STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225334	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakdale Rehabilitation & Skilled Nursing Center	76 North Main Street West Boylston, MA 01583

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed for one Resident (#187), with an indwelling urinary catheter (Foley Catheter/Foley - a tube placed through the urethra into the bladder to drain urine), out of a total sample of 19 residents, to maintain his/her Foley catheter in a privacy bag to maintain their dignity. Findings include: Review of Agency for Healthcare Research and Quality (AHRQ) article titled Catheter Care and Maintenance, published March 2017, retrieved from: https://www.ahrq.gov/hai/quality/tools/cauti-ltc/modules/implementation/education-bundles/indwelling-urinary-catheter-use/catheter-care/slides.html indicated: -Residents sometimes prefer leg bags, which can improve mobility and dignity Resident #187 was admitted to the facility in June 2025 with a diagnosis of Malignant Neoplasm of the Prostate. Review of Resident #187's Brief Interview for Mental Status Evaluation completed on 6/8/25 indicated that the Resident was cognitively intact with a score of 15 out of 15. On 6/8/25 at 9:33 A.M., the surveyor observed Certified Nurse Aide (CNA) #1 ambulate Resident #187 in the Resident's room. The Resident's Foley catheter was not covered in a privacy bag. During an observation with interview on 6/8/25 at 4:14 P.M., the surveyor observed Resident #187 seated in a chair in his/her room watching television. The Foley catheter drainage bag was not observed in a privacy bag. The Resident did not have a leg bag. Resident #187 said the facility staff had not offered him/her a leg bag and that he/she wanted one. Review of Resident #187's June 2025 Physician's Orders indicated: - Assure urinary drainage and privacy bag, keep off the floor every shift for dignity, initiated 6/5/25. - Change leg bag weekly on bath/shower day, initiated 6/5/25. (continued on next page)

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 6/9/25 at 6:53 A.M., the surveyor and the Rehab Director observed Resident #187's Foley catheter during morning care and the drainage bag was not in a privacy bag. The Rehab Director said the Foley catheter was not in a privacy bag and it should have been. During an interview on 6/9/25 at 7:02 A.M., Unit Manager (UM) #1 said Resident #187's Foley catheter should have been in a privacy bag, but it was not. UM #1 further said the Resident should have a leg bag when he/she was out of bed, but this has not been done. During an interview on 6/9/25 at 8:42 A.M., the Director of Nursing Services (DON) said when Resident #187 was admitted to the facility, the Resident's Foley catheter bag should have been switched to the facility's specific urinary drainage bag as that would have allowed for the drainage bag to be covered and maintained for privacy and dignity. The DON said the facility staff failed to change Resident #187's Foley catheter drainage bag to the Assure urinary drainage and privacy bag as ordered by the Physician.

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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 observation, interview, and record review, the facility failed to provide appropriate care and nutrition services relative to an altered texture diet for one Resident (#14), out of a total sample of 19 residents. Specifically, the facility failed to provide Resident #14 with thickened beverages in accordance with the Resident's plan of care, placing Resident #14 at risk for swallowing complications. Findings include: Review of the facility's policy titled Therapeutic Diets, undated, indicated the following: -A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet or to alter the texture of a diet i.e.: altered consistency diet -A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider) The attending physician may delegate this task to a registered or licensed dietitian as permitted by state law -If a mechanically altered diet is ordered the provider will specify the texture modification Resident #14 was admitted to the facility in November 2023 with diagnoses including Dysphagia (difficulty swallowing), unspecified and Cerebral Infarction due to Thrombosis. Review of the Minimum Data Set (MDS) assessment, dated 5/16/25, indicated Resident #14 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #14's active Physician's Orders, dated 6/9/25, indicated the following order initiated 6/18/24: -No Added Salt (NAS) diet, Ground texture, Nectar thick Consistency, no hard dry bread, no mixed consistencies, no fruit with high water content allowed on diet. Review of a Nutritional Risk Assessment, dated 5/12/25, indicated Resident #14 was prescribed a ground texture diet with nectar thickened liquids. Review of a Speech Language Pathology (SLP) Discharge summary, dated [DATE] through 5/2/25, indicated that Resident #14 required a minced moist diet with mildly thickened liquids. On 6/8/25 at 9:14 A.M., the surveyor observed Resident #14 seated in bed with a breakfast meal in front of him/her. The surveyor observed a clear plastic cup one quarter full of cranberry juice and a plastic mug one half full of hot tea. Resident #14 said the tea wasn't warm but he/she liked it anyway. The surveyor observed that both the cranberry juice and the tea were of a thin, regular consistency. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 12:32 P.M., the surveyor and Unit Manager #2 (UM #2) observed Resident #14's lunch meal tray together. UM #2 said that she saw an issue with the beverages on the Resident's meal tray. UM #2 said Resident #14 required nectar thickened liquids and that the two cups of hot tea on the Resident's meal tray were not thickened to the appropriate consistency. UM #2 further said that Resident #14 had a physician's order for nectar thick consistency beverages and Resident #14 should not have been provided with any beverages that were not thickened as ordered. During a follow up interview on 6/9/25 at 3:18 P.M., the SLP said during the evaluation of Resident #14 she noted the Resident would cough occasionally while drinking thin consistency beverages because the thin consistency beverages moved too fast down the Resident's throat and end up going the wrong way into the windpipe. She said it is safer for Resident #14 to have nectar thick consistency beverages because they don't move as quickly down his/her throat and that Resident #14 should not have had any thin consistency beverages provided on his/her meal trays.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for two Residents (#188 and #10), out of a total sample of 19 residents. Specifically, 1. For Resident #188, the facility failed to ensure that Physician orders with the appropriate liter flow were obtained for oxygen use when the Resident was being administered oxygen. 2. For Resident #10, the facility failed to obtain active Physician orders for the use of PRN (as needed) oxygen with the required liter flow when the Resident was being administered PRN oxygen. Findings include: Review of the facility's policy titled Oxygen, dated 2001, indicated: -Verify that there is a Physician's order for this procedure. -Review the Physician's orders for oxygen administration. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All Oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for Oxygen therapy. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in PaCO2. -Equipment maintenance and supervision: >All oxygen delivery equipment should be checked at least once daily >Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. 1. Resident #188 was admitted to the facility in April 2025 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Acute Respiratory Failure with Hypoxia and Pleural Effusions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 5/16/25, indicated Resident #188: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. -was dependent on staff for activities of daily living (ADLs - bathing, grooming, dressing, hygiene). -required the use of oxygen related to shortness of breath (SOB). During an interview on 6/8/25 at 9:45 A.M., Resident #188 said he/she required the use of oxygen but was not sure of the rate (liter flow) of the oxygen being administered. Resident #188 further said he/she was recently hospitalized with hypoxia (low oxygen in the blood) and needed to use oxygen. The surveyor observed the oxygen liter flow was set at 1 liter per minute (LPM) on the oxygen concentrator. Review of Resident #188's June 2025 Physician's orders failed to indicate any oxygen orders and the prescribed liter flow of oxygen to be administered to the Resident. Review of Resident #188's Respiratory Care Plan, initiated 5/9/25, indicated the Resident required the use of oxygen related to altered respiratory status, difficulty breathing related to COPD, Acute Respiratory Failure with Hypoxia and was dependent on oxygen. On 6/10/25 at 6:52 A.M., the surveyor observed Resident #188 lying in bed asleep with the nasal cannula in place in his/her nostrils. The surveyor also observed that the oxygen concentrator was turned off. During an interview at the time, Resident #188 said that he/she was not aware the oxygen had been shut off and how long the oxygen had been turned off. During an interview on 6/10/25 at 7:05 A.M., Nurse #1 said he was the Nurse that worked on the 11:00 P.M. to 7:00 A.M. shift (night shift). Nurse #1 said the Resident's oxygen concentrator was turned off when he came on shift and Nurse #1 had not turned the Resident's oxygen on. During an interview on 6/10/25 at 7:25 A.M., Unit Manager (UM) #1 said Resident #188 required the use of Oxygen. UM #1 said she was not aware the Resident's oxygen was turned off. UM #1 further said that Resident #188 did not have a Physician's order for the use of oxygen. During a follow-up interview on 6/10/25 at 9:45 A.M., UM #1 said Resident #188 did not have a Physician's order for the use of oxygen and that the Resident required oxygen and had been using the oxygen. UM #1 said there should have been a Physician's order but there was not. During an interview on 6/10/25 at 11:05 A.M., the Director of Nursing (DON) said the Physician should have been notified by the facility staff to obtain oxygen orders based on the Resident's need but that had not been done. 2. Resident #10 was admitted to the facility in September 2023, with diagnoses including COPD, Congestive Heart Failure (CHF), Obstructive Sleep Apnea, and Obesity Hypoventilation Syndrome. Review of the MDS assessment, dated 5/23/25, indicated Resident #10: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was cognitively intact as evidenced by a BIMS score of 15 out of 15 -utilized oxygen -utilized a non-mechanical ventilator Review of Resident #10's active Physician's Orders indicated the following: -C-PAP is to be worn at night. Please ensure it is on, every night shift related to Dependence of Supplemental oxygen, document if refused, initiated 11/15/23. -C-PAP with Home settings @ bedtime, attach 2 liters oxygen, at bedtime for OSA. Please fill cannister with distilled water Daily, initiated 9/8/23. Further review of Resident #10's June 2025 Physican's orders failed to indicate any order for the use of intermittent oxygen, and the prescribed liter flow to administer PRN oxygen. Review of the Physician's Progress Note, dated 5/2/25 at 19:34 (7:34 P.M.), indicated: -Resident was recently hospitalized for CHF exacerbation and returned 5/1/25. -Resident was admitted with acute infection as well as CHF exacerbation. -Resident had chronic hypoxia due to COPD, CHF, and obesity hypoventilation syndrome. -He/she required 3 Liters (L) of supplemental Oxygen on admission to the hospital and is now saturating well on room air following treatment of fluid overload. -He/she uses nocturnal Oxygen 2L with CPAP overnight. -He/she is on 1 to 2L nasal cannula at baseline with intermittent daytime use and continuous overnight use with CPAP. On 6/8/25 at 9:05 A.M., the surveyor observed Resident #10 lying in bed with a CPAP machine connected to an oxygen concentrator which was running and set at 2 LPM. During an interview at the time, the Resident said that staff assist him/her in donning (putting on) the CPAP at night and removing it in the morning. Review of Resident #10's medical record indicated the following: -Nursing Skilled Note on 5/6/25 at 5:50 A.M.: on Oxygen at 2L (liters) via nasal cannula. -Nurse Practitioner (NP) Progress Notes documenting on intermittent daytime O2 [oxygen] on: >5/9/25 at 9:15 A.M. [late entry] >5/21/25 at 10:18 A.M. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>5/22/25 at 13:40 (1:40 P.M.) >5/28/25 at 18:41 (6:41 P.M.) >6/5/25 at 11:52 A.M. -Nursing Shift Note on 6/8/25 at 14:30 (2:30 P.M.): O2 (Oxygen) used to good effect (no liter flow was documented). Further review of Resident #10's medical record failed to indicate any NP orders for the use of intermittent daytime oxygen and the prescribed liter flow, when the NP documentation indicated oxygen was used intermittently from 5/9/25 through 6/5/25. On 6/10/25 at 9:38 A.M., the surveyor and Nurse #2 observed Resident #10 lying in bed and wearing oxygen via nasal cannula. During an interview at the time, Resident #10 said he/she was tired today. The surveyor observed Nurse #2 obtain pulse oximetry measurements from each hand, reading between 86% and 87%. Nurse #2 said that she would clarify the MD order for PRN oxygen use as sometimes the MD order has a range of liter flow rates and includes parameters for SPO2 (oxygen saturation) levels. The surveyor and Nurse #2 reviewed Resident #10's chart and Nurse #2 said there were no MD orders in place for supplemental oxygen (daytime use). Nurse #2 said based on her observation and assessment from this morning, the Resident had an acute change in condition and O2 SATS were below 90%. Nurse #2 said that typical nursing practice is to provide PRN oxygen at 2 LPM. During an interview on 6/10/25 at 9:48 A.M., UM #2 said when PRN oxygen is administered there should be a Physician's order in place. During a follow-up interview on 6/10/25 at 11:02 A.M., UM #2 said that Resident #10 did not have current orders for oxygen usage and there should have been.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent foodborne illness to residents. Specifically, the facility failed to: 1. Ensure that food items were stored properly labeled and dated as required; and 2. Ensure that the dietary staff were wearing hair coverings in the kitchen while preparing food. Findings include: 1. Review of the facility policy titled Food Storage, dated 2017, indicated: -All containers must be legible and accurately labeled and dated. -Food should be dated as it is placed on shelves if required by state regulation -Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2013 Federal Food Code. (Also see policy on Use of Leftovers later in this chapter.) Check state regulations as state regulations may allow shorter time frames for use of leftovers. -All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. During the initial tour of the facility kitchen on 6/8/25 at 7:10 A.M., the surveyor observed the following: In the stand-up refrigerator: -One plate of green peppers, covered not labeled and dated. -One plastic cup with dressing, covered not labeled and dated. -One metal container of tuna salad, covered not labeled and dated. -One metal container of ham salad, covered not labeled and dated. -One metal container of cooked meat, covered not labeled and dated -Two prepared salads, covered not labeled and dated. -Four fruit cups, covered not labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the walk-in refrigerator: - Seafood packaged in plastic and sealed, not labeled or dated. On the shelf below the food prep table: -Four sandwiches wrapped and labeled but not dated. During an interview on 6/8/25 at 7:35 A.M., Dietary Staff #1 said all the items in the refrigerators should have been labeled and dated. 2. Review of the facility's policy and procedure titled Food Safety and Sanitation (undated) indicated: -Beard nets are required when facial hair is visible During the initial tour of the facility kitchen on 6/8/25 at 7:10 A.M., the surveyor observed two of three dietary staff with beards preparing food and not wearing beard coverings. During an observation on 6/9/25 at 8:24 A.M., the surveyor observed a dietary aide with a full beard, covering his cheeks and neck, leave the dining room and enter the kitchen. The surveyor went into the kitchen and observed the dietary aide plating food from the food line with no beard covering in place. During an interview on 6/9/25 at 8:30 A.M., the Food Service Director (FSD), said the dietary aide should have been wearing a beard covering and was not. During an observation on 6/9/25 at 8:53 A.M., the surveyor observed the same dietary aide enter the dining area wearing a beard covering that was covering his cheeks but not pulled down over his chin and neck to cover his beard completely. He was observed handing food items to staff. During an observation on 6/11/25 at 11:16 A.M., surveyors observed three dietary staff members with beards preparing food. None of the three staff members observed were wearing beard coverings. During an interview on 6/11/25 at 11:20 A.M., the FSD said the staff members should have been a wearing beard covering while they were preparing the food.

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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 observation, interview, and record review, the facility failed to implement infection control practices in accordance with professional standards to prevent the potential spread of infection for one Resident (#187), out of a total sample of 19 residents. Specifically, the facility staff failed to ensure the required personal protective equipment (PPE) was adhered to when Resident #187 was admitted with a surgical abdominal wound and an indwelling urinary catheter (Foley Catheter/Foley - a tube placed through the urethra into the bladder to drain urine) that required Enhanced Barrier Precautions, increasing the Residents' risk for infection and preventing the potential spread of multidrug-resistant organisms (MDROs) during high-contact resident care activities. Findings include: Review of Centers for Disease Control and Prevention (CDC) Guideline for Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revised June 28, 2024, retrieved from, https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html indicated: - Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. - Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). - Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. - Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). - Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. Resident #187 was admitted to the facility in June 2025 diagnosis of Malignant Neoplasm of Prostate, Surgical Abdomen Wound with a Wound Vac and Foley catheter. Review of Resident #187's Brief Interview for Mental Status Evaluation completed on 6/8/25 indicated that the Resident is cognitively intact with a Brief Interview for Mental Status score of 15 out of a total of 15. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/8/25 at 9:27 A.M., the surveyor observed Certified Nurse Aide (CNA) #1 holding Resident #187's Foley catheter drainage bag and also holding onto the Resident while the Resident was ambulating to the bathroom. CNA #1 was not wearing an isolation gown. There was a sign outside the Resident's room indicating the Resident was on Enhanced Barrier Precaution (EBP). During an interview on 4/8/25 at 9:27 A.M., CNA #1 said she was not aware that Resident #187 was on EBP. On 6/8/25 at 9:33 A.M., the surveyor observed two staff members enter Resident #187's room with no PPE and close the door. At 9:36 A.M., CNA #3 exited the Resident's room and said she should have worn a gown and gloves before entering the Resident's room, but she did not. At the same time CNA #2 exited the room. CNA #2 said she was a new CNA at the facility and was in training. CNA #2 said she assisted Resident #187 off the toilet, and into his/her bed but was not aware she needed to wear a gown during the high contact care. During an interview on 6/9/25 at 7:45 A.M., the Infection Preventionist/Staff Development Coordinator (IP/SDC) said the CNAs had been educated on Enhanced Barrier Precaution. IP/SDC further said the CNAs should have adhered to the EBP sign at the door to Resident #187, but they did not.