STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225357	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winchester Rehabilitation and Nursing Center	223 Swanton Street, #1968 Winchester, MA 01890

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 0578 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on record review, and interview, the facility failed to ensure Advance Directives (written documents that instruct health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were consistently documented in the medical record for one Resident (#75), out of a total sample of 23 residents. Findings include: Review of the facility policy titled Residents' Rights Treatment and Advance Directives, revised 2/23, indicated: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate and advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. 7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directive. 8. Decisions regarding advance directive and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 9. Any decision making regarding the resident's choices will be documented in the residents' medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. Resident #75 was admitted to the facility in October 2024 with diagnoses that included adult failure to thrive, anxiety disorder, Parkinson's Disease, diabetes, and hallucinations. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #75'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 intact cognition. Review of Resident #75's advanced directives care plan, dated 10/15/24, indicated: This resident has established Advanced Directives which include: DNR, DNI. (Do Not Resuscitate, Do Not Intubate). -Provide information on the state form POLST/MOLST. (Physician Orders for Life-Sustaining Treatment, Medical Orders for Life-Sustaining Treatment). -Review advanced directives upon admission and quarterly with care plan reviews with the resident or invoked resident representative. Review of Resident #75's medical record failed to indicate a physician order for advance directive in place. Review of Resident #75"s medical record did not have MOLST form on file or in the electronic medical chart. Review of Resident #75"s nursing progress notes failed to indicate a code status was discussed upon admission. During an interview on 11/6/24 at 9:30 A.M., Unit Manager #2 (UM) said Resident #75 is a full code but he/she does not have a MOLST form on file. UM #2 and the surveyor looked in the medical record and UM #2 said she is not sure why the care plan indicates DNR/DNI and said Resident #75 should have a signed MOLST form and physician order on file and that the medical record should be accurate to match the care plan. UM #2 said Resident #75 is not a DNR/DNI. During an interview on 11/6/24 at 1:15 P.M., the Director of Nurses (DON) and the surveyor reviewed Resident #75's medical record and were unable to locate a MOLST form. The DON said the Resident's physician order should be full code and said the care plan will be updated with the code status to match the MOLST form. During an interview on 11/6/24 at 1:24 P.M., Social Worker #1 said Resident #75 should have MOLST form in place indicating code status and it should be in the chart.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on observation, record review and interview the facility failed to develop and implement the plan of care for three Residents (#23, #13, #48) out of a total sample of 23 residents. Specifically: 1. For Resident #23, the facility failed to implement a left hand splint care plan. 2. For Resident #13, the facility failed to develop a pacemaker care plan. 3. For Resident #48, the facility failed to develop a risk for bleeding care plan. Findings Include: 1. Resident #23 was admitted to the facility in November 2016 with diagnoses including cerebral vascular disease, cerebral infarction, hemiplegia and hemiparesis affecting left non-dominant side. Review of Resident #23's most recent Minimum Data Set (MDS) assessment, dated 8/14/24, indicated Resident #23 has severe cognitive deficits. The MDS further indicated Resident #23 requires dependent assistance for activities of daily living (ADL). On 11/5/24 at 8:37 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair eating breakfast. Resident #23 was not wearing his/her left-hand grip splint. On 11/5/24 at 10:32 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair. Resident #23 was not wearing his/her left-hand grip splint. On 11/5/24 at 11:20 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 8:07 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair eating breakfast. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 10:05 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 11:56 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair eating lunch. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 1:31 P.M., the surveyor observed Resident #23 sitting in his/her wheelchair outside on the patio. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 3:25 P.M., the surveyor observed Resident #23 sitting in his/her wheelchair participating in an afternoon activity. Resident #23 was not wearing his/her left-hand grip splint. (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 #23's physician order indicated the following order initiated on 8/10/24: - Apply left hand-grip splint as tolerated - on AM off PM, one time a day related to unspecified sequelae of unspecified cerebrovascular disease and remove per schedule. Review of Resident #23's ADL care plan interventions indicated the following: - Will wear his/her left-hand splint daily as tolerated. During an interview on 11/7/24 at 8.44 A.M., Unit Manager #3 said we put the splint on Resident #23 after morning care and get him/her out of bed to his/her wheelchair. Unit Manager #3 said the schedule should be followed as ordered by the physician and that she was not aware Resident #23's left hand splint was not on the past 2 days. During an interview on 11/7/24 at 9:30 A.M., the Director of Nursing said a splint schedule should be followed as ordered by the physician. The Director of Nursing said if a resident refuses to wear the splint it should be documented in the medical record. Review of Resident #23's medical record failed to indicate he/she refused to wear his/her splint. 48671 2. Resident #13 was admitted to the facility in April 2024 with diagnoses that included presence of cardiac pacemaker, atrial fibrillation, atherosclerotic heart disease, hypertension and dementia. Review of Resident #13's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 6 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident had severe cognitive impairment. Further review of the MDS indicated the presence of a cardiac pacemaker. On 9/5/24 at 9:05 A.M., Resident #13 was observed sitting up in a chair eating breakfast. A white box was observed placed on the nightstand next to the Residents bed. Resident #13 said he/she has a pacemaker and said, nobody ever checks it. Review of Resident #13's pacemaker care plan, dated 4/5/24, indicated Resident is at risk for a cardiac event R/T (related to) HTN (hypertension), CAD (coronary artery disease), A-fib (atrial fibrillation), pacemaker. -Pacemaker is in place. The date the pacemaker was inserted: _____ The model is: _____ The serial # is: _____ The setting is: _____ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interrogation of the pacemaker as ordered. The Cardiologist name & phone # is: _____ The date of insertion, model, serial number, setting, and cardiologist name and phone number were left blank. Review of Resident #13's medical record failed to indicate information on the cardiac pacemaker. During an interview on 11/6/24 at 9:02 A.M., Nurse #1 said Resident #13 does not have a pacemaker. During an interview on 11/6/24 at 9:27 A.M., Unit Manager (UM) #2 said Resident #13 does have a pacemaker and said the care plan should be completed with information related to the pacemaker and not left blank. UM #2 said transmission of the pacemaker was done last month but she did not have any information regarding when and could not find any information in the medical record. During an interview on 11/6/24 at 1:11 P.M., the Director of Nurses (DON) said the pacemaker care plan should be updated with information on how the pacemaker is monitored and specifics of the pacemaker. 3. Resident #48 was admitted to the facility in January 2022 with diagnoses including myocardial infarction, diastolic congestive heart failure, and paroxysmal atrial fibrillation. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/19/24, indicated that Resident #48 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS indicated Resident #48 is taking an anticoagulant (blood thinner) medication. Review of Resident #48's plan of care related to high-risk medications, dated as revised 8/7/24, failed to indicate the use of an anticoagulant and did not contain interventions related to high-risk medications or bleeding risks. Review of Resident #48's Medication Administration Record dated November 2024, indicated the following physician orders: - Apixaban Oral Tablet 5 milligrams (Apixaban) Give 1 tablet by mouth two times a day related to paroxysmal atrial fibrillation. Hold 11/10/24 to 11/12/24. Resident #48 was administered Apixaban twice daily during the month of November 2024. During an interview on 11/6/24 at 9:06 A.M., Unit Manager #1 said that Resident #48 is on an anticoagulant and said the care plan should be updated with bleeding risks and monitoring. During an interview on 11/6/24 at 1:12 P.M., the Director of Nurses said Resident #48's high risk medications care plan should have been updated to include bleeding risks due to the use of an anticoagulant medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48671 Based on observations, interviews, and record review, the facility failed to provide services that met professional standards of quality for one Resident (#48) out of a total sample of 23 residents. Specifically, the facility failed to ensure nursing implemented a physician's order for weekly weights. Findings include: Review of the facility policy titled Weights Monitoring, dated as revised February 2023, indicated the following: - A weight monitoring schedule will be developed upon admission for all residents: - Weights should be recorded at the time obtained. 6. Weight analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% change in weight in one month (30 days) b. 7.5% change in weight in three months (90 days) c. 10% change in weight in six months (180 days) 7. Documentation: a. The physician should be informed of a significant change in weight in may order nutritional interventions. e. The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutritional progress notes. g. The interdisciplinary plan of care communicates care instructions to staff. Resident #48 was admitted to the facility in January 2022 with diagnoses including myocardial infarction, diastolic congestive heart failure, and paroxysmal atrial fibrillation. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/19/24, indicated that Resident #48 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS indicated Resident #48 required setup or clean-up assistance for eating and had experienced weight loss of 6.2% in one month and received a mechanically altered therapeutic diet. Review of Resident #48's nutrition care plan, dated as revised 8/7/24, indicated: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor po (oral intake), wts (weights), labs and skin. - Dietitian consult as needed. Review of Resident #48's physician's order, dated 2/9/24, indicated: Weekly weight, every day shift, every Monday for weight. Review of Resident #48's Medication and Treatment Administration record did not contain documentation to support nursing obtained the weights. Review of Resident #48's weights in the electronic health record indicated the following: - 9/9/24 174.6 lbs. - 10/15/24 163.8 lbs. These values indicated a significant change in weight (6.2% loss) in approximately a one month period. No weekly weights were documented in the medical record between 10/15/24 and 11/7/24 (over a three week period). Review of Resident #48's, Nutrition Assessment -Dietary/Nutrition Note, dated 8/5/24, indicated the following: -WT (weight) is stable overall at 173# w/in (within) his/her baseline. WT changes of a few pounds overall; not significant. -No new recommendations at this time POC (plan of care) updated. -Diet Recommendations/ Monitoring: weight, skin labs as ordered. Review of the weekly Risk Meeting Notes indicated the following information for Resident #48: 10/17/24- needs reweigh - down 10.8 lbs in 1 month s/p hospitalization during this time. Currently 163.8. 10/24/24- needs reweigh-down 10.8 lbs in 1 month s/p hospitalization during this time. Currently 163.8. 10/31/24-needs reweigh - down 10.8 lbs in 1 month s/p (status post) hospitalization during this time. Currently 163.8. Review of the clinical record failed to indicate recommended re-weights occurred. Review of Resident #48's Quarterly Nutrition assessment dated [DATE], was blank, not completed and documented as in progress. There was no reference to the Resident's significant weight loss. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 9:23 A.M. the Dietician said Resident #48 returned from the hospital on 10/12/24 and his/her weight loss should have been monitored with weekly weights and should have been assessed. The Dietician said Resident #48's weights should have been discussed at risk meeting and a reweight should have been done on 10/15/24 and after to confirm the weight. The Dietician said Resident #48 has had a significant weight loss and said an assessment would determine if it was planned or not and said labs and weight monitoring should have been implemented and physician orders should be followed. The Dietician said she did not complete the nutrition assessment on 10/24/24. The Dietician said she would complete an assessment today and weigh the Resident because the missing weights are concerning. During an interview on 11/07/24 at 9:59 A.M., the Assistant Director of Nurses (ADON) said weights should have been completed and documented and a nutrition assessment should have been completed. The ADON said she would expect the weights and reweights to be reviewed and discussed at the risk meeting and followed up on. The ADON said the significant weight loss requires monitoring and supplements should have been discussed and reviewed. During an interview on 11/07/24 at 10:41 A.M., the Director of Nurses (DON) said she expects weights to be monitored and assessed and said Resident #48 should have been weighed and discussed at risk meeting to monitor continued weight loss, and care plan interventions updated with dietary recommendations and supplements if needed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 45984 Based on observation, record review and interview, the facility failed to ensure staff adhered to professional standards of practice for the administration of enteral tube feeding (nutrition taken through a tube directly into the stomach) for one Resident (#259) out of a total sample of 23 residents. Specifically, the facility failed to consistently label and date the tube feeding bag. Findings include: Review of the facility policy titled Care and Treatment of Feeding Tube, dated and revised August 2024, indicated the following: - Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided: Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders and ensuring that the product has not exceeded the expiration date. Resident #259 was admitted to the facility in November 2024 with diagnoses including encephalopathy, dysphagia, and type 2 diabetes mellitus. Review of Resident #259's admission assessment indicated he/she has no memory impairment. Review of Resident #259's physician's order dated 11/5/24 indicated the following: - Tube feeding via G-tube (gastric tube): Jevity 1.5 at 75 ml (milliliter) per hour for 12 hours. ON at 8 PM; OFF at 8 AM. Provides: 900 ml volume; 1350 cal (calorie); 50 gm (gram) protein. The surveyor made the following observations: - On 11/5/24 at 7:50 A.M., Resident #259 was sleeping in his/her bed and receiving tube feeding. The tube feeding formula was in an open system bag with an opening on the top allowing staff to pour the formula directly into the bag which will deliver the tube feeding formula to the resident. The tube feeding bag was not labeled with what tube feeding product it contained and it was not dated indicating when it was first administered and when its expiration date was. - On 11/6/24 at 7:04 A.M., Resident #259 was sleeping in his/her bed and receiving tube feeding. The tube feeding formula was in an open system bag with an opening on the top allowing staff to pour the formula directly into the bag which will deliver the tube feeding formula to the resident. The tube feeding bag was not labeled with what tube feeding product it contained, and it was not dated with an expiration date. During an interview on 11/7/24 at 7:00 A.M., Unit Manager #4 said Resident #259's tube feeding formula gets poured directly into the bag and we follow the physician's orders for it. Unit Manager #4 said the bag should be labeled and dated so we know what is in it, when the formula was hung and when it should stop since it is an open system. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/24 at 10:13 A.M., the Director of Nursing said tube feeding bags should always be labeled and dated so we know what is in them and when it was hung.

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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	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. 44095 Based on observations and interviews the facility failed to ensure drugs and biologicals were stored in accordance with accepted professional standards of practice for four of four medication rooms. Specifically, nursing failed to ensure the codes to the medication rooms were not disclosed to unauthorized personal. Findings include: Review of the facility of policy, Medication Storage, dated 2/2023, indicated that it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. 1. On 11/6/24 at 7:54 A.M., two surveyors were located at the C Unit nursing station when there was one nurse who asked for the code to get into the medication room. Another nurse loudly yelled from across the hall the code, there were residents and staff members in the hallway. On 11/6/24 at 9:14 A.M., the surveyor was able to independently gain access to the B Unit nursing station medication room. The medication room contained the following: - one bottle of folic acid, - one bottle of polyethylene glycol, - one bottle of naproxen sodium, - one bottle magnesium oxide, - one box of guaifenesin tablets, - on bottle of Maalox, - two boxes of omeprazole, - two bottles of acidophilus, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- three boxes of lidocaine 4% patches, and - one plastic container of insulin vials. On 11/6/24 at 9:16 A.M., Unit Manager #1 entered the medication room. Unit Manager #1 said only nurses are supposed to be in the medication room. 2. On 11/6/24 at 9:18 A.M., the surveyor was able to independently gain access to the A Unit nursing station medication room. The code to the door was posted above the pad lock. The medication room contained the following: -one bottle of allergy relief, -one bottle of folic acid, -one bottle of iron, -one bottle of B complex vitamins, -one bottle of vitamin D, -one bottle of lactulose, -one Novolin pen, -one box of Bisacodyl suppositories, -one box acetaminophen suppositories, -three bottles of MiraLAX, -ten bottles of various over the counter medications, -one anaphylaxis kit, -one Narcan kit, -one coumadin kit, and -one insulin kit. 3. On 11/6/24 at 9:21 A.M., the surveyor was able to independently gain access to the D Unit nursing station medication room. The medication room contained the following: - 53 bottles of over-the-counter medications - one Narcan kit, (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	- one anaphylaxis kit, - one emergency kit, - one IV hydration kit, - one box of Trulicity, - one insulin kit, - one box of Bisacodyl suppositories, and - two boxes of acetaminophen suppositories. 4. On 11/6/24 at 9:30 A.M., the surveyor was able to independently gain access to the C Unit nursing station. The medication room contained the following: - one Narcan kit, - one anaphylaxis kit, - one bottles of folic acid, - one bottle of meclizine, - one bottle of simethicone, - one bottle of Maalox, - one bottle of vitamin D, - one box of omeprazole, - one bottle of MiraLAX, - one bottle of ProSource, - one Humalog insulin pen, - one bottle of acidophilus, - one box containing Bisacodyl suppositories, - two bottles of calcium carbonate, - two bottles of Bisacodyl, - three bottles of Senna, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225357	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winchester Rehabilitation and Nursing Center	223 Swanton Street, #1968 Winchester, MA 01890

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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	- three bottles of Colace, and - ten bottles of acetaminophen. During an interview on 11/6/24 at 9:36 A.M., Unit Manager #2 said that only nursing is supposed to be in the mediation room. During an interview on 11/6/24 at 12:55 P.M., the Director of Nursing said that only nurses should know the code to the medication rooms.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45343 Based on observation record review, and interview, the facility failed to ensure staff maintained an accurate medical record for two Residents (#23 and # 259) out of a sample of 23 residents. Specifically: 1. For Resident # 23, the facility failed to accurately document the wearing of a left hand splint . 2. For Resident #259, the facility failed to accurately document the start time for a tube feeding formula to be hung as ordered by the physician. Findings include: Review of the facility policy titled, Documentation in Medical Record, last revised February 2023, indicated the following: - Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. - Policy Explanation and Compliance Guidelines: 4. Principles of documentation include, but not limited to: a. Documentation shall be factual, objective, and resident centered. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. 1. Resident #23 was admitted to the facility in November 2016 with diagnoses including cerebral vascular disease, cerebral infarction, hemiplegia, and hemiparesis affecting left non-dominant side. Review of Resident #23's most recent Minimum Data Set (MDS) assessment, dated 8/14/24, indicated Resident #23 has severe cognitive deficits. The MDS further indicated Resident #23 requires dependent assistance for activities of daily living. On 11/5/24 at 8:37 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair eating breakfast. Resident #23 was not wearing his/her left-hand grip splint. On 11/5/24 at 10:32 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair. Resident #23 was not wearing his/her left-hand grip splint. On 11/5/24 at 11:20 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair. Resident #23 was not wearing his/her left-hand grip splint. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 at 8:07 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair eating breakfast. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 10:05 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 11:56 A.M., the surveyor observed Resident #23 sitting in his/her wheelchair eating lunch. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 1:31 P.M., the surveyor observed Resident #23 sitting in his/her wheelchair outside on the patio. Resident #23 was not wearing his/her left-hand grip splint. On 11/6/24 at 3:25 P.M., the surveyor observed Resident #23 sitting in his/her wheelchair participating in an afternoon activity. Resident #23 was not wearing his/her left-hand grip splint. Review of Resident #23's physician orders indicated the following order initiated on 8/10/24: - Apply left hand-grip splint as tolerated - on AM off PM, one time a day related to unspecified sequelae of unspecified cerebrovascular disease and remove per schedule. Review of Resident #23's ADL care plan interventions indicated the following: - Will wear his/her left-hand splint daily as tolerated. Review of Resident #23's Treatment Administration Record (TAR) for 11/5/24 through 11/6/24 indicated staff had signed off that he/she was wearing his/her left-hand splint. During an interview on 11/7/24 at 8:44 A.M., Unit Manager #3 said Resident #23 has a left-hand splint we put on him/her once he/she is washed and dressed and out of bed in the morning. Unit Manager #3 said it should be documented correctly in the medical record and indicated if the resident refuses. During an interview on 11/7/24 at 9:30 A.M., the Director of Nursing said she expects the splint to be worn as ordered by the physician, accurately documented in the medical record, and indicated if the resident refuses. Review of Resident #23's medical record failed to indicate he/she refused to wear his/her splint. 45984 2. Resident #259 was admitted to the facility in November 2024 with diagnoses including encephalopathy, dysphagia, and type 2 diabetes mellitus. Review of Resident #259's admission assessment indicated he/she has no memory impairment. Review of Resident #259's physician's order dated 11/5/24 indicated the following: (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Tube feeding via G-tube (gastric tube): Jevity 1.5 at 75 ml (milliliter) per hour for 12 hours. ON at 8 PM; OFF at 8 AM. Provides: 900 ml volume; 1350 cal (calorie); 50 gm (gram) protein. Start: 1400 (2:00 P.M.). The description of the physician's order indicated that the tube feeding solution should be administered at 8:00 P.M., the start time in the medical record system has the tube feeding solution start time as 2:00 P.M. - On 11/5/24 at 7:50 A.M., Resident #259 was sleeping in his/her bed and receiving tube feeding via a G-tube. - On 11/6/24 at 7:04 A.M., Resident #259 was sleeping in his/her bed and receiving tube feeding via a G-tube. Review of the facility document titled Medication Administration Audit Report for Resident #259 indicated that nursing signed off on Resident #259's tube feeding order as being administered at 2:14 P.M. on 11/5/24 and 2:32 P.M. on 11/6/24 despite Resident #259 not receiving his/her tube feeding formula until 8:00 P.M., as described in the order. During an interview on 11/7/24 at 8:22 A.M., Unit Manager #4 and the surveyor observed the audit report, and she said Resident #259 did not receive his/her tube feeding at the documented times as she was working both days and it was not administered. Unit Manager #4 continued to say staff should not be signing off on a treatment if it is not being done at that time. During an interview on 11/7/24 at 9:18 A.M., the Registered Dietitian said the timing of Resident #259's order should match the time in the description of the order to make sure Resident #259 is receiving his/her tube feeding at the correct time. During an interview on 11/7/24 at 10:13 A.M., the Director of Nursing said staff should not be documenting treatments being done if it is not happening at that time. The DON continued to say nursing should let someone know if there is a discrepancy with the order timing and the description of the order.