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	09/18/2025

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview the facility failed to ensure treatment and care was provided in accordance with professional standards of practice for one Resident (#87) out of a total sample of 21 residents. Specifically, for Resident #87 the facility failed to ensure timely treatment was provided when the Resident experienced a change in condition following a fall, that resulted in a fractured femur. Findings include:The facility policy titled Change in Condition, dated 7/2019, indicated the following:-Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an):a. accident or incident involving the resident;d. significant change in the resident's physical/emotional/medical condition;g. need to transfer the resident to a hospital/treatment center.2. A significant change of condition is a major decline or improvement in the resident's status that:a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self limiting);d. ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. Resident #87 was admitted to the facility in October 2023 and has diagnoses that include displaced midcervical fracture of the right femur, repeated falls and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/17/25, indicated that on the Brief Interview for Mental Status exam Resident #87 scored a 11 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated Resident #87 requires partial to moderate assistance with Activities of Daily Living (ADLs). Review of the falls care plan for Resident #87, indicated Resident #87 is at risk for falls. R/T (related to) Decrease mobility, Poor Safety awareness, Impaired Balance, Use of assistive devices, legal blindness. (sic). Review of the assessment titled FALL-Initial Occurrence Note, dated 7/28/25 at 19:44 P.M., indicated Resident #87 sustained an unwitnessed fall on 7/28/25 at 17:00 P.M. The assessment indicated that Resident #87 complained of no pain and no change in range of motion from normal baseline. Review of the assessment titled Occurrence F/U Charting, dated 7/29/25 at 7:48 A.M., indicated the following:-Resident #87 reported 8/10 pain in the right hip and that this pain was new;-Resident #87 was demonstrating a change in ROM (range of motion) and that he/she was guarding the right hip;-That the writer called the on-call MD after 2am with no return call. Review of Resident #87's clinical progress notes indicated the following:-A note dated 7/28/25 at 19:43 P.M.: This nurse heard a loud bang as she left the room, rushed back and the patient was observed lying on the floor near the door with his/her wheelchair behind him/her. When asked what happened, he/she stated he/she is not in pain, he/she just slid off the chair The patient was assessed while on the floor, no injuries noted at this time. Denied hitting his/her head. Was assisted off the floor to his/her wheelchair by two nursing staff. Neuros initiated, WNL (within normal limits). The patient was reminded to use his/her call light whenever he/she required assistance. -A note dated 7/29/25 at 7:48 A.M., indicated the following: *The resident is experiencing pain. Pain rating is 8. Right Hip. This is a new complaint of pain. Pain medication administered. *New limitations noted in ROM. Resident guarding hip area. New interventions added following occurrence. Refer to care plan. New intervention(s) are effective. *MD notified of new (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change in condition @ Writer called on call after 2 am, No return call Writer called on call after 2 am, No return call (sic). -A note dated 7/29/25 at 8:38 A.M.: Call placed to on call service again after 8 am. Writer spoke with NP (name redacted). Order obtained to assess vitals and update. Resident has stable vitals but s/s of right hip pain continues. NP made aware and gave new orders for STAT Chest X-Ray 2 views and STAT X-RAY of R/HIP (right hip). -A note dated 7/29/25 at 11:36 A.M.: Pt. sent out to (name redacted) Hospital d/t (due to) stat x-ray results, acute impacted right femoral fracture, NP in building and gave order to send out, HCP Daughter aware. Review of the x-ray report dated 7/29/25 at 10:32 A.M., indicated: There is a fracture involving right femoral neck with impaction without displacement. The joint shows no dislocation. Pubic rami are intact. There is mild osteoporosis. During an interview with the Nurse Practitioner (NP) #1 on 9/17/2025 at 10:43 A.M., she said that the Physician's on-call system is in effect from 6:00 P.M., until 7:00 A.M. NP #1 said that if a call is placed to the on-call system at 2:00 A.M., technically the facility should hear back within the hour. NP #1 said that if a call was placed when Resident #87 had a change in condition that resulted in a new fracture later being identified, and the facility never received a call back from the on call physician, that is a problem. During a telephone interview with the Nurse #3 on 9/17/2025 at 11:45 A.M., she said that she was the Resident #87's nurse on 7/29/25. Nurse #3 said that during the middle of the night Resident #87 was having increased pain and a change in condition, so she called the on-call physician at 2:00 A.M., but never got a call back. Nurse #3 said that she gave Resident #87 Tylenol but cannot remember if it was effective and that she passed the concern on to the 7-3 shift nurse's to follow-up further. During an interview with the Director of Nursing on 9/18/2025 at 8:44 A.M., she said that it is her expectation that if a resident has a change of status several hours following a fall, that includes new pain reported at 8/10, a change in range of motion and guarding the hip, and it is 2:00 A.M., and the nurse is unable to reach the on-call provider, that the patient should be sent to the emergency room and the nurse should notify the provider as soon as they are able to reach them.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow up on a significant weight change for two Residents (#21 and #98) out of a total sample of 21 residents. Specifically, the facility failed to assess two Residents with significant weight changes in a timely manner, as indicated in the facility policy.Findings include: Review of the facility policy titled Weight Assessment and Interventions, revised 05/2019, indicated the following: Monthly weights will be obtained each month or as ordered by physician. Weights will be recorded in the medical record (electronic health record where available) for each resident. Any weight change of 5lb in a month and 3lbs in a week since their last assessment should be retaken within 72 hours for confirmation and verified by nursing. Licensed nurse should notify dietitian of identified weight change once reviewed. Dietitian notification should be documented within resident's medical record. Dietitian or diet technician should respond within 72 hours of receipt of notification. The threshold for significant and undesired weight changes will be based on the following criteria: 1 month- 5% weight change is significant; greater than 5% is severe. 3 months- 7.5% weight change is significant; greater than 7.5% is severe. 6 months- 10% weight change is significant; greater than 10% is severe. 1. Resident #98 was admitted in May 2016 with diagnoses including cerebral palsy, anxiety, and protein calorie malnutrition. Review of the Minimum Data Set (MDS) assessment, dated 8/7/25, indicated Resident #98 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. Review of the plan of care related to nutrition, dated 3/20/24, indicated: Monitor/record/report to physician as need for signs and symptoms of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs. in 1 week, > 5% in 1 month, >7.5% in 3 months, >10% in 6 months. Review of the weight record for Resident #98 indicated the following weights: 1/21/25: 147.0 pounds (lbs.) 3/17/25: 136.0 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/2/25: 127.7 lbs. 5/9/25: 128.0 lbs. 6/3/25: 139.0 lbs. 8/7/25: 142.3 lbs. 9/5/25: 130.0 lbs. Review of the weight record indicated that from 1/21/25 to 4/2/25, Resident #98 lost 19.3 lbs. in three months, which is a 13.1% significant weight loss. Review of the physician progress notes and nutrition progress notes failed to indicate that either were made aware of the significant weight loss or followed up on the weight loss. Review of the medical record indicated that on 5/9/25, a quarterly nutrition assessment was completed, one month after a significant weight loss was identified, indicating that Resident #98 had gradual weight loss, but weight was within range and no additional nutrition intervention indicated at this time. Review of the weight record indicated that from 5/9/25 to 6/3/25, Resident #98 gained 11.0 lbs. in one month, which is a 7.9% significant weight gain. Review of the physician progress notes, and nutrition progress notes failed to indicate that either were made aware of the significant gain or assessed the Resident after the significant weight gain. Review of the medical record indicated that on 8/7/25, a quarterly nutrition assessment was completed, two months after the significant weight gain was identified, indicating that Resident #98 had gradual weight loss, but weight was within range and no additional nutrition intervention indicated at this time. Review of the weight record indicated that from 8/7/25 to 9/5/25, Resident #98 lost 12.3 lbs. in one month, which is an 8.6 % significant weight loss. Review of the physician progress notes, and nutrition progress notes failed to indicate that either were made aware of the significant loss or assessed the Resident after the significant weight loss. Review of Resident #98's physician orders dated 9/17/25 indicated a daily 237 milliliter supplement had been added on 12/29/23 and that there had not been any nutrition interventions implemented since then. During an interview on 9/17/25 at 12:23 P.M., the Dietitian said that she would expect that nursing would notify her of notable discrepancies in resident weights. She would put in an order to confirm the discrepancy or establish if the change is a new baseline for that resident. She said that if a resident had weight loss, either she or nursing can add supplements or other interventions to improve weight. She said that Resident #98's significant weight changes are consistent with his/her known overall decline and the reason she had not added any additional supplements. The Dietitian acknowledged that she had just noted on 9/17/25 the weight loss of 12 lbs. over the past month and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that there was a lag time from the weight being obtained on 9/5/25 until 9/17/25. She said the weight loss should have been identified sooner and that interventions should have been put in place within 72 hours or at the most a week after the weight change being identified. She said residents should be assessed with any significant weight changes and at least quarterly. During an interview on 9/17/25 at 12:45 P.M., Nurse #1 said that significant changes in weights would be discussed during morning report which is attended by the Director of Nursing and that also it would be reported to the Dietitian and Nurse Practitioner. She said Resident #98's weight loss was expected because of his/her fluctuations in behaviors. During an interview on 9/17/25 at 10:22 A.M., the Director of Nursing said that she reviews monthly weights and that any other discrepancies in weights are discussed in morning rounds. She said the dietitian is in the building everyday so she will either discuss with her or send her an email to notify of weight changes. She would have expected a follow up or assessment from the dietitian or physician if a significant weight loss occurs within a week at the most after the weight change was identified. She said that Resident #98's weight fluctuations were his/her usual status. 2. Resident #21 was admitted in April 2023 with diagnoses including dementia and dysphagia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #21 is severely impaired and could not participate in the Brief Interview for Mental Status exam. Review of the weight record for Resident #21 indicated the following weights: 2/3/25: 173.6 pounds (lbs) 3/14/25: 174.2 lbs 4/3/25: 161.2 lbs 5/3/25: 163.4 lbs 7/31/25: 161.1 lbs Review of the Nutrition progress notes indicated that Resident #21 was evaluated on 3/14/25 and had no acute nutrition concerns and would continue to monitor the Resident. Review of the weight record indicated that from 3/14/25 to 4/3/25, Resident #21 lost 13 lbs in one month, which is a 7.4% significant weight loss. Review of the physician progress notes and nutrition progress notes failed to indicate that either were made aware of the significant weight loss or addressed the significant weight loss for Resident #21. Resident #21 was signed onto hospice on 4/17/25. Review of the medical record failed to indicate that a comprehensive nutrition assessment was completed after the significant change with admission to hospice or after the significant weight loss. Review of the medical record indicated that on 7/14/25, a nutrition quarterly assessment was completed, 3 months after the significant weight loss and admission to hospice. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/25 at 12:23 P.M., the Dietitian said that she would expect that nursing would notify her of notable discrepancies in resident weights. She would put in an order to confirm the discrepancy or establish if the change is a new baseline for that resident. She said that if a resident had weight loss, either she or nursing can add supplements or other interventions to improve weight. She said that interventions should be put in place within 72 hours or at the most a week after a weight change is identified. She said residents should be assessed with any significant weight changes and at least quarterly. During an interview on 9/17/25 at 10:22 A.M., the Director of Nursing said that she would have expected a follow up from the dietitian or physician if a significant weight loss occurs and that weights are reviewed in morning meeting if there is a weight change.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on record review, and interview, the facility failed to provide care and services in accordance with professional standards of practice for one Resident (#109) out of a total sample of 21 residents, who required a vascular access device (device that provides access to the veins for the delivery of medications or fluids).Specifically, the facility failed to provide care and maintenance of Resident #109's midline catheter (a flexible tube inserted through a peripheral vein above the elbow that ends just below the axilla [armpit]) and monitor for catheter related complications. Findings include:Review of the facility policy titled ?Midline Dressing Change' dated January 2023, indicated the following:-Transparent dressings are changed every 7 days or sooner if the integrity of the dressing is compromised (wet, soiled, or loose).-Assessment is to include the absence or presence of erythema, drainage, swelling, induration, skin temperature at site, or complaint of tenderness at the site or along the vein tract.-Apply transparent dressing with insertion site centered in the dressing. Smooth dressing around catheter starting at insertion site and moving to periphery.-Label dressing with date, time, and initials of person performing dressing change.Resident #109 was admitted to the facility in September 2025 with diagnosis including other gram-negative sepsis.Review of Resident #109's Brief Interview for Mental Status (BIMS) score indicated the Resident scored a 15 out of possible 15 indicating intact cognition.On 9/16/25 at 8:51 A.M., the surveyor observed a right arm peripheral inserted catheter dressing undated, the bottom part dressing was lifting with hanging tape. The insertion site was not visible due to a disk and surrounding area was reddened. The Resident said the dressing had not been changed since he/she was at the hospital.Review of Resident #109's physician orders indicated the following orders initiated on 9/11/25: IV (intravenous) midline right arm transparent dressing change every day shift every Friday.-IV-midline right arm measure external catheter length with each dressing change, and as needed every day shift every Friday.9/15/25: Cefazolin Sodium Injection Solution Reconstituted 2 GM (Cefazolin Sodium) Use 2 gram intravenously three times a day for MSSA (methicillin-sensitive staphylococcus aureus) bacteremia for 10 Days until finished 2 gram/50 mL Piggyback - Infuse 50 mL stop date 9/26/25.Care plan date initiated 9/12/25: The resident has infection of the blood (septicemia)Intervention: Monitor site for placement signs/symptoms of infection every shift. -Change midline dressing every 7 days and PRN (as needed). Review of Resident #109's Medication Administration Record (MAR) indicated the midline dressing was changed on 9/12/25, the external catheter measuring 8cm.Review of the medical record hospital discharge paperwork infusion support systems, nurse visit record dated 8/31/25, indicated the midline external catheter measured zero centimeter.Review of Resident #109's progress notes failed to indicate the physician was notified due to possible midline migration. During an interview on 9/17/25 at 8:54 A.M., Nurse #2 said midline dressing changes are done weekly and should be dated when completed. She said every shift monitors for sign of infection but with the disk at the insertion site they are not able to visualize the insertion site.During an Interview on 9/17/25 at 9:54 A.M., the Director of Nursing said dressing changes are done weekly with measurements and documented in the MAR. Nurse responsible for changing the dressing should date and initial the dressing. During an interview on 9/17/25 at 10:53 A.M., Nurse #1 said she changed the midline dressing on 9/12/25 and measured from the insertion site to the end of the catheter. Nurse #1 said that during dressing changes they monitor for catheter migration, she said she assumed she dated the dressing.During an interview on 9/18/25 at 9:23 A.M., the Director of Nursing (DON) and the surveyor reviewed the photograph of Resident #109's midline. The DON said looking at it if the dressing was not changed that would be falsifying documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interview the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to maintain Contact Precautions while administering medication to a resident. Findings include:Review of the Centers for Disease Control (CDC) website indicated the following, dated June 28, 2024:- Contact Precautions require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident. Residents on Contact Precautions are recommended to be restricted to their rooms and restricted from participation in group activities. On 9/17/25 at 8:50 A.M., the surveyor observed Nurse #2 entering a resident's room to administer medications. Beside the entrance of the resident room was a sign that indicated:- Contact Precautions- Everyone must: - Clean their hands, including before entering and when leaving the room.- Providers and staff must also: - Put on gloves before room entry. Discard gloves before room exit. - Put on gown before room entry. Discard gown before room exit. The nurse entered the room and failed to put on gloves or a gown. After administering the oral medications, she had to administer an injection, so she put on gloves but did not put on a gown. Outside of the room was a drawer with gowns and gloves stocked in it. Prior to Nurse #2 entering the resident's room, there was another resident in the room visiting and that resident wheeled himself/herself out to hallway to ask Nurse #2 for medication and then wheeled back in to continue visiting with the resident in that room. The visiting resident was, at no time, wearing any personal protective equipment (PPE), nor did he/she wash or sanitize their hands. During an interview on 9/17/25 at 8:54 A.M., Nurse #2 said that residents with C-diff (a highly contagious bacterium that causes diarrhea and colitis) require the use of Contact Precautions. Nurse #2 said that she didn't think she needed to wear a gown and gloves if she was just giving meds to a resident on Contact Precautions and she didn't know what was necessary for precautions for another resident visiting a resident on Contact Precautions. During an interview on 9/18/25 at 8:54 A.M., the Director of Nurses said that any resident with C-diff would require the use of Contact Precautions but did not think PPE was required unless someone entering the resident room was providing direct care.