STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225333	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar View Rehabilitation and Healthcare Center	480 Jackson Street Methuen, MA 01844

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for one Resident (#22), out of a total sample of 21 residents. Specifically, for Resident #22 the MDS dated [DATE] indicated Resident #22 had a gradual dose reduction (GDR) of his/her antipsychotic medication administered on a routine basis dated 11/11/24. Review of the physician's orders failed to indicate a GDR was implemented therefore the MDS assessment failed to be accurate. Findings include: Resident #22 was admitted to the facility in September 2024 and has diagnoses that include major depressive disorder with recurrent severe psychotic symptoms. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #22 scored a 12 out of 15 on the Brief Interview for Mental Status exam indicating that he/she as having moderately intact cognition. Further review of MDS indicated Resident #22 is administered an antipsychotic medication on a routine basis and was coded that a gradual dose reduction of the antipsychotic medication was completed and documented on 11/11/24. Review of Resident #22's medical record failed to indicate documentation of a gradual dose reduction. Review of the physician's orders indicated the following order: -Seroquel (an antipsychotic medication) oral tablet 50 mg (milligrams) (Quetiapine Fumarate) (generic name) Give 50 mg by mouth at bedtime for anxiety. Start date 9/23/24. Review of the December 2024 Medication Administration Record (MAR) indicated Resident #22 was administered Seroquel 50 mg. Further review of the MAR failed to indicate that the dose of Seroquel was reduced, which conflicts with the MDS dated [DATE]. During an interview on 1/23/25 at 8:40 A.M., Unit Manager #1 said Resident #22 did not have a gradual dose reduction of the Seroquel in November 2024. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 1/23/25 at 9:49 A.M., MDS Nurse #1 reviewed Resident #22's orders and said he did not see a dose reduction in the Seroquel. MDS Nurse #1 said he would need to look into it further. During an interview on 1/23/25 at 11:50 A.M., MDS Nurse #1 said the coding of the MDS dated [DATE] that Resident #22 had a gradual dose reduction of the antipsychotic medication (Seroquel) was a data entry error and that there was no medication change or reduction of the antipsychotic medication.

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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** 49880 Based on record review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for one Resident (#85) out of a total sample of 21 residents. Specifically, for Resident #85 the facility failed to develop a fall risk care plan. Findings include: Review of facility policy titled Care Plans, Comprehensive Person- Centered, dated as revised March 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. -A comprehensive, person centered care plan is developed within seven (7) days of the completion of the required MDS (Minimum Data Set) assessment, and no more than 21 days after admission. Resident # 85 was admitted to the facility in November 2024 with diagnoses that include hemiplegia (paralysis to one side of the body) and hemiparesis (weakness to one entire side of the body) following cerebral infarction affecting left dominant side. Review of Resident #85's most recent comprehensive Minimum Data Set Assessment (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating that the Resident has moderate cognitive impairment. Further the MDS indicated that the Resident is dependent with activities of daily living (ADLs) and transfers. Review of the discharge referral from hospital, dated 11/27/24, indicated the following: -Precautions/Restrictions: Fall Precautions, Left Hemiparesis. Review of Resident #85's Admission/Readmission Evaluation Packet, dated 1/7/25 indicated a fall risk score of 20, indicating that the resident is at high risk for falls. Review of Resident #85's nursing progress note, dated 1/18/25 indicated the following: Pt [patient] s/p [status post] fall at 5pm. Pt was found on floor by wheelchair and assisted back to bed via hoyer lift [a mechanical lift used to transfer residents from one place to another].[sic] Review of Resident #85's fall risk assessment completed on 1/18/25 indicated a fall risk score of 22, indicating that the Resident is at high risk for falls. Review of Resident #85's active care plan indicated a risk for falls care plan, initiated on 1/22/25, four days after sustaining a fall in the facility, and 15 days after being assessed as having a fall score of 20 and being at high risk for falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #85's resolved plan of care that indicated a focus indicating that Resident #85 is at risk for falls related to impaired mobility, dated as initiated on 11/29/24 and resolved on 1/22/25. The incomplete care plan failed to indicate a measurable goal or any interventions to prevent falls in the facility. During an interview on 1/23/25 at 11:53 A.M., Nurse #1 said that a resident with a cerebral infarction and hemiplegia would be at risk for falls and should probably have a fall care plan in place with interventions to prevent falls. He said Resident #85 is at risk for falls. During an interview on 1/23/25 at 12:11 P.M., the Director of Nursing said Resident #85 is at risk for falls and should have had a complete and comprehensive falls care plan with interventions in place but did not.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure for 3 out of 3 sampled residents (#49, #23 and #65), out of 6 applicable residents, in a total sample of 21 residents, that professional standards of practice were provided for the treatment related to urinary catheter output. Specifically, for Resident #49, #23 and #65 the facility failed to implement the physician's order to measure each resident's urinary output. Findings include: 1. Resident #49 was readmitted to the facility in August 2024 and has diagnoses that include hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side and neuromuscular dysfunction of bladder unspecified. Review of the Minimum Data Set (MDS) assessment, dated 8/31/24, indicated Resident #49 scored an 11 out of 15 on the Brief Interview of Mental Status indicating he/she has a moderately intact cognition, has an indwelling catheter and is dependent on staff for toileting. During an observation and interview on 1/22/25 at 2:11 P.M., Resident #49 was in his/her bed. A urinary catheter collection bag was hanging on the side of the bed in a privacy cover. Resident #49 said he/she required care and has been at the facility since 2019. Review of Resident #49's physician's orders indicated the following: -Measure urinary out every shift document output in mls [milliliters], active 9/4/2024. Review of the Treatment Administration Record dated November 2024 indicated the following: -Day 11/22/24, 11/26/24 did not have measured or recorded output. -Evening 11/6/24, 11/16/24 did not have measured or recorded output. -Night 11/4/24, 11/11/24, 11/13/24, 11/19/24 did not have measured or recorded output. -A total of 8 sifts out of 90 shifts failed to have measured and recorded output for Resident #49. Review of the Treatment Administration Record dated December 2024 indicated the following: -Day 12/17/24 did not have measured or recorded output . -Evening 12/2/24, 12/8/24, did not have measured or recorded output. -Night 12/6/24, 12/13/24, 12/19/24, 12/20/24, 12/28/24, 12/30/24, 12/31/24 did not have measured or recorded output . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A total of ten shifts out of 93 shifts failed to have measured and recorded output for Resident #49. Review of the Treatment Administration Record dated January 2025 (1/1/25-1/22/25) indicated the following: -Day 1/3/25, 1/7/25, 1/10/25, did not have measured or recorded output. -Evening 1/17/25, did not have measured or recorded output. -Night 1/8/25, 1/13/25, 1/18/25, did not have measured or recorded output. -A total of seven shifts out of sixty-six shifts failed to have measured and recorded output for Resident #49 During an interview on 1/23/25 at 1:12 P.M., Certified Nursing Assistant (CNA) #1 said Resident #49 has a catheter. CNA #1 said the CNAs empty the catheter and report the amount to the nurse. During an interview on 1/23/25 at 1:14 P.M., Nurse #4 said Resident #49 has a urinary catheter. Nurse #4 said the purpose of having the output measurement is to make sure the Resident is not experiencing any urinary retention. Nurse #4 said the CNA staff are to report to the nurses the amount each shift. Nurse #4 said the CNA staff leave quickly at the end of a shift and do not always report to the nurse the output. Nurse #4 said the Nurse is responsible to document in the medical record the amount of output each shift. 2. Resident #23 was admitted to the facility in December 2024 and has diagnoses that include but are not limited to paraplegia and neuromuscular dysfunction of the bladder. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/16/24, indicated Resident #23 scored a 15 out of 15 on the brief interview of Mental Status exam indicating that the Resident is cognitively intact. Further review of the MDS indicated Resident #23 had a urinary indwelling catheter. During an observation on 1/23/25 at 12:54 P.M., Resident #23 was observed resting in his/her bed. A urinary collection bag was hanging on his/her right side of the bed. Review of the physician's order indicated the following: -order: Measure Urinary Output every shift for foley document output in mls (milliliters) dated as active 12/11/2024. Review of the November 2024 Treatment Administration Record (TAR) indicated the following: Measure Urinary Output every shift document in mls start date 7/15/2024 DC date 11/25/2024. -Day: 11/1/24, 11/9/24, 11/15/24, 11/20/24, 11/21/24 and 11/23/24 did not have measured or recorded output. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Evening: 11/1/24, 11/2/24, 11/3/24 11/8/24, 11/9/24, 11/15/24, 11/17/24, 11/19/24, 11/23/24 did not have measured or recorded output. -Night: 11/3/24, 11/20/24 and 11/22/24 did not have measured or recorded output. -Review of the November 2024 TAR indicated a total of 17 shifts out of 75 shifts failed to have documented urinary output for Resident #23. Review of December 2024 TAR indicated the following: Measure Urinary Output every shift for foley document output in: mls start date 12/11/24 -Day 12/12/24, 12/14/24, 12/15/24, 12/17/24, 12/19/24, 12/20/24, 12/22/24, 12/26/24, did not have measured or recorded output. -Evening: 12/14/24, 12/15/24, 12/20/24, 12/27/24, 12/28/24, 12/29/24, 12/31/24 did not have measured or recorded output. -Night: 12/18/24, 12/23/24. 12/28/24 did not have measured or recorded output. -Review of the December 2024 TAR indicated that a total of 19 shifts out of 63 shifts failed to have documented urinary output for Resident #23. Review of the January 2025 TAR indicated the following: Measure Urinary Output every shift for foley document output in: mls start date 12/11/24 -Day: 1/5/25, 1/8/25, 1/10/25, 1/11/25 1/15/25, 1/17/25, 1/21/25 did not have measured or recorded output. -Evening: 1/1/25, 1/3,25, 1/14/25, 1/15/25, 1/16/25, 1/17/25 did not have measured or recorded output. -Review of the January 2024 TAR indicated 15 shifts out of 44 day and evening shifts failed to have documented urinary output on Resident #23. During an interview on 1/24/25 at 9:38 A.M., Nurse #1 said that the Certified Nurses aids (CNAs) generally empty the urinary catheters and should let the nurse know the amount that is drained. Sometimes they do not let us know so we cannot document it, but it should be documented per physician's orders. 46339 3. Resident #65 was admitted to the facility in September 2023 with diagnoses including urinary retention. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #65's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated the Resident had a urinary catheter (a tube used to remove urine directly from the bladder). On 1/22/25 at 8:59 A.M., the Resident was observed lying in his/her bed foley catheter observed draining and in a privacy bag. On 1/23/25 at 9:28 A.M., the Resident was observed lying in his/her bed, foley catheter observed draining and in a privacy bag. Review of the physician order dated 9/30/23 indicated the following: -Measure urinary output every shift document output in mls (milliliter). Review of a care plan date initiated 12/27/23 with a focus of indwelling urinary catheter related to urinary retention. Had the following intervention: Monitor/record/report as needed signs and symptoms of UTI (urinary tract infection), pain burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior change in eating patterns. Review of the Treatment Administration Record (TAR) indicated on the following months there were incomplete documentation for urinary output: During the month of November 2024- there were seven undocumented shifts without urinary output. During the month of December 2024- there were ten undocumented shifts without urinary output. During the month of January 2025- there were seven undocumented shifts without urinary output. During an interview on 1/23/25 at 12:50 PM., Unit Manager #1 said physician orders should be followed as ordered and urinary output should be documented following the physician's orders. During an interview on 1/24/25 at 10:25 A.M., the Director of Nursing said nursing should follow physician order and document output as per the orders.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure for one Resident (#146), out of a total sample of 21 residents that a physical therapy evaluation was completed timely. Findings include: Resident #146 was admitted to the facility in January 2025 and has diagnoses that include but are not limited to muscle wasting and atrophy and acute systolic (congestive) heart failure. Review of Resident #146's Minimum Data Set assessment dated [DATE] indicated he/she scored a 14 out of 15 on the Brief Interview for Mental Status exam, indicating his/her as having intact cognition. During an observation and interview on 1/22/25 at 11:17 A.M., Resident #146 was resting in bed. Resident #146 said he/she was admitted to the facility in early January 2025, after being in the hospital for CHF (congested heart failure). Resident #146 said he/she needed to have therapy to walk again. Resident #146 said he/she has both physical therapy and occupational therapy, but they have been inconsistent. Review of Resident #146's physician's orders indicated the following: PT (physical therapy)-Screen, Evaluate, and Treat as indicated, dated 1/4/25. Review of Resident #146's Physical Therapy Evaluation and Plan of Treatment, dated with a certification period of 1/8/2025-2/8/2025 indicated treatment approaches may include, therapeutic exercises, neuromuscular reeducation, gait training therapy, manual therapy techniques, group therapeutic procedures, Physical therapy evaluation: moderate complexity, Therapeutic activities, Wheelchair management training. Frequency 5 time(s)/week Duration 4 weeks. Review of the Physical Therapy and Evaluation and Treatment Plan indicated the evaluation was completed on day five after Resident #146 was admitted to the facility. Review of progress notes in Resident #146's medical record from 1/4/25 through 1/8/25 failed to indicate any refusal or documented obstacles impacting the physical therapy evaluation. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 9:24 A.M., the Director of Rehabilitation (DOR) said the physical therapy staff aim to evaluate a resident within 24 hours of admission. The DOR said following the Medicare guidelines a PT evaluation and treatment plan must be completed by day three of admission and that day one is the admitted . The DOR said Resident #146 was admitted for skilled rehabilitation. The DOR said Resident #146 was scheduled to be evaluated by physical therapy on 1/6/25 and that she is unsure what happened and is just now looking into it. The DOR said Resident #146 should have been evaluated by physical therapy by day three of admission.

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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. 46339 Based on observation, record review and interview the facility failed to ensure accuracy of the medical record for one Resident (#24) out of a total sample of 21 residents. Specifically: For Resident #24 the facility failed to ensure accurate documentation for a hand roll. Resident #24 was admitted to the facility in November 2016 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side. Review of Resident #24's Minimum Data set (MDS) assessment, dated 10/24/24, indicated the Resident scored a 13 out of a total possible 15 on the Brief Interview for Mental Status indicating he/she was cognitively intact. The MDS further indicated impairment on one side to the upper extremity. On 1/22/25 at 8:18 A.M., the surveyor observed Resident #24 sitting in his/her room, left hand clenched in a fist, the surveyor observed a hand roll sitting on the bedside table. On 1/23/25 at 9:26 A.M., the surveyor observed Resident #24 sitting in his/her room . The Resident did not have the hand roll on. On 1/23/25 at 12:38 P.M., the surveyor observed Resident #24 sitting in his/her room, the Resident did not have the handroll on. Resident #24 said he/she only wears the splint at night. Review of the physician order dated 11/20/20 indicated the following: Left hand roll, remove during care check skin integrity every shift. Review of the care plan focus: Activity of Daily Living (ADL) care performance deficit date initiated: 3/18/2019 had the following interventions: Left hand roll, remove during care-check skin integrity. Review of the January 2025 Treatment Administration Record (TAR) indicated staff documented that the Resident had been wearing the hand roll continuously throughout the three shifts. During an interview on 1/23/25 at 12:40 P.M., Nurse #5 said the Resident wore the hand roll all the time. During an interview on 1/23/25 at 2:52 P.M., Unit Manager #1 said the Resident only wears the hand roll at nighttime, and staff should document accurately if Resident is not wearing the hand roll. During an interview on 1/24/25 at 10:25 A.M., the Director of Nursing said the Resident has been wearing the splint only at night and had worked with occupational therapy to put the hand roll on and take it off. She said the staff should document accurately if the Resident is not utilizing the hand roll.