STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jml Care Center Inc	184 Ter Heun Drive Falmouth, MA 02540

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 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. 34145 Based on record review and interview, the facility failed to ensure the Resident Representative was notified of a fall for one Resident (#48), out of a total sample of 19 residents. Specifically, the facility failed to ensure the activated Health Care Proxy (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) was notified of one fall resulting in a large bruise. Findings include: Review of the facility's policies, Notification of Changes Policy/Incident Reporting Process and Fall Prevention and Management Program Policy, undated, indicated but was not limited to: -The MD (physician) and responsible party MUST be notified at the time of the occurrence. Document in both incident report and the nurse's note this was completed. -The Nurse and/or Physician will notify and involve the family or significant others. Resident #48 was admitted to the facility in 10/2023 and had diagnoses including Alzheimer's disease, vascular dementia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 1/7/25, indicated Resident #48 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, and had two falls since the last assessment. The assessment indicated Resident #48 had an activated Health Care Proxy. Review of the medical record and fall incident/accident reports indicated but was not limited to the following: -1/19/25 at 6:40 A.M. the nurse was at the nurse's station when the Resident's alarm sounded, and the nurse found the Resident sitting on the floor at the end of the bed. The Resident had a large reddish/purple bruise on his/her midback. Further review of the documentation failed to indicate staff notified the Resident's Healthcare Proxy of the fall. (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: 225369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 11:36 A.M., Unit Manager #4 reviewed Resident #48's medical record and the 1/19/25 fall incident/accident report. Unit Manager #4 said the Resident's physician was notified of the fall, but she could not find evidence that the Resident's Health Care Proxy was notified. During an interview on 2/5/25 at 4:01 P.M., the Director of Nursing said Resident #48's Health Care Proxy should have been notified of the fall on 1/19/25 and the notification should have been documented in the medical record. He said if it wasn't documented, it wasn't done.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42742 Based on interview and record review, the facility failed to report an allegation of physical abuse to the State Agency (SA) within the mandated timeframes as required for one Resident (#13), out of a total sample of 19 residents. Findings include: Review of the facility's policy titled Abuse Policy, undated, indicated but was not limited to the following: -It is the policy that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. -The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made. -The Administrator or designee will inform the resident or resident's representative of the report of an incident and that an investigation is being conducted. -Covered individuals are obligated to comply with reporting requirements. If uncertain whether or not to report an incident, call the State Agency for further direction. -Inquiries concerning the abuse reporting and investigation should be referred to the Administrator. Resident #13 was admitted to the facility in November 2024 and had diagnoses including open wound of the left lower leg, paroxysmal atrial fibrillation, obstructive sleep apnea (OSA-sleep disorder where the upper airway repeatedly becomes blocked during sleep, leading to interrupted breathing), major depressive disorder, venous insufficiency, falls, and bilateral hearing loss. Review of the Minimum Data Set (MDS) assessment, dated 11/7/24, indicated Resident #13 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/3/25 at 10:58 A.M., Resident #13 said he/she would like the surveyor to speak with Family Member #1 to help answer any questions and called Family Member #1 from his/her cellular device placing her on speaker in the Resident's room. Resident #13 said late at night staff are pushing and shoving him/her and are abusive but provided no further details. Family Member #1 said the facility was poorly staffed to the point where she saw three fingerprint marks on the Resident's left upper arm as if someone had grabbed him/her. Family Member #1 said the left upper arm had three lines, maybe a couple inches each, but may now be faded. She said she could not remember when this happened, maybe one or two weeks ago, but she didn't report it to anyone. Family Member #1 further said abuse seemed to occur, but did not elaborate. Resident #13 said he/she could not recall if staff caused the red marks. Family Member #1 said staff can be too forceful and get frustrated at times. On 2/3/25 at 11:33 A.M., upon completion of the Resident/Family Member #1's interview, the surveyor immediately reported the allegation of physical abuse to the Administrator. Review of the Health Care Facility Reporting System (HCFRS) failed to indicate the alleged violation involving abuse was reported immediately by staff, but no later than 2 hours after the allegation was made as required. During an interview on 2/4/25 at 3:52 P.M., the Administrator said she did not report the allegation because neither the Resident nor Family Member #1 would discuss it. She said it should have been reported within two hours but wasn't. She said the investigation was in progress as she'd like the spouse to provide more information.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 48362 Based on record review and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for three Residents (#70, #6, #33), out of 19 sampled residents. Specifically, the facility failed: 1. For Resident #70, to ensure the MDS assessment was accurately coded for dialysis; 2. For Resident #6, to ensure the MDS assessment was accurately coded for hospice; and 3. For Resident #33, to ensure the MDS assessment was accurately coded for a diagnosis of dementia. Findings include: 1. Resident #70 was admitted to the facility in August 2023 with diagnoses including end stage renal disease, dependence on renal dialysis and vascular dementia. Review of Resident #70's Physician's Orders indicated but were not limited to the following: - 5/13/24: [Name of Dialysis Center] scheduled Tuesday/Thursday/Saturday with 6:35 A.M. arrival time Review of the MDS assessment, dated 12/9/24, failed to indicate Resident #70 was receiving dialysis. During an interview on 2/5/25 at 7:23 A.M., MDS Nurse #1 said Resident #70 was the only resident in the facility receiving dialysis. MDS Nurse #1 reviewed Resident #70's MDS assessment and said the assessment was coded incorrectly and needed to be modified. 2. Resident #6 was admitted to the facility in May 2023 with diagnoses including dementia and anxiety. Review of Resident #70's Physician's Orders indicated but were not limited to the following: - 2/26/24: Admit to Hospice 2/22/24 Review of the MDS assessment, dated 12/11/24, failed to indicate Resident #6 was receiving hospice services. During an interview on 2/5/25 at 7:25 A.M., MDS Nurse #1 said Resident #6 was receiving hospice services. MDS Nurse #1 reviewed Resident #6's MDS assessment and said the assessment was coded incorrectly and needed to be modified. 48695 (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	3. Resident #33 was admitted to the facility in February 2024 with diagnoses including anxiety and Parkinson's disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination). Review of Resident #33's Physician's Progress Notes, dated as follows, indicated he/she had a diagnosis of dementia: - 4/23/24 - 7/25/24 - 7/29/24 - 9/1/24 - 9/19/24 Review of Resident #33's MDS assessment, dated 11/5/24, failed to indicate he/she had a diagnosis of dementia. During an interview on 2/5/25 at 4:28 P.M., MDS Nurse #1 reviewed Resident #33's physician's progress notes and the MDS. MDS Nurse #1 said Resident #33 had a diagnosis of dementia and the MDS assessment was coded incorrectly and should have indicated that Resident #33 had dementia. During an interview on 2/5/25 at 4:43 P.M., the Director of Nursing (DON) said the expectation was for MDS assessments to be completed accurately for all residents.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 42742 Based on record review and interview, the facility failed to ensure staff provided the resident and/or their representative with a summary of the baseline care plan for one Resident (#291), out of a total sample of 19 residents. Specifically, the facility failed to provide the Resident with a written summary of the baseline care plan and document receipt of the information within the Resident's clinical record. Findings include: Review of the facility's policy titled Care Plans - Baseline indicated but was not limited to the following: -The baseline care plan includes instructions needed to provide effective, person-centered care of the residents that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the residents including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy Services; e. Social Services; and f. PASARR recommendations, if applicable. -The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). Resident #291 was admitted to the facility in January 2025 and had diagnoses including morbid obesity, type 2 diabetes mellitus, uncontrolled hypertension, coronary artery disease, and a history of falls. Review of the Minimum Data Set (MDS) assessment, dated 1/26/25, indicated Resident #291 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #291 and their daughter on 2/3/25 at 2:06 P.M., Resident #291 said he/she had been at the facility for about 1.5 weeks after having three falls at home and had been receiving nursing and therapy services. The Resident said he/she never had a meeting within the first several days of being there and never received a copy of the baseline care plan. The Resident's daughter said there was no care plan meeting and they never received a copy of the care plan information. Resident #291 said Social Worker (SW) #1 had stopped in that morning and said she was working on a discharge plan, but there was no update on a timeframe or what services would be in place. The Resident said SW #1 said she would try to contact his/her other daughter in Pennsylvania but the last update from his/her daughter was that no one had contacted her yet. Review of Resident #291's Baseline Care Plan indicated the patient or representative's signature line on the document was blank and was not dated to indicate it had been reviewed with the Resident/Resident's representative. Further review of the medical record failed to indicate documentation that the Resident was provided with a written summary of his/her baseline care plan that included initial goals for the resident, current medications and dietary instructions, and services and treatments to be administered by the facility and personnel acting on behalf of the facility. During an interview on 2/5/25 at 9:38 A.M., Resident #291 said when he/she was admitted to the facility from the hospital no one had met with her to discuss her plan of care until SW #1 did a day or two ago. She said she had asked to speak with SW #1 over and over and over again but didn't see her. The surveyor reviewed the Baseline Care Plan document with the Resident who said she had never seen it, no one reviewed it with her, and she never received a copy of it, but would have liked for those things to have happened. She said she used to work in the medical field and is aware of the process that should be followed. During an interview on 2/5/25 at 9:47 A.M., Nurse #3 said when residents are admitted either the admitting nurse or a supervisor will complete the baseline care plan within 48 hours, but the social worker typically would review the plan of care with the residents. She said she didn't know though what time period this should be done. During an interview on 2/5/25 at 9:56 A.M., SW #1 said she met with the Resident upon admission on 1/24/25 for an assessment, but the assessment format is the same for all new admissions and does not review specifically a summary of the baseline care plan. She said every admission goes through the same process. She said the summary is on the actual Baseline Care Plan document, but unfortunately it was not dated. She said she does not review other disciplines such as rehabilitation therapy, but each discipline will go in and speak to the Resident separately. The surveyor reviewed the medical record with SW #1 who said she reviews her own care goals with the residents and does not document a summary of the baseline care plan. She said she is in email communication with the Resident's daughters. During an interview on 2/5/25 at 12:16 P.M., SW #1 said there wasn't an Interdisciplinary (IDT) meeting with the Resident because they find that to be too overwhelming to the residents so each discipline will meet with the resident separately. She said she had no documentation that a summary of the baseline care plan was provided to the resident and/or representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 12:45 P.M., the surveyor reviewed a copy of the Baseline Care Plan with the Director of Nurses (DON) who said if it was not signed or dated by the resident, then he could not say if it was reviewed or not with the Resident and provided to him/her. He said he would keep looking for documentation to provide to the surveyor. During an interview on 2/5/25 at 4:03 P.M., the DON said he couldn't locate any documentation that the Resident was provided with a written summary of his/her baseline care plan that included initial goals for the resident, current medications and dietary instructions, and services and treatments to be administered by the facility and personnel acting on behalf of the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34145 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 four Residents (#40, #48, #84, and #33), out of a total sample of 19 residents. Specifically, the facility failed to ensure a comprehensive care plan was developed: 1. For Resident #40, to address the use of antidepressant medication (used to treat obsessive compulsive disorder) that identified target behaviors, individualized, measurable non-pharmacological interventions and measurable goals of treatment; 2. For Resident #48, to address the use of antianxiety, antidepressant, and antipsychotic medication that identified target behaviors and individualized, measurable non-pharmacological interventions and measurable goals of treatment; 3. For Resident #84, to address a wound to the Resident's right medial calf; and 4. For Resident #33, to address an antipsychotic medication that identified target behaviors and individualized, measurable non-pharmacological interventions and measurable goals of treatment. Findings include: Review of the facility's policy titled Care Plans, undated, indicated but was not limited to: -The Interdisciplinary Team shall develop a comprehensive, individualized plan of care for each resident and is reviewed and revised in accordance with State and Federal regulations and professional standards of nursing care. The Care Plan guides the care and treatment provided to each resident. -Resident specific plans of care (e.g. Hospice or Behavioral Health) will be integrated into the resident's comprehensive core care plan. -The total Plan of Care includes established routines of care, professional standards of practice, physician's orders and progress notes, consultant reports, MARs (Medication Administration Record), TARs (Treatment Administration Record), flow sheets, various medical records and resident/family preferences. 1. Resident #40 was admitted to the facility in August 2023 and had diagnoses including obsessive compulsive disorder (OCD) and depression. Review of the Minimum Data Set (MDS) assessment, dated 10/29/24, indicated Resident #40 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, and received antidepressant medication daily. Review of Physician's Orders indicated but was not limited to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Fluvoxamine (antidepressant) 100 milligrams (mg) twice daily for obsessive compulsive disorder (last renewed 1/29/25) Review of September 2024 through February 2025 MARs indicated Fluvoxamine was administered to Resident #40 as ordered by the physician. Review of comprehensive care plans indicated but was not limited to: -Focus: Psychotropic Drug Use-antidepressant (1/12/24) -Interventions: Monitor psychotropic medications for side effects, especially lethargy and fall risk; monitor mood/behaviors with response to effectiveness of psychotropic medication, provide instruction/redirection for episodes of behaviors; assess and monitor cause of behaviors and measures taken to de-escalate; attempt gradual dose reduction at direction of medical provider. -Goals: Resident's mood and behavior will be monitored for stability and managed medically as evidenced by participation in activities of daily living (ADLs) and ordered rehab services. The care plan for the use of Fluvoxamine failed to identify resident specific, targeted behaviors for the use of the medication and failed to include measurable goals to ascertain the effectiveness of the medication and non-pharmacological interventions. During an interview on 2/5/25 at 11:36 A.M., Unit Manager #4 reviewed Resident #40's medical record including comprehensive care plans. She said Resident #40 has been taking Fluvoxamine for obsessive compulsive disorder for over a year. She said the care plan for the use of Fluvoxamine did not identify resident specific, targeted behaviors for the use of the medication and failed to include measurable goals of treatment to determine the effectiveness of treatment. During an interview on 2/5/25 at 4:01 P.M., the Director of Nursing (DON) said Resident #40's comprehensive care plan must include resident specific, targeted behaviors for the use of Fluvoxamine and have measurable goals of treatment. 2. Resident #48 was admitted to the facility in October 2023 and had diagnoses including Alzheimer's disease, vascular dementia, and anxiety disorder. Review of the MDS assessment, dated 1/7/25, indicated Resident #48 had moderate cognitive impairment as evidenced by a BIMS score of 10 out of 15, exhibited physical behaviors toward others and received antipsychotic, antidepressant and antianxiety medication daily. Review of Physician's Orders indicated but was not limited to: -Ativan (antianxiety) 0.5 mg tablet, give 1 tablet three times daily (11/15/24) -Depakote (used as a mood stabilizer) 250 mg tablet, give 1 tablet once daily (1/11/25) -Escitalopram (antianxiety) 10 mg tablet, give 1 tablet once daily (6/17/24) -Remeron (antidepressant) 30 mg tablet, give 1 tablet once daily before bedtime (11/30/23) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Zyprexa (antipsychotic) 2.5 mg tablet, give one tablet at breakfast and one at dinner (11/14/24) -Strattera (used to treat attention deficit hyperactivity disorder) 80 mg capsule, give 1 capsule once daily (1/10/25) Review of the September 2024 through February 2025 MARs indicated the psychotropic medications were administered to Resident #48 as ordered by the physician. Review of comprehensive care plans indicated but was not limited to: -Focus: Psychotropic Drug Use- Antianxiety, Antidepressant (1/12/24) -Interventions: Monitor psychotropic medications for side effects, especially lethargy and fall risk; monitor mood/behaviors with response to effectiveness of psychotropic medication; provide instruction/redirection for episodes of behaviors; assess and monitor cause of behaviors and measures taken to de-escalate; attempt gradual dose reduction at direction of medical provider. -Goals: Resident's mood and behavior will be monitored for stability and managed medically as evidenced by participation in ADLs and ordered rehab services. The care plan for the use of psychotropic medications failed to identify Resident #48 was receiving Zyprexa, and failed to identify resident specific, targeted behaviors for the use antianxiety and antidepressant medications and failed to include measurable goals to ascertain the effectiveness of the medication and non-pharmacological interventions. During an interview on 2/5/25 at 2:19 P.M., Unit Manager #4 reviewed Resident #48's medical record and said Zyprexa should be included in the care plan and resident specific, targeted behaviors should be identified for the use of all psychotropic medications but were not. During an interview on 2/5/25 at 4:01 P.M., the DON said the Resident's Zyprexa should be included in the comprehensive care plan and resident specific, targeted behaviors should be identified for the use of all psychotropic medications. 48362 3. Resident #84 was admitted to the facility in June 2024 with diagnoses including peripheral vascular disease. Review of Resident #84's MDS assessment, dated 12/3/24, indicated he/she had moderate cognitive impairment as evidenced by a BIMS score of 10 out of 15. Further review of the MDS assessment indicated Resident #84 was at risk for pressure ulcers/injuries and had an unhealed wound. Review of Resident #84's Physician's Orders indicated but were not limited to the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/27/24: Right (R) medial calf dressing to be changed every other day; skin barriers/periwound: moisturizing lotion, dampen a piece of gauze with VASHE and gently scrub the wound bed; dampen a second piece of gauze and cleanse an area extending at least six inches around the wound including the entire area covered by the dressing and gauze wrap; soak a third piece of gauze with solution until just starting to drip, place on the wound and let sit for 5-10 minutes; remove gauze and cover with layer of Xeroform dressing; secondary dressing: cover with abdominal (ABD) pad, roll gauze and secure with tape. - 8/24/24: Weekly skin check: comment on condition of skin; include normal and abnormal finding in the comment section. Further review of Resident #84's medical record indicated he/she has been seen by the Wound Clinic for the right medial calf wound since 11/25/24. Wound Clinic documentation for Resident #84 indicated he/she seen was seen every two weeks. Review of Resident #84's medical record indicated a comprehensive care plan related to alteration in skin integrity with focus related to immobility, skin tears of the left upper extremity (LUE), venous ulcers left lower extremity (LLE), and potential for alteration in skin integrity. Further review of Resident #84's medical record failed to indicate a comprehensive care plan related to the right medial calf injury including the Resident's need to be treated by the Wound Clinic. During an interview on 2/5/25 at 10:07 A.M., Nurse #4 said Resident #84 had an active wound to the right medial calf and the Resident is treated by the Wound Clinic every two weeks and they make any dressing recommendations. Nurse #4 said typically the Unit Manager (UM) updates the care plan related to any skin integrity issues. During an interview on 2/5/25 at 12:39 P.M., UM #2 reviewed Resident #84's medical record and said the comprehensive care plan related to alteration in skin integrity did not include documentation related to the Resident's active wound areas. UM #2 said the comprehensive care plan did not include specific information about the Resident being treated by the Wound Clinic, and could be more individualized. During an interview on 2/5/25 at 1:21 P.M., the DON said any nurse can update the care plans for a resident but historically at the facility the unit managers were responsible for making sure they are up to date. The DON said comprehensive care plans should be updated with any changes or interventions specific to the resident. The DON said the care plan was not individualized and should be more specific to the Resident to include their needs. 48695 4. Resident #33 was admitted to the facility in February 2024 with diagnoses including anxiety and Parkinson's disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination). Review of Resident's #33's MDS assessment, dated 11/5/24, indicated he/she had a moderate cognitive deficit as evidenced by a BIMS score of 10 out of 15. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jml Care Center Inc	184 Ter Heun Drive Falmouth, MA 02540

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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 - Some	Review of Resident #33's current Physician's Orders indicated but was not limited to: - Seroquel (antipsychotic medication) give 12.5 mg daily, dated 1/4/25 - Trazodone (antidepressant medication) give 50 mg twice daily as needed for agitation or anxiety, dated 11/12/24 - Trazodone 50 mg daily at bedtime, dated 4/23/24 Review of Resident #33's January and February MARs indicated he/she received Seroquel and Trazodone as ordered. Review of Resident #33's comprehensive care plans included but was not limited to: - Focus: Psychotropic Drug Use: Antidepressant medication (effective date 3/1/24) - Goal: Resident's mood and behavior will be monitored for stability and managed medically as evidenced by participation in ADLs (activities of daily living) and ordered rehab services (effective date 3/1/24) - Interventions: Monitor psychotropic medications for side effects, especially lethargy and fall risk (effective date 3/1/24), Monitor mood/behaviors with response to effectiveness of psychotropic medication (effective date 3/1/24) - Notes: Resident is on scheduled and PRN (as needed) Trazodone to help with sundowning. (effective date 3/1/24) Further review of Resident #33's comprehensive care plans failed to indicate a comprehensive care plan was developed for the use of his/her antipsychotic medication, identifying specific targeted signs/symptoms, Resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of antipsychotic medication to meet the Resident's needs. During an interview on 2/5/25 at 3:10 P.M., UM #4 said comprehensive care plans were developed and updated by her, the MDS Nurse, and Social Services. UM #4 said Resident #33 did not have an individualized comprehensive care plan developed for the use of antipsychotic medication. During an interview on 2/5/25 at 4:43 P.M., the Director of Nursing (DON) said their expectation was for all residents to have individualized comprehensive care plans.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide an environment that was free from accidents and hazards on three of three units. Specifically, the facility failed: 1. For the Naushon Unit, to ensure that medicated treatment supplies and an unlocked treatment cart in the Clean Utility Room were accessible only to licensed staff; 2. For the Nobska Unit, to ensure that: a. medicated treatment supplies and an unlocked treatment cart in the Clean Utility Room were accessible only to licensed staff, and b. the daily supply closet door was locked and not accessible to residents; 3. For Resident #33, (Nobska Unit) that sharps were properly placed in the sharps container to decrease the risk of needlestick injuries and exposure to bloodborne pathogens; and 4. For Resident #73 (Penzance Unit), to ensure sharps containers were replaced routinely and not overfilled to decrease the risk of needlestick injuries and exposure to bloodborne pathogens. Findings include: Review of the facility Matrix (used to identify pertinent care categories for residents) provided to surveyors by the Director of Nursing on 2/3/25 indicated but was not limited to the following: -The Naushon Unit had 23 out of 36 residents with a diagnosis of Alzheimer's Disease/Dementia. -The Nobska Unit had 15 out of 35 residents with a diagnosis of Alzheimer's Disease/Dementia. Review of the facility Storage of Medication Policy, dated January 2024, indicated but was not limited to: Policy: The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1. On 2/3/25 at 10:00 A.M., and 5:18 P.M., and on 2/4/25 at 8:49 A.M., 2:19 P.M., and 2:25 P.M., the surveyor observed the Clean Utility Room door unlocked on the Naushon Unit. The surveyor was able to open the door easily and enter the room which contained medicated treatment supplies and an unlocked treatment cart. The supplies stored and accessible in the clean utility room included but were not limited to: - Hydrocortisone Cream (a steroidal cream) (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

- Bacitracin (an antibiotic ointment used to treat minor skin infections, such as cuts, scrapes, and burns)

- Skin Prep Wipes (prepare intact skin for attachment sites, tapes, films, and adhesive dressings)

- Alcohol Wipes

- Iodine solution (an antiseptic and disinfectant agent, used for the treatment and prevention of infections in wounds and cuts)

- Benzocaine (local anesthetic that numbs pain by blocking nerve signals)

- Disinfection bleach wipes

- An unlocked treatment cart which contained medicated treatment supplies including but was not limited to:

 - Antifungal cream

 - Antifungal powder

 - Hemorrhoidal Ointment

 - Betamethasone Topical Cream (used to help relieve redness, itching, swelling, or other discomforts caused by certain skin conditions)

 - Acyclovir Ointment (a prescription medication that treats herpes simplex virus infections)

 - Triamcinolone Cream (used to reduce inflammation and itching of the skin)

 - Lidocaine 4% cram (topical anesthetic)

During an interview on 2/5/25 at 10:48 A.M., Nurse #4 said the clean utility room did not have a door that could be locked. Nurse #4 said the treatment cart should be locked for Resident safety and treatment supplies should not be accessible to residents.

During an interview on 2/5/25 at 10:54 A.M., Unit Manager (UM) #2 said the clean utility room contained treatment supplies and the treatment cart contained resident specific treatment supplies. UM #2 said the treatment cart should have been locked as it contained prescription and non-prescription medicated treatment supplies. UM #2 said the door to the clean utility room did not have a lock on it because it contained the eye wash station, but treatment supplies should have been kept in a locked cabinet for safety and not potentially accessible to residents.

During an interview on 2/5/25 at 4:43 P.M., the Director of Nursing (DON) said treatment carts should be locked when there is not a nurse directly in front of them and the medicated treatment supplies in the clean utility room should be locked up and not accessible to residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. On 2/3/25 at 10:32 A.M. and 5:13 P.M., and on 2/4/25 at 8:37 A.M., 2:07 P.M., 2:40 P.M., and 4:47 P.M., the surveyor observed the Clean Utility Room door on the Nobska Unit unlocked. The Clean Utility Room contained medicated treatment supplies and an unlocked treatment cart. On 2/4/25 at 2:04 P.M., the surveyor observed the door to the Clean Utility Room unlocked and open with treatment supplies visible and accessible and an unlocked treatment cart. The supplies stored and accessible in the clean utility room included but were not limited to: - Hydrocortisone Cream - Bacitracin - Skin Prep Wipes - Alcohol Wipes - Disinfection bleach wipes - An unlocked treatment cart which contained medicated treatment supplies including but was not limited to: - Antifungal cream - Antifungal powder - Hemorrhoidal Ointment - Betamethasone Topical Cream - Triamcinolone Cream - Arthritis pain relieving cream - Desonide cream (a topical corticosteroid medication used to treat inflammatory skin conditions such as eczema and psoriasis) - Premarin Cream (estrogen hormonal cream used to treat adults with vaginal symptoms due to menopause) - Diclofenac Sodium Topical Gel (used to treat the symptoms of rheumatoid arthritis) - Mupirocin Ointment (used to treat some skin infections) - Tinactin powder (used to treat infections such as athlete's foot, jock itch, and ringworm) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 5:13 P.M., UM #4 said having the door to the clean utility room unlocked and treatment supplies out and accessible to residents is a safety concern. UN #4 said the treatment supplies and the treatment cart should be locked to ensure resident safety in case a resident walks in. During an interview on 2/5/25 at 4:43 P.M., the DON said treatment carts should be locked when there is not a nurse directly in front of it and the medicated treatment supplies in the clean utility room should be locked up and not accessible to residents. b. On 2/3/25 at 8:53 A.M., 10:36 A.M., and 5:08 P.M., and on 2/4/25 at 8:37 A.M., 1:10 P.M., 1:56 P.M., and 2:04 P.M., the surveyor observed the door to the Daily Supply Closet on the Nobska Unit closed and locked. The key to the door, however, was still inserted and accessible to any residents passing by. The Daily Supply Closet contained but was not limited to: - Razors - Saline Enemas - Mouthwash with alcohol - Denture Cleanser Tabs - Hand Sanitizer containing 70% Ethyl Alcohol - Germicidal Wipes During an interview on 2/4/25 at 2:34 P.M., Certified Nursing Assistant (CNA) #1 and the surveyor observed the key in the door of the daily supply room. CNA #1 said the clean utility room contained soap, mouth wash, sanitizer, urinals, patient bags, razors, and hand sanitizer just to name a few things in there. CNA #1 said the key to the daily supply room should not be in the lock so no one can get in there and this was not safe if a resident was to get into the room. During an interview on 2/4/25 at 4:45 P.M., the Director of Maintenance (DOM) said the key to the daily supply room should not be kept in the lock of the door but in a closable magnetic key box to limit access to anyone who shouldn't be in there. During an interview on 2/5/25 at 4:43 P.M., the DON said the daily supply room should be locked with the key in the magnetic key box at the top of the door to limit access to staff only. 3. Review of the facility's service agreement for regulated medical waste and reusable sharps program, dated 4/23/24, indicated but was not limited to the following: -Waste company will provide reusable sharps containers for all customer locations designated as Group A and Group B, in Exhibit A, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Waste company will provide the resources and labor to install Reusable Sharps containers throughout the healthcare network and all reusable Sharps containers will be serviced by our trained service technicians. Service Program Details: Waste Solutions Efficiency Program: -Waste company will provide continuous monitoring of the customers' total regulated medical waste and sharps volumes. Review of the facility's policy titled Sharps Disposal, undated, indicated but was not limited to the following: - Policy Statement: This facility shall discard contaminated sharps into designated containers. -Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers. -Containers sharps will be discarded into containers that are: a. closable; b. puncture resistant; c. leakproof on sides and bottom; and d. impermeable and capable of maintaining impermeability through final waste disposal. -During use, containers for contaminated sharps will be handled as follows: c. Designated individual will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container. Review of the Occupational Safety and Health Administration (OSHA) web-based fact sheet titled, Protecting Yourself When Handling Contaminated Sharps, indicated but was not limited to the following: - A needlestick or a cut from a contaminated sharp can result in a worker being infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and other bloodborne pathogens. The standard specifies measures to reduce these types of injuries and the risk of infection. Careful handling of contaminated sharps can prevent injury and reduce the risk of infection. Employers must ensure that workers follow these work practices to decrease the workers' chances of contracting bloodborne diseases. Sharps Containers: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The containers must be replaced routinely and not be overfilled, which can increase the risk of needlesticks or cuts. Occupational Safety and Health Administration. (2011, January). Protecting Yourself When Handling Contaminated Sharps. https://www.osha.gov/sites/default/files/publications/bbfact02.pdf Resident #33 was admitted to the facility in February 2024 with diagnoses including dementia and Parkinson's disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination). Review of Resident's #33's Minimum Data Set (MDS) assessment, dated 11/5/24, indicated he/she had a moderate cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. The surveyor observed a wall mounted sharps container less than 25% full in Resident #33's room with a blood-filled tubing from a blood collection vacutainer tube (a sterile plastic test tube with a colored rubber stopper creating a vacuum seal inside of the tube, facilitating the drawing of a predetermined volume of liquid) sticking out of the top of the sharps container. The tubing was visible from the hallway and accessible to residents that walk by Resident #33's room on the following days and times: - 2/3/25 at 9:20 A.M., Resident not in room - 2/3/25 at 10:39 A.M., Resident not in room - 2/3/25 at 12:35 P.M., Resident not in room - 2/3/25 at 2:14 P.M., two staff members walked into Resident's room - 2/3/25 at 2:48 P.M., Resident alone and unsupervised in room - 2/3/25 at 5:09 P.M., Resident alone and unsupervised in room - 2/4/25 at 8:19 A.M., Resident not in room - 2/4/25 at 1:11 P.M., Resident alone and unsupervised in room - 2/4/25 at 2:02 P.M., Resident alone and unsupervised in room - 2/4/25 at 2:39 P.M., MDS Nurse #1 in room with Resident During an interview on 2/4/25 at 2:39 P.M., MDS Nurse #1 said the vacutainer blood collection tube should not be sticking out of the sharps container but fully inside the sharps container. MDS Nurse #1 said if someone were to take or grab the vacutainer blood collection tube that could become a potential for blood borne pathogen contamination. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/25 at 4:43 P.M., the DON said all sharps should be fully submerged in the sharps container below the full line to decrease the potential for blood borne pathogen contamination. 42742 4. On 2/4/25 at 10:02 A.M. and 2/5/25 at 7:15 A.M., the surveyor observed a wall mounted sharps container in Resident #73's room grossly overfilled with contaminated sharps material with items such as a razor and blood-filled tubing from a blood collection vacutainer protruding from the container's opening increasing the risk for potential staff needlestick injuries and exposure to bloodborne pathogens. During an observation with interview on 2/5/25 at 10:57 A.M., Nurse #2 entered the Resident's room with the surveyor and said she didn't realize the sharps container was full, but any nurse could swap it out when it gets full with an empty one. She said she didn't know if maintenance routinely checked them, but there is a company that comes in to take the full ones that are stored in the soiled utility room. Nurse #2 said there is the potential for cross-contamination of blood from the exposed sharps contents and said it was a hazard due to the items sticking out of the container. Nurse #2 said the contents should be below the fill line. Nurse #2 sealed and removed the sharps container but was unable to replace it as she could not locate empty containers on the unit. Nurse #2 asked another staff member to get one for the Resident's room. During an interview on 2/5/25 at 12:33 P.M., the Administrator said the designated individuals responsible for sealing and replacing the containers was a waste company the facility had a contract with, but the agreement did not include frequency of visits. She said if a sharps container is full then nursing staff should call maintenance who will come and replace it. She said there were two wings in the facility not being used so could not understand why the container would be full. She said the contracted company does go into the resident rooms to collect full containers but there were no set dates or times. She said that the potential was there for cross-contaminations of blood-borne pathogens and a hazard risk related to exposed sharps. During an interview on 2/5/25 at 1:05 P.M., Maintenance Staff #1 said the waste company comes twice a month to do rounds in the facility, but they won't go in rooms sometimes if residents are sick. He said maintenance is the backup and nursing staff will call him to replace it but he hadn't heard about the overfilled container in Resident #73's room. He said he couldn't understand how the container got so full without being replaced.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42742 Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for one Resident (#50), out of a total sample of 19 residents. Specifically, the facility failed to ensure a physician's order was obtained for the administration of oxygen (O2). Findings include: Review of Lippincott Nursing Procedures, Eighth Edition [Philadelphia: Wolters Kluwer, (2019)] indicated but was not limited to the following: Oxygen Administration: -Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed. Review of the facility's policy titled Oxygen Administration, revised October 2012, indicated but was not limited to the following: -Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. -The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. -Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate prescribed per MD order. Resident #50 was admitted to the facility in December 2024 and had diagnoses including pneumonitis due to inhalation of food and vomit, acute and chronic respiratory failure with hypoxia, centrilobular emphysema (lung condition that causes shortness of breath), chronic obstructive pulmonary disease (COPD- group of lung diseases that block airflow and make it difficult to breathe), chronic diastolic heart failure, and dependence on supplemental oxygen. Review of the Minimum Data Set (MDS) assessment, dated 12/26/24, indicated Resident #50 was cognitively intact and was receiving continuous oxygen therapy. During an observation with interview on 2/3/25 at 1:16 P.M. and 2/4/25 at 11:15 A.M., the surveyor observed Resident #50 in his/her room. Nasal cannula (NC - lightweight tube which one end splits into two prongs which are placed in the nostrils from which a mixture of oxygen and air flows) tubing was observed inserted into the Resident's nostrils with the end of the tubing attached to an oxygen concentrator (provides oxygen for breathing) which was delivering a flow of 2 liters per minute (LPM) of oxygen. Resident #50 said he/she used the oxygen to help with his/her breathing. Review of current Physician's Orders failed to indicate an order for oxygen administration. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 10:38 A.M., Nurse #5 said there was an order for oxygen on 1/27/25 but it was no longer being monitored because the Resident was now receiving hospice care for symptom management. During an interview on 2/5/25 at 11:10 A.M., Nurse #2 said the oxygen was for comfort only secondary to hospice so the order and monitoring typically falls off. During an interview on 2/5/25 at 4:01 P.M., the surveyor reviewed the medical record with the Director of Nurses (DON) who said Resident #50 was admitted to hospice on 1/27/25 but said there should still be an order for oxygen and there wasn't. He said the order was entered on 1/27/25, signed off by the physician, then discontinued the same day and didn't know why. The DON said oxygen is a medication and there should have been an order for it. During an interview on 2/6/25 at 7:36 A.M., the DON said Unit Manager #3 discontinued the order because it was a titrated (adjusted liter flow) order that would require monitoring and forgot to enter the order for O2 for comfort measures. He said there was no order, but there should have been.

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F 0712 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 48362 Based on interviews and record review, the facility failed to ensure five Residents (#84, #6, #76, #47, #31), in a sample of 19 residents, had been seen by a physician every 60 days and had the required visits alternated between the Physician and the Nurse Practitioner (NP). Findings include: Review of the facility's policy titled Physician Visits, dated April 2013, indicated but was not limited to the following: - The attending physician must make visits in accordance with applicable state and federal regulations. - The attending physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. - After the first ninety (90) days, if the attending physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established, but not to exceed every sixty days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation. - The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. 1. Resident #84 was admitted to the facility in June 2024. Review of the Physician progress notes indicated Resident #84 was last seen by the MD (Doctor of Medicine) on 6/6/24. Resident #84's Physician progress notes also indicated an incomplete progress note was initiated by the MD on 6/13/24. Further review of the medical record indicated all subsequent visits were completed by the NP. Review of the medical record indicated Resident #84 had not been seen by a MD in 238 days. During an interview on 2/5/25 at 9:55 A.M., Nurse #1 said residents are typically seen by the NP on a regular basis. Nurse #1 said she does not know when the MD comes into the facility to see their residents. Nurse #1 said all providers are able to document directly in the electronic medical record. During an interview on 2/5/25 at 12:25 P.M., Unit Manager (UM) #2 said the NP typically visits the residents on her unit. UM #2 said she was not sure when the MD came to see residents at the facility. UM #2 reviewed the medical record for Resident #84 and confirmed the Resident was last seen by a MD on 6/6/24 and 6/13/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Jml Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 184 Ter Heun Drive Falmouth, MA 02540	

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F 0712 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 2/5/25 at 1:15 P.M., the Director of Nursing (DON) said residents should be seen by an MD every 30 days for the first 90 days after admission and then every 60 days thereafter. The DON reviewed the findings for Resident #84 and said he was not aware the visits needed to be alternating between the MD and the NP. 2. Resident #6 was admitted to the facility in May 2023. Review of the Physician progress notes indicated Resident #6 was last seen by the MD on 5/15/24. Further review of the medical record indicated all subsequent visits were completed by the NP. Review of the medical record indicated Resident #6 had not been seen by a MD in 267 days. During an interview on 2/5/25 at 9:55 A.M., Nurse #1 said residents are typically seen by the NP on a regular basis. Nurse #1 said she does not know when the MD comes into the facility to see their residents. Nurse #1 said all providers are able to document directly in the electronic medical record. During an interview on 2/5/25 at 12:25 P.M., UM #2 said the NP typically visits the residents on her unit. UM #2 said she was not sure when the MD came to see residents at the facility. UM #2 reviewed the medical record for Resident #6 and confirmed that the Resident was last seen by a MD on 5/15/24. During an interview on 2/5/25 at 1:15 P.M., the DON said residents should be seen by an MD every 30 days for the first 90 days after admission and then every 60 days thereafter. The DON reviewed the findings for Resident #6 and said he was not aware the visits needed to be alternating between the MD and the NP. 3. Resident #76 was admitted to the facility in January 2024. Review of the Physician progress notes indicated Resident #76 was last seen by the MD on 6/5/24. Further review of the medical record indicated all subsequent visits were completed by the NP. Review of the medical record indicated Resident #76 had not been seen by a MD in 244 days. During an interview on 2/5/25 at 9:55 A.M., Nurse #1 said residents are typically seen by the NP on a regular basis. Nurse #1 said she does not know when the MD comes into the facility to see their residents. Nurse #1 said all providers are able to document directly in the electronic medical record. During an interview on 2/5/25 at 12:25 P.M., UM #2 said the NP typically visits the residents on her unit. UM #2 said she was not sure when the MD came to see residents at the facility. UM #2 reviewed the medical record for Resident #76 and confirmed that the Resident was last seen by a MD on 6/5/24. During an interview on 2/5/25 at 1:15 P.M., the DON said residents should be seen by a MD every 30 days for the first 90 days after admission and then every 60 days thereafter. The DON reviewed the findings for Resident #76 and said he was not aware the visits needed to be alternating between the MD and the NP. (continued on next page)

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F 0712 Level of Harm - Potential for minimal harm Residents Affected - Some	4. Resident #47 was admitted to the facility in October 2022. Review of the Physician progress notes indicated Resident #47 was last seen by the MD on 4/24/24. Further review of the medical record indicated all subsequent visits were completed by the NP. Review of the medical record indicated Resident #47 had not been seen by an MD in 286 days. During an interview on 2/5/25 at 9:55 A.M., Nurse #1 said residents are typically seen by the NP on a regular basis. Nurse #1 said she does not know when the MD comes into the facility to see their residents. Nurse #1 said all providers are able to document directly in the electronic medical record. During an interview on 2/5/25 at 12:25 P.M., UM #2 said the NP typically visits the residents on her unit. UM #2 said she was not sure when the MD came to see residents at the facility. UM #2 and the surveyor reviewed the medical record for Resident #47. UM #2 confirmed the Resident was last seen by a MD on 4/24/24. During an interview on 2/5/25 at 1:15 P.M., the DON said residents should be seen by an MD every 30 days for the first 90 days after admission and then every 60 days thereafter. The DON reviewed the findings for Resident #47 and said he was not aware the visits needed to be alternating between the MD and the NP. 48695 5. Resident #31 was admitted to the facility in April 2024 with diagnoses including thrombocytopenia (a condition that occurs when the platelet count in your blood is too low) and atrial fibrillation. Review of Resident #31's Physician Progress Note indicated he/she was seen by the MD on 4/22/24. Further review of the medical record indicated all subsequent visits were completed by the NP. Review of the medical record indicated Resident #31 had not been seen by an MD in 287 days. During an interview on 2/5/25 at 10:23 A.M., UM #4 said the Physician had two NPs that he worked with; the Physician would come in when a resident is a new admission, after that the NP would see the resident. UM #4 said she was not aware what day the Physician comes to the unit. UM #4 reviewed Resident #31's medical record and confirmed that the Resident was last seen by a MD on 4/22/24. During an interview on 2/5/25 at 4:43 P.M., the DON said residents should be seen by an MD every 30 days for the first 90 days after admission and then every 60 days thereafter alternating with the NP. The DON said Resident #31 should have been seen by the MD at a minimum of every 120 days.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48695 Based on record review and interview, the facility failed to ensure three Residents' (#33, #40, and #48) drug regimen was free from unnecessary psychotropic medications, out of a total sample of 23 residents. Specifically, the facility failed: 1. For Resident #33, to adequately identify and monitor target behaviors related to his/her antipsychotic use; 2. For Resident #40, to adequately monitor for potential side effects of fluvoxamine (antidepressant used in the treatment of obsessive-compulsive disorder); and 3. For Resident #48, to adequately monitor for potential side effects for the use of Ativan (antianxiety), Depakote (anticonvulsant used as a mood stabilizer), Escitalopram (antianxiety), Remeron (antidepressant), Zyprexa (antipsychotic), and Strattera (norepinephrine reuptake inhibitor (SNRI) used to treat attention deficit hyperactivity disorder). Findings include: Review of the facility's policy titled Antipsychotic Medication Use, last revised July 2022, indicated but was not limited to: - Policy Statement: Antipsychotic medications can be considered for residents with dementia only after medical, physical, functional, psychosocial, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The attending physician and other staff will gather document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 3. The attending physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. 7. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident. 18. The staff will observe, document, and report to the physician information regarding the effectiveness of any interventions, including antipsychotic medications. 19. Nursing staff shall monitor for any and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. General/anticholinergic: Constipation, blurred vision, dry mouth, urinary retention, sedation; b. Cardiovascular: orthostatic hypotension, arrhythmias; c. Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; d. Neurological: akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke or TIA. Review of the facility's policy titled Psychotic Medication Use, last revised July 2022, indicated but was not limited to: - Policy Statement: Residents will not receive medications that are not clinically indicated to treat specific conditions. 12. Residents receiving psychotropic medications are monitored for adverse consequences, including: a. Anticholinergic effects- flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation and constipation; b. Cardiovascular effects- Irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure, orthostatic hypotension; c. Metabolic effects- increased cholesterol and triglycerides, poorly controlled or unstable blood sugar, weight gain; d. Neurologic effects- agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events; and e. Psychosocial effects- inability to perform ADLs or interact with others, withdrawal or decline from usual social patterns, decreased engagement in activities, diminished ability to think or concentrate. 13. If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued and document the rationale for this decision. 1. Resident #33 was admitted to the facility in February 2024 with diagnoses including anxiety and Parkinson's disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination). Review of Resident #33's Minimum Data Set (MDS) assessment, dated 11/5/24, indicated he/she had a moderate cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Review of Resident #33's current Physician's Orders indicated but was not limited to: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Seroquel (antipsychotic medication) give 12.5 milligrams (mg) daily, dated 1/4/25 The physician order failed to provide an indication for the use of the antipsychotic medication. Review of Resident #33's January and February 2025 Medication Administration Record (MAR) indicated he/she received the Seroquel as ordered. Review of Resident #33's January and February 2025 behavior sheets indicated he/she was being monitored for the following behaviors: - Difficulty falling asleep - Inappropriate behaviors Review of Resident #33's Physician Note, dated 1/3/25, indicated but was not limited to: - nursing staff concern that the agitated behavior seem to be escalating - Dementia with sundowning/agitation - Resident will call out and say he/she wants to go home now Review of Resident #33's Physician Note, dated 2/3/25, indicated but was not limited to: - Apparently these late afternoon sundowning episodes are interfering with communication between staff and patient - Resident was started on low dose Seroquel; in my discussion with staff and spouse a few weeks ago - unclear if it has been helpful or not - Parkinson's dementia with hallucinations and sundowning The Physician notes failed to indicate what the target behavior or specific symptoms the staff should be monitoring to determine if the Seroquel is effective. During an interview on 2/4/25 at 2:34 P.M., Certified Nursing Assistant (CNA) #1 said she had never seen Resident #33 exhibit any behaviors that were inappropriate or physical. CNA #1 said Resident #33 would get more confused as the day would go on and call out for his/her spouse. During an interview on 2/4/25 at 2:34 P.M., CNA #2 said Resident #33 would sometimes have verbal outbursts but mostly he/she would become more confused or call out for his/her spouse. During an interview on 2/4/25 at 1:48 P.M., Nurse #1 said antipsychotic medications were used for restlessness and agitation. Nurse #1 said she was not aware why Resident #33 was started on Seroquel. Nurse #1 said Resident #33 would exhibit behaviors, at times, of trying to get out of bed and would call out for their spouse. Nurse #1 said she did not know what inappropriate behaviors on the behavior sheets referred to. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 4:33 P.M., Nurse # 8 said Resident #33 would hallucinate sometimes or would call out for his/her spouse. Nurse #8 said behaviors that were exhibited would be documented in his/her nurse's notes or on the behavior sheets. Nurse #8 and the surveyor reviewed Resident #33's behavior sheets. Nurse #8 said she was not aware what the inappropriate behaviors section on the Residents behavior monitoring sheet would refer to for Resident #33, but maybe just any behaviors that are out of his/her normal behavior. Nurse #8 said Resident #33 behavior sheets did not list the targeted behaviors of hallucinations or calling out, which are the only behaviors she known Resident #33 to exhibit. During an interview on 2/5/25 at 7:19 A.M., Nurse #6 reviewed Resident #33's behavior sheets and said he had not seen Resident #33 exhibit any inappropriate behaviors or difficulty falling asleep. Nurse #6 said he believed inappropriate behaviors were considered anything out of the normal for Resident #33. Nurse #6 said he was told in report Resident #33 was rude to staff and resistive to care but had never experienced that. Nurse #6 said Resident #33's behaviors should have been more specific and should include resistance to care. During an interview on 2/5/25 at 9:52 A.M., Nurse #7 and the surveyor reviewed Resident #33's behavior sheets. Nurse #7 said inappropriate behaviors are considered talking to staff sexually inappropriately, being sexually inappropriate, inappropriate vocabulary, or being physically inappropriate. Nurse #7 said she had never seen never seen those types of behaviors from Resident #33. Nurse #7 said Resident #33 would generally not exhibit any behaviors during the day, but around 2:00 P.M. or 3:00 P.M., he/she would start calling out for their spouse or for help and would become paranoid about missing the train or something with the family. Nurse #7 said Resident #33's behavior sheets did not include any specific or target behaviors for his/her needs or Seroquel use. During an interview on 2/4/25 at 4:47 P.M., Unit Manager #4 (UM) said Resident #33 would exhibit behaviors that would include looking for the bus, becoming agitated, afraid family is in danger or missing some event with their family. UM #4 said the nurses would document target behaviors for residents on their behavior sheets or in their nurses' notes. UM #4 reviewed Resident #33's behavior sheets and nurses notes and said Resident #33's behavior sheets were not specific and should include behaviors including paranoia and yelling out. UM #4 said the behavior sheets are used to monitor resident behaviors to determine if interventions are effective. UM #4 said it would be difficult to quantify the frequency, type, and time of day Resident #33 exhibited behaviors of paranoia and/or yelling because the behavior sheets did not match those known behaviors. During an interview on 2/5/25 at 4:43 P.M., the Director of Nursing (DON) said residents who receive antipsychotic medications should have specific targeted behaviors that they were being monitored for on their behavior sheets in accordance with the reason they are receiving the medication. The DON said difficulty falling asleep and inappropriate behaviors were not specific behaviors targeted to Resident #33. The DON said Resident #33 should have been monitored for yelling out and paranoia so the Physician could evaluate the efficacy of his/her Seroquel use. 34145 2. Resident #40 was admitted to the facility in August 2023 and had diagnoses including obsessive compulsive disorder (OCD), and depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent MDS assessment, dated 10/29/24, indicated Resident #40 was cognitively intact as evidenced by a BIMS score of 13 out of 15, and received antidepressant medication daily. Review of physician's orders indicated, but was not limited to: -Fluvoxamine 100 milligrams (mg) twice daily for obsessive-compulsive disorder (new order with dose increase on 11/5/24) -Monitor side effects of fluvoxamine-drowsiness, insomnia, constipation, weight gain, sexual problems, tremors, and dry mouth (1/10/24). Review of November 2024 through February 2025 MAR indicated fluvoxamine was administered as ordered by the physician. Further review of the medical record indicated staff monitored Resident #40 for side effects of Fluvoxamine only during the evening shift (3:00 P.M. - 11:00 P.M.). Staff failed to monitor the Resident for side effects during the day shift (7:00 A.M. - 3:00 P.M.) and night shift 11:00 P.M. - 7:00 A.M.). During interviews on 2/5/25 at 4:01 P.M. and 2/6/25 at 9:44 A.M., the DON said staff are supposed to monitor all residents on psychotropic medications for potential side effects of their use during all shifts on all days. He said staff should have monitored Resident #40 for side effects of fluvoxamine on all shifts. 3. Resident #48 was admitted to the facility in October 2023 and had diagnoses including Alzheimer's disease, vascular dementia and anxiety disorder. Review of the most recent MDS assessment, dated 1/7/25, indicated Resident #48 had moderate cognitive impairment as evidenced by a BIMS score of 10 out of 15, exhibited physical behaviors toward others and received antipsychotic, antidepressant and antianxiety medication daily. Review of Physician's Orders indicated but was not limited to: -Ativan 0.5 mg tablet, give 1 tablet three times daily (11/15/24) -Monitor for side effects of Ativan-nausea, blurry vision, headaches, confusion, fatigue, nightmares. -Depakote 250 mg tablet, give 1 tablet once daily (1/11/25) -Monitor side effects of Depakote-stomach upset, drowsiness, weight gain, dizziness, tremors, blurry vision, and confusion. -Escitalopram 10 mg tablet, give 1 tablet once daily (6/17/24) -Remeron 30 mg tablet, give 1 tablet once daily before bedtime (11/30/23) -Monitor side effects of Remeron-drowsiness, insomnia, constipation, weight gain, sexual problems, tremors, and dry mouth (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Zyprexa 2.5 mg tablet, give one tablet at breakfast and one at dinner (11/14/24) -Monitor side effects of Zyprexa-drowsiness, tardive dyskinesia, akathisia, twitching, hyperglycemia, increased appetite, and weight gain. -Strattera 80 mg capsule, give 1 capsule once daily (1/10/25) Further review of physician's orders failed to indicate monitoring for side effects for Escitalopram and Strattera. Review of November 2024 through February 2025 MAR indicated all psychotropic medications were administered as ordered by the physician. Further review of the medical record indicated staff monitored the Resident for side effects of Ativan, Depakote, Remeron and Zyprexa only during the day shift (7:00 A.M. - 3:00 P.M.) and not during the evening shift (3:00 P.M. - 11:00 P.M.) and night shift (11:00 P.M. - 7:00 A.M.). Staff did not monitor Resident #48 for side effects of Escitalopram and Strattera. During interviews on 2/5/25 at 4:01 P.M. and 2/6/25 at 9:44 A.M., the DON said staff are supposed to monitor all residents on psychotropic medications for potential side effects of their use during all shifts on all days. He said Resident #48 should have been monitored for side effects for the use of Escitalopram and Strattera and monitoring should have been done during all shifts on all days for the Resident's other psychotropic medication.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on record review and interview, the facility failed to ensure two Residents (#33, #67), out of a total sample of five residents reviewed for immunization, were screened for eligibility to receive the recommended pneumococcal vaccination, were educated on the benefits and potential side effects of the vaccine and were offered and administered (if applicable) the vaccine in a timely manner. Specifically, the facility failed to ensure Residents #33 and #67 were offered the Pneumococcal Conjugate Vaccine (PCV-a vaccine that helps protect against diseases caused by pneumococcal bacteria) at the time of admission or shortly thereafter, putting the Residents at risk for developing facility acquired pneumonia. Findings include: Review of the facility's policy titled Pneumococcal Immunization Program: Pneumococcal Vaccination, undated, indicated but was not limited to the following: - Purpose: to reduce morbidity and mortality from pneumococcal disease by vaccinating all patients who meet the criteria established by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP). - [Facility Name] follows the requirements of The Centers for Medicare and Medicaid Services (CMS) and recommendations of the CDC's ACIP and the Massachusetts Department of Public Health (MDPH) for the control of Pneumococcal disease in Long-Term Care Facilities (LTCF). - ACIP recommends that all persons living in a long term care facility are assessed for, and receive the pneumococcal immunization if eligible. - All patient/resident admissions to [Facility Name] will be assessed for indications and contraindications (e.g. anaphylaxis) for the pneumococcal vaccine. ACIP recommends vaccination for: a. Age 65 or older with no or unknown history or prior vaccination; c. Person age [AGE] years of age or older who got their first dose when they were under [AGE] years of age should be revaccinated with a single dose after 5-years have passed since the first dose. - This information will be documented on the [Facility Name] Medication Reconciliation form: a. Pneumococcal Polysaccharide 23 Valent (PPV23) Vaccine is recommended for any person age [AGE] years of age or older; b. A 2nd vaccine, if the 1st vaccine was prior to age 65 and is recommended at least 5 years between the 1st and 2nd vaccine; c. If the patient/resident has already received the pneumococcal (PPV23) immunization then date of immunization needs to be recorded; i. If vaccination date unknown: notify Medical Staff for further recommendations; d. If the patient/resident meets the above criteria to be vaccinated, a Pneumococcal Vaccine Information Statement (VIS) will be provided, and the patient/resident or healthcare proxy (HCP) will be queried for vaccination consent. - The Infection Control Preventionist maintains a list of all resident/patients on each Unit with their vaccination status. a. Review of the medical record for Resident #33 indicated but was not limited to the following: (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- admitted to the facility in February 2024. - Failed to produce a signed Immunization Consent form indicating consent/declination of the Pneumococcal vaccine. - Medication Reconciliation form failed to indicate a history of a Pneumococcal vaccination and was not signed by the Physician or Nurse Practitioner (NP). - Failed to indicate education of the Pneumococcal vaccine was provided to the Resident. Review of Resident #33's Massachusetts Immunization Information System (MIIS) form indicated a Pneumococcal vaccine (PPSV23) was administered on 6/22/16. b. Review of the medical record for Resident #67 indicated but was not limited to the following: - admitted to the facility in June 2024. - Failed to produce a signed Immunization Consent form indicating consent/declination of the Pneumococcal vaccine. - Medication Reconciliation form failed to indicate a history of a Pneumococcal vaccination. - Failed to indicate education of the Pneumococcal vaccine was further provided to the Resident. Review of Resident #67's MIIS form indicated a Pneumococcal vaccine (PPSV23) was administered on 2/12/16. During an interview on 2/5/25 at 1:58 P.M., the Infection Preventionist (IP) said when a resident is initially admitted to the facility the nurse completes a Medication Reconciliation form and indicates any vaccination history. The form is then reviewed and signed by the Physician or Nurse Practitioner (NP) and any further recommendations are followed. She said she will run the MIIS for each resident to determine when their last vaccinations were administered. The IP said the facility has no process for following up with the Physician or NP about vaccination history and recommendations, and the facility does not follow up with the resident or their representatives regarding obtaining vaccination history and or education about Pneumococcal vaccinations after admission. The IP reviewed the medical records of Resident #33 and Resident #67 and said both Residents were due for an updated Pneumococcal vaccination but had not been followed up in order to determine if they would like the vaccinations. The IP said she had not had any conversations with Resident #33 or Resident #67's providers regarding recommendations for Pneumococcal vaccinations.