Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 225344 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Abbott Skilled Nursing & Rehabilitation Center | 28 Essex Street<br>Lynn, MA 01902 |

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) |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807<br><br>Based on record review and interviews, the facility failed to formulate an advance directive for one Resident (#5) out of a total sample of 14 residents. Specifically, the facility failed to initiate the court process to renew an expired [NAME] guardianship (a treatment plan that states that antipsychotic medications are so intrusive, and their side effects are potentially so severe, that a court must approve them).<br><br>Findings include:<br><br>Review of the facility policy titled 'Advanced Care Planning' revised [DATE] indicated the following:<br><br>- Advance Directives-written or verbal directions related to specific treatment choices that communicate the resident's preferences about designation of a decision making proxy.<br><br>- A resident/patient's role in advance care planning depends on the extent of their decision-making capacity.<br><br>- A resident's/patient's role in advance care planning depends on their decision-making capacity, family considerations and other factors. A resident/patient may still be able to participate to some extent in advance care planning even if someone else is the primary decision maker.<br><br>- When a substitute decision maker is involved, staff guides them regarding their roles and relevant procedures.<br><br>- New or revised documents and orders may be needed to implement revised or new treatment choices.<br><br>Resident #5 was admitted to the facility in [DATE] with diagnoses including paranoid schizophrenia and bipolar disorder.<br><br>Review of Resident #5's most recent Minimum Data Set (MDS), dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 indicating the Resident has moderate cognitive impairment.<br><br>Review of Resident #5's [DATE] physician's orders indicated the following:<br><br>(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 |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Olanzapine (an antipsychotic medication) oral tablet 5 milligrams, give 2 tablets by mouth two times a day for schizophrenia. Start date [DATE].<br><br>Review of the medical record indicated that the Resident has a legal guardian and a [NAME] monitor.<br><br>Further review of Resident #5's medical record indicated a [NAME] treatment plan with permission from court to treat the Resident with Olanzapine 5 milligrams twice a day. The treatment plan was approved on [DATE]. The treatment plan further indicated that that it would be reviewed one year from [DATE] on [DATE] and shall expire at 4:00 P.M., on [DATE].<br><br>Review of the [DATE] Medication Administration Record (MAR) indicated the following:<br><br>- Resident #5 was administered Olanzapine twice daily as ordered from [DATE] to [DATE].<br><br>Review of the [DATE] Medication Administration Record (MAR) indicated the following:<br><br>- Resident #5 was administered Olanzapine twice daily as ordered from [DATE] to [DATE].<br><br>During an interview on [DATE] at 8:54 A.M., the Social Worker said she was not aware that Resident #5's [NAME] treatment plan had expired. She said she was waiting for the court to inform her that the treatment plan was expired so she could start the renewal process.<br><br>During an interview on [DATE] at 11:01 A.M., the Director of Nurses (DON) #2 said the Social Worker is responsible for tracking all [NAME] treatment plans and start the renewal process in advance before they expire. The Director of Nurses said starting the renewal process in advance ensures that the treatment plan is renewed in a timely manner so that the Resident can continue to receive their antipsychotic medication as ordered. She said the Social Worker started the renewal process today.<br><br>During a telephone interview on [DATE] at 1:56 P.M., the Guardian/[NAME] Monitor said that Resident #5's treatment plan is currently expired. She said it is the facility's responsibility to start the treatment plan's renewal process months in advance. She said this would ensure the renewed treatment plan is in place so that the Resident can continue to receive his/her antipsychotic medication as ordered. The Guardian/[NAME] monitor said she heard from the facility's lawyer today about starting the treatment plan renewal process. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984<br><br>Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADLs) for residents who are dependent on staff for one Resident (#22) out of a total sample of 14 residents. Specifically, the facility failed to provide supervision while eating for Resident #22.<br><br>Findings include:<br><br>Review of the facility policy titled Activities of Daily Living, dated 1/1/15, indicated the following:<br><br>- A program of ADLs is provided to residents by the following method: The ability of each resident to meet the demands of daily living is assessed by a licensed nurse and/or member of the interdisciplinary team. A program of assistance and instruction in ADL skills is implemented.<br><br>- Feeding: Meals are planned considering needs and desires of residents.<br><br>Resident #22 was admitted to the facility in August 2021 with diagnoses including cerebral infarction, hemiplegia, aphasia and dysphagia.<br><br>Review of Resident #22's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 0 out of a possible 15 indicating severe cognitive impairment. Further review of the MDS indicated that Resident #22 requires supervision or touching assistance while eating.<br><br>The surveyor made the following observations:<br><br>- On 6/4/23 at 8:33 A.M., Resident #22 was observed laying in bed. A certified nursing assistant (CNA) brought in his/her breakfast, set up the tray and left the room. At 9:03 A.M., 30 minutes since Resident #22 received his/her breakfast, no staff member supervised him/her eating or provided any assistance.<br><br>- On 6/4/24 at 12:49 P.M., Resident #22 was observed laying in his/her bed, a CNA brought in his/her lunch, set up the tray and left the room. Resident #22's bedside curtain was drawn, and he/she could not be seen from the hallway. At 1:11 P.M., 22 minutes later, no staff members entered the Resident's room to provide supervision or assistance.<br><br>- On 6/5/24 at 8:23 A.M., Resident #22 was observed laying in his/her bed, a CNA brought in his/her breakfast, set up the tray and left the room. At 8:29 A.M., with no staff supervision or assistance, Resident #22 was heard making a wet cough for about ten seconds with food in his/her hands. The surveyor asked CNA #2 to check in on Resident #22 after he/she was heard coughing. CNA #2 said Resident #22's food should be cut up but he/she does fine with eating on his/her own. CNA #2 left Resident #22's room at 8:41 A. M., at 8:46 A.M., the surveyor observed Resident #22 eating a muffin with his/her hands with crumbs throughout his/her face. At 8:54 A.M., Resident #22 had not received supervision while eating since CNA #2 left the room at 8:41 A.M.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #22's care plan dated 3/28/23 indicated the following:<br><br>- Focus: Resident #22 is on a mechanically altered diet d/t (due to) dysphagia. He/she is at risk for dysphagia<br><br>- Interventions: diet as ordered<br><br>Review of Resident #22's Speech/Language Pathology Discharge Summary dated 5/1/23 to 5/12/23 indicated the following:<br><br>- He/she requires assist for set up and use of safe swallowing strategies, i.e. 90 degrees upright, slow rate, small sips and bites and to alternate bites and sips.<br><br>Review of Resident #22's physician's order dated 5/12/23 indicated the following:<br><br>- Regular diet, regular texture, upgrade diet to regular texture, cut-up food.<br><br>Review of Resident #22's active Kardex (a nursing care card), indicated the following under the eating section: Continual supervision (1:8).<br><br>Review of Resident #22's Nutritional assessment dated [DATE] indicated the following:<br><br>- encourage good po (by mouth)/fluid intake, supervise eating.<br><br>During an interview on 6/5/24 at 9:45 A.M., the Unit Manager said supervision with meals means someone should always be watching the Resident while they are eating. The Unit Manager continued to say if a resident is eating in his/her room then a nurse or CNA should be in the room with the resident. The surveyor and Unit Manager reviewed Resident #22's medical record and the Unit Manager said Resident #22 should be supervised with meals and a staff member should be in the room with him/her while eating.<br><br>During an interview on 6/5/24 at 11:58 P.M., Director of Nursing (DON) #2 said a resident who needs supervision with meals can be checked in on by staff while they are eating and then staff can leave and check in on other residents eating and return to the resident. When asked how is the resident supervised at all times while a staff member is checking in on other residents, the DON #2 could not answer. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984<br><br>Based on record review and interview, the facility failed to follow up with recommendations made by the Audiologist for one Resident (#17) out of a total sample of 14 residents. Specifically, for Resident #17 the facility failed to follow up with the Audiologist's recommendation to remove ear wax from the Resident's right ear within a reasonable amount of time.<br><br>Findings include:<br><br>Resident #17 was admitted to the facility in November 2021 with diagnoses including Alzheimer's disease and vascular dementia.<br><br>Review of Resident #17's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 0 out of 15 indicating that he/she has severe cognitive impairment. Further review of the MDS indicated that Resident #17 has not refused care and is dependent for all activities of daily living.<br><br>Review of Resident #17's physician's order dated 8/8/22 indicated the following:<br><br>- Audiologist consult as needed.<br><br>Review of Resident #17's form titled Request for service dated September 2022 indicated that the Resident requested to be seen by the Audiologist.<br><br>Review of Resident #17's Audiologist referral evaluation dated 2/21/24 indicated the following:<br><br>- Reason for Referral: Resident complains of newly decreased hearing. Newly decreased participation in social activities including decreased interaction.<br><br>- Comment: Otoscopy found impacted cerumen (ear wax) deep in the right ear. Once the canal is cleaned further testing can be attempted.<br><br>- Recommendations for Attending MD (Medical Doctor)/nursing staff: Wax needs removal right ear<br><br>- Action to be taken by Audiologist: Re-evaluate patient after Wax Removal.<br><br>Review of a binder at the nursing station containing the contracted Audiologist visit summaries from 2/21/24 indicated the following for Resident #17:<br><br>- Wax needs removal right ear.<br><br>During an interview on 6/4/24 at 12:30 P.M., Nurse #1 said the facility uses a contracted company for hearing services. She continued to say that if the Audiologist makes recommendations the facility should follow up on them as soon as possible.<br><br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/5/24 at 9:45 A.M., the Unit Manager and Social Worker #1 said the facility uses a contracted company for Audiology services and once a Resident gets admitted a consent form is filled out. The Unit Manager and the surveyor reviewed Resident #17's Audiology visit from 2/21/24 and the medical record, the Unit Manager was unable to locate any follow up or any implemented interventions that the Audiologist recommended. The Unit Manager said interventions should have been implemented since the Audiology visit from 2/21/24.<br><br>During an interview on 6/5/24 at 11:58 P.M., Director of Nursing (DON) #2 said the recommendations made by the audiologist should have been followed up on right away so interventions and physician's orders could be implemented. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338<br><br>Based on observation, interviews, policy review and record review the facility failed to maintain respiratory equipment according to professional standards of practice for two Residents (#289 and #9), out of a total sample of 14 residents. Specifically,<br><br>1. For Resident #289 the facility failed to obtain a physician's order for the use of a continuous positive airway pressure machine (CPAP, machine used to treat sleep apnea).<br><br>2. For Resident #9, the facility failed to ensure the oxygen concentrator filter was clean.<br><br>Findings include:<br><br>1. Review of the facility's policy titled CPAP Management, dated as revised 12/28/22, indicated nursing will provide CPAP to treat sleep apnea or sleep disorders as ordered by the physician.<br><br>Resident #289 was admitted to the facility in May 2024 with diagnoses including vascular dementia, coronary artery disease, and sleep apnea (interrupted breathing during sleep).<br><br>On 6/4/24 at 7:42 A.M., the surveyor observed Resident #289 in bed with a CPAP at bedside.<br><br>During an interview on 6/4/24 at 12:30 P.M., Resident #289 said he/she wears CPAP every night.<br><br>Review of the hospital discharge summary, dated 5/28/24, indicated Resident #289 has sleep apnea and uses CPAP.<br><br>Review of the nursing progress note, dated 5/30/24 at 6:20 A.M., indicated:<br><br>- CPAP machine at bedtime.<br><br>Review of the nursing progress note, dated 6/1/24 at 10:51 P.M., indicated:<br><br>- CPAP machine on at bedtime.<br><br>Review of the nursing progress note, dated 6/2/24 at 8:01 P.M., indicated:<br><br>- CPAP machine on at bedtime.<br><br>Review of the nursing progress note, dated 6/4/24 at 3:34 A.M., indicated:<br><br>- CPAP machine utilized at bedtime.<br><br>Review of nursing progress note, dated 6/5/24 at 6:56 A.M., indicated:<br><br>- CPAP on and functioning properly.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #289's physician's orders failed to indicate an order for the use of CPAP.<br><br>Review of the plan of care on 6/5/24, dated as initiated on 5/29/24, failed to include the use of CPAP.<br><br>During an interview on 6/5/24 at 6:45 A.M., Certified Nurse Assistant (CNA) #1 said Resident #289 wears CPAP at night.<br><br>During an interview on 6/5/24 at 7:05 A.M., Nurse #3 said Resident #289 wears CPAP at night. Nurse #3 said Resident #289 wore CPAP last night and she removed it before medication administration this morning.<br><br>During an interview on 6/5/24 at 8:40 A.M., Nurse #4 said Resident #289 wears a CPAP at night and requires physicians' order for use.<br><br>During an interview on 6/5/24 9:14 A.M., the Unit Manager said use of a CPAP machine requires a physicians' order. The Unit Manager reviewed the medical record and said Resident #289 did not have a physician's order for the use of a CPAP, but should have.<br><br>During an interview 6/5/24 at 11:36 A.M., Director of Nursing #2 said Resident #289 did not have physician's order for CPAP machine, but should have.<br><br>43846<br><br>2. Review of the facility policy titled Oxygen Concentrator Cleaning, reviewed 1/3/24, indicated Oxygen company will change concentrator filters weekly.<br><br>Resident #9 was admitted to the facility in August 2022 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), anxiety and dependence on supplemental oxygen.<br><br>Review of Resident #9's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. Further review of the MDS indicated the Resident is receiving oxygen therapy.<br><br>On 6/4/24 at 8:12 A.M. and 11:28 A.M., the surveyor observed Resident #9 in bed receiving oxygen via nasal cannula. The surveyor observed the oxygen filter on the oxygen concentration had a layer of gray dust.<br><br>On 6/5/24 at 7:52 A.M., the surveyor observed Resident #9 in bed receiving oxygen via nasal cannula. The surveyor observed the oxygen filter on the oxygen concentration had a layer of gray dust.<br><br>Review of Resident #9's physician order, dated 11/30/23, indicated oxygen @ (at) 1-4 LPM (liters per minute) via nasal cannula or to maintain Sats (saturation) above 90%.<br><br>On 6/5/24 at 7:56 A.M., the surveyor, Nurse #1 and Director of Nurses (DON) #1 observed Resident #9's oxygen concentrator filter. The oxygen filter was observed to have a thick layer of gray dust, Nurse #1 and DON #1 said the filter needs to be changed immediately because it is dirty. DON #1 said she would have to find out what the policy is for changing the oxygen concentrator filters.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/5/24 at 8:06 A.M., Nurse #2 said Resident #9's oxygen concentrator filter is very dirty and said nursing should be changing the filter weekly with the oxygen tubing change. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984<br><br>Based on observations, interviews and record review, the facility failed to provide food in a form that meets the needs of one Resident (#22) out of a total sample of 14 residents. Specifically, for Resident #22 the facility failed to provide food in a cut-up texture as ordered by the physician.<br><br>Findings include:<br><br>Review of the facility policy titled Texture and Consistency-Modified Diets, undated, indicated the following:<br><br>- Policy: Texture and consistency-modified diets will be individualized with modifications made by the speech/language pathologist and physician in conjunction with the registered dietitian or designee and director of food and nutrition services. A written order is needed.<br><br>Resident #22 was admitted to the facility in August 2021 with diagnoses including cerebral infarction, hemiplegia, aphasia and dysphagia.<br><br>Review of Resident #22's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 0 out of a possible 15 indicating severe cognitive impairment. Further review of the MDS indicated that Resident #22 requires supervision or touching assistance while eating.<br><br>The surveyor made the following observations:<br><br>- On 6/4/23 at 8:33 A.M., Resident #22 was lying in his/her bed and received breakfast. On the tray were pancakes cut into pieces that were larger than the fork prongs and two, sausage links not cut up.<br><br>- On 6/5/24 at 8:23 A.M., Resident #22 was lying in his/her bed and received breakfast. On his/her tray was a muffin, not cut up and a piece of egg bake containing large chunks of broccoli, not cut up. At 8:29 A.M., with no staff supervision or assistance, Resident #22 was heard making a wet cough for about ten seconds with food in his/her hands. The surveyor asked Certified Nurse Aide (CNA) #2 to check in on Resident #22 after he/she was heard coughing. CNA #2 said Resident #22's food should be cut up. The surveyor and CNA #2 observed Resident #22's meal ticket stating, soft cut up food. CNA #2 said the kitchen should be cutting up Resident #22's food but if we notice it is not cut up then we should do it. CNA #2 left Resident #22's room at 8:41 A.M., at 8:46 A.M., the surveyor observed Resident #22 eating a muffin with his/her hands with crumbs throughout his/her face.<br><br>Review of Resident #22's physician's order dated 5/12/23 indicated the following:<br><br>- Regular diet, regular texture, upgrade diet to regular texture, cut-up food.<br><br>Review of Resident #22's care plan dated 3/28/23 indicated the following:<br><br>(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) |
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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Focus: Resident #22 is on a mechanically altered diet d/t (due to) dysphagia. He/she is at risk for dysphagia.<br><br>- Interventions: diet as ordered.<br><br>Review of Resident #22's Speech/Language Pathology Discharge Summary dated 5/1/23 to 5/12/23 indicated the following:<br><br>- Pt (patient) is tolerating advanced diet texture to regular cup up textures with thin liquids without overt s/sx (signs/symptoms) of aspiration. He/she requires assist for set up and use of safe swallowing strategies, i.e. 90 degrees upright, slow rate, small sips and bites and to alternate bites and sips.<br><br>During an interview on 6/5/24 at 9:45 A.M., the Unit Manager and surveyor reviewed Resident #22's physician's order and the Unit Manager said he/she should be receiving cut up foods. The surveyor showed the Unit Manager the photos of his/her meals from 6/4/24 and 6/5/24 and he said they are not cut up properly. He continued to say either the kitchen or the CNAs should be cutting up Resident #22's food before he/she receives it.<br><br>During an interview on 6/5/24 at approximately 10:00 A.M., the Food Service Director (FSD) and FSD in training said the cook should be cutting up foods if the resident's meal ticket says to.<br><br>During a phone interview on 6/5/24 at 11:25 A.M., the Registered Dietitian said Resident #22's food should be cut up and usually the CNAs will cut it up for the resident.<br><br>During an interview on 6/5/24 at 11:58 P.M., the Director of Nursing (DON) #2 reviewed the photos of Resident #22's meals and she said they are not cut up. She continued to say if the physician's order is for cut up foods then the food should be cut up. |