 12:12 P.M., the surveyor observed Resident #52 sitting in the dining room eating lunch. The Resident was observed eating a large square piece of corn bread. One large white Styrofoam cup was filled with dark soda. There was no lid on the cup. Resident #52 was observed drinking from the Styrofoam cup throughout the lunch meal. There were no sippy cups on the lunch tray. There was one staff member sitting at another table with their back to Resident #52. There were no staff proving supervision or cueing throughout the lunch meal. On 10/9/24 at 8:16 A.M., the surveyor observed Resident #52 sitting in the dining room eating breakfast. The Speech Language Pathologist (SLP) was present. The Resident had two whole slices of toast, eggs and soda on the breakfast tray. Throughout the observation Resident #52 did not eat his/her toast with the SLP present. On 10/9/24 at 12:14 P.M., the surveyor observed Resident #52 sitting in the dining room eating lunch. The lunch tray contained a large whole bread roll. There was one sippy cup on the lunch tray containing a red liquid. The sippy cup did not have a lid. There were two staff members providing feeding assistance to other Residents in the dining room. There were no staff providing supervision or cueing throughout the lunch meal. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 5:26 P.M., the surveyor observed Resident #52 sitting in the dining room eating dinner. The dinner tray contained one ground chicken sandwich cut in half and several whole orange cheese curls. The surveyor observed the Director of Nursing stop a staff member from placing covers on to two sippy cups. The DON said, she doesn't need a lid and the DON removed the lid off one of the sippy cups. The surveyor observed loose ice cubes inside the sippy cup. The surveyor observed Resident #52 drinking from the sippy cup and two ice cubes could be seen inside of the Residents mouth as he/she kept opening and closing his/her mouth moving the ice around. The DON was observed to be standing behind the Resident during this observation. There were no staff proving supervision or cueing throughout the lunch meal. During an interview on 10/09/24 at 12:24 P.M., Certified Nursing Assistant (CNA) #1 said Resident #52 needs sippy cups with handles because he/she shakes and said the Resident can have bread because it's soft. CNA # 1 said staff will check the Kardex to know how to care for the Resident and to check for eating issues or concerns. During an interview on 10/9/24 at 12:45 P.M., Nurse #2 said Resident #52 eats too fast and needs to slow down so he/she doesn't choke because he/she does this kind of thing often. Nurse #2 said Resident #52 is on a mechanical soft diet because he/she had swallowing issues in the past and said the Resident needs supervision with eating. Nurse #2 said the Resident has a care plan in place for diet needs and it is expected to be followed. During an interview on 10/09/24 at 5:38 P.M., The DON said Resident #52 needs a sippy cup with lids and handles and requires a mechanical soft diet. The DON said Residents who need supervision during meals need to be in the communal dining room and not eating alone. The DON said Resident #52 requires supervision and cueing throughout the meal to slow down his/her pace while eating. During an interview on 10/09/24 at 5:38 P.M., with the Administrator, Regional Clinical Director and the Director of Nursing (DON), The DON said Resident #52 requires supervision and cueing during meals and needs sippy cups with lids. The DON said Resident #52 should not have received bread products prior to the speech evaluation and said she removed the no bread products from the care plan after Resident #52 was evaluated by the speech therapist. The DON said the Resident should not have cheese curls without being evaluated by the speech therapist first. The DON said the Resident has no prior issues with swallowing or choking on food items and said the no bread products should have been removed from the care plan last year, but it was not. The Regional Clinical Director said, the no bread products are erroneous on the care plan and said the correct diet order is the physician order and said the Resident can have bread products. The Regional Clinical Director said she is not aware of any prior history of choking here at the facility, does not have swallowing issues and is not at risk for aspiration. The Regional Clinical Director said there is no reason Resident #52 can't have whole ice because ice melts into thin liquids and the Resident can drink thin liquids. The Administrator said he is not aware of any choking or swallowing issues related to Resident #52. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 7:18 A.M. the Speech Therapist (ST) said she evaluated Resident #52 yesterday morning after she was notified of the choking incident at breakfast. The ST said Resident #52 is on a mechanical soft diet that includes meat that is ground up, nothing sticky or difficult to chew and said she did not implement or alter any care plans at this time. The ST said mechanical soft diet does include soft breads and said she was not aware that the care plan indicated no bread products and was not aware of any history of choking or prior swallowing concerns. The ST said Resident #52 did not want to eat the toast yesterday morning and she did not see the Resident eat any bread products. The ST said Resident #52 should not be eating cheese curls without being assessed first and said Resident #52 requires supervision and cueing during meals and the use of sippy cups with handles to assist with holding the cup. The ST said Resident #52 needs reminders to slow down and to take small bites and said whole chunks of ice would not be a concern because the Resident has no history of aspirating or choking prior to yesterday. During a follow up interview on 10/10/24 at 7:41 A.M., the DON said the Resident was placed on a mechanical soft diet after she was admitted to the hospital for pneumonia and said a prior diet order for ground meat with no bread products was dated 8/11/23 due to an issue of choking at the hospital. The DON said the care plan should have been updated in January 2024, but it was not. The DON said she was not aware that the Resident had an issue while swallowing pasta in August and said Resident #52 should have been evaluated by speech therapy. During an interview on 10/10/24 at 9:32 A.M., the Dietician said Resident #52 requires supervision and cueing and must be supervised while eating due to his/her history of choking. The Dietician said she was notified by nursing staff of a choking incident in August while eating pasta and said she was also notified by the Occupational Therapist. The dietician said she would expect the Resident to be evaluated by speech therapy. During an interview on 10/10/24 at 10:23 A.M., the DOR said she is also an Occupational Therapist, is not familiar with the Resident and said Resident #52 was not evaluated after 2/2/24. The DOR said the resident is currently on a mechanical soft diet. The DOR said she does not recall an incident in August regarding an issue while eating pasta.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, record review, and interviews, the facility failed to provide supervision with meals for two Residents, (#34 and #52) out of a total sample of 27 residents. Findings include: Review of the facility policy titled Activities of Daily Living (ADL) Supporting, dated as revised June 2022, indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 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: D. dining (meals and snacks). 1. Resident #34 was admitted to the facility in August 2021 with diagnoses including dysphagia, gastro esophageal reflux disease, hyperlipidemia, and vitamin D deficiency. Review of the Minimum Data Set (MDS) assessment, dated 7/26/24, indicated Resident #34 had a Brief Interview for Mental Status (BIMS) exam score of 3 out of a possible 15, which indicated he/she had severely impaired cognition. The MDS further indicated Resident #34 requires assistance with ADL care. On 10/8/24 at 8:42 A.M., the surveyor observed Resident #34 in bed, with their privacy curtain pulled halfway across the bed with his/her breakfast attempting to eat the meal. The Resident had eggs on his/her clothing and on the floor. The Resident was not visible from the hallway, no staff were present in the room throughout the breakfast meal. On 10/9/24 at 12:08 P.M., the surveyor observed Resident #34 in bed, with their privacy curtain pulled halfway across the bed with his/her lunch attempting to eat the meal. The Resident had food items on his/her clothing and on the floor. The Resident was not visible from the hallway, no staff were present in the room throughout the lunch meal. On 10/9/24 at 5:32 P.M., the surveyor observed Resident #34 in bed, with his/her dinner attempting to eat the meal. The Resident had chips and pieces of bread on his/her clothing and blankets. The Resident was not visible from the hallway, no staff were present in the room throughout the dinner meal. Review of Resident #34's Dietary care plan, last revised on 7/29/24, indicated: -Eating: Set up. Devices: Lip plate. -Setup -Supervision/Touching Review of Resident #34's dysphagia care plan, last revised on 7/29/24, indicated: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. -Monitor /report PRN (as needed) any s/sx (signs and symptoms) of difficulty swallowing; Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing. Refusing to eat, appears concerned during meals. Review of Resident #34's nutritional assessment dated [DATE], indicated independent with setup, supervision, adaptive eating devices used lip plate and built-up utensils. Review of the Dietician progress note dated 8/22/24, indicated the following: The resident requires supervision for feeding. The resident uses an adaptive feeding device. Adaptive Feeding Device Type: lip plate and built-up utensils. Review of Resident #34's October 2024 Kardex (form indicating level of care needs) indicated the following: -Adaptive Equipment: Lip plate and built-up utensils. -Eating: Set up. -DEVICES: lip plate _X_ Setup _X_ Supervision/Touching -Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. Review of the medical record indicated Resident #34 had an Occupational Therapy evaluation completed on 12/1/23, indicating: -due to unwitnessed fall and s/s of dysphagia requiring slp (Speech Language Pathology) eval (evaluation) and rec (recommendation) for modified diet and general aspiration precautions and indicated the following: S/u (setup) for self-feeing with lip plate and built-up utensils. During an interview on 10/9/24 at 12:24 P.M., Certified Nursing Assistant (CNA) #1 said Resident #34 is a setup for meals but needs supervision and cueing to make sure he/she is eating. CNA #1 said staff follow the information on the Kardex to know each resident's level of care. During an interview on 10/9/24 at 12:45 P.M., Nurse #2 said Resident #34 is a feeder and requires supervision with eating and cannot eat alone. Nurse #2 said Resident #34 will try to feed him/herself but needs help to make sure he/she eats. During an interview on 10/09/24 at 12:38 P.M., the Director of Nursing (DON) said she expects the Kardex and care plan to be followed, and said Residents who need assistance with setup and supervision/touching assistance during meals should not be left alone while eating. The DON said Resident #34 requires supervision with meals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 9:48 A.M., the Dietician said Residents requiring setup/ supervision and touching assistance must be supervised while eating and not in their rooms unsupervised. The Dietician said Resident #34 requires supervision. During an interview on 10/10/24 at 10:23 A.M., the Director of Rehabilitation (DOR) said Residents' who require setup, supervision/touching assistance should not be eating alone in their rooms and require supervision while eating. 2. Resident #52 was admitted to the facility in October 2021 with diagnoses including major depressive disorder, diabetes, traumatic brain injury, and vitamin D deficiency. In June 2023, Resident #52 was diagnosed with dysphagia (difficulty chewing and swallowing). Review of the most recent Minimum Data Set (MDS) assessment, dated 9/24/24, indicated Resident #52 had a Brief Interview for Mental Status (BIMS) exam score of 3 out of a possible 15, which indicated he/she had severely impaired cognition. The MDS further indicated Resident #52 requires partial/moderate physical assistance with eating. On 10/8/24 at 8:28 A.M., the surveyor observed Resident #52 sitting in the dining room eating whole French toast, oatmeal, and yogurt. Two sippy cups without lids were observed on the breakfast tray. The Resident was observed drinking from one sippy cup containing red liquid. The sippy cup did not have a lid. There were no staff members assisting or supervising the Resident during the meal. The Resident was observed placing a large piece of French toast into his/her mouth. The Resident began to choke and was leaning forward in his/her wheelchair. The Resident's facial color turned red, and the Resident could be heard making gargling and coughing sounds. Two staff members could hear the sounds from the nurses' station, and both came over to check on the Resident. The Resident continued to lean forward and was able to expectorate the French toast from his/her mouth. The Resident could be heard saying I choke a lot all the time to a staff member as the staff member assisted Resident #52 back to the table. The surveyor observed Nurse #1 checking the oxygenation saturation of the Resident and said to the Resident 98% you're good. On 10/8/24 at 12:12 P.M., the surveyor observed Resident #52 sitting in the dining room eating lunch. The Resident was observed eating a large square piece of corn bread. One large white Styrofoam cup was filled with dark soda. There was no lid on the cup. Resident #52 was observed drinking from the Styrofoam cup throughout the lunch meal. There were no sippy cups on the lunch tray. There was one staff member sitting at another table with their back to Resident #52. There were no staff proving supervision or cueing throughout the lunch meal. On 10/9/24 at 12:14 P.M., the surveyor observed Resident #52 sitting in the dining room eating lunch. The lunch tray contained a large whole bread roll. There was one sippy cup on the lunch tray containing a red liquid. The sippy cup did not have a lid. There were two staff members proving feeding assistance to other Residents in the dining room. There were no staff proving supervision or cueing throughout the lunch meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 5:26 P.M., the surveyor observed Resident #52 sitting in the dining room eating dinner. The dinner tray contained one ground chicken sandwich cut in half and several whole orange cheese curls. The surveyor observed the Director of Nursing stop a staff member from placing covers on to two sippy cups. The DON said, she doesn't need a lid and the DON removed the lid off one of the sippy cups. The surveyor observed loose ice cubes inside the sippy cup. The surveyor observed Resident #52 drinking from the sippy cup and two ice cubes could be seen inside of the Residents mouth as he/she kept opening and closing his/her mouth moving the ice around. The DON was observed to be standing behind the Resident during this observation. There were no staff proving supervision or cueing throughout the lunch meal. Review of Resident #52's medical record indicated he/she choked while eating chicken in July 2022, requiring the Heimlich maneuver (a first aid procedure to treat airway obstructions by a foreign object) and, at that time, physician orders were obtained to downgrade the Resident's diet to a Mechanical Soft Diet (an altered textured diet for individuals with difficulty chewing and swallowing). Further review of the medial record indicated a second choking incident that occurred in July 2023, resulting in Resident #52 being transferred to the hospital, and a third swallowing incident that occurred in August 2024. Review of the Activities of Daily Living Care Plan dated 4/23/24 indicated the following: -Eating: Requires feeding assist at times, cueing. Lip Plate and sippy cups with meals. Cut up food to bite size, No bread products. Dated 4/23/23 -Supervision/touching. Dated 4/23/24. Review of the nutritional risk care plan dated 10/25/21 indicated the following interventions: - Increase initiation cues to help promote independence. Dated 10/27/23. -Resident to use lip plate and sippy cups to promote independence. Revised 2/16/24. -Supervised with meals. Dated 10/27/23. Review of Resident #52's nutritional assessment dated [DATE], indicated: Regular diet, mechanical soft, thin liquids. recent choking sensation eating pasta noted, NP aware. Eating skills: Independent with set up, Supervision, Limited Assist and eating devices - lipped plate, sippy cup. -New/recent indications or complaints: Constipation, Swallowing. Review of Resident #52's active physician orders indicated the following: -Regular diet Mechanical soft with Ground meat texture, Thin Liquids consistency. Dated 2/29/24. - Diet Recommendations: 3 sippy cups with lids on her tray with meals. Dated 1/11/24. - pt (patient) issued lip plate with meals. Dated 10/3/23. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/24 at 12:24 P.M., Certified Nursing Assistant (CNA) #1 said Resident #52 needs sippy cups with handles because he/she shakes and said the Resident can have bread because it's soft. CNA # 1 said staff will check the Kardex to know how to care for the Resident and to check for eating issues or concerns. During an interview on 10/9/24 at 12:45 P.M., Nurse #2 said Resident #52 eats too fast and needs to slow down so he/she doesn't choke because he/she does this kind of thing often. Nurse #2 said Resident #52 is on a mechanical soft diet because he/she had swallowing issues in the past and said the Resident needs supervision with eating. Nurse #2 said the Resident has a care plan in place for diet needs and it is expected to be followed. During an interview on 10/09/24 at 5:38 P.M., The DON said Resident #52 needs a sippy cup with lids and handles and requires a mechanical soft diet. The DON said Residents who need supervision during meals need to be in the communal dining room and not eating alone. The DON said Resident #52 requires supervision and cueing throughout the meal to slow down his/her pace while eating. During an interview on 10/10/24 at 7:18 A.M. the Speech Therapist (ST) said she evaluated Resident #52 yesterday morning after she was notified of the choking incident at breakfast. The ST said Resident #52 is on a mechanical soft diet that includes meat that is ground up, nothing sticky or difficult to chew and said she did not implement or alter any care plans at this time. The ST said Resident #52 needs reminders to slow down and to take small bites. During an interview on 10/10/24 at 9:32 A.M., the Dietician said Resident #52 requires supervision and cueing and must be supervised while eating due to his/her history of choking. The Dietician said she was notified by nursing staff of a choking incident in August while eating pasta and said she was also notified by the Occupational Therapist. The dietician said she would expect the Resident to be evaluated by speech therapy.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45763 Based on observation, record review, policy review and interview, the facility failed to provide adequate supervision for one Resident (#49) out of a total sample of 27 Residents, and ensure an environment free from accidents and hazards in two resident rooms. Specifically, the facility failed to: 1. Ensure that Resident #49 was not left unattended in the dining room, subsequently the Resident sustained a fall resulting in nasal fracture. 2. Properly store oxygen cylinders in an upright and firmly secured manner on two out of three units. Findings Include: Review of the facility policy titled Accidents and Incidents, revised October 2022, indicated, but was not limited to, the following: - An incident is any occurrence not consistent with the routine operation of the center, normal care of the resident, a happening involving visitors, malfunctioning equipment, or observation of a condition which might be a safety hazard. The occurrence may be a fall, skin tear, bruise, new pressure ulcer and may involve abuse, neglect, and mistreatment or an injury of unknown origin. - All incidents and accidents will be evaluated by the interdisciplinary team. - The team will review the investigation and continue, if necessary, discuss and determine from the investigation the root causes, make recommendations for additional intervention, education and conclude the investigation. (sic.) Resident #49 was admitted to the facility in February 2024 with a diagnosis of dementia. Review of the most recent Minimum Data Set (MDS) Assessment, dated 8/7/24, indicated that Resident #49 scored a 0 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairment. Further review of the MDS indicated the Resident was dependent on staff for all mobility, including sitting to standing and transferring. Review of the fall-unwitnessed report dated 4/7/24 indicated that Resident #49 had sustained an unwitnessed fall in the dining room, the Resident had fallen out of his/her wheelchair and sustained a skin tear on his/her left eyebrow and a hematoma. Further review of the incident report indicated that the Resident's plan of care was updated to not be left in the dining room area unattended, and that the Resident should be out to nursing station after meals. Review of the hospital paperwork dated 4/8/24, indicated Resident #49 had a laceration on his/her left eyelid with sutures in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #49's care plan indicated the Resident was at risk for falls related to confusion, gait/balance problems, incontinence, unaware of safety needs, anxiety, restlessness, and impulsivity with the following intervention: - Ensure Resident is out in common area after meals, do not leave in dining area unattended, initiated 4/15/24. Review of Resident #49's incident reports indicated the Resident had also sustained falls on 8/16/24, 8/17/24, and 9/3/24. Review of Resident #49's incident report dated 9/11/24 indicated that Resident #49 had sustained a fall on 9/7/24 at 9:40 A.M. The incident report indicated that the nurse responded to a noise and observed Resident #49 on the floor with an abrasion on his/her forehead and bleeding from the left nostril; the Resident was subsequently sent to the hospital for evaluation and returned to the facility on the same day with a diagnosis of nasal fracture. Further review of the incident report indicated that per the certified Nursing Aides (CNA's) witness statements that the Resident was last seen sleeping in his/her wheelchair while staff were collecting breakfast trays and putting them in the food truck located outside of the dining room area. Review of four out of four witnesses' statements, including one that was completed by CNA #3, indicated that the fall was not witnessed and that the fall had occurred in the dining room. Review of Resident #49's fall with head injury report, dated 9/7/24, indicated that the nurse had heard a bang in the dining room and observed the resident lying on the floor; the Resident was bleeding from a gash in the middle of his/her forehead and left nostril. Further review of the report indicated that the incident was not witnessed. Review of the staffing schedule, dated 9/7/24, indicated that CNA #3 was working on Resident #49's unit at the time of the fall. During an interview on 10/10/24 at 7:55 A.M., CNA #3 said that she was working on 9/7/24 when the fall had occurred. CNA #3 said that while she was picking up breakfast trays and taking them to the food trucks located near the nurse's station and at the end of the hall Resident #49 had fallen in the dining room. CNA #3 said that all staff had left the dining room and that no staff or visiting family members were within eyesight of the dining room or witnessed Resident #49 fall. CNA#3 said the Resident was at risk for falls due to his/her progressive decline and that the Resident should have been taken out of the dining room after he/she had finished eating as the Resident required supervision. Review of the hospital paperwork, dated 9/7/24, indicated that Resident #49 arrived to the emergency department after sustaining a fall. The hospital paperwork indicated that Family Member #3 arrived with the Resident and helped provide the story. The hospital paperwork indicated that the Resident was in a wheelchair, fell forward, and that this was witnessed by facility staff. Further review of the hospital paperwork indicated that the Resident had sustained an abrasion over the nose and forehead, and that a CT (computed tomography) scan showed a nasal fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/9/24 at 4:36 P.M., Family Member #3 said that Family member #2 had called her after being notified that Resident #49 had fallen. Family Member #3 said she had arrived to the facility before Resident #49 had left and had accompanied the Resident to the hospital. Family Member #3 said that she knew the Resident had fallen out of his/her chair in the dining room from speaking to Family Member #2 but had not spoken to staff about the fall and was unaware of any other details surrounding the fall. Family Member #3 said the hospital staff had asked her about the fall and that she did not know if staff were present at the time of the fall. Family Member #3 said that no family members were visiting the Resident at the time of the fall. During an interview on 10/9/24 at 1:45 P.M., Family Member #1 said that Family Member #2 was told by staff that Resident #49 had fallen in the dining room on 9/7/24 and that there were no staff present at the time of the fall, and that no staff witnessed the Resident fall. Family Member #2 said no family members were visiting at the time of the fall. During an interview on 10/9/24 at 2:01 P.M., Family Member #2 said she was initially contacted by the staff on 9/7/24 about Resident #49's fall and was told that the Resident fell while staff were picking up trays. During an interview on 10/10/24 at 9:23 A.M., Nurse #4 said that when a resident falls their care plan should be reviewed and updated with new interventions to prevent future falls. Nurse #4 said that the risk for not implementing a care plan created to prevent falls was injury or death and that she would expect the care plan to be implemented. Nurse #4 said Resident #49 was at high risk for falls due to dementia and incontinence and that the Resident had sustained injuries from previous falls; Nurse #4 said that Resident #49 should be near the nurse's station for supervision. During an interview on 10/10/24 at 9:56 A.M., the Director of Nursing (DON) said she wasn't in the building at the time of the fall but that based on the incident reports the fall on 9/7/24 was unwitnessed. The DON said the Resident should not be left in the dining room unattended. The DON said she would expect care plans created to prevent falls to be implemented. During a follow-up interview on 10/10/24 at 12:45 P.M. the DON said that the hospital paperwork from the 9/7/24 fall, which indicated the fall was witnessed by staff, was not accurate as the facility reports indicated the fall was unwitnessed. 49880 2a. Review of the National Fire Protection Association (NFPA) 99 section 11.6.2.3 (11) states that freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. During an observation on the first floor on 10/8/24 at 8:13 A.M. and 9:57 A.M., the surveyor observed two oxygen cylinders free standing in a resident room. The two oxygen cylinders were free standing without any chain, stand or cart supporting it. During the observation at 9:57 A.M., the Resident was up in his/her wheelchair and moving around the room. During an interview on 10/8/24 at 10:26 A.M., CNA #1 said that oxygen cylinders should be in a black carrier attached to a wheelchair or in a cart. He said they should not be just on the floor because they can fall over and explode or cause a fire. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/8/24 at 10:28 A.M., Nurse #1 said oxygen cylinders should be stored either in a black bag on the back of a wheelchair or in a metal rolling rack when in a resident's room. She said without proper storage it could fall over and potentially explode. Nurse #1 and the surveyor observed the two oxygen tanks in the resident's room, and she said they should absolutely not be stored like that. During an interview on 10/08/24 at 2:48 P.M., the Director of Nursing (DON) said oxygen cylinders should not be free standing on the floor and must be placed in the proper storage holders to prevent accidents or injuries. 48671 2b. During an observation on the second floor on 10/8/24 at 9:01 A.M. and 10:25 A.M., the surveyor observed one oxygen cylinder free standing in a resident room. The oxygen cylinder was free standing without any chain, stand or cart supporting it. During the observation at 9:01 A.M., the Resident was up and walking around the room. During an interview on 10/8/24 at 10:25 A.M., Certified Nursing Assistant (CNA) #4 said oxygen cylinders should not be on the floor in the room because they can fall over and explode. During an interview on 10/8/24 at 10:29 A.M., Nurse #2 said oxygen cylinders should not be stored directly on the floor because it is unsafe. Nurse #2 observed the oxygen cylinder with the surveyor and the oxygen cylinder was not empty. Nurse #2 said the oxygen cylinder should be placed in a holder and pointed to a metal oxygen cylinder container that was placed next to the oxygen cylinder. During an interview on 10/08/24 at 2:48 P.M., the Director of Nursing (DON) said oxygen cylinders should not be free standing on the floor and must be placed in the proper storage holders to prevent accidents or injuries.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48671 Based on interviews and record review, the facility failed to ensure that sufficient staffing levels were maintained to safely and adequately meet each resident's personal care needs. Finding include: Review of the facility assessment indicated the following: -Our Resident Profile: 111 number of beds. Average daily census 89-94 residents -Staffing Plan: 1 DON (Director of Nurses) RN (Registered Nurse) full-time days; ASST (Assistant Director of Nurses) RN full-time days; RN or LPN (Licensed Practical Nurse): 2 for each shift 2-3 RN/LPN per shift; per unit Direct Care Staff: 3-4 CNA per shift; per unit Registered Nurses & LP Nurses total number needed 18. Number of weekly Hours 1008. Certified Nursing Assistants total number needed 33. Number of weekly Hours 1848. -Individual staff assignment is based on staff competency and preference to the type of care they like to provide and have experience providing i.e. residents with advanced dementia vs. short term rehab patients. The facility strives to maintain consistent assignments to ensure continuity of resident and care giver relationships. Assignments are reassessed when residents or staff leave the facility to maintain person centered care. -All staffing is primarily based on the daily census on each unit. Each resident's preference for schedule, waking times, naps, bathing, bedtime, etc. is reflected in their individual plan of care. Out staffing patterns allow for these needs to be met on an individual basis. Staffing patterns are increased based on acuity and behavior i.e., a resident requires 1:1 attention for a period of time or there is a need for two staff members to handle a transfer, such as with a resident that requires a hoyer lift. During an interview on 10/10/24 at 1:31 P.M., The Scheduler said the facility is having a difficult time finding dependable staff and said the facility is below the budgeted hours. Review of the actual working schedules provided to the surveyor for the past 30 days, the facility failed to meet the appropriate staffing levels for 30 out of 30 days. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/10/24 at 1:21 P.M., The Administrator said he expects the facility to staff according to the regulation and said the budgeted hours per patient per day (HPPD) for the facility census is 3.58. The Administrator said staffing has been an issue in the facility and they are working on recruiting more staff.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on observations, record review and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when one out of two nurses observed made two errors out of 25 opportunities, resulting in a medication error rate of 8%. Those errors impacted one Resident (#52), out of two residents observed. Specifically, for Resident #52, Nurse #2 failed to administer the correct doses of his/her medications. Findings Include: Review of facility policy titled Medication Administration, dated as revised 10/2022 indicated the following: -3. Medications must be administered in accordance with the orders, including any required time frame. -6. The medications nurse shall assure that the correct medication is administered by checking the physician's order and the medication label. Review of facility policy titled Physician Orders, dated as revised 10/2022 indicated the following: -Medication orders will include: -c. dosage Resident #52 was admitted to the facility in October 2021 with diagnoses that include metabolic encephalopathy and altered mental status. Review Resident #52's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicating that the Resident has severe cognitive impairment. During the medication pass observation on 10/9/24 at 7:37 A.M., the surveyor observed Nurse #2 prepare and administer the following medications to Resident #52: -Simethicone 125 milligrams (mg) two tablets prepared and administered. -Cranberry Capsule 450 mg one capsule prepared and administered. Review of Resident #52's physician's orders indicated the following orders: -Cranberry tablet 300 mg give one tablet by mouth two times a day for prevention, dated 2/22/24. -Simethicone oral tablet 80 mg, give two tablets by mouth two times a day for complaints of increased ABD (abdominal) pain after eating, dated 5/31/24. (continued on next page)

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	225332	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Newburyport	180 Low Street Newburyport, MA 01950

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/2024 at 8:44 A.M., the surveyor and the Director of Nurses reviewed Resident #52's physician's orders and the over-the-counter medication bottles for simethicone and cranberry capsules present in the medication cart and the Director of Nurses said that the wrong doses were administered to Resident #52.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45763 Based on observation and interview the facility failed to store and handle food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure food was labeled in the main kitchen and on the unit kitchenettes and that staff did not contaminate ready to eat food during service. Findings include: Review of the facility's policy titled Food Storage (Dry, Refrigerated, and Frozen), dated 2020, indicated, but was not limited to, the following: - All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. - Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration. - Leftover contents of cans and prepared food will be stored in covered, labeled, and dated containers in refrigerators and/or freezers. Review of the facility's policy titled HACCP (Hazard Analysis Critical Control Point) and Food Safety, dated 2013, indicated, but was not limited to, the following: - Food borne illness (FBI) is an illness that is transmitted to humans through food. A hazard is a food product that may cause a health risk to customers. These hazards may be biological, chemical, or physical. Physical hazards may include: foreign objects such as metal, glass, plastic or wood. Cross contamination occurs when harmful substances are transferred from one source (i.e., hands, food contact surfaces, unsanitary cleaning cloths, raw foods) to the food. - Be aware of sources of food-borne organisms in food service: o Humans (nose and throat, hands, infections, feces, and clothing): poor personal hygiene; poor handwashing practices. - Pay special attention to individuals at risk for FBI: older adults, children, pregnant women, immune-compromised individuals, those who had recent surgery or have chronic illness. - The lead cause of FBI is improperly cooled foods, followed by: o Food not thoroughly heated or cooked. o Infected employees/poor personal hygiene. o Food prepared a day or more in advance of serving. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Raw, contaminated ingredients added to food. o Food left too long at temperatures that favor bacterial growth. o Failure to reheat food to temperatures to kill bacteria. o Cross contamination - cooked food by raw food, equipment not properly. cleaned/sanitized, mishandling of food by employees. During the initial walk-through of the kitchen on 10/8/24 at 7:07 A.M., the surveyor observed an open water bottle stored with resident food and ingredients in the reach-in refrigerator. The kitchen staff said it was his water bottle. On 10/8/24 at 7:23 A.M., the surveyor made the following observations in the refrigerator of the third-floor kitchenette: - A container of prepared soup, undated and unlabeled. - A yogurt with an expiration date of 9/10/24, there was also a date of 9/9/24 written on the lid in marker. - A container of soy milk, open but undated. On the outside of the third-floor refrigerator the surveyor observed a sign, titled Kitchenette Food Storage, which indicated the following: - Please label all items with the date opened before placing items in the refrigerator. - All resident food/drinks need to be labeled with name, room number and date. - If anything is past the expiration date or is not labeled it will be thrown out. On 10/8/24 at 7:28 A.M., the surveyor made the following observations in the refrigerator of the second-floor kitchenette: - A lunch bag containing food was stored next to resident food. During an interview on 10/8/24 at 7:29 A.M., Nurse #5 said that it was her lunch bag and that it should be stored downstairs and not in the resident food refrigerator. On 10/8/24 at 7:31 A.M., the surveyor made the following observations in the refrigerator of the first-floor kitchenette: - A pizza box containing three slices of pizza, undated and unlabeled. The surveyor made the following observations during a continuous observation on 10/9/24 from 7:47 A.M. until 7:58 A.M. during the breakfast tray line: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An open bag of hard-boiled eggs in the reach in refrigerator, undated. - The container used to store serving utensils had visible debris in the bottom of the container where utensils were being stored. - The cook contaminated his gloves by touching the handles of tongs and serving utensils, the reach-in refrigerator door and the outside of a pan containing a cooked omelet. The cook then, with the same contaminated gloves, grabbed the cooked omelet and put it on a plate and into the microwave; the omelet was then served to a resident. - The cook's name-badge, which was hanging from his neck, made direct contact with ready-to-eat scrambled eggs when the cook leaned over on three separate occasions. - The cook contaminated his gloves by touching the handles of serving utensils then, with the same contaminated glove, grabbed a ready-to-eat muffin and placed it on a resident plate to be served. During an interview on 10/9/24 at 9:39 A.M., the Food Service Director (FSD) said that food service staff were expected to check the kitchenette refrigerators three times a day to ensure that food was not past expiration dates, and that food and drinks were labeled; the FSD said all food and drinks should be labeled and dated when prepared or opened. The FSD said employees should not store their own food or drinks with resident food or ingredients as this poses a risk for cross contamination, and that there was a designated employee refrigerator. The FSD said nurse or family were expected to date and label food brought in from outside of the facility which would be discarded after two days. The FSD said staff should not use contaminated gloves to touch ready-to-eat food.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on record reviewed and interviews the facility failed to ensure nursing maintained an accurate medical record for one Resident (#49) out of a sample of 27 residents. Specifically, for Resident #49 nursing documented they obtained blood pressure from his/her left arm when they did not. Findings include: Review of the facility policy, titled Charting and Documentations, revised January 2023, indicated, but was not limited to, the following: - All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. Resident #49 was admitted to the facility in February 2024 with a diagnosis of dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #49 scored a 0 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Review of Resident #49's active physician orders indicated the following order: - No IVs (intravenous)/ blood draws/BP (blood pressure readings) on left arm, initiated 2/23/24. Review of Resident #49's blood pressure readings indicated nursing obtained his/her blood pressure on his/her left arm on the following dates: 6/15/24, 6/16/24, 6/17/24, 6/18/24, 6/19/24, 6/20/24, 6/21/24, 6/23/24, 6/28/24, 6/29/24, 7/1/24, 7/2/24, 7/4/24, 7/9/24, 7/10/24, 7/11/24, 8/17/24, 8/18/24, 9/7/24, and 10/9/24. During an interview on 10/10/24 at 7:23 A.M., Nurse #3 said Resident #49's left arm should not be used to take blood pressure readings as the Resident had a mastectomy in the past. During a follow-up interview on 10/10/24 at 9:34 A.M., Nurse #3 said she had taken the blood pressure reading on 10/9/24, and that she had used Resident #49's right arm and had documented left arm in error. During an interview on 10/10/24 at 9:56 A.M., The Director of Nursing (DON) said her expectation was that nurses accurately document which arm the blood pressure was taken from.