

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/12/2024
NAME OF PROVIDER OR SUPPLIER  Chestnut Woods Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 73 Chestnut Street Saugus, MA 01906	

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)
<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763</b></p> <p>Based on interviews and record review the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately completed to reflect the status for three Residents (#80, #237, and # 27), in a total sample of 21 residents. Specifically:</p> <ol style="list-style-type: none"> <li>1) For Resident #80, the facility failed to ensure the MDS accurately reflected the Resident's discharge destination.</li> <li>2) For Resident #237, the facility failed to ensure the MDS accurately reflected the Resident's type of intravenous line.</li> <li>3) For Resident #27, the facility failed to ensure MDS accurately reflected the Resident's Special Treatments.</li> </ol> <p>Findings Include:</p> <p>Review of the facility policy titled Resident Assessments, revised October 2023, indicated, but was not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews.</li> </ul> <p>1. Resident #80 was admitted to the facility in July 2024 with a diagnosis of cancer.</p> <p>Review of the Discharge Assessment - Return not Anticipated Minimum Data Set (MDS), dated [DATE], indicated that Resident #80 scored an 11 out of a possible 15 on a Brief Interview for Mental Status (BIMS), indicating the Resident had moderate cognitive impairment. Further review of the MDS indicated that Resident #80 was being discharged to a short-term general hospital.</p> <p>Review of the Care Navigation-Week in Advance Reporting progress note, authored by Social Worker (SW) #1, indicated Resident #80 was discharging from the facility to his/her son's home.</p> <p>During an interview on 9/11/24 at 11:23 A.M., SW #1 said Resident #80 discharged home with family.</p> <p>During an interview on 9/11/24 at 12:19 P.M., Consulting MDS staff #1 said that Resident #80 was discharged home and that the discharge MDS was not completed accurately.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/11/24 at 12:22 P.M., the Director of Nursing (DON) said that Resident #80 discharged home and that he would expect the MDS to be completed accurately.</p> <p>46339</p> <p>2. Resident #237 was admitted to the facility in August 2024 with diagnoses including acute gastric ulcer with perforations, dependent on parenteral nutrition.</p> <p>Review of Minimum Data Set (MDS), dated [DATE], indicated that Resident #237 had a midline intravenous line.</p> <p>On 9/10/24 at 8:51 A.M., the surveyor observed Resident #237 lying in his/her bed with a dual lumen PICC line to his/her right upper arm.</p> <p>Review of the medical record indicated the Resident had a (PICC) peripheral inserted central catheter to his/her right upper arm.</p> <p>During an interview on 9/12/24 at 9:44 A.M., the Director of Nursing said the Resident had a PICC and that should be accurately documented in the MDS.</p> <p>50338</p> <p>3. Resident #27 was admitted to the facility in April 2024 with diagnoses including acute respiratory failure with hypoxia (low levels of oxygen in body tissues), chronic obstructive pulmonary disease (COPD) (disease that restricts breathing), anxiety, and congestive heart failure (CHF) (heart does not pump blood as well as it should).</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 7/24/24, indicated that Resident #27 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS indicated Resident #27 did not require oxygen therapy.</p> <p>On 9/10/24 at 8:44 A.M., the surveyor observed Resident #27 in his/her bed, his/her oxygen was being administered at three liters per minute via nasal cannula (a device that delivers extra oxygen through a tube and into your nose). Resident #27 said he/she always uses oxygen.</p> <p>On 9/11/24 at 7:06 A.M., the surveyor observed Resident #27 in his/her bed, his/her oxygen was being administered at four liters per minute via nasal cannula.</p> <p>Review of Resident #27's active physician's order indicated the following order:</p> <p>-Oxygen at four liters per minute via nasal cannula every shift initiated 5/9/24.</p> <p>Review of Resident #27's plan of care related to oxygen therapy, dated 4/9/24, indicated the Resident required supplemental oxygen related to chronic obstructive pulmonary disease, respiratory failure, pneumonia.</p> <p>Review of Resident #27's nursing progress note, dated 7/19/24, indicated the Resident received oxygen via nasal cannula.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #27 Medication Administration Record (MAR), dated July 2024, indicated oxygen at four liters per minute was administered via nasal cannula.</p> <p>During an interview on 9/11/24 at 8:20 A.M., Unit Manager (UM) #2 said Resident #27 uses oxygen therapy.</p> <p>During an interview on 9/11/24 at 12:23 P.M., Director of Nurses (DON) said he would expect the MDS to be documented accurately.</p> <p>During an interview on 9/11/24 at 12:48 P.M., the MDS nurse said Resident 27's MDS should be coded as using oxygen therapy, but it was not.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36876</p> <p>Based on observation, record review and interview, the facility failed to implement the plan of care related to assistance with meals for one Resident, (#36), out of a total sample of 21 residents.</p> <p>Findings include:</p> <p>Review of the facility's Care Plans, Comprehensive Person Centered policy, dated March 2022 indicated:</p> <p>Policy statement: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>7. The comprehensive, person centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well being.</p> <p>Resident #36 was admitted to the facility in June of 2022 with diagnoses including dementia and weakness.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #36 scored 5 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating severe cognitive impairment. The MDS also indicated Resident #36 required supervision/touching assistance with eating.</p> <p>On 9/10/24 at 7:58 A.M., the surveyor observed Resident #36 eating breakfast alone in his/her room. The Resident was served a waffle that was not cut and he/she was attempting to open a container of maple syrup with his/her hands. At 8:21 A.M., Resident #36 was eating with his/her hands and also still attempting to open the container of maple syrup. There were no staff in the area providing supervision and Resident #36 was not observable from the hallway.</p> <p>Review of Resident #33's care plans indicated:</p> <p>Focus: I have an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) Dementia, Impaired Mobility, Pain, Date Initiated: 06/30/2024</p> <p>Interventions: Eating: I require set-up assistance [i.e., opening packages, cutting meat, arranging plate, etc] supervision with eating and drinking. Offer bedtime snack.</p> <p>On 9/11/24 at 7:59 A.M. and 8:10 A.M., the surveyor observed Resident #36 in bed, eating alone in his/her room. There were no staff providing supervision as indicated in his/her plan of care and Resident #36 was not observable from the hallway.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/11/24 11:44 A.M., Certified Nursing Aide (CNA) #1 said she was assigned to care for Resident #36. CNA #1 said that Resident #36 often eats in his/her room as he/she refuses to get out of bed. CNA #1 said that Resident #36 was independent with eating after his/her tray is set up. CNA #1 said that Resident #36 did not need to be supervised or physically assisted during meals.</p> <p>On 9/12/24 at 8:10 A.M., the surveyor observed Resident #12 eating his/her breakfast meal alone without staff supervision per the plan of care. Resident #36 was not observable from the hallway.</p> <p>Review of the CNA documentation from 8/1/24 through 9/10/24 indicated that Resident #36 received supervision or physical assistance with 41 out of 121 documented meals.</p> <p>During an interview on 9/12/24 at 9:51 A.M., the Director of Nursing (DON) said that care plans should be followed.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45763</p> <p>Based on observation, record review and interview, the facility failed to meet professional standards of quality for four Residents (#49, #15, #42 and #17), out of a total sample of 21 residents.</p> <p>Specifically:</p> <ol style="list-style-type: none"> <li>1) For Resident #49 the facility failed to follow physician orders for weekly skin checks.</li> <li>2) For Resident #15 the facility failed to complete skin checks as ordered.</li> <li>3) For Resident #42 the facility failed to implement air mattress setting as indicated in the physician order.</li> <li>4) For Resident #17 the facility failed to to obtain weekly weights according to physician's order.</li> </ol> <p>Findings Include:</p> <p>Review of the facility policy, titled Assessment of Skin Condition and Integrity, adopted March 2021, indicated, but was not limited to, the following:</p> <p>Skin Assessment:</p> <ol style="list-style-type: none"> <li>1) Conduct a comprehensive head-to-toe skin assessment upon admission, weekly, prior to discharge and as needed.             <ol style="list-style-type: none"> <li>a.) During the skin assessment, inspect for:                 <ol style="list-style-type: none"> <li>i. Presence of skin impairment(s);</li> <li>ii. Type of skin impairment(s); and</li> <li>iii. Location of skin impairment(s);</li> </ol> </li> </ol> </li> <li>2) Inspect the skin daily when performing or assisting with personal care or ADL's (activities of daily living).</li> </ol> <p>Documentation:</p> <ol style="list-style-type: none"> <li>1. The type of skin assessment(s) conducted.</li> <li>2. The date and time and type of skin care provided, if appropriate.</li> <li>3. The name and title of the individual who conducted the assessment.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 9/12/24 at 9:07 A.M., Resident #49 said he/she had a chronic wound on his/her right foot. Unit Manager #2 and the surveyor observed Resident #49's right foot wound.</p> <p>During an interview on 9/12/24 at 12:32 P.M., Nurse Practitioner #1 said she would expect nurses to follow physician orders.</p> <p>During an interview on 9/12/24 at 1:59 P.M., the Director of Nursing (DON) said nurses complete skin checks weekly, and that if a resident refuses a skin check that this would be documented.</p> <p>During a follow-up interview on 9/12/24 at 2:44 P.M., the DON said that he would expect nurses to complete and document a full skin evaluation when completing the physician-ordered weekly skin check.</p> <p>46339</p> <p>2. Resident #15 was admitted to the facility in December 2020 with diagnoses including Dementia and Parkinson's disease.</p> <p>Review of Resident #15's Minimum Data Set (MDS) assessment, dated 6/19/24, indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status indicating he/she was severely cognitively impaired. The MDS further indicated the Resident is dependent of staff for activities of daily living.</p> <p>Review of the current physician orders indicated the following:</p> <p>-Skin checks weekly on Thursday 3-11 every evening shift. Every Thursday for monitoring.</p> <p>Review of the clinical record indicated a skin assessment evaluation had not been completed since 8/8/24.</p> <p>During an interview on 9/11/24 at 12:25 P.M., Nurse #3 said a weekly skin assessment should be completed as ordered, the nurses document in the treatment administration record and also complete a skin evaluation assessment.</p> <p>During an interview on 9/12/24 at 8:37 A.M., Unit Manager #2 said weekly skin checks should be completed as ordered and if refusal the nurse would document in the nurse progress notes.</p> <p>During an interview on 9/12/24 at 9:49 A.M., the Director of Nursing said weekly skin checks should be completed weekly and a skin evaluation assessment completed</p> <p>3. Resident #42 was admitted to the facility in July 2023 with diagnosis including unspecified abnormalities of gait and mobility.</p> <p>Review of Resident #42 Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status indicating he/she was cognitively intact.</p> <p>Review of Resident #42's current physician order indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Air mattress on bed check function and placement set according to weight every shift.</p> <p>Review of Resident #42's active Activity of daily living (ADL) care plan indicated an intervention dated 10/16/23 'Resident requires air mattress on bed check inflation set according to weight'.</p> <p>On 9/10/24 at 8:55 A.M., the surveyor observed Resident #42 lying in his/her bed the air mattress was set to 350 lbs (pounds).</p> <p>On 9/10/24 at 4:02 P.M., the surveyor observed Resident #42 lying in his/her bed the air mattress was set at 350 lbs.</p> <p>On 9/11/24 at 7:00 A.M., the surveyor observed Resident #42 lying in his/her bed the air mattress was set at 350 lbs.</p> <p>Review of Resident #42's most recent weight dated 8/5/24 indicated the following:</p> <p>-140.4 lbs.</p> <p>During an interview and an observation on 9/11/24 at 9:26 A.M., the surveyor and Nurse #3 observed Resident #42 lying in bed. His/her air mattress was set at 350 lbs. Nurse #3 said the mattress should be set according to the resident's weight.</p> <p>During an interview on 9/12/24 at 8:38 A.M., Unit Manager #2 said the air mattress setting is based on the resident's weight. She said Resident #42 prefers a firm surface and the orders should reflect that.</p> <p>During an interview on 9/12/24 at 9:08 A.M., the Director of Nursing said the air mattress should be set per resident's weight. The physician order should be followed as ordered.</p> <p>50338</p> <p>4. Review of the facility policy titled Weight Assessment and Intervention dated March 2022, indicated the following:</p> <p>-Resident weights are monitored for undesirable or unintended weight loss or gain.</p> <p>-Residents are weighed upon admission and at intervals established by the interdisciplinary team and/or as ordered by the physician.</p> <p>-Weights are recorded in each unit's weight record chart and in the individual's medical record.</p> <p>Resident #17 was admitted to the facility in July 2024 with diagnoses including epilepsy, dysphagia, gastrostomy status, and malnutrition.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #17's nursing progress notes, dated 8/2, 8/8, 8/22, 8/29 and 9/5 failed to indicate Resident #17 had refused to be weighed or that the physician had been notified that the Resident had not been weighed.</p> <p>Review of Resident #17's nursing progress note, dated August 15, 2024, indicated patient was off floor and outside with family, unable to obtain weight, physician aware.</p> <p>Review of Resident #17's weight summary, indicated recorded weights:</p> <p>7/18/24- 106.4 pounds.</p> <p>8/19/24- 107.0 pounds.</p> <p>9/12/24- 105.8 pounds.</p> <p>Review of Resident #17's nutritional risk assessment, dated 7/25/24, indicated the Resident's estimated ideal body weight (IBW) was 130 pounds and that the most recent recorded weight dated 7/18/24 was 106.4 pounds. Further review of the nutritional risk assessment indicated that the dietitian had recommended to continue with the current nutritional regimen and to monitor weights weekly.</p> <p>Review of Resident #17's nutrition note, dated 9/10/24, indicated that the Resident continued weekly weight checks, dietitian will continue to monitor and reassess as needed.</p> <p>During an interview on 9/11/24 at 12:25 P.M., Unit Manager #2 said all residents were discussed during weekly rounds with the clinical team and that the physician reviews all residents. Unit Manager #2 was not aware that Resident #17 did not have a weight recorded since 8/19/24.</p> <p>During an interview on 9/12/24 at 1:22 P.M., the dietitian said the clinical team meet weekly to discuss weights. Her expectation is for the physician order to be followed. The dietitian said up to date weights are needed to calculate appropriate caloric needs and enteral orders.</p> <p>During an interview on 9/12/24 at 12:33 P.M., Nurse Practitioner #1 said she would expect a resident receiving enteral nutrition to be weighed at least weekly and that it was important for weights to be obtained correctly so that orders for jevity can be determined.</p> <p>During an interview on 9/12/24 at 1:04 P.M., the Director of Nursing (DON) said he would expect physician orders to be followed. The DON said if a weight was not obtained that a note should have been written and it was not.</p>		

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NAME OF PROVIDER OR SUPPLIER  Chestnut Woods Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 73 Chestnut Street Saugus, MA 01906	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36876</p> <p>Based on observation record review and interview, the facility failed to provide necessary treatment and care for one Resident (#33) out of a total of 21 sampled residents. Specifically, the facility failed to ensure treatment orders were initiated for Resident #33's skin tears.</p> <p>Findings include:</p> <p>Review of the Wound Treatment policy, dated April 2024, indicated: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify that there is a physician's order for this procedure.</p> <p>Resident #33 was readmitted to the facility in September 2024 with diagnoses including chronic obstructive pulmonary disease, dysphagia and venous insufficiency.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE], indicated Resident #33 scored 15 out of a possible 15 on the Brief Interview for Mental Status exam (MDS) indicating intact cognition. The MDS also indicated Resident #33 requires assistance with bathing and dressing.</p> <p>During an interview on 9/10/24 at 8:57 A.M., the surveyor observed Resident #33 in bed. Resident #33's right arm was resting on his/her lap and had a dressing dated 9/7/24 on the forearm. Resident #33 said he/she could not recall what happened to his/her arm or why he/she had a dressing. The surveyor was unable to observe Resident #33's left arm.</p> <p>Review of the physicians orders on 9/10/24 at 11:30 A.M., failed to indicate any active treatment orders were in place for Resident #33.</p> <p>Review of Resident #33's care plans failed to indicate he/she had any wounds requiring treatment.</p> <p>Review of the Weekly Skin Check dated 9/3/24 indicated Resident #93 had open areas on both his/her arms. The skin check did not indicate measurements or descriptions of the wounds</p> <p>Review of the hospital discharge paperwork dated 9/3/24 indicated Resident #33 had skin tears on his/her right and left forearm requiring dressings.</p> <p>Review of the hospice note dated 9/4/24 indicated the following: Some bruising noted to upper extremities, bandages to both arms perhaps from IV placements. Pt (patient) declines further assessment of the skin.</p> <p>Review of the Nurse Practitioner Note dated 9/5/24: Skin: No rash, warm and dry; left forearm dressing clean dry and intact.</p> <p>On 9/11/24 at 7:31 A.M., the surveyor observed Resident #33 asleep in bed with a bandage on his/her right arm dated 9/10/24. The surveyor was unable to observe Resident #33's left arm.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/11/24 at 7:43 A.M., Unit Manager #1 said that Resident #33 was admitted with wounds from the hospital that needed daily dressings. Unit Manager #1 said orders for treatment were not in place until yesterday, (9/10/24).</p> <p>Review of Resident #33's physicians orders on 9/11/24 at 7:44 A.M., indicated:</p> <p>-Wound Description for Site: RIGHT ARM: Normal Saline Wash, Pat dry and apply Xeroform followed by an Island dressing. Ordered 9/10/24</p> <p>-Wound Description for Site: LEFT ARM; Normal Saline Wash, Pat dry and apply Xeroform followed by an Island dressing. Ordered 9/10/24</p> <p>Further review of Resident #33's physicians orders indicated that the treatments for the Resident's wounds were implemented seven days after they were first identified by the facility.</p> <p>On 9/11/24 at 12:59 P.M. the surveyors observed Resident #33's dressing changes. Nurse #1 removed the dressings and the surveyors observed Resident #33 had skin tears on his/her bilateral forearms with some drainage and swelling.</p> <p>During an interview on 9/11/24 at 1:33 P.M., the Director of Nursing said that when residents are admitted from the hospital with wounds it is expected that orders to treat the wounds would implemented.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>36876</p> <p>Based on observation, record review and interview, the facility failed to ensure physicians orders and care plans related to the use of a catheter were implemented for one Resident (#33) out of a total of 21 sampled residents.</p> <p>Findings include:</p> <p>Review of the Urinary Incontinence - Clinical Protocol policy dated April 2018 indicated:</p> <p>Assessment and Recognition: As part of the initial assessment, the physician will help identify individuals with impaired urinary continence. For example, review of a hospital discharge summary may reveal that the individual was incontinent with or without catheter placement during a recent hospitalization .</p> <p>Resident #33 was initially admitted to the facility in August 2024 with diagnoses including chronic obstructive pulmonary disease, dysphagia and venous insufficiency.</p> <p>Review of the Minimum Data Set Assessment (MDS) 8/26/24 indicated Resident #33 scored 15 out of a possible 15 on the Brief Interview for Mental Status exam (MDS) indicating intact cognition. The MDS also indicated Resident #33 requires assistance toileting and did not have an indwelling catheter.</p> <p>Review of Resident #33's physicians orders failed to indicate any orders in place regarding the use or care of a catheter.</p> <p>Review of Resident #33's care plans indicated:</p> <p>Focus: I have urinary incontinence r/t (related to) physical limitations. 8/13/24</p> <p>Interventions: Provide incontinence care and apply moisture barrier as needed. Observe buttocks, peri-area and groin during care for possible skin problems. Offer/encourage toileting prior to bedtime. Check resident approximately every two hours and provide incontinence care as needed.</p> <p>Focus: I have an ADL (activities of daily living) self care performance deficit r/t deconditioned s/p hospitalization , impaired mobility, weakness. Interventions: Toileting: I require one staff assist with toileting.</p> <p>On 9/11/24 at 12:59 P.M., the surveyors observed Resident #33 resting in bed with a catheter bag hanging off the side of the bed.</p> <p>On 9/12/24 at approximately 7:45 A.M., the surveyor observed Resident #33 in bed with a catheter bag hanging off the side of the bed.</p> <p>During an interview on 9/12/24 at 7:49 A.M., Nurse #2 said that Resident #33 had a catheter.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/24 at 8:00 A.M., Unit Manager #1 said that Resident #33 had previously resided on a different unit then was hospitalized . Unit Manager #1 said that he believed the catheter was implemented during Resident #33's hospitalization .</p> <p>During an interview on 9/12/24 at 8:05 A.M., Certified Nursing Aide (CNA) #3 said that Resident #33 has had a catheter since he/she was admitted to the unit (9/3/24).</p> <p>During an interview on 9/12/24 at 9:51 A.M., the Director of Nursing (DON) said that residents should have physicians orders and care plans in place for catheter care, management and monitoring.</p> <p>During an interview on 9/12/24 at 12:20 P.M., the Nurse Practitioner said that nurses have to put in orders for catheters and she was not aware that Resident #33 had no orders related to his/her catheter use or care.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46339</p> <p>Based on observation, policy review and interviews, the facility failed to provide care and maintenance of a peripheral inserted central catheter (PICC), consistent with professional standards of practice for one Resident (#237), out of a total sample of 21 residents. Specifically, the facility failed to implement dressing changes routinely as required.</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Central Venous Catheter Care and Dressing Changes' dated March 2022, indicated the following but not limited to:</p> <ul style="list-style-type: none"> <li>-Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g, damp, loosened or visibly soiled).</li> <li>-Maintain sterile dressing ( transparent semi-permeable membrane (TSM) dressing or sterile gauze for all central vascular access devices. The type of dressing is based on the condition of then resident and his or her preference.</li> <li>-Change the dressing if it becomes damp loosened or visibly soiled and: <ul style="list-style-type: none"> <li>a. Every seven days for TSM dressing</li> </ul> </li> <li>-measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion.</li> </ul> <p>Resident #237 was admitted to the facility in August 2024 with diagnoses including dependent on parenteral nutrition.</p> <p>Review of Resident #237 Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 12 out of possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was moderately cognitively impaired. The MDS further indicated the Resident had an intravenous access line.</p> <p>On 9/10/24 at 8:50 A.M., the surveyor observed Resident #237 lying in his/her bed with a PICC line to his/her right upper arm. The dressing on the insertion site was transparent and dated 8/25.</p> <p>Review of the physician orders dated 8/29/24 indicated the following:</p> <ul style="list-style-type: none"> <li>-IV (midline, PICC, CVAD) change transparent dressing on admission and then every 7 days. Caps to be changed during dressing change. Every day shift every 7 days.</li> </ul> <p>Review of Resident #237's medication administration record (MAR), dated 8/30/24, indicated nursing implemented the PICC dressing change as ordered.</p> <p>During an interview on 9/11/24 at 12:29 P.M., Nurse #3 said PICC line dressing changes are done upon admission and then weekly.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/11/24 at 12:35 P.M., Unit Manager #2 said dressing changes should be done weekly. When asked if the date on the dressing should have been different from 8/25/24 she said yes.</p> <p>During an interview on 9/11/24 at 12:40 P.M., the Director of Nursing said PICC line dressing should be changed upon admission and every 7 days.</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>45343</p> <p>Based on record review, policy review and interview the facility failed to ensure a plan of care was developed for Trauma Informed Care, with individualized interventions, for one Resident (#7) who had a history of trauma out of a total sample of 21 residents. Specifically, for Resident #7, the facility failed to develop a comprehensive trauma care plan, with individualized triggers.</p> <p>Findings include:</p> <p>Review of the facility policy titled Trauma Informed and Culturally Competent Care, dated 8/2022, indicated the following:</p> <p>Purpose:</p> <ul style="list-style-type: none"> <li>-To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice.</li> <li>-To address the needs of trauma survivors by minimizing triggers and/or re-traumatization.</li> </ul> <p>Definitions:</p> <ul style="list-style-type: none"> <li>- Trigger is a psychological stimulus and prompts recall of a previous traumatic event, even if the stimuli itself is not traumatic or frightening.</li> </ul> <p>Resident Care Planning:</p> <ul style="list-style-type: none"> <li>-Develop and individualized care plan that addresses past trauma in collaboration with the resident and family, as appropriate.</li> <li>-Identify and decrease exposure to triggers that may re-traumatize the resident.</li> <li>-Recognize the relationship between past trauma and current health concerns (e.g. substance abuse, eating disorders, anxiety, and depression).</li> </ul> <p>Resident #7 was admitted to the facility in March 2019, with diagnoses including traumatic Post-Traumatic Stress Disorder (PTSD), major depressive disorder and anxiety.</p> <p>Review of Resident #7's most recent Minimum Data Set (MDS) assessment, dated 6/19/24, indicated that Resident #7 had a Brief Interview for Mental Status (BIMS) exam score of 15 out of 15 indicating he/she is cognitively intact. Further review of the MDS indicated Resident #7 has an active diagnosis of PTSD and requires partial/moderate to dependent assistance for daily activities.</p> <p>Review of the care plan on 9/11/24 at 2:02 P.M., last revised 3/31/20, indicated Resident #7 has a diagnosis of PTSD. Further review indicated interventions including the following:</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Accept my current level of function, be consistent, positive, honest and nonjudgmental while working with me.</p> <p>-After every outburst, discuss with me how my anger escalates.</p> <p>-Allow me to use displacement when angry by providing things that I can manipulate or destroy (example: clay).</p> <p>-Encourage me to accept forgiveness from myself and others.</p> <p>-Encourage me to express my anger verbally rather than physically.</p> <p>-Help me to regain control and identify sources of emotions so that I may manage outbursts.</p> <p>-Offer me medications for prevention or treatment of post-traumatic stress disorder as needed; Evaluate responses to these medications.</p> <p>-Provide me a safe comfortable space when I am overwhelmed or stressed.</p> <p>-Remind me that setbacks on the process of treatment are not failures but an expected part of therapy.</p> <p>-When Stress/Anxiety arises allow me to vent/share feelings.</p> <p>Review of Resident #7's care plan failed to indicate the development of a comprehensive trauma informed care plan with identified triggers and interventions for his/her diagnosis of PTSD.</p> <p>During an interview on 9/12/24 at 8:45 A.M., Unit Manager #1 said if a resident is identified with a PTSD diagnosis, there should be a care plan developed with specific triggers for staff to better care for the resident.</p> <p>During an interview on 9/12/24 at 9:34 A.M., Social Worker #1 said residents with PTSD should be formally assessed and a care plan developed with his/her strengths and weaknesses as well as identified triggers.</p> <p>During an interview on 9/12/24 at 9:55 A.M., the Director of Nursing said if PTSD is identified following a trauma informed assessment, a patient centered care plan will be developed with triggers identified.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46339</p> <p>Based on observation, record review and interviews, the facility failed to ensure that one Resident (#64) was free from significant medication errors out of a total sample of 21 residents. Specifically, the nurses did not administer the wrong dispensed dosage of Trazadone (an antidepressant).</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Administering Medications' revised April 2019, indicated the following but not limited to:</p> <p>-If a dosage is believed to be inappropriate or excessive for a resident or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences the person preparing or administering the medication will contact the prescriber the residents attending physician or the facilities medical director to discuss the concerns.</p> <p>-The individual administering the medication checks the label three times to verify the right resident right medication right dosage right time right method route of administration before giving the medication.</p> <p>Resident #64 was admitted to the facility in July 2024 with diagnoses including dementia and psychotic disorder.</p> <p>Review of Resident #64's Minimum Data Set (MDS) dated [DATE], indicated the Resident had impaired short term and long term memory on the Brief Interview for Mental Status (BIMS).</p> <p>During a medication observation pass on 9/11/24 at 9:41 A.M., Nurse #4 said to the surveyor the medication card containing Trazadone (an antidepressant) 50 milligram tablet half tablets was not the correct dosage per the physician orders. Nurse #4 said she was going to call the pharmacy for clarification and did not administer the half tablets.</p> <p>Review of the medication blister pack, the following was observed two missing pills out of 30 tablets that had been dispensed by the pharmacy. The label read as following:</p> <p>-Trazadone HCl tab 50 milligrams. Give one quarter tablet (12.5mg) by mouth two times a day for anxiety.</p> <p>Review of the medical record failed to indicate that the physician had been notified of the wrong medication that had been dispensed to the facility.</p> <p>Review of Resident #64's current Medication Administration Record (MAR) indicated the medication trazadone had been administered the last two days.</p> <p>During an interview on 9/11/24 at 9:45 A.M., Nurse #4 said the two missing medications from the blister pack would be an indication that the medication had been administered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/24 at 9:44 A.M., the Director of Nursing (DON) said the pharmacy had acknowledged the medication that had been dispensed to the facility was the wrong dosage. The DON said that the nurses should use their judgment during medication pass to prevent administering wrong dosages.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46339</p> <p>Based on observations, policy review, and interview the facility failed to ensure medications with short expirations dates were dated when opened.</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Medication Labeling and Storage' revised February 2023, indicated the following but not limited to:</p> <p>*Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p> <p>*Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date.</p> <p>1. During an inspection of the [NAME] unit on 9/12/24 at 6:35 A.M., the following medications were available for administration:</p> <ul style="list-style-type: none"> <li>- Two incruze Ellipta inhalers 62.5 (mcg) microgram inhalation powder opened and undated.</li> <li>- One Advair 100/50 mcg opened and undated.</li> <li>- One Advair 250/50 mcg opened and undated.</li> <li>- One albuterol sulfate 90 mcg opened and undated.</li> <li>- One Symbicort inhaler 80-4.5mcg opened and undated.</li> <li>- One fluticasone nasal spray 50 mcg opened and undated.</li> </ul> <p>During an interview on 9/12/24 at 6:45 A.M., Nurse #5 said the inhalers should be dated when opened and indicate a date to discard.</p> <p>During an interview on 9/12/24 at 9:47 A.M., the Director of Nursing said the inhalers are to be dated with an open date and an expiration date.</p>		

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NAME OF PROVIDER OR SUPPLIER  Chestnut Woods Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 73 Chestnut Street Saugus, MA 01906	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36876</p> <p>Based on record review and interview, the facility failed to: 1. ensure medication administration was accurately documented for two Residents (#33 and #35) and 2. failed to accurately document blood pressure readings for one Resident (#37) out of a total of 21 sampled Residents.</p> <p>Findings include:</p> <p>1a. Resident #33 was readmitted to the facility in September 2024 with diagnoses including chronic obstructive pulmonary disease, dysphagia and venous insufficiency.</p> <p>Review of the Minimum Data Set Assessment (MDS) 8/26/24 indicated Resident #33 scored 15 out of a possible 15 on the Brief Interview for Mental Status exam (MDS) indicating intact cognition. The MDS also indicated Resident #33 requires assistance with bathing, dressing and toileting.</p> <p>Review of the September 2024 Medication Administrative Record (MAR) indicated the following medication were not documented as administered on the 7:00 A.M. - 3:00 P.M. shift on 9/8/24:</p> <p>Aripiprazole (an antipsychotic medication) Oral Tablet 5 MG: Give one tablet by mouth one time a day, 9/4/24.</p> <p>Aspirin Oral Tablet Chewable 81 MG: Give one tablet by mouth one time daily, 8/14/24</p> <p>Fenofibrate Micronized (a medication used to lower cholesterol) Oral Capsule 200 MG: Give one tablet by mouth in one time a day, 9/4/24</p> <p>Fexofenadine HCL (an antihistamine) 180 MG Tablet: Give one tablet by mouth daily, 8/14/24</p> <p>Furosemide (a diuretic) Oral Tablet 20 MG: Give two tablets by mouth one time a day, 9/4/24</p> <p>Duloxetine (an antidepressant) HCL Oral Capsule Delayed Release 60 MG: Give one capsule by mouth two times a day, 9/4/24</p> <p>Fluticasone-Salmeterol Inhalation (an inhaler) 500-50 MCG/ACT: One puff inhale orally every morning and at bedtime, 9/3/24</p> <p>Levetiracetam (an anticonvulsant) Oral Tablet 250 MG: Give two tablet by mouth, 9/4/24</p> <p>Gabapentin (a pain medication) Oral Capsule 100 MG: Give two tablets by mouth three times a day related to pain.</p> <p>Humalog Kwipen (insulin) Subcutaneous Solution 100 UNIT/ML: inject per sliding scale with meals, 9/4/24</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Metformin (a medication used to treat diabetes) HCL Oral Tablet 500 MG: Give one tablet by mouth with meals, 9/4/24</p> <p>1b. Resident #35 was admitted to the facility in October 2021 with diagnoses including, dementia, cerebral infarction, and diabetes.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #35 scored three out of a possible 15 indicating severe cognitively impairment. The MDS also indicated Resident #35 is dependent on staff for activities of daily living.</p> <p>Review of the September 2024 Medication Administrative Record (MAR) indicated the following medication were not documented as administered on the 7:00 A.M. - 3:00 P.M. shift on 9/8/24:</p> <p>Amlodipine Besylate tablet 10 MG (a medication used to treat hypertension): give one tablet via G-tube, 12/14/22</p> <p>Aspirin Tablet Chewable: Give 81 mg via G-tube one time a day, 6/14/24</p> <p>Clopidogrel Bisulfate (a medication used to lower risk of a stroke) tablet 75 MG: give one tablet via G-tube one time a day, 12/14/22</p> <p>Escitalopram Oxalate Tablet (an antidepressant): Give 20 mg via G-tube one time a day, 8/28/24</p> <p>Ezetimibe (a medication used to lower cholesterol) 10 MG tablet: Give one tablet via G-tube one time a day; 12/14/22</p> <p>Pantoprazole Sodium Packet (a medication used to treat acid reflux) 40 MG: Give one packet via G-tube one time a day, 12/14/22</p> <p>Polyethylene Glycol 3350 Kit (a medication used to treat constipation): Give 17 gram via G-tube one time a day; 12/14/22</p> <p>Venlafaxine (an antidepressant) HCL Oral Tablet 75 MG Give .5 tablet via G-tube one time a day Carvedilol (a medication used to treat hypertension) Tablet 25 MG: Give one tablet via G-tube every morning and at bedtime; 12/14/22</p> <p>Ferrous Sulfate (used to treat low iron): Give 325 MG via G-tube two times a day; 10/10/22</p> <p>Sennosides (a laxative) Tablet 8.6 MG: Give 2 tablets via G-tube two times a day; 12/14/22</p> <p>Humalog Injection Solution (insulin) 100 unit/ml: Inject six unit subcutaneously with meals, 8/13/24</p> <p>Novolog Flexpen Subcutaneous Solution (insulin) 100 unit/ml: Inject per sliding scale subcutaneously before meals, 7/18/23</p> <p>During an interview on 9/11/24 at 1:33 P.M., the Director of Nursing said that blank spaces on the MAR could be the result of the nurse forgetting to document the administration of the medication.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45343</p> <p>2. Resident #37 was admitted to the facility in September 2023 with a diagnosis of end stage renal disease.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 8/14/24, indicated that Resident #37 scored a 12 out of 15 on the Brief Interview for Mental Status exam indicating Resident #37 had moderate cognitive impairment. The MDS further indicated Resident #37 received dialysis treatment.</p> <p>Review of Resident #37's active physician's orders indicated the following:</p> <p>- No blood draws, IV, BPs (blood pressure) on left arm (shunt/dialysis access arm), every shift related to end stage renal disease. Date initiated 9/11/23.</p> <p>Review of Resident #37's blood pressure readings indicated nursing obtained his/her blood pressure using his/her left arm on the following dates: 7/5/24, 7/12/24, 7/13/24, 8/10/24, 8/11/24, 8/16/24, 8/17/24, 8/18/24, 8/19/24, 8/20/24, 8/22/24, 8/26/24, 9/3/24, 9/5/24, 9/6/24, 9/7/24, and 9/8/24.</p> <p>During an interview on 9/11/24 at 9:25 A.M., Resident #37 said staff never take blood pressure readings from his/her left arm, and that staff only use his/her right arm for blood pressure readings.</p> <p>During an interview on 9/12/24 at 8:40 A.M., Nurse #2 said Resident #37's left arm should not be used to take his/her blood pressure and it should be documented correctly in the medical record. Nurse #2 said it must have been documented in the left arm in error.</p> <p>During an interview on 9/12/24 at 10:07 A.M., The Director of Nursing (DON) said his expectation was that nurses accurately document which arm the blood pressure was taken from, and that documentation should reflect exactly what was completed by nursing.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36876</p> <p>Based on observation, record review and interview, the facility failed to 1. ensure staff initiated and followed Enhanced Barrier Precautions for one Resident (#33) out of a total of 21 sampled residents, and 2. failed to ensure shared medical equipment was properly cleaned between the use of residents during the medication pass.</p> <p>Findings include:</p> <p>Review of the Enhanced Barrier Precautions policy, dated August 2022 indicated:</p> <ol style="list-style-type: none"> <li>1. Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents.</li> <li>2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not apply otherwise. Gloves and gown are applied prior to performing high contact resident care activity (as opposed to entering the room).</li> <li>3. Examples of high contact resident care activities requiring the use of gown and gloves for EBP's include: dressing, transferring, device care or use (central line, urinary catheter, feeding tube, etc); wound care.</li> <li>6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.</li> <li>10. Signs are posted including the type of precautions and PPE (personal protective equipment) required.</li> <li>11. PPE is readily available.</li> </ol> <p>1. Resident #33 was initially admitted to the facility in August 2024 with diagnoses including chronic obstructive pulmonary disease, dysphagia and venous insufficiency.</p> <p>Review of the Minimum Data Set Assessment (MDS) 8/26/24 indicated Resident #33 scored 15 out of a possible 15 on the Brief Interview for Mental Status exam (MDS) indicating intact cognition. The MDS also indicated Resident #33 requires assistance toileting and did not have an indwelling catheter.</p> <p>During routine observations on 9/10/24 and 9/11/24, the surveyor observed signs on various doors on the 2nd floor unit indicating the residents in the room were on EBP. There was no sign on Resident #33's door.</p> <p>On 9/11/24 at 12:59 P.M., the surveyors observed Resident #33 resting in bed with a catheter bag hanging off the side of the bed. The surveyors observed Nurse #1 prepare and complete dressing changes on Resident #33's arms without donning a gown.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #33's clinical record failed to indicate physicians orders or care plans were initiated for EBP.</p> <p>During an interview on 9/12/24 at 7:49 A.M., Nurse #2 said that Resident #33 had a catheter and should be on EBP. Nurse #2 said residents on EBP have signs posted on their doors to alert staff. Nurse #2 then joined the surveyor and observed there was no signage or cart of PPE outside of Resident #33's room.</p> <p>On 9/12/24 at 7:55 A.M. the surveyor observed Certified Nursing Aide (CNA) #1 and CNA #2 reposition Resident #33 in bed without wearing gowns.</p> <p>During an interview on 9/12/24 at 8:05 A.M., CNA #3 said that Resident #33 has had a catheter since he/she was admitted to the unit (on 9/3/24).</p> <p>During an interview on 9/12/24 at 9:51 A.M., the Director of Nursing (DON) said that residents with catheters should be on EBP.</p> <p>46339</p> <p>2. The facility failed to sanitize shared medical equipment after entering a precaution room.</p> <p>Review of facility policy titled 'Cleaning and disinfecting of Resident-Care Items and Equipment' revised September 2022 indicated the following but not limited to:</p> <p>-Reusable items are cleaned and disinfected or sterilized between residents.</p> <p>During a medication observation pass on 9/11/24 at 9:56 A.M., the surveyor observed Nurse #4 remove a blood pressure cuff from the medication cart and brought it into Resident #64's room. The signage on the doorway indicated that the Resident was on enhanced barrier precaution indicating he/she could have the potential for infections. Nurse #4 was then observed bringing back the blood pressure cuff and placed it back in the medication cart without disinfecting it.</p> <p>On 9/11/24 at 9:59 A.M., the surveyor observed Nurse #4 bring into Resident #64's room a blood pressure tower, Nurse #4 proceeded to check the Resident's blood pressure, she then brought the blood pressure tower machine and left it in the hallway without disinfecting it.</p> <p>During an interview on 9/11/24 at 12:43 P.M., Nurse #4 said she should have sanitized the blood pressure equipment after using them in the enhanced barrier precaution room.</p> <p>During an interview on 9/12/24 at 9:44 A.M., the Director of Nursing said shared medical equipment should be sanitized after each use.</p>		