STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER: Norwood Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 460 Washington Street Norwood, MA 02062	

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on record review and interview, the facility failed to ensure a [NAME] treatment plan (court approved treatment plan for the administration of antipsychotic medications) was active and current for administration of an antipsychotic medication for two Residents (#16 and #25), out of 39 sampled residents with legal guardians (a person who has been appointed by a court or otherwise has the legal authority to care for the personal and property interests of another person who is deemed incapacitated). The facility identified an additional 21 residents with legal guardians that are being administered antipsychotic medication and require a [NAME] Treatment plan. Of these 21 residents, the facility failed to ensure 19 residents had valid, court approved [NAME] treatment plans in place for the administration of antipsychotic medication. Findings include: 1. Resident #16 was admitted to the facility in [DATE] and had diagnoses including paranoid schizophrenia and dementia. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #16 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15, received antipsychotic medication, and had a legal guardian. Review of the medical record indicated Resident #16 was found to be incapable of taking care of himself/herself by reason of mental illness and Guardianship was appointed on [DATE] by the Commonwealth of Massachusetts Probate and Family Court. Subsequent review of the medical record indicated the court last renewed the [NAME] Treatment Plan to authorize the administration of antipsychotic medication on [DATE], which expired on [DATE] at 4:00 P.M. Review of current Physician's Orders indicated but was not limited to: -Risperidone (antipsychotic) 1 milligram (mg) by mouth two times a day ([DATE]) Review of the [DATE] through [DATE] Medication Administration Record (MAR) indicated Risperidone was administered to Resident #16 as ordered by the physician. 2. Resident #25 was admitted to the facility in [DATE] and had diagnoses including paranoid schizophrenia. (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: 225343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated [DATE], indicated Resident #25 had severe cognitive impairment as evidenced by a BIMS score of 4 out of 15, received antipsychotic medication, and had a legal guardian. Review of the medical record indicated Resident #25 was found to be incapable of taking care of himself/herself by reason of mental illness and Guardianship was appointed on [DATE] by the Commonwealth of Massachusetts Probate and Family Court. Subsequent review of the medical record indicated the court last renewed the [NAME] Treatment Plan to authorize the administration of antipsychotic medication, which expired on [DATE]. Review of current Physician's Orders indicated but was not limited to: -Risperidone 1 mg by mouth two times a day ([DATE]) -Olanzapine 5 mg by mouth one time a day ([DATE]) Review of the [DATE] through [DATE] MAR indicated Risperidone and Olanzapine were administered to Resident #25 as ordered by the physician. During an interview on [DATE] at 12:00 P.M., the Administrator said he is unaware of the status of Resident #16 and #25's [NAME] guardianships. He said the Social Worker is responsible for tracking and following up on all guardianship issues and ensuring all [NAME] treatment plans are up to date, but the facility has not had a full time Social Worker since [DATE]. He said they have a consultant Social Worker that comes into the facility on ce a week and he is responsible for tracking and following up on all guardianship issues and [NAME] treatment plans. During a telephone interview on [DATE] at 12:50 P.M., the consultant Social Worker said he comes into the building one or two times a week and spends the bulk of his time doing social service evaluations (about four to five hours) and the rest of his time in the building he walks the floors and talks to residents. The consultant Social Worker said he has nothing to do with tracking or following up with guardianships or residents' [NAME] treatment plans. During an interview on [DATE] at 12:55 P.M., the Administrator provided the survey team with a current list of all residents in the facility with legal guardianships and those residents receiving antipsychotic medication requiring [NAME] treatment plans. Review of the list indicated a total of 41 residents (including Residents #16 and #25) in the facility had legal guardians and of those residents, 23 had [NAME] treatment plans. Review of legal documentation for 23 residents identified as receiving antipsychotic medication, 21 did not have valid, court approved [NAME] treatment plans. During an interview on [DATE] at 2:15 P.M., the Administrator said he had no additional information regarding the status of the 21 residents' [NAME] treatment plans but would look into it and provide the survey team with any documents he finds. As of the end of survey, on [DATE], the survey team did not receive any additional evidence that the required paperwork for [NAME] treatment plans had been completed, submitted and approved by the courts. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], the facility faxed the survey team 90 pages of documentation related to guardianship and [NAME] treatment plans for 15 residents (and not 21 as requested). None of the documents indicated that any of the 21 residents requiring [NAME] treatment plans for the administration of antipsychotic medication had valid, court approved [NAME] treatment plans.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43935 Based on observation, interview, and record review, the facility failed to notify the Physician and/or responsible party of recommendations or changes in condition for two Residents (#86 and #8), out of a total sample of 39 residents. Specifically, the facility failed: 1. For Resident #86, to notify the Physician of recommendations from the Dietitian for a change in nutritional formula to enhance the caloric intake of the malnourished Resident; and 2. For Resident #8, to notify the Health Care Proxy (HCP- health care agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions) when the Resident developed a deep tissue injury to the left heel and a stage 3 pressure wound (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are NOT exposed) to the left buttock. Findings include: Review of the facility's policy titled Change in Resident's Condition or Status, last revised 7/2024, indicated but was not limited to: -The facility professional staff will communicate with physicians, resident, and family regarding changes in condition as warranted. -The nurse/designee shall notify the resident's representative when there is a significant change in the resident's condition. -The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 1. Resident #86 was admitted to the facility in August 2023 with diagnoses including unspecified protein-calorie malnutrition, cerebral infarction (stroke), and Type 2 diabetes. Review of the Minimum Data Set (MDS) for Resident #86, dated 8/23/24, indicated under C1000 (cognitive skills for daily decision making) that the Resident was severely cognitively impaired. On 10/29/24 at 12:50 P.M., the surveyor observed Resident #86 in bed with Glucerna 1.2 carbsteady (enteral nutritional formula) infusing at a rate of 50 milliliters (ml) per hour. Review of the current Physician's Orders (as of 10/29/24) for Resident #86 indicated but were not limited to the following: - NPO (nothing by mouth) diet (8/18/23) (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Glucerna 1.2 cal oral liquid (nutritional supplement), give 50 ml per hour. Food schedule as follows: food up at 8:00 A.M. and down at 8:00 P.M. (8/18/24) Review of the Medical Nutrition Therapy assessment for Resident #86, effective date 8/19/24, indicated but was not limited to the following: - Annual assessment, Diet: NPO - Nutritional Diagnosis, intervention, monitoring and evaluation: Nutritional diagnosis #1: less than optimal enteral nutrition composition or modality related to: low BMI, tube feed (TF) not meeting nutritional needs as evidenced by: pt with BMI < 18.5 Nutritional diagnosis #2: inadequate suboptimal oral intake related to dysphagia as evidenced by: need for TF to meet nutritional needs Goal: Resident will show weight gain trend toward healthy BMI range, will tolerate TF without overt issue - Assessment, summary and care plan decision Request to change formula to Glucerna 1.5 at same volume for 900 calories (21 calories / kilogram) Review of the medical record on 10/29/24 failed to indicate the Physician was ever made aware of the Dietitian's request/recommendation for a formula change to Glucerna 1.5 or that a change ever occurred. During an interview on 10/29/24 at 3:34 P.M., the Nursing supervisor reviewed the medical record of Resident #86 and said the recommendation for Glucerna 1.5 was never addressed with the physician as it should have been. During an interview on 10/29/24 at 3:57 P.M., Physician #2 said she was not aware of a recommendation from the Dietitian to change the Glucerna from 1.2 to 1.5 for increased calories and said adjusting the calorie intake through a formula change is a good recommendation that she would have approved had she been notified of the request, but she was not. During an interview on 10/30/24 at 8:05 A.M., the Director of Nurses (DON) said the physician should have been made aware of the request for a change in nutritional formula for the Resident following the August evaluation, but that does not appear to have occurred as it should have. 34145 2. Resident #8 was admitted to the facility in October 2021 and had diagnoses including dementia. Review of the MDS assessment, dated 9/6/24, indicated Resident #8 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 11 out of 15, had one stage 3 pressure ulcer and one unstageable deep tissue injury. The assessment indicated Resident #8 had an activated HCP. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nursing Progress Note, dated 8/21/24, indicated the Resident was noted to have a half dollar sized blackened left heel and the physician and administration would be notified. The note failed to indicate the Resident's HCP was notified. Review of the consultant wound physician's evaluation, dated 8/22/24, indicated Resident #8 had an unstageable deep tissue injury of the left heel measuring 3.5 centimeters (cm) in length, 4.5 cm in width with no measurable depth. Review of the consultant wound physician's evaluation, dated 8/29/24, indicated Resident #8 had an unstageable deep tissue injury of the left heel and a newly identified stage 3 pressure wound of the left buttock. Review of a Nursing Progress note, dated 8/29/24, indicated Resident #8 was seen by the consultant wound physician for a left buttock wound with a recommendation for Silvadene 1% cream with house barrier cream daily. The note indicated the physician was aware and agreed with the recommendation. The note failed to indicate the Resident's HCP was notified. During a telephone interview on 10/25/24 at 10:42 A.M., Resident #8's HCP said he was not aware that Resident #8 had a deep tissue injury on his/her heel on 8/21/24 or a stage 3 pressure ulcer on his/her left buttock on 8/29/24 or was currently being seen by the wound physician. He said the communication from the facility is not good.

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41065

Based on observation and interview, the facility failed to provide a safe, clean, comfortable and homelike environment on one unit out of a total of four units. Specifically, the facility failed to ensure the North Two unit temperature was maintained between 71-81 degrees Fahrenheit.

Findings include:

On 10/28/24 at 8:31 A.M., the surveyor entered the North 2 unit between rooms [ROOM NUMBERS]. The temperature was noticeably colder than the rest of the facility.

During an interview on 10/28/24 at 8:31 A.M., Resident #24 said, It is cold on the unit and it has been all weekend. It was reported to the nurse over the weekend but nothing had been done.

During an interview with observation on 10/28/24 at 9:14 A.M., Resident #98 said, It's been cold in here for a few days now. It feels like there is no heat. It's very cold. The surveyor observed Resident #98 to be wearing long flannel pants and a long sleeve shirt.

During an interview on 10/28/24 at 9:20 A.M., the Regional Facility Engineer said he was trying to figure out why it was cold on the North 2 unit and said it feels colder than usual. He said the thermostat was reading 67 degrees when he last checked.

During an interview with observation on 10/28/24 at 9:23 A.M., Resident #110 said, It feels cold, like the windows are open, but they are all closed. The Resident then repeated, I am freezing, freezing, freezing. The surveyor observed Resident #110 standing in the doorway of his/her room wearing a long sleeve shirt and a hospital gown.

During an interview with observation on 10/28/24 at 9:25 A.M., Resident #96 said, I normally don't dress like this indoors, but I am so cold. I have my outdoor jacket on. The surveyor observed the Resident wearing a fleece jacket, a long sleeve shirt, and long pants.

During an interview on 10/28/24 at 9:29 A.M., Certified Nursing Assistant (CNA) #3 said it has been cold since the start of the shift this morning. He said he was told it had been cold since last evening but he was not working yesterday.

On 10/28/24 at 9:32 A.M., the surveyor observed Resident #24 self-propelling down the hallway, speaking loudly saying, It's been cold like this since yesterday, they don't adjust the temperatures for the season.

On 10/28/24 at 9:40 A.M., the surveyor observed the thermostat, located in the hallway outside of room [ROOM NUMBER]. The thermostat read 62 degrees Fahrenheit. The Director of Nurses was present for the observation who confirmed the reading and said, It looks like it's reading 61.5-62 degrees currently.

(continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Directly following the observation, the surveyor and Director of Nurses entered the sitting room at the end of the hallway, near room [ROOM NUMBER]. The thermostat in the sitting room read 58 degrees Fahrenheit. The Director of Nurses was present for the observation and closed the doors to the sitting room as they left. During an interview on 10/28/24 at 9:50 A.M., the Administrator said the heat has been fixed and should be working again. On 10/28/24 at 12:32 P.M., the surveyor entered the North 2 unit between rooms [ROOM NUMBERS]. The temperature was noticeably colder than the rest of the facility. The surveyor observed the thermostat located in the hallway outside of room [ROOM NUMBER]. The thermostat was reading 62 degrees Fahrenheit. On 10/28/24 at 1:29 P.M., the surveyor observed the Regional Facility Engineer checking the temperatures on the North 2 unit. At the time of the observation, the air temperature was reading 66 degrees Fahrenheit. The surveyor observed the unit to be feeling cool but warmer than the observations made that morning. During an interview on 10/28/24 at 1:56 P.M., the Administrator said he spoke with the Regional Facility Engineer who had been testing the temperatures from the baseboard heat and said the temperature is appropriate. The Administrator could not speak to how the temperature was being measured or what tool was being used to determine the temperature levels at the baseboards but said he will ask that the air temperatures be checked again. The Administrator said the unit should be warmer than it has been.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34145 Based on record review and interview, the facility failed to ensure a Notice of Transfer/Discharge was issued to two Residents (#16 and #25), out of a sample of 39 residents. Specifically, the facility failed to notify the Resident/Resident Representative in writing for the reason of transfer and send a copy of the notice to the ombudsman when emergently transferred to the hospital. Findings include: Review of the facility's policy titled Bed Holds/Returns, last revised 5/2018, indicated but was not limited to: -Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed hold and return policy. -Prior to a transfer, written information will be given to the residents and/or the resident representatives that explains in detail: -The rights and limitations of the resident regarding bed-holds; -The reserve bed payment policy as indicated by the state plan; -The facility per diem rate required to hold a bed, or to hold a bed beyond the state bed-hold period -The details of the transfer (per the Notice of Transfer) 1. Resident #16 was admitted to the facility in May 2014 and had diagnoses including diabetes mellitus type 2, anxiety, and dementia. Review of the Minimum Data Set (MDS) assessment, dated 8/16/24, indicated Resident #16 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15, and received intravenous (administered into a vein) medication. The assessment indicated Resident #16 had a legal guardian (a person who has been appointed by a court or otherwise has the legal authority to care for the personal and property interests of another person who is deemed incapacitated). Review of a Nursing Progress Note, dated 7/1/24, indicated Resident #16 pulled out his/her Peripherally Inserted Central Catheter (PICC-a thin, flexible tube that's inserted into a vein in the arm and threaded into a large vein in the chest. It's used to deliver intravenous IV fluids) line and was transferred to the hospital. Review of a Nursing Progress Note, dated 8/17/24, indicated Resident #16 pulled out his/her PICC line and was transferred to the hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of the entire medical record failed to indicate Notices of Transfer/Discharge had been issued to the Resident/Resident Representative or sent to the ombudsman. 2. Resident #25 was admitted to the facility in May 2019 and had diagnoses including chronic obstructive pulmonary disease and unsteadiness on feet. Review of the MDS assessment, dated 10/11/24, indicated Resident #25 had severe cognitive impairment as evidenced by a BIMS score of 4 out of 15 and had a legal guardian. Review of a Nursing Progress Note, dated 3/24/24, indicated Resident #25 was having difficulty breathing and was transferred to the hospital. Review of a Nursing Progress Note, dated 8/24/24, indicated Resident #25 was found lying on the floor in his/her room and was transferred to the hospital. Further review of the entire medical record failed to indicate Notices of Transfer/Discharge had been issued to the Resident/Resident Representative or sent to the ombudsman. During an interview on 10/30/24 at 9:18 A.M., Nurse #8 reviewed Resident #16 and #25's medical records and said she could not find evidence the Notices of Transfer/Discharge had been issued to the Resident/Resident Representatives and ombudsman. During an interview on 10/30/24 at 11:45 A.M., the Regional Nurse said she was unable locate and provide the surveyor with copies of Resident #16's Notices of Transfer/Discharge for 7/1/24 and 8/17/24 and Resident #25's Notices of Transfer/Discharge for 3/24/24 and 8/24/24.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 34145 Based on record review and interview, the facility failed to ensure a Bed Hold Policy Notice was issued upon transfer to the hospital for two Residents (#16 and #25), out of a sample of 39 residents and two discharge records reviewed. Specifically, the facility failed to provide written notice of the facility's bed-hold policy to the resident/resident representative when transferred to the hospital. Findings include: Review of the facility's policy titled Bed Holds/Returns, last revised 5/2018, indicated, but was not limited to: -Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed hold and return policy. -Prior to a transfer, written information will be given to the residents and/or the resident representatives that explains in detail: -The rights and limitations of the resident regarding bed-holds; -The reserve bed payment policy as indicated by the state plan; -The facility per diem rate required to hold a bed, or to hold a bed beyond the state bed-hold period -The details of the transfer (per the Notice of Transfer) 1. Resident #16 was admitted to the facility in May 2014 and had diagnoses including diabetes mellitus type 2, anxiety, and dementia. Review of the Minimum Data Set (MDS) assessment, dated 8/16/24, indicated Resident #16 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15, and received intravenous (administered into a vein) medication. The assessment indicated Resident #16 had a legal Guardian (a person who has been appointed by a court or otherwise has the legal authority to care for the personal and property interests of another person who is deemed incapacitated). Review of a Nursing Progress Note, dated 7/1/24, indicated Resident #16 pulled out his/her Peripherally Inserted Central Catheter (PICC-a thin, flexible tube that's inserted into a vein in the arm and threaded into a large vein in the chest. It's used to deliver intravenous IV fluids) line and was transferred to the hospital. Review of a Nursing Progress Note, dated 8/17/24, indicated Resident #16 pulled out his/her PICC line and was transferred to the hospital. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of the entire medical record failed to indicate Bed Hold Policy Notices had been issued to the Resident/Resident Representative. 2. Resident #25 was admitted to the facility in May 2019 and had diagnoses including chronic obstructive pulmonary disease and unsteadiness on feet. Review of the MDS assessment, dated 10/11/24, indicated Resident #25 had severe cognitive impairment as evidenced by a BIMS score of 4 out of 15 and had a legal Guardian. Review of a Nursing Progress Note, dated 3/24/24, indicated Resident #25 was having difficulty breathing and was transferred to the hospital. Review of a Nursing Progress Note, dated 8/24/24, Resident #25 was found lying on the floor in his/her room and was transferred to the hospital. Further review of the entire medical record failed to indicate Bed Hold Policy Notices had been issued to the Resident/Resident Representative. During an interview on 10/30/24 at 9:18 A.M., Nurse #8 reviewed Resident #16 and #25's medical records and said she could not find evidence the Bed Hold Policy Notices had been issued to the Resident/Resident Representative. During an interview on 10/30/24 at 11:45 A.M., the Regional Nurse said she was unable locate and provide the surveyor with copies of Resident #16's Bed Hold Policy Notices for 7/1/24 and 8/17/24 and Resident #25's Bed Hold Policy Notices for 3/24/24 and 8/24/24.

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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. 48362 Based on observation, interview, and record review, the facility failed to develop and implement an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs for two Residents (#109, #58), out of a total sample of 39 residents. Specifically, the facility failed: 1. For Resident #109, to develop and implement a care plan to address the Resident's chronic pain and pain management; and 2. For Resident #58, to develop and implement a care plan to address the care and management of the Resident's left hand and elbow contracture. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised 1/2024, indicated but was not limited to: - A comprehensive, person-centered care plan will be developed for each resident. - The care plan will include objectives that meet the resident's physical, psychosocial and functional needs and is developed for each resident. - The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, may assist with the development of a comprehensive, care plan for each resident. - The care plan interventions are derived from information gathered as part of the comprehensive assessment. - The resident comprehensive care plan will identify problem areas and their causes as warranted and developing interventions that are targeted and meaningful to the resident. - Evaluation of residents is ongoing and care plans are revised as information about the resident and the resident conditions change. 1. Resident #109 was admitted to the facility in September 2024 with diagnoses which included low back pain, muscle wasting and atrophy, and unsteadiness on feet. Review of the Minimum Data Set (MDS) assessment, dated 9/17/24, indicated the Resident was cognitively intact based on a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of Section J of the MDS indicated the Resident received scheduled and as needed (PRN) pain medications. Review of Resident #109's current Physician's Orders indicated but were not limited to: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Norwood Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Washington Street Norwood, MA 02062	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/11/24: Tylenol Oral Tablet; give two 325 milligram (mg) tabs to equal 650 MG every six hours for pain as needed every 6 hours for pain. - 10/17/24: Oxycodone Tablet 10 mg; give one tablet by mouth every 8 hours as needed for pain. During an interview on 10/22/24 at 12:52 P.M., Resident #109 said he/she frequently has pain during the day. Resident #109 said he/she takes pain medication as needed in the facility. Review of Resident #109's medical record failed to indicate the facility developed a comprehensive care plan addressing chronic pain or pain management, including but not limited to pain diagnoses. During an interview on 10/29/24 at 10:03 A.M., the Nursing Supervisor said care plans are initially generated based off the admission MDS assessment and then updated to reflect new interventions, treatments or changes based on the care plan area. The Nursing Supervisor reviewed the comprehensive care plans for Resident #109 and said there was not a specific care plan related to Resident #109's pain and/or pain management. The Nursing Supervisor said there should have been a specific care plan related to pain and pain management developed and implemented initially when the Resident was admitted to the facility. During an interview on 10/29/24 at 10:59 A.M., the Regional Nurse said care plans are initiated when a resident is admitted to the facility and should be specific and comprehensive to the individual resident's needs. The Regional Nurse said Resident #109 did not have a care plan related to pain and/or pain management. 41106 2. Resident #58 was admitted to the facility in January 2023 with diagnoses which included: non-traumatic intracerebral hemorrhage (brain bleed), aphasia (unable to formulate language due to brain injury), dysarthria and anarthria (complete loss or partial loss of speech), cerebral infarction (stroke), hemiplegia (paralysis on one side) affecting left dominant side. Review of the Hospital Discharge Summary, dated June 2023, indicated but was not limited to the following: - Left arm contracted, spastic. There were no range of motion (ROM) measurements of the left upper extremity (LUE) contracture. Review of the Occupational Therapy Evaluation, dated 9/20/24, indicated patient required skilled occupational services to establish a splint wearing schedule and train caregivers on donning/doffing (putting on/taking off) splint for improved hygiene and to prevent skin breakdown. Review of Occupational Therapy Discharge Summary, dated 3/20/24, indicated the discharge recommendations dated 3/20/24 indicated the following: -Recommending wear palm guard daily (day hours) on LUE: Dependent on nursing to don/doff. -Recommend patient wear left elbow wedge daily (day hours on LUE): Dependent on nursing to don/doff. (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 #58's Care Plan indicated there was no care plan developed for contractures of the left upper extremity since admission. During an interview on 10/29/24 at 3:50 P.M., the Director of Rehabilitation (Rehab) said Resident #58 was currently receiving Occupational Therapy and was also seen last November 2023 through March 2024 for the left arm contracture. During a follow-up interview on 10/30/24 at 11:15 A.M., Rehab Staff #1 reviewed the Occupational Discharge Summary dated 3/20/24 and said there should have been follow-up with the nurses to continue using the palm guards and the elbow wedge for the LUE. During an interview on 10/30/24 at 1:36 P.M., the Director of Nurses (DON) said Resident #58 should have a care plan for the contracture management of the LUE.

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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 34145

Based on observation, interview, and document review, the facility failed to ensure professional standards of care were met for one Resident (#107), out of a total sample of 39 residents. Specifically, the facility failed to ensure staff provided care and maintained the central venous catheter (CVC) tunneled into the right jugular (vein in the neck) of Resident #107 for medication infusions in accordance with current standards.

Findings include:

Review of the Massachusetts 244 CMR Board of Registration in Nursing, Section 3, dated 6/11/21, indicated but was not limited to the following:

-A registered nurse shall bear full and ultimate responsibility for the quality of nursing care he or she provides to individuals or groups. Included in such responsibility is health maintenance, teaching, counseling, collaborative planning and restoration of optimal functioning and comfort.

-A registered nurse shall systematically assess health status, plan, and implement nursing intervention, evaluate outcomes and initiate change when appropriate, collaborate, communicate and cooperate as appropriate with other health care providers.

-A licensed practical nurse bears full responsibility for the quality of health care she or he provides to patients or health care consumers.

-A licensed practical nurse shall assess an individual's basic health status, evaluate outcomes of basic nursing intervention, and initiate or encourage change in plans of care, and collaborate, cooperate, and communicate with other health care professionals.

Review of the Massachusetts Board of Registration in Nursing Advisory Ruling #9324, titled Accepting, Verifying, Transcribing and Implementing Orders, dated as last revised 4/11/2018, indicated but was not limited to the following:

-It is the responsibility of the licensed nurse to ensure there is a proper patient care order from a duly authorized prescriber prior to the administration of any prescription or non-prescription medication or activity that requires which order in accordance with accepted standard of practice and in compliance with the Boards regulations.

-Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.

-The nurse is accountable for ensuring that any orders he or she implements are reasonable based on the nurses knowledge of that particular patient's care.

It is the responsibility and obligation of the nurse to question a patient care order that is deemed inappropriate by a nurse according to his/her educational preparation and clinical experience.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #107 was admitted to the facility in September 2024 and had diagnoses including Staphylococcal arthritis of the left hip, Methicillin Resistant Staph Aureus (MRSA) infection, and chronic renal disease. Review of the Minimum Data Set (MDS) assessment, dated 9/17/24, indicated Resident #107 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 14 out of 15, received intravenous (IV) medications and dialysis. Review of the hospital discharge summary, dated 9/11/24, indicated Resident #107 was hospitalized , d+[DATE]-[DATE] for recurrent infection in his/her left hip caused by MRSA infection. During the hospitalization , a right-sided dual-lumen tunneled cuffed PowerLine catheter (a type of central line) was placed in the right external jugular (REJ) vein for IV antibiotic administration on 9/10/24. Review of PowerLine catheter manufacturer's guidelines indicated: -Flushing: For frequently accessed catheters (accessed at least every 8 hours), flush with 10 milliliters of normal saline between infusions. According to The National Institute of Health (July 2023), needleless connectors and components should be changed with each IV administration set to change, no more frequently than every 72 hours. Central line catheters must be flushed (a manual injection of 0.9% sodium chloride to clean the lumen of the catheter) before and after each fluid or medication infusion, and before and after drawing blood from the central line. Review of admission telephone orders (T.O.), signed and dated as received on 9/11/24 by the Nurse Supervisor included but was not limited to: -Ceftaroline (antibiotic) 400 milligrams (mg) IV every 8 hours until follow up with Infectious Disease Clinic -Vancomycin (antibiotic) 500 mg IV every Tuesday, Thursday, and Saturday at dialysis -Right chest tunneled catheter: double lumens, monitor for signs/symptoms (s/s) of infection, **Dressing to be done at dialysis FYI** -Complete Blood Count with differential, Basic Metabolic Panel, Liver Function Test, Erythrocyte Sedimentation Rate, C-Reactive Protein weekly on Wednesday and fax result to Infectious Disease Clinic The admission T.O.s did not indicate any orders for the care and maintenance of the REJ catheter including flushing the catheter between medication infusions and changing the needleless connectors and components with each IV administration. Review of comprehensive care plans indicated but was not limited to: -Focus: IV access line: Potential for infection and/or trauma related to catheter direct access to blood; type of line: Double lumen line right chest (9/13/24) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: IV medication/flushes per physician's order; IV site care and maintenance as ordered (9/13/24) -Goal: Resident will have no signs/symptoms of any IV related complications through next review (9/13/24) Review of the entire medical record, including the Medication/Treatment Administration Record (MAR/TAR) from 9/11/24 to 9/22/24 failed to indicate catheter flushes between antibiotic medication infusions and a change of the needleless connectors and components with each IV infusion was completed as ordered. Review of September 2024 Physician's Orders indicated but was not limited to: *12 days after the Resident was admitted to the facility: -IV-Central Line (all types) change needleless connector on admission, after any blood draw, every 24 hours with total parenteral nutrition (TPN), otherwise weekly and as needed (prn) (9/23/24) -IV-Central Line (all types) change transparent dressing on admission, weekly and prn (9/23/24) -IV-Central Line (all types) for intermittent use or TPN, change tubing and connectors daily (9/23/24) -IV-Central Line (all types) measure external catheter length on admission, with each dressing change and prn (9/23/24) *14 days after the Resident was admitted to the facility: -IV-Central Line (all types) when being used intermittently, flush with 10 milliliters (ml) NS, infuse medication, and flush again with 10 ml NS (9/25/24) Further review of the September 2024 MAR/TAR failed to indicate: -the needleless connector was changed weekly -the transparent dressing was changed weekly -tubing and connectors were changed daily -the external catheter length was measured with each dressing change Review of October 2024 MAR/TAR failed to indicate: -the needleless connector was changed weekly -the transparent dressing was changed weekly -tubing and connectors were changed daily (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the external catheter length was measured with each dressing change During an interview on 10/28/24 at 1:38 P.M., Nurse #13 said all documentation related to medication and treatment administration for Resident #107's REJ is on the MAR/TAR. She said there is no other place they document that information. During an interview on 10/28/24 at 1:43 P.M., the Nursing Supervisor reviewed Resident #107's paper and electronic medical record and said on 9/23/24 and 9/25/24 he entered batch orders used for residents with central lines that include dressing changes, changing the tubing and connectors, flushing, and to measure the external length of the catheter. He could not explain why there were no orders to care for the Resident's REJ line until he entered the batch orders. He said the dressing changes to the REJ line are done at dialysis so that order should not be an order for the facility. He said the remaining orders did not populate to the MAR/TAR and said he was unable to provide evidence that the physician's orders were implemented. During an interview on 10/28/24 at 3:04 P.M., the Director of Nursing (DON) reviewed Resident #107's physician's orders and said the order to change the dressing and measure the external catheter length should not be there. She said with an REJ device, there are no measurements to be taken and the dressing changes are done at dialysis. The DON said all of the other physician's orders should have been implemented.

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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. 41106 Based on observations, record review, and interviews, the facility failed to monitor and document the range of motion (ROM) for a resident admitted with left arm contractures, failed to implement recommendations from the Occupational therapy assessments for contracture management, and failed to educate the staff on proper application of the position devices currently in use for one Resident (#58), out of a total sample of 38 residents. Findings include: Resident #58 was admitted to the facility in January 2023 with diagnoses which included: non-traumatic intracerebral hemorrhage (brain bleed), aphasia (unable to formulate language due to brain injury), dysarthria and anarthria (complete loss or partial loss of speech), cerebral infarction (stroke), hemiplegia (paralysis on one side) affecting left dominant side. Review of the Minimum Data Set (MDS) assessment, dated 9/13/24, indicated Resident #58 scored 1 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had severe cognitive impairment. Additionally, the MDS indicated the following: -Section B0200 Hearing: Hearing adequate -Section B0600 Speech clarity: speech unclear slurred or mumbled -Section B0700 Makes self-understood: Sometimes understands- responds adequately to simple direct communication only. -Section B0800 Ability to understand others: understands clear comprehension. -Section GG: Resident is dependent with bed mobility, upper body dressing and personal hygiene. Review of the Hospital Discharge Summary, dated June 2023, indicated but was not limited to the following: - Left arm contracted, spastic. There were no range of motion (ROM) measurements of the left upper extremity (LUE) contracture. Review of the Occupational Therapy Evaluation, dated 9/20/24, indicated there was no ROM measurements for the left hand or elbow. The current referral indicated Resident #58 was referred to therapy for evaluation for a left upper extremity contracture. Patient required skilled occupational services to establish a splint wearing schedule and train caregivers on donning/doffing (putting on/taking off) splint for improved hygiene and to prevent skin breakdown. Review of the Occupational Therapy Evaluation, dated 11/29/23, and Discharge Summary, dated 3/20/24, indicated there were no ROM measurements for the left elbow or hand. The discharge recommendations dated 3/20/24 indicated the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Recommending wear palm guard daily (day hours) on LUE: Dependent on nursing to don/doff. -Recommend patient wear left elbow wedge daily (day hours on LUE): Dependent on nursing to don/doff. Resident #58 was also seen by Occupational Therapy 1/5/23 through 2/10/23, however the documentation could not be assessed in the electronic medical record. Review of the Physician's Order Summary report 1/5/24 through 10/31/24 indicated there were no orders for Resident #58 to don/doff palm guards, foam carrot, or elbow wedge for contracture management. On 10/22/24 at 10:43 A.M., the surveyor observed Resident #58 lying in bed with the foam wedge by his/her elbow and the foam carrot on the windowsill. On the wall behind the Resident's bed was a sign posted which read Please keep foam wedge between Resident #58's left elbow. On 10/29/24 at 1:02 P.M., the surveyor observed the foam carrot lying on the bed next to his/her right hand. The elbow wedge was observed to be between the left elbow and left upper side rail (not in the elbow crease). During an interview on 10/29/24 at 3:50 P.M., the Director of Rehabilitation (Rehab) said Resident #58 was currently receiving Occupational Therapy and was also seen last November 2023 through March 2024 for the left arm contracture. Rehab Staff #1 said he started working back in this facility in September 2024 and noticed Resident #58's left arm contracture and had Resident #58 evaluated by the occupational therapist for contracture management. The surveyor requested the occupational therapy evaluations, daily notes, and discharge summaries. During an interview on 10/29/24 at 4:42 P.M., Resident #58 was able to answer the surveyors' questions by nodding his/her head yes and no. Resident #58 nodded yes to wearing the foam carrot in his/her left hand. Resident #58 picked up the foam carrot with their right hand and attempted to place the carrot in their left hand but was unsuccessful due to the left-hand contracture. The surveyor observed the left elbow foam wedge placed between the left elbow and the left upper side rail. Resident #58 nodded no when the surveyor asked if he/she knew where the foam wedge was supposed to be placed. On 10/30/24 at 9:30 A.M., the surveyor observed Resident #58 lying in bed with the Foam carrot on the overbed table and the left elbow foam wedge located between the left elbow and the left upper side rail. The left elbow and wrist were observed to be fully flexed. During a follow-up interview on 10/30/24 at 11:15 A.M., Rehab Staff #1 reviewed the Occupational Evaluations, Discharge Summary, and daily notes on the computer and said he noticed there was no documentation of ROM of the LUE since admission. He said the rehab staff should have documented the ROM of the LUE at the very least on the evaluation and discharge summaries. He reviewed the Occupational Discharge Summary dated 3/20/24 and said there should have been follow-up with the nurses to continue using the palm guards and the elbow wedge for the LUE. On 10/30/24 at 11:35 A.M., the surveyor with Rehab Staff #1 entered Resident #58's room and observed the foam carrot on the overbed table and the foam wedge positioned between the left elbow and the left upper side rail (Foam wedge was not in the elbow crease). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 11:35 A.M., Resident #58 answered questions by using hand gestures, motioning thumbs up/down or nodding yes/no with Rehab Staff #1 present. Resident #58 indicated with a thumbs down he/she did not know where the foam wedge was supposed to go and a thumbs up for the foam carrot. Resident #58 attempted to put the foam carrot in his/her left hand but was unsuccessful due to the contracted fingers. Resident #58 nodded yes to his/her hand and elbow contracture have gotten worse since he/she came to this facility. Rehab Staff #1 attempted to open Resident #58's left hand and extend the left elbow; the surveyor observed the left thumb to be restricted flexed across the palm of the hand and the left elbow restricted to approximately minus 120 degrees of extension. During a telephonic interview on 10/30/24 at 12:55 P.M., Rehab Staff #2 said she has been working with Resident #58 for contracture management and the foam carrot should be placed in his/her palm and the foam wedge should be placed in his/her left elbow crease for contracture management. Rehab Staff #2 said she posted the sign on the wall to remind staff to reposition the elbow wedge when Resident #58 removes it or it falls out of place. Rehab Staff #2 said she has not educated the nursing staff on donning/doffing the elbow foam wedge. She said she was not aware the nursing staff was positioning the wedge on the outside of the elbow (not in the crease). Rehab Staff #2 said she is not aware of the ROM measurements for the left wrist and elbow but does not feel the contractures are any worse since Resident #58's admission. During an interview on 10/30/24 at 1:00 P.M., Nurse Supervisor #1 said if a resident is seen by rehab and they recommend any type of support for positioning, they tell us, and we get the physician's orders for the treatment. He said he does not have any orders for an elbow wedge or foam carrot for Resident #58 in the computer. He said if there is no order then the nurses would not know to put the foam carrot or wedge on the Resident. Nurse Supervisor #1 said Resident #58 has had a contracture of the left arm since he/she was admitted . During an interview on 10/30/24 at 1:06 P.M., Nurse #12 (Agency nurse) said she is taking care of Resident #58 and is not aware he/she is supposed to use a foam carrot or foam wedge for positioning on the LUE. She said when she cares for a resident, she looks at the Medication and Treatment Administration Record (MAR and TAR) for what she is supposed to do with a resident. She reviewed Resident #58's MAR and TAR and said there are no physician's orders so she would never check for the foam carrot or the foam wedge as part of her treatment. During an interview on 10/30/24 at 1:08 P.M., Nurse #11 said sometimes she works with Resident #58, but she doesn't know anything about the foam carrot, foam wedge, or positioning for his/her contractures. During an interview on 10/30/24 at 1:10 P.M., Certified Nursing Assistant (CNA) #4 said she regularly cares for Resident #58. She said she has seen Rehab put the foam pad under Resident #58's elbow so that is what she does. She demonstrated and showed the surveyor under the elbow, not in the elbow crease, and showed how she pulls back the fingers to put the foam carrot in the left hand. She said she never received any instructions on how to put on the foam elbow pad or the carrot. During an interview with the Director of Nurses (DON) and Regional Clinical Nurse on 10/30/24 at 1:36 P.M., the DON said once rehab makes a recommendation and it is communicated to the nurses, the nurses should follow-up with obtaining physician's orders if that's what they want. The Regional Clinical Nurse said they do not have a policy for contracture management. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of the end of the survey, the Occupational Therapist (OT) who performed the most recent OT evaluation was not available to the surveyor for interview.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48695 Based on observation and interview, the facility failed to ensure staff provided residents with an environment free from accident hazards. Specifically, the facility failed to ensure: 1. On one unit of three units, hazardous items were stored in a secure location and were not easily accessible to residents on the South 2 Unit; and 2. For Resident (#54) and one unit (Unit 2) of three units in the facility, nail clippers, diabetic testing supplies and medications (not prescribed by the Resident's physician) were not stored in the Resident's bureau and were not easily accessible to the Resident and wandering residents on the unit. Findings include: Review of the facility Matrix (used to identify pertinent care categories for residents) provided to surveyors by the Director of Nursing on 10/22/24 indicated the South 2 Unit had 29 out of 34 residents with diagnoses of Alzheimer's disease/Dementia. 1. On 10/23/24 at 12:38 P.M., the surveyor observed in the South 2 Unit hallway: - A yellow bucket (unattended) containing: - Three metal scrappers - A box of nails - A metal trowel - Loose screws - A one-gallon bucket (unattended) of vinyl composition tile adhesive On 10/23/24 at 2:00 P.M., the surveyor observed a resident, on the South 2 Unit, walk by the vinyl composition tile adhesive and the yellow bucket and its contents. During an interview with observation on 10/23/24 at 4:27 P.M., Nurse #8 and the surveyor reviewed the contents of the yellow bucket and the vinyl composition tile adhesive. Nurse #8 said the maintenance department was doing work and that it was a safety hazard. Nurse #8 then took a linen cart and moved it in front of the yellow bucket and the vinyl composition tile adhesive. During an interview on 10/29/24 at 12:03 P.M., the Regional Director of Maintenance and the surveyor reviewed the contents of the yellow bucket and the one-gallon bucket of vinyl composition tile adhesive. The Regional Director of Maintenance said they should never have been left out in the hallway and accessible to residents because it was a safety hazard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/24 at 12:39 P.M., the Regional Clinical Nurse said the yellow bucket with its contents and the bucket of vinyl composition tile adhesive should not have been left out in the hallway unattended and accessible to residents for their safety. 34145 2. Resident #54 was admitted to the facility in February 2024 and had diagnoses including diabetes mellitus, dementia, and psychotic disorder. Review of the Minimum Data Set assessment, dated 8/9/24, indicated Resident #54's cognitive status was not assessed and the Resident received insulin injections daily. On 10/22/24 at 10:35 A.M., the surveyor observed two nail clippers placed on top of the bedside dresser, one bottle of glipizide (anti-diabetic medication), two large prescription bottles of metformin (anti-diabetic medication), a zippered pouch with six insulin pens of Novolog (anti-diabetic), two zippered pouches with a glucometer (device used to measure the concentration of glucose in the blood), test strips, and lancet pen (used to make punctures, such as a fingerstick, to obtain small blood specimens). Resident #54 said he/she keeps these items in his/her bureau and checks his/her own blood sugar. The Resident said the Nurses also check his/her blood sugar. Review of the medical record failed to indicate a self-administration assessment or physician's order to keep medications and diabetic testing supplies at the bedside. On 10/29/24 at 10:30 A.M., the surveyor observed three residents ambulating in the Unit 2 hallway unsupervised. No staff were noted in the vicinity at the time of the observation. On 10/29/24 at 10:33 A.M., the surveyor observed two nail clippers, one pair of scissors, one disposable razor, two zippered pouches with a glucometer, test strips, and a lancet pen placed on top of the bedside dresser. The top drawer of the Resident's bureau was open and contained two large prescription bottles of metformin and a plastic case containing six insulin pens of Novolog. Resident #54 was not in his/her room and the door was wide open and accessible to any wandering residents on the unit. On 10/29/24 at 10:42 A.M., Nurse #8 and the surveyor observed two nail clippers, one pair of scissors, one disposable razor, two zippered pouches with a glucometer, test strips, and a lancet pen placed on top of the bedside dresser. Inside the top drawer of the Resident's bureau were two large prescription bottles of Metformin and a plastic box containing six insulin pens of Novolog and lancets. The Nurse said she had no idea they were there. Nurse #8 said the Resident does not self-administer any medications and they should not be in his/her room as it is a safety hazard.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42742 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for the care of an indwelling suprapubic catheter (tube that drains urine from the bladder through a small incision in the lower abdomen and into a collection bag outside the body) for one Resident (#12), out of total sample of 29 residents. Specifically, the facility failed to ensure the Resident's suprapubic catheter device was maintained in a sanitary way. Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance titled Summary of Recommendations, Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated March 2024, indicated but was not limited to the following: -Do not rest the bag on the floor. Resident #12 was admitted to the facility in October 2020 and had diagnoses including neuromuscular dysfunction of the bladder and hydronephrosis (excess fluid in a kidney due to a backup of urine) with renal and ureteral calculus (stone) obstruction. Review of the Minimum Data Set (MDS) assessment, dated 9/6/24, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had an indwelling catheter. Review of current Physician's Orders indicated the following: -Change Foley catheter bag as needed if blockage or out as needed for blockage/leakage, 12/6/19 -Privacy bag for supra pubic Foley cath (sic) drainage bag every shift, 6/28/19 -Suprapubic Catheter 20 French (Fr)/10 milliliter (ml) continuous to drainage bag every shift, 10/30/24 Review of the Suprapubic Catheter care plan, initiated 7/1/19, indicated the goal was to not develop any complications associated with catheter usage. During an observation with interview on 12/10/24 at 8:22 A.M. and 9:29 A.M., the surveyor observed Resident #12 lying in bed. A urinary catheter was observed draining yellow urine into a drainage bag which was fully resting on the floor. The bag did not have a protective barrier underneath potentially exposing it to environmental contaminants. The drainage bag was not stored inside a privacy bag per physician's orders. Resident #12 said he/she goes to the urologist every two weeks to have the catheter changed but staff care for it at the facility. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 12/10/24 at 9:32 A.M., the surveyor entered the Resident's room with Nurse #7 and observed Resident #12 lying in bed. A urinary catheter was observed draining yellow urine into a drainage bag which was fully resting on the floor. The bag did not have a protective barrier underneath potentially exposing it to environmental contaminants. The drainage bag was not stored inside a privacy bag per physician's orders. Nurse #7 said the bag should not have been on the floor because of infection control reasons and it could get stuck. She said it's usually hanging. As Nurse #7 lifted the drainage bag off the floor, the surveyor observed yellow urine dripping from the valve and the corner of the drainage bag onto the floor. Nurse #7 said she adjusted the valve, but the bag was still leaking so she needed to find a bucket and replace the drainage bag. During an interview on 12/10/24 at 1:45 P.M. with the Director of Nursing (DON) and Consulting Staff #1, the DON said the Resident puts the bag on the floor and was care planned for it to address it. The surveyor reviewed the Resident's comprehensive care plans with the DON who said he was not. She said the catheter drainage bag should not have been on the floor due to infection control purposes and to ensure the bag does not get damaged. The DON further said it should have been stored inside a privacy bag.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 48362 Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care and services to three Residents (#51, #31, #17), out of a total sample of 39 residents. Specifically, the facility failed to maintain sanitary conditions of respiratory equipment, including nasal cannula tubing, nebulizer mask/tubing, bilevel positive airway pressure (BiPAP) mask/tubing, and/or continuous positive airway pressure (CPAP) mask/tubing to decrease the risk of potential contamination of germs and/or exposure to infection. Findings include: 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: -Undesirable results or events may result from noncompliance with physicians' orders or inadequate instruction for oxygen therapy. -Equipment maintenance and supervision: All oxygen delivery equipment should be checked at least once daily. 1. Resident #51 was admitted to the facility in September 2021 with diagnoses including complete C1-C4 (Cervical Spine Vertebra 1-4) quadriplegia and chronic respiratory failure. Review of the Minimum Data Set (MDS) assessment, dated 9/6/24, indicated Resident #51 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS assessment indicated the Resident did not require continuous oxygen use and had shortness of breath (SOB) when lying flat. Review of Resident #51's current Physician's Orders indicated but was not limited to: - 9/3/23: Oxygen at 2 liters per minute (LPM) via nasal cannula as needed. - 8/12/24: Albuterol Sulfate Nebulization Solution 0.083%; 3-milliliters (mL) via mask every 6 hours as needed for SOB/wheezing. On 10/22/24 at 10:48 A.M., the surveyor made the following observations: - Oxygen concentrator was in the room below the windowsill and was not being utilized by the resident. - Oxygen tubing was attached to the concentrator and located on the ground underneath Resident #51's bed, not located in a plastic bag. The oxygen tubing was not dated. - A nebulizer mask and tubing were located on top of a bedside dresser, undated. The nebulizer mask and tubing were open to air and not located in a plastic bag or other storage system. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 10:48 A.M., Resident #51 said he/she uses a nebulizer and oxygen as needed. Resident #51 said nursing staff change the tubing for the oxygen and nebulizer but he/she was unsure of the last time it was completed. 2. Resident #31 was admitted to the facility in May 2024 with diagnoses including chronic respiratory failure, asthma and chronic obstructive pulmonary disorder (COPD). Review of the MDS assessment, dated 8/30/24, indicated Resident #51 was cognitively intact as evidenced by a BIMS score of 14 out of 15. Further review of the MDS assessment indicated the Resident required oxygen use and had shortness of breath (SOB) when lying flat. Review of Resident #31's current Physician's Orders indicated but were not limited to: - 5/29/24: Oxygen at 3 LPM via nasal cannula continuous during the day. - 5/29/24: Change oxygen tubing every night shift every Friday. - 5/29/24: Albuterol Sulfate Inhalation Nebulization Solution (2.5MG/3mL) 0.083%; 3 mL via mask every two hours as needed for SOB/wheezing. - 5/29/24: BiPAP scheduled start at 10:30 P.M.; Discontinue 7 A.M. - 5/29/24: BiPAP Machine Non-Disposable Tubing Care: wash tubing in warm soapy water, rinse and let air dry weekly every Thursday. - 5/29/24: BiPAP Machine Daily Care: remove mask from head gear, clean mask with warm soapy water, BIPAP wipe or approved cleaner, dry daily. On 10/22/24 at 11:03 A.M., the surveyor made the following observations: - Resident #31 was resting in bed on 3 liters (L) of oxygen via nasal cannula. - The nasal cannula inserted into Resident #31's nose was noted to have an orange/brown discoloration. - The nasal cannula oxygen tubing was dated 10/4/24. - A nebulizer mask and tubing were located on Resident #31's bedside dresser not dated or located in a plastic bag. - A BiPAP mask was located inside a cardboard box filled with papers and not stored in a plastic bag. During an interview on 10/22/24 at 11:03 A.M., Resident #31 said he/she has their nasal cannula tubing and nebulizer mask/tubing changed every two weeks. Resident #31 said he/she can take off his/her BiPAP mask, but staff need to store it after it is removed. Resident #31 said he/she could not remember the last time respiratory equipment was changed or cleaned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #17 was admitted to the facility in May 2024 with diagnoses including chronic respiratory failure and obstructive sleep apnea. Review of the MDS assessment, dated 8/30/24, indicated Resident #17 was cognitively intact as evidenced by BIMS score of 14 out of 15. Further review of the MDS assessment indicated the Resident required oxygen use. Review of Resident #17's current Physician's Orders indicated the following: - 5/25/24: Oxygen at 2 LPM via nasal cannula continuous every shift. - 5/25/24: Change oxygen tubing every night shift every Thursday. - 5/25/24: Wipe down concentrator and clean filter weekly every evening shift every Thursday. - 5/25/24: May titrate oxygen from 2 L to 3.5 L to maintain oxygen saturation above 89% every shift and as needed. - 5/25/24: CPAP/BiPAP Machine Non-Disposable Tubing Care: wash tubing in warm soapy water, rinse and let air dry weekly every evening shift every Thursday. - 5/25/24: CPAP Machine Daily Care: remove mask from head gear, clean mask with warm soapy water or CPAP wipe, clean humidifier chamber with warm soapy water, rinse humidifier chamber with water and let air dry, no refill water needed, every evening shift. - 5/25/24: CPAP at Bedtime: setting device; auto set CPAP oxygen 2 LPM auto set; 4-20 centimeters (cm) water full mask size large; apply CPAP at 10 P.M.; remove in A.M. On 10/22/24 at 9:00 A.M., the surveyor made the following observations: - A nebulizer and CPAP mask/tubing were resting on a bookshelf next to Resident #17's bed. The nebulizer and CPAP mask/tubing were not stored in plastic bags. The nebulizer mask tubing was dated 10/5/24. - An oxygen concentrator was set to 2.5 LPM and running. Resident #17 was utilizing oxygen via nasal cannula tubing that was not dated. On 10/28/24 at 9:19 A.M., the surveyor made the following observations: - A nebulizer mask/tubing was undated and observed on the floor next to Resident #17's bed. - A CPAP mask/tubing was resting on a bookshelf next to Resident #17's bed not stored in a plastic bag. During an interview on 10/22/24 at 9:07 A.M., Resident #17 said nursing staff try to change the oxygen tubing once a week. Resident #17 said he/she was not sure when the last time their respiratory equipment was changed or cleaned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/28/24 at 9:52 A.M., Resident #17 said their nebulizer mask and tubing had been on the floor for a while. Resident #17 said he/she was not sure how the nebulizer mask/tubing got on the floor. Resident #17 said he can remove his/her nebulizer mask and/or CPAP mask but cannot store them without assistance from staff. During an interview on 10/28/24 at 10:04 A.M., Nurse #1 said respiratory equipment is typically changed or replaced on a weekly basis. Nurse #1 said orders will populate for the nurse on the shift when respiratory equipment is due to be changed or cleaned. Nurse #1 said respiratory equipment is typically stored in a plastic bag when not in use. Nurse #1 said if respiratory equipment is improperly stored or found on the floor it should be replaced with new equipment. During an interview on 10/29/24 at 9:57 A.M., the Nursing Supervisor said nasal cannula oxygen tubing is changed on a weekly basis. The Nursing Supervisor said respiratory tubing should be dated when it is changed by nursing staff. The Nursing Supervisor said when respiratory equipment is not in use it should be stored in plastic bags in the resident room. The Nursing Supervisor and the surveyor reviewed the observations made for Residents #51, #31 and #17. The Nursing Supervisor said the respiratory equipment was not stored or changed properly. During an interview on 10/29/24 at 10:59 A.M., the Regional Nurse said the facility changes respiratory tubing on a weekly basis. The Regional Nurse said respiratory equipment should be stored in a plastic bag when not in use. The Regional Nurse said respiratory equipment should be replaced if it was found on the floor or improperly stored.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. 34145 Based on record review and interview, the facility failed to address a history of trauma (results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being) identified on trauma assessments and failed to thoroughly assess and to develop a plan of care accounting for Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for one Resident (#8), with a self-reported history of trauma, out of a total sample of 39 residents. Findings include: Review of the facility's policy titled Trauma Informed Care, last revised 10/2019, indicated but was not limited to: -As part of the comprehensive assessment, identify history of trauma or interpersonal violence when such information is provided to the facility. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. Resident #8 was admitted to the facility in October 2021 and had diagnoses including major depression, anxiety, and psychotic disorder. Review of the Minimum Data Set (MDS) assessment, dated 9/6/24, indicated Resident #8 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 11 out of 15, expressed having little interest or pleasure in doing things (7-11 days during the review period) and feeling down depressed or hopeless (2-6 days during the review period). Review of a comprehensive Social Service Evaluation, section IV Psychosocial Well-Being/Trauma Informed Care, dated 5/17/24 and completed by a Social Worker no longer employed at the facility, indicated but was not limited to: Have you witnessed or experienced: -Assault with a weapon- witnessed -Sexual assault of any kind- witnessed -Combat or Exposure to War-Zone- witnessed -Captivity (kidnapping or abduction)- witnessed -Life threatening illness or injury- witnessed -Severe human suffering of others- witnessed (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sudden or violent death- witnessed -Unexpected death of someone close to you- witnessed -Serious injury you caused to someone- witnessed -Discrimination based you your gender identity- witnessed -Bullying- witnessed Review of a comprehensive Social Service Evaluation, section IV Psychosocial Well-Being/Trauma Informed Care, dated 8/20/24 and completed by a Social Worker no longer employed at the facility, indicated but was not limited to: Have you witnessed or experienced: -Assault with a weapon- witnessed -Sexual assault of any kind- witnessed -Combat or Exposure to War-Zone- witnessed -Captivity (kidnapping or abduction)- witnessed -Life threatening illness or injury- witnessed -Severe human suffering of others- witnessed -Sudden or violent death- witnessed -Unexpected death of someone close to you- witnessed -Serious injury you caused to someone- witnessed -Discrimination based you your gender identity- witnessed -Bullying- witnessed Review of a comprehensive Social Service Evaluation, section IV Psychosocial Well-Being/Trauma Informed Care, dated 9/10/24 and completed by the consultant Social Worker, indicated, but was not limited to: -Life threatening illness or injury- witnessed -Severe human suffering of others- witnessed -Bullying- witnessed (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the medical record failed to indicate a care plan with individualized interventions with identified triggers for the prevention of potential re-traumatization had been developed. During a telephone interview on 10/29/24 at 12:50 P.M., the consultant Social Worker said he has been a consultant at the facility for many years and comes into the facility on e to two times per week. He said over the past three to six months, he has helped with resident evaluations to keep up with MDS assessments. He said he does not participate in the care planning process at all. However, if something comes up during the social service evaluations, he checks the care plans and creates one if there isn't one there. The surveyor reviewed the documented results of section IV Psychosocial Well-Being/Trauma Informed Care of the comprehensive Social Service Evaluations dated 5/17/24, 8/20/24, and 9/10/24 with the consultant Social Worker. He said Resident #8 should have had a trauma care plan developed with approaches tailored to the Resident's experiences to minimize re-traumatization based on all three of the Social Service evaluations, and it wasn't done. During an interview on 10/30/24 at 10:49 A.M., the Administrator said the facility has not had a full time Social Worker employed by the facility in several months.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48695 Based on observations and interview, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to ensure the treatment carts were locked when not in direct supervision of the licensed nurse on three of three units. Findings include: Review of the facility's policy titled Storage of Medications, dated September 2018, indicated but was not limited to: - Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access. The surveyor made the following observations on: -10/23/24 at 8:51 A.M., a treatment cart unlocked and unattended on the North 1Unit. -10/23/24 at 12:34 P.M., a treatment cart unlocked and unattended on the South 2 Unit. -10/23/24 at 12:41 P.M., a treatment cart unlocked and unattended on the South 2 Unit. -10/23/24 at 2:11 P.M., a treatment cart unlocked and unattended on the North 2 Unit, 1 resident walked by the treatment cart. -10/23/24 at 3:12 P.M., a treatment cart unlocked and unattended on the North 1 Unit. -10/23/24 at 4:26 P.M., a treatment cart unlocked and unattended on the South 2 Unit, 2 residents in the hallway near the treatment cart. -10/29/24 at 3:05 P.M., a treatment cart unlocked and unattended on the North 1 Unit. During an interview on 10/23/24 at 3:29 P.M., Nurse #4 observed the unlocked and unattended treatment cart on the North 1 Unit and said the treatment cart contains medicated creams and treatment supplies and should be locked for safety reasons. During an interview on 10/29/24 at 3:16 P.M., Nurse #8 said if a treatment cart was not being used, then it should be locked. Nurse #8 said treatment carts should never be unlocked and unsupervised. During an interview on 10/30/24 at 8:04 A.M., Nurse #10 said it was not safe to leave treatments carts unlocked and unsupervised. Nurse #10 said treatment carts should be locked when not in use and not in direct view of the nurse. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/24 at 8:12 A.M., Nurse #9 said treatment carts must be locked when unattended for safety. During an interview on 10/30/24 at 10:23 A.M., the Regional Clinical Nurse said the expectation was for treatment carts to be locked and secured when not in use and should not be left unsupervised if the treatment cart was unlocked.

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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. 48695 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to properly label and date food products in the main kitchen. Findings include: Review of the facility's policy titled Food and Supply Storage, last revised 6/2018, indicated but was not limited to: - Policy: Food, non-food items, and supplies used in food preparation and service shall be stored in such a manner as to maintain safety and sanitation of the food or supply for human consumption as outlined in the Federal Drug Administration Food Code, state regulations, and city/county health codes. - Labeling and rotating food supply -Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and use by dates. -Follow recommendations from the manufacturer when indicated on the product for storage time and storage location. -Food removed from its original container must be labeled with the common name of the food. -Discard food that exceeds their use by date or expiration date, is damaged, is spoiled, has exceeded the time and temperature danger zone requirements, or is incorrectly stored such that it is unsafe or its safety is uncertain. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated but was not limited to: - 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A)Except when PACKAGING FOOD using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 Celsius (41 Fahrenheit) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(B)Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. - 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). On 10/22/24 at 7:35 A.M., the surveyor observed in the main kitchen walk-in refrigerator: - Pasta salad open date 10/11/24, expiration date 10/17/24. - Cucumber peeled and wrapped in plastic wrap, not dated. - Container of cooked breakfast sausage, not dated. - Container of cooked chicken tenders, dated 10/18/24, use by 10/21/24. - Container of gravy, not dated. - Container of cooked rice, dated 10/18/24, use by 10/21/24. - Opened container of hot dogs, not dated. - A bag of cubed cheese, best by 8/27/24. On 10/28/24 at 7:57 A.M., the surveyor observed in the main kitchen walk-in refrigerator: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Container of cooked rice, dated 10/23/24, use by 10/26/24. During an interview on 10/22/24 at 7:35 A.M., the Food Service Director (FSD) said the pasta salad, peeled cucumber, breakfast sausage, chicken tender, gravy, cooked rice, hot dogs, and cubed cheese should have been disposed of and open food items should be labeled. During an interview on 10/29/24 at 2:36 P.M., the Regional FSD said food should always be labeled with an open/prepared on date and use by date. The Regional FSD said once a food is prepared it is only good for three days. The Regional FSD said food should not be in the refrigerator after the use by date or the expiration date. The Regional FSD said her expectation is for food to be stored and labeled properly and should be discarded after the use by date/expiration date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43935 Based on record review and interview, the facility failed to maintain medical records that were complete and accurate within accepted professional standards of practice for six Residents (#86, #96, #24, #12, #45 and #54), out of a total sample of 39 residents. Specifically, the facility failed to: 1. Ensure physician visits were available in the medical record within a timely manner for Residents #86 and #96; 2. Ensure the medical record contained accurate information regarding Residents #24 and #12's suprapubic tube (a tube surgically placed to empty the bladder of urine); and 3. Ensure clinical Substance Abuse assessments and notes were readily accessible and part of the medical record for Residents #45 and #54. The facility identified an additional 32 residents diagnosed with alcohol abuse and/or substance abuse. Of these 32 residents, the facility failed to ensure 32 residents' Substance Abuse assessments and notes were readily accessible and part of the medical record. Findings include: Review of the facility's policy titled Charting and Documentation, dated as last revised 10/2019, indicated but was not limited to the following: - all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition should be documented in the resident's medical record - documentation of treatments will include care-specific details 1A. Resident #86 was admitted to the facility in August 2023 with diagnoses including unspecified protein-calorie malnutrition, cerebral infarction (stroke), and Type 2 diabetes. Review of Resident #86's medical record on 10/29/24 failed to indicate the Resident had been seen by a Physician or Nurse practitioner (NP) in the facility since February 2024. During an interview on 10/29/24 at 3:34 P.M., the Nursing Supervisor said all Physician and NP notes should be uploaded in the miscellaneous section of the Resident's medical record. He reviewed the medical record for Resident #86 and said no facility Physician or NP notes were available in the medical record since February 2024. (continued on next page)

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 10/29/24 at 3:57 P.M., Physician #2 said she sees Resident #86 routinely. She said she personally visited and evaluated the Resident in both August and September of this year and her Physician Assistant (PA) saw and evaluated the Resident recently this month. She said her notes must not have been uploaded into the medical record yet. She said she would send the visit notes to the facility today to ensure the medical record is complete and up to date with the most recent information.

During an interview on 10/30/24 at 8:05 A.M., the Director of Nurses reviewed Resident #86's medical record and said the record remained incomplete with missing physician visit notes since February 2024 at this time. She said records should always be up to date and complete and that missing months of physician or clinician notes makes the record incomplete. She said the system needs to be worked on to ensure notes are being uploaded into the medical record timely.

During an interview on 10/30/24 at 9:13 A.M., the Medical Records Clerk said there was a glitch in the electronic medical record system a few months ago. He said that Physician #2 had just started securely emailing all the visit notes to him for them to be placed into the medical record approximately three or four weeks ago and he has not gotten around to putting them in the medical record yet. He said he realizes that the medical record for any given resident is incomplete if it does not contain documentation of visits provided and he is trying to find time to complete that task and get the facility back into compliance.

48695

B. Resident #96 was admitted to the facility in November 2023 with diagnoses including right hip fracture and dementia.

Review of the medical record for Resident #96 failed to indicate the Resident had been seen by a Physician or PA in the facility since February 2024.

During an interview on 10/29/24 at 10:11 A.M., Nurse #3 reviewed Resident #96's medical record. Nurse #3 said she had not seen any current Physician or PA notes in Resident #96's medical record.

During an interview on 10/30/24 at 9:32 A.M., the Medical Records Clerk said he had not realized until recently that he was supposed to upload the Physician/PA notes into each resident's medical record, and he had not been trained on how to upload the notes.

During a telephonic interview on 10/30/24 at 10:57 A.M., Physician #2 said either she or her PA had seen Resident #96 at a minimum of once a month. Physician #2 said she had last seen Resident #96 in September 2024 and Resident #96 had been seen by the PA two more times since then.

During an interview on 10/30/24 at 10:23 A.M., the Regional Clinical Nurse said Resident #96's medical record was incomplete with missing physician/PA visit notes and the expectation was for each resident to have a complete and accurate medical record.

2. Review of the facility's policy titled Foley Catheter Insertion, Male Resident, last revised December 2020, indicated but was not limited to:

- Documentation:

(continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The size of the Foley catheter inserted and the amount of fluid used to inflate the balloon. A. Resident #24 was admitted to the facility in May 2020 with diagnoses which included urinary tract infection and urethral fistula (abnormal opening that forms between the urethra and another hollow organ, such as the bladder or bowel). Review of Resident #24's Minimum Data Set (MDS) assessment indicated Resident #24 had an indwelling catheter. Review of Resident #24's current Physician's Orders indicated but were not limited to: - Suprapubic catheter 14F (sic) (dated 7/8/24) Review of Resident #24's care plan indicated but was not limited to: - Focus: Resident #24 has a Supra Pubic (sic) catheter 16 Fr (French) and 10 mL (milliliter) [NAME]. (revision date 10/14/24) Review of Resident #24's interventional radiology brief post operative report, dated 8/5/24, indicated but was not limited to: - Findings: 18 Fr Foley in the bladder. During an interview with observation on 10/29/24 at 3:05 P.M., Nurse #3 and the surveyor observed Resident #24's suprapubic catheter labeled 18 Fr/10 cc (milliliter) balloon. Nurse #3 said Resident #24 had his/her suprapubic catheter changed by his/her urologist. During an interview on 10/30/24 at 8:04 A.M., Nurse #10 said when a resident goes out to an appointment, he/she would return to the facility and the nurse on duty would review the information from the appointment and examine the catheter for size. Then, the nurse would call the physician or the physician extender and obtain a physician's order for the updated size. During an interview on 10/30/24 at 9:58 A.M., the Nursing Supervisor said when Resident #24 returned to the facility from his/her appointment the nurse on duty should have reviewed the paperwork and inspected the catheter for the size. The Nursing Supervisor said it was important to know the correct size of Resident #24's catheter in case it fell out and needed to be replaced. During an interview on 10/30/24 at 10:23 A.M., the Regional Clinical Nurse said Resident #24's medical record should have accurately identified the size of his/her catheter. B. Resident #12 was admitted to the facility in June 2019 with diagnoses including neuromuscular dysfunction of bladder (condition that occurs when the nerves and muscles of the bladder don't work together properly). Review of Resident #12's MDS assessment indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had an indwelling catheter. Review of Resident #12's current Physician's Orders indicated but were not limited to: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Suprapubic catheter 14Fr/10ml continuous to drainage bag (6/28/19) - Suprapubic Foley to be changed at Urologist office monthly with 20Fr/10ml (7/3/24) Review of Resident #12's care plan indicated but was not limited to: - Focus: Suprapubic Catheter (revision date 7/3/23) - Intervention: Catheter size 14 [NAME] size 10cc (Revision date 7/1/19) Review of Resident #12's medical record indicated but was not limited to the following: - Urology Consult, dated 4/4/24, 20 French Foley catheter was inserted - Urology Consult, dated 5/6/24, 20 French Foley catheter was inserted - Urology Consult, dated 8/22/24, 20 French Foley catheter was inserted - Urology Consult, dated 9/17/24, 20 French Foley catheter was inserted - Urology Consult, dated 10/8/24, 20 French Foley catheter was inserted During an interview on 10/22/24 at 9:06 A.M., Resident #12 said he/she would go out to the urologist to have his/her suprapubic catheter changed. During an interview with observation on 10/28/24 at 1:32 P.M., Nurse #4 and the surveyor examined Resident #12's suprapubic catheter labeled 20 Fr/10 cc balloon. Nurse #4 said Resident #12 had his/her suprapubic catheter changed by his/her urologist and not at the facility. During an interview on 10/30/24 at 8:04 A.M., Nurse #10 said when a resident would go out to an appointment, he/she would return to the facility and the nurse on duty would review the information from the appointment and examine the catheter for size. Then, the nurse would call the physician or the physician extender and obtain a physician's order for the updated size. During an interview on 10/30/24 at 9:58 A.M., the Nursing Supervisor said when Resident #12 returned to the facility from his/her appointment the nurse on duty should have reviewed the paperwork and inspected the catheter for the size. The Nursing Supervisor said it was important to know the correct size of Resident #12's catheter in case it fell out and needed to be replaced. During an interview on 10/30/24 at 10:23 A.M., the Regional Clinical Nurse said Resident #12's medical record should have accurately identified the size of his/her catheter. 34145 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an interview on 10/30/24 at 10:49 A.M., the Administrator said the facility contracts with a Licensed Alcohol and Drug Counselor (LADC) who comes into the building and sees residents when needed. He said nursing provides the referrals for residents that are admitted with diagnoses of substance abuse. He said the LADC last visited the building in May of 2024 and met with several residents. He provided the surveyor with an invoice for visits to 32 residents (including Residents #45 and #54) on 5/4/24 and two residents on 5/6/24. The Administrator said he does not know where the Counselor's assessments and notes are kept but will search for them. -Resident #45 was admitted to the facility in March 2018 and had diagnoses including alcohol abuse with intoxication. Review of the MDS assessment, dated 8/16/24, indicated Resident #45 was cognitively intact as evidenced by a BIMS score of 15 out of 15 and had a diagnosis of alcohol abuse with intoxication. Review of the medical record failed to indicate any documentation from the LADC's assessment on 5/4/24. -Resident #54 was admitted to the facility in February 2024 and had diagnoses including paranoid schizophrenia. Review of the MDS assessment, dated 5/10/24, indicated Resident #54 was cognitively intact as evidenced by a BIMS score of 15 out of 15 and had a diagnosis of alcohol abuse. Review of the medical record failed to indicate any documentation from the LADC's assessment on 5/4/24. During a telephone interview on 10/30/24 at 2:25 P.M., the LADC said she and her staff come to the building on an as-needed basis. She said she is notified when there is a new resident with a diagnosis of substance abuse and she and her team come to the facility and conduct a substance abuse assessment and develop a care plan to meet the resident's needs. The LADC said she places her documentation in a folder and leaves it in the Director of Nursing's (DON) office or under the Administrator's door. She said it is her understanding that her documentation is available to staff in the medical record. During an interview on 10/30/24 at 2:45 P.M., the Administrator said that he, the DON and Regional Nurse have been unable to find any documentation from the LADC's visits with 34 residents in May 2024. He said these documents should be a part of the medical record. As of the end of survey, on 10/30/24, the survey team did not receive any documentation from 34 visits made by the LADC on 5/4/24 and 5/6/24. On 10/31/24 and 11/1/24, the facility faxed the survey team 131 pages of documentation of the LADC's substance abuse assessment and notes. Review of the documents indicated clinical Substance Abuse assessments, notes and care plans for only 19 (including Residents #45 and #54), out of a total of 34 residents seen by the LADC on 5/4/24 and 5/6/24.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 48362 Based on interview and record review, the facility failed to employ a full time Social Worker as required for any facility with more than 120 beds. Findings include: During the Entrance Conference meeting on 10/22/24 at 10:00 A.M., the Administrator and Regional Nurse said there has been no full time Social Worker in the facility since July 2024. Review of the Facility Assessment indicated total licensed bed capacity of 170, with 162 active beds. During an interview on 10/23/24 at 10:00 A.M., the Administrator said the facility had consulting Social Workers in the facility from July to current covering a few hours per week, but the coverage was not for full time hours. Review of the Consulting Social Worker Hours indicated the following: - 7/1/24 through 7/6/24: 10.75 hours - 7/7/24 through 7/13/24: 23.32 hours - 7/14/24 through 7/20/24: 14.02 hours - 7/21/24 through 7/27/24: 4.00 hours - 7/28/24 through 8/3/24: 15.00 hours - 8/4/24 through 8/10/24: 23.65 hours - 8/11/24 through 8/17/24: 7.33 hours - 8/18/24 through 8/24/24: 19.05 hours - 8/25/24 through 8/31/24: 6.00 hours - 9/1/24 through 9/7/24: 11.00 hours - 9/8/24 through 9/14/24: 13.00 hours - 9/15/24 through 9/21/24: 0.00 hours - 9/22/24 through 9/28/24: 9.00 hours - 9/29/24 through 10/5/24: 0.00 hours (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 10/6/24 through 10/12/24: 0.00 hours - 10/13/24 through 10/19/24: 0.00 hours - 10/20/24 through 10/26/24: 0.00 hours - 10/27/2024 through 11/2/24: 24 hours During an interview on 10/23/24 at 1:30 P.M., the Administrator said a job posting for a full time Social Worker position had been posted since July 2024. The Administrator again reiterated there had been no full time Social Worker coverage since July 2024. During an interview on 10/28/24 at 9:56 A.M., the Administrator said the facility will have a consistent consulting Social Worker for 24 hours per week beginning 10/28/24. The Administrator said the facility was still working on achieving full time hour coverage for a Social Worker.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43935 Based on observation, interview, and document review, 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 potential transmission of communicable diseases and infections. Specifically, the facility failed to: 1. Maintain a complete and accurate system of surveillance and analyze their collected surveillance data to identify any trends of actual or potential infections within the facility to validate the effectiveness of their program; 2A. For Resident #86, who has a gastrostomy tube (feeding tube), ensure staff use appropriate personal protective equipment (PPE) for enhanced barrier precautions (EBP) when providing care; B. For Resident #3, ensure staff use the appropriate PPE for EBP when providing catheter care; and C. For Resident #107, ensure staff wore PPE while providing care for the Resident who was on EBP for a Central venous catheter (CVC) inserted into their right jugular vein. Findings include: 1. Review of the facility's policy titled Surveillance for Infections, dated as revised 4/2021, indicated but was not limited to the following: - the Infection Preventionist (IP) will conduct ongoing surveillance for healthcare-associated infections (HAI) and other epidemiologically significant infections that have a substantial or potential impact on resident outcomes and may require transmission based precautions (TBP) and other preventative interventions - the purpose of surveillance is to identify both individual cases and trends of organisms and HAI, and prevent future infections - criteria for such infections are based on current standard definitions of infections - infections included in routine surveillance include those pathogens associated with serious outbreak and pathogens considered in surveillance include those with limited transmittability in the healthcare environment - nursing staff will monitor signs and symptoms (s/s) that may suggest infection, according to criteria and definitions of infection, and will document and report suspected infections to the charge nurse GATHERING SURVEILLANCE DATA: - the IP or designated personnel is responsible for gathering and interpreting surveillance data, the quality assurance performance improvement (QAPI) committee may be involved in interpreting data (continued on next page)

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Norwood Healthcare	460 Washington Street Norwood, MA 02062

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 - Some	- surveillance should include a review of any or all of the following information to help identify possible indicators of infection: lab records, skin care sheets, infection control rounds, verbal reports from staff, infection documentation records, temperature logs, pharmacy records, antibiotic review and transfer logs/summaries - lab reports are used to identify relevant information that merits further evaluation, i.e.: positive cultures - in addition to collecting data on the incidence of infections, the surveillance system is designated to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted DATA COLLECTION AND RECORDING: - for residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: identifying information (resident name, room number), diagnoses, date of onset (DOO), infection site, pathogens, invasive procedures or risk factors, pertinent remarks (symptoms of specific infection), treatment measures - using the current suggested criteria for HAI, determine if the resident has a HAI - Daily: record detailed information about the resident - Monthly: collect information and enter line listing (surveillance sheet) of infections by resident for the entire month; summarize monthly data for each nursing unit by site and pathogen; identify predominant pathogens or sites in the facility on units month to month and observe for trends; compare incidence of current infections to previous data to identify trends and patterns (use an average infection rate over a previous time period as a baseline); compare subsequent rates to the average rate to identify possible increases in infection rates. CALCULATING INFECTION RATES: - to determine the incidence of infection per 1000 resident days, divide the number of new HAI for the month by the total resident days for the month, times 1000 INTERPRETING SURVEILLANCE DATA: - analyze the data to identify trends; compare previous months in the current year and to the same month in previous years to identify seasonal trends; consider how increases or decreases might relate to recent process changes, events or activities in the facility and monitor these trends (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER: Norwood Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 460 Washington Street Norwood, MA 02062	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 12:10 P.M., the IP said the facility uses McGeer criteria to determine if an illness rises to the definition of an infection and therefore should be counted as in infection within the facility. He said he completes the surveillance line listing sheets monthly and sends them to the lab. He said he does not interpret or evaluate the data that he collects and places on the surveillance sheets and that is completely done by the lab on a look back basis quarterly, not ongoing by the facility. He said he does not calculate an infection rate and has no idea what the facility infection rate is from month to month and does not supply that information to the lab or the QAPI committee. He said there is no way to know if there is any current ongoing fluctuation in infection rate, type, organism or site of infection from month to month and that is all done on a look back basis by the lab who provides a report to the quarterly QAPI committee. He said his understanding is the lab uses the data he sends them on the completed and signed surveillance line listing sheets and there is no one in the facility that interprets or analyzes it on an ongoing basis from month to month. He said the nurses are supposed to use McGeer evaluation sheets in the individual residents' medical records to help determine if an illness rises to the level of an infection and he does refer to those completed evaluations when he completes the monthly line listing surveillance sheets and then marks yes or no in the count column. Review of McGeer criteria, currently in use by the facility indicated but was not limited to the following: Syndrome: Urinary Tract Infection (UTI) without indwelling catheter Criteria: Must fulfill both 1 and 2 1. At least one of the following sign or symptom Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate Fever or leukocytosis, AND greater than 1 of the following: Acute costovertebral angle pain or tenderness, Suprapubic pain Gross hematuria, New or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency * If no fever or leukocytosis, then greater than 2 of the following: Suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency 2. At least one of the following microbiologic criteria 50,000 cfu/mL of no more than 2 species of organisms in a voided urine sample 20,000 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter Syndrome: Pneumonia (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Criteria: Must fulfill 1, 2, AND 3.

1. Chest X-ray with pneumonia or a new infiltrate

2. At least one of the following criteria:

New or increased cough, new or increased sputum production, O2 sat (oxygen saturation) <94% on room air, or >3% decrease from baseline O2 sat, new or changed lung exam abnormalities, pleuritic chest pain, respiratory rate =25 breaths/min

3. At least one of the following criteria

Fever, leukocytosis, acute mental status change, acute functional decline

Review of the facility's surveillance line listings for July 2024 through September 2024 indicated but were not limited to the following:

Surveillance sheets include columns for the following information: Name, Room, Category of illness, Date of onset (DOO), s/s, Culture (cx) date, site, results, treatment, infection cleared: Yes (y) or No (n), Comment, Final status: HAI/CAI, Count: Yes (y) or No (n).

JULY 2024:

Resident #49; Category: PNU (pneumonia); DOO: 7/8/24; s/s: cough, MD (medical doctor), cx - n/a; results - n/a; treatment azithromycin; cleared: y; final status: HAI, count: n

Resident #59; Category: UTI (urinary tract infection); DOO: 7/19/24; s/s: lab (L); cx - urine (U); result - proteus mirabilis; cleared: y; final status: HAI; count: y

The surveillance sheets miscategorized Resident #49's respiratory illness as PNU (since no chest x-ray (CXR) was complete) and failed to indicate necessary s/s for Resident #59 to have his/her illness rise to the level of an infection in accordance with McGeer criteria.

During an interview on 10/23/24 at 4:19 P.M., the IP reviewed the surveillance sheets and McGeer criteria for Resident #49 and said the Resident should have been categorized under a different respiratory category since the Resident was treated at the hospital for a Chronic obstructive pulmonary disease (COPD) exacerbation. In addition, he said Resident #59 did not have enough s/s documented on their McGeer evaluation (in the medical record) to meet the definition of a UTI and the surveillance line listing is incomplete and inaccurate.

AUGUST 2024:

Resident #51; Category: PNU; DOO: blank; s/s: blank; cx date: blank; results: blank; treatment: blank; cleared: y; final status: blank; count: blank

Resident #25; Category: UTI; DOO: 8/24/24; s/s: urgency (U), confusion (CF), cx date: n/a; site: n/a; result: n/a; treatment: Cefpodoxime; cleared: y; final status: CAI; count: y

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	225343	A. Building B. Wing	10/30/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveillance listings were incomplete for Resident #51, who on record review was being actively treated with intravenous antibiotics for pneumonia. Resident #25 did not have a culture available due to them being sent to the hospital following their first s/s of UTI (which was confusion) and therefore the final status of CAI (community acquired infection) is incorrect since the first s/s of infection were identified in the facility prior to the Resident being hospitalized , which means the final status should have been HAI. During an interview on 10/23/24 at 4:21 P.M., the IP said the surveillance for Resident #51 was blank because they were unsure how to complete the surveillance following the Resident's hospitalization and the surveillance for that Resident is incomplete. He said on review of Resident #25's medical record there is no documented evidence that the Resident ever had any urgency and the final status should be HAI since the s/s of infection first started in the facility prior to the Resident being hospitalized and the surveillance is inaccurate. SEPTEMBER 2024: Resident #104; Category: UTI; DOO: 9/15/24; s/s: L; cx date: 9/16/24; site: U; result: Klebsiella; treatment: Cipro; cleared: y; final status: HAI; count: y Resident #214; Category: UTI; DOO: 8/28/24; s/s: other (O); cx date: 9/2/24; site: n/a; result: n/a; treatment: Macrobid; cleared: y; final status: HAI; count: y Resident #98; Category: PNU; DOO: 9/30/24; s/s: diagnosis (DX); cx date: n/a; site: CXR; result: left lower lobe pneumonia; treatment: Doxycycline; cleared: sent to hospital/resolved at hospital; final status: HAI; count: y The surveillance indicated Resident #104 did not meet criteria for a UTI and therefore should not have been counted as having a UTI. In addition, the symptom of O (other) for Resident #214 was undefined and with no other s/s available the Resident did not meet criteria for a UTI. Resident #98 surveillance sheets lacked s/s for the PNU to be counted in accordance with the facility defined McGeer criteria and therefore the surveillance was inaccurate and incomplete for the three reviewed Residents. During an interview on 10/23/24 at 4:26 P.M., the IP reviewed the surveillance and medical records for the three Residents reviewed for the month of September. He said Resident #104 does not meet criteria for a UTI and there were not enough s/s documented to meet criteria. Resident #214 had a s/s of other documented on surveillance but on review of the record and surveillance he had no way of identifying what the other symptom of infection was and the surveillance for this Resident was inaccurate and incomplete. He said Resident #98 had an inaccurate McGeer evaluation completed in the medical record and did not meet the criteria necessary with s/s for the PNU to count on the surveillance sheets and the surveillance for September of 2024 was inaccurate and incomplete. (continued on next page)

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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 10/23/24 at 4:39 P.M., the IP said the three months of surveillance reviewed by him with the surveyor were both inaccurate and incomplete and there is room for improvement in the surveillance process. He said he was unaware he needed to evaluate and review all resident record information and ensure the McGeer evaluation forms completed by the nursing staff were correct prior to using them. He said he was unaware that he was responsible for identifying and monitoring trends in infection types and infection rates on an ongoing basis and had not even filled in the average daily census on the surveillance sheets prior to supplying them to the lab for a quarterly look back evaluation of the submitted data. He reviewed the facility policy on Surveillance for infections and said he was unaware of his duty to not only collect the data but analyze it and quantify it for accuracy prior to submitting it to the lab. He said the process needed work to ensure all pieces of the process were being met.

48362

2. Review of the Centers for Medicare and Medicaid Services (CMS) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated but was not limited to:

-Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities.

-EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing

-EBP are indicated for residents with any of the following:

a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or

b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO

-EBP should be used for any residents who meet the above criteria, wherever they reside in the Facility.

Review of the facility's policy titled Infection Control Guidelines for Nursing Procedures, last revised 7/2024, indicated but was not limited to:

- EBP are an infection control intervention designed to reduce transmission of MDROs.

- EBP is indicated for nursing home residents with any of the following: 1. Infection or colonization with an MDRO when Contact Precautions don't otherwise apply; 2. Chronic wounds; 3. Indwelling medical devices, including but not limited to IV, feeding tubes, tracheostomy, drains/pleuex, urinary catheters.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- PPE: use of gown and gloves during high-contact resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing examples of high contact resident activities are: dressing, bathing, shower, transferring, changing linen, personal hygiene, toileting/brief change, device care. - Signs - the facility will implement a system to alert staff and visitors to the type of precaution the resident requires. A. Resident #86 was admitted to the facility in August 2023 with diagnoses including but not limited to protein-calorie malnutrition, type II diabetes, and gastrostomy status. Review of the most recent Minimum Data Set (MDS) assessment for Resident #86, dated 8/23/24, indicated under C1000 (cognitive skills for daily decision making) that the Resident was severely cognitively impaired. Review of Resident #86's current Physician's Orders indicated but were not limited to: - 11/14/23: Enteral Feed Order: every four hours, give free water (H2O) 120 milliliters (mL) every four hours. Review of Resident #86's comprehensive care plan indicated he/she required a tube feeding related to dysphagia (difficulty swallowing). Resident #86's interventions included he/she was placed on EBP due to risk of infection, effective 5/30/24. Resident #86 had an EBP sign, undated, from the CDC on the door to his/her room, which indicated but was not limited to the following: - In addition to standard precautions Staff and Providers must: - Clean hands prior to entering and when exiting the room - Wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (tube feeding, central line, urinary catheter, tracheostomy), and wound care. On 10/29/24 at 10:14 A.M., the surveyor observed Nurse #4 preparing Resident #86's gastric tube feeding and medications as follows: - 10:38 A.M., Nurse #4 pulls down blankets and moves gown to expose the Resident's gastric tube with only gloves donned (on). Nurse #4 assesses and touches the gastric tube and completes a water flush with a syringe. - 10:40 A.M., Nurse #4 begins to administer medications via the gastric tube using a syringe with only gloves donned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/24 at 10:55 A.M., Nurse #4 said the resident was not on any precautions. Nurse #4 said she only needed to wear gloves to provide medications via the Resident's gastric tube. Nurse #4 and the surveyor reviewed the EBP sign outside of the Resident's room. Nurse #4 said she did not wear a gown because there was not a PPE cart outside of the Resident's room. During an interview on 10/29/24 at 11:09 A.M., the Regional Nurse said all residents who have gastric tubes would be placed on EBP. The Regional Nurse said the nurse providing direct care or use of the gastric tube should have utilized gloves and a gown. 48695 B. Resident #24 was admitted to the facility in May 2020 with diagnoses which included urinary tract infection and urethral fistula (abnormal opening that forms between the urethra and another hollow organ, such as the bladder or bowel). Review of Resident #24's MDS assessment indicated Resident #24 had an indwelling catheter. Resident #24 had an EBP sign, undated, from the CDC on the door to his/her room, which indicated but was not limited to the following: - Stop Enhanced Barrier Precautions - Everyone Must: - Clean their hands, including before entering and when leaving the room. - Providers and staff must also: - Wear gloves and a gown for the following High-Contact Resident Care Activities. - Dressing - Bathing/Showering - Transferring - Changing Linens - Providing Hygiene - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy - Wound Care: any skin opening requiring a dressing Review of Resident #24's care plan indicated but was not limited to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Resident #24 has a Supra Pubic catheter (revision date 10/14/24) -Interventions: resident placed on enhanced barrier precautions due to risk of infection (date initiated 5/30/24) On 10/22/24 at 12:32 P.M., the surveyor observed Certified Nursing Assistant (CNA) #3 perform hand hygiene and don (put on) gloves prior to performing catheter care. CNA #3 failed to don a gown. On 10/28/24 at 1:53 P.M., the surveyor observed CNA #3 perform hand hygiene and don gloves. CNA #3 then performed catheter care. CNA #3 failed to don a gown. During an interview on 10/28/24 at 1:56 P.M., CNA #3 said Resident #24 was on EBP precautions. CNA #3 said when a resident was on EBP you must perform hand hygiene, don gloves and a gown prior to providing direct care. CNA #3 said he did not don a gown. On 10/29/24 at 3:05 P.M., the surveyor observed Nurse #3 perform hand hygiene and don gloves. Nurse #3 assisted Resident #24 transfer from his/her wheelchair to his/her own bed. Nurse #3 doffed (took off) her gloves performed hand hygiene, donned gloves, and performed catheter care. Nurse #3 failed to don a gown prior to performing catheter care. During an interview on 10/29/24 at 3:12 P.M., Nurse #3 said she did not see the EBP precaution sign on Resident #24's door. Nurse #3 said she should have donned a gown before transferring Resident #24 and performing catheter care but did not. During an interview on 10/30/24 at 10:23 A.M., the Regional Nurse said catheter care and transfers are considered high contact care. The Regional Nurse said CNA #3 and Nurse #3 should have donned a gown for high contact care. 34145 C. Resident #107 was admitted to the facility in September 2024 with diagnoses including Staphylococcal arthritis of the left hip and methicillin resistant staph aureus (MRSA) infection and received intravenous (IV) antibiotic therapy. Review of the MDS assessment, dated 9/17/24, indicated Resident #107 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 14 out of 15, received IV medications and dialysis. Review of September 2024 Physician's Orders indicated but was not limited to: -Right chest tunneled catheter, double lumen (9/11/24) -Ceftaroline (antibiotic) 400 milligrams (mg) IV every 8 hours until follow up with Infectious Disease Clinic -Vancomycin (antibiotic) 500 mg IV every Tuesday, Thursday, and Saturday at dialysis -MRSA precaution every shift (9/11/24) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/28/24 at 1:30 P.M., the surveyor observed a CDC Contact Precaution sign taped to Resident #107's door. The sign indicated but was not limited to the following: -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. -Do not wear the same gown and gloves for the care of more than one person. -Use dedicated or disposable equipment. -Clean and disinfect reusable equipment before use on another person. On 10/28/24 at 1:38 P.M., the surveyor observed Nurse #13 enter Resident #107's room with a pulse oximeter (a small device that measures the oxygen saturation of your blood and your pulse rate) and an infrared thermometer (non-contact thermometer) in her hands. She approached the Resident in his/her room and placed the pulse oximeter device on his/her finger and used the infrared thermometer to take his/her temperature. Nurse #13 failed to perform hand hygiene and put on gloves and a gown prior to entering the room and failed to perform hand hygiene before exiting the room. During an interview on 10/28/24 at 1:40 P.M., Nurse #13 said she should have worn gloves, a gown and performed hand hygiene prior to entering the Resident's room. During an interview on 10/29/24 at 9:30 A.M., the Nursing Supervisor said anyone entering Resident #107's room must wear PPE as indicated on the sign posted on the Resident's door.