STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Mayflower Place Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 579 Buck Island Road West Yarmouth, MA 02673	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42742 Based on observation, interview, and document review, the facility failed to maintain comfortable room temperatures for two Residents (#18 and #19) residing on one of two units, out of a total sample of 17 residents. Findings include: 1. Resident #18 was readmitted to the facility in March 2024 and had diagnoses including urinary tract infection, type 2 diabetes mellitus, heart failure, obstructive and reflux uropathy, COVID-19, cough, and impaired vision. Review of the Minimum Data Set (MDS) assessment, dated 6/5/24, indicated Resident #18 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an observation with interview on 8/5/24 at 11:08 A.M., the surveyor, upon entering the room, felt the room to be very warm and humid. Resident #18 was lying in bed. The windowpane on the wall to the Resident's left was in an open position with warm air entering the room. The air conditioning (AC) unit was blowing warm air. The Resident said he/she was positive for COVID-19 and the window kept blowing open off and on for a week now. The Resident said he/she said was waiting for maintenance to fix it but said they've done what they can and no one seemed to know. The Resident said staff have to push it closed from the outside. Resident #18 said it's too hot for me and was usually quite hot. At 11:56 A.M., Nurse #6 entered the room and was overheard telling the Resident that she could not close the window all the way and that the room was hot. She said the AC was blowing, but not enough and would tell maintenance. Resident #18 told Nurse #6 that he/she gets soaked. Nurse #6 said the heat from outside was coming into the room. During an observation with interview on 8/6/24 at 11:42 A.M., the surveyor observed the room to be cooler than the day prior with the window closed. The AC was blowing cool air. Resident #18 was lying in bed and said the room was much cooler than yesterday. He/she said they fixed it and that the AC temperature valve had been stuck. The Resident said the room used to be so hot but was now cooled. (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: 225374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/5/24 at 12:34 P.M., Maintenance Staff #1 said staff were not supposed to be opening the windows, it was too hot outside, and the plastic isolation door for COVID-19 was not helping because the air could not circulate. Maintenance Staff #1 said the window was open and he was not able to close it all the way and it was broken. He said he'd need a part to fix it. He further said he was not made aware of the temperature issue or window until today after surveyor intervention. He said no one told him. 2. Resident #19 was admitted to the facility in January 2023 and had diagnoses which included major depressive disorder, chronic congestive heart failure, and COVID-19. Review of the Minimum Data Set (MDS) assessment, dated 6/12/24, indicated Resident #19 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. During an observation with interview on 08/05/24 at 10:50 A.M., the surveyor, upon entering the room, felt the room to be hot and humid. The wall thermostat was set at 90 degrees Fahrenheit (F). Two vertical fans were observed circulating in the room, one on the opposite side of the room and one near the Resident's window. Resident #19 was observed sitting in his/her wheelchair next to the bed. The Resident had a long-sleeved shirt on with his/her arms pulled out of the sleeves and the shirt collar hanging low from his/her neck exposing the skin. Resident #19 said he/she was miserable and so warm and was thirsty all the time. A Styrofoam cup was observed in a cup holder on the wheelchair with condensation around its perimeter. The Resident's AC unit felt slightly warm to touch. Resident #19 said he/she told someone last week, but they didn't do anything about it. He/she said, It's always hot in here. During an interview on 8/5/24 at 11:19 A.M., Nurse #6 said she hadn't been in the Resident's room yet that day but saw him/her stripping down. Nurse #6 said she worked last Friday (three days prior), and the room was hot. She said she told Unit Manager (UM) #1 that day. Nurse #6 said she also worked the day after in the morning and the Resident's window was open, but it wasn't helping. She said the room was hot. She said staff tried to open the windows over the weekend to cool the room down, but it got worse, so they closed them. She said she used the roommate's fan who wasn't there to help circulate the air. She said she had just told Maintenance Staff #1 today while he was on the unit about the hot rooms. Nurse #6 said there used to be a log to document on but now staff enter requests into the TELS (web-based technology designed to tackle to day-to-day challenges of building operations) system. She said she didn't enter any work requests for Resident #18 and Resident #19's rooms and said a lot of the rooms were really hot since the weekend. During an interview on 8/5/24 at 12:33 P.M., Maintenance Staff #1 said staff were not supposed to be opening the windows and Resident #19 had a plastic door for COVID-19, so the air was not circulating. He said the AC unit was turned on low, so he turned it up to high. On 8/6/24 at 11:07 A.M., the surveyor observed Resident #19 lying in bed clothed with blankets on. The room temperature was noticeably cooler. During an interview on 8/7/24 at 2:26 P.M., UM #1 said staff had not notified her of Resident #18 or Resident #19's rooms being so hot last Friday or over the weekend and was just made aware of it by the surveyor. She said maintenance requests are either verbal or get entered into the TELS system. She said there was no hard copy log for requests. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/24 at 2:55 P.M., with the Maintenance Director (MD) and Maintenance Staff #2, the MD said he was not notified verbally or through the TELS system of the Residents' room temperatures until Monday. He said all work orders need to go into the TELS and he would review for any work requests related to the hot temperatures and get back to the surveyor. Maintenance Staff #2 said he found out on Monday and saw that Resident #19's thermostat was set at 90 degrees F and that's why the room was so hot and didn't understand why staff didn't think to turn it down. He said once he turned it down, the room cooled right down. Maintenance Staff #2 said Resident #18's AC unit valve was stuck and needed to be fixed. During an interview on 8/7/24 at 3:42 P.M., the MD reviewed the TELS work orders, dated 8/2/24 through 8/4/24, and said there was nothing there to address Residents #18 and Resident #19's hot room temperatures. During an interview on 8/8/24 at 11:10 A.M., the Director of Nursing said the process is to enter work requests into the TELS, but staff will text as well or communicate verbally. She said all should be entered, however, into the TELS system. She said this process was not followed for Residents #18 and #19. She said she was not made aware of the hot room temperatures either.

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	225374	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayflower Place Nursing & Rehabilitation Center	579 Buck Island Road West Yarmouth, MA 02673

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49425 Based on interview and document review, the facility failed to ensure there was a resolution for a grievance/complaint of an allegation of physical abuse for one Resident (#57), out of six grievances reviewed. Findings include: Review of the Facility's Grievance policy, dated 8/8/2017, included but was not limited to the following: - The facility Director of Social Services is the Grievance official who is responsible for overseeing the grievance process including receiving and tracking grievances to conclusion. - If the grievance involves an allegation of abuse, neglect, mistreatment, misappropriation of property, exploitation or injuries of unknown source, the incident or allegation shall be investigated and reported immediately to the Director of Nursing, Administrator or grievance official. - Upon completion of the review, the grievance official should document the following: steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the grievance, a statement as to whether the grievance was confirmed or not, and any corrective action taken or to be taken in response Review of the Grievance Book included a grievance log (a list of grievances filed for each month), which indicated on 7/25/24 Resident #57 filed a grievance against a Certified Nursing Assistant (CNA), saying the CNA was pushing him/her while getting onto the bedpan. Review of the Grievance/Concern form indicated on 7/25/24 Resident #57 reported the CNA came to help him/her use the bed pan, and the CNA shoved me over. The summary of pertinent findings indicated: - CNA statement differs from resident concerns - What action was taken to resolve the concern: CNA put on administrative leave as further investigation ongoing. CNA will be removed from Resident #57 assignment if she returns. - Grievance was confirmed: blank - Grievance was not confirmed: blank - Recommended corrective action: blank - Was grievance/concern resolved: blank (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident notified by staff member: blank - This form was completed by: blank - Administrator review/Signature; blank Further review of the grievance form failed to indicate the facility addressed and thoroughly investigated Resident #57's report of physical mistreatment as an allegation of potential abuse. Resident #57 was admitted to the facility in July 2024 with diagnoses which included left hip hemiarthroplasty (partial hip replacement). Review of the most recent Minimum Data Set (MDS) assessment, dated 7/22/24, indicated Resident #57 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. During an interview on 8/6/24 at 12:18 P.M., Resident #57 said that a CNA was assisting him/her onto the bed pan and pushed him/her over very roughly, and it really hurt. Resident #57 said he/she reported the incident to a nurse the night it occurred and to the Social Worker the next day. Resident #57 said no one updated her on the outcome of her complaint. During an interview on 8/7/24 at 10:35 A.M., the Director of Social Services said she was the Grievance Official. The surveyor reviewed the grievance with the Director of Social Services. She said it is her responsibility to track and follow up on resolutions of grievances and she did not complete the investigation as she should of, and it was incomplete.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49425 Based on interview and record review, the facility failed to implement policies and procedures for potential physical abuse by a staff member for one Resident (#57), out of 17 sampled residents. Specifically, the facility failed to investigate and report an allegation of physical abuse for Resident #57, in accordance with the facility's abuse policy. Findings include: Review of the facility's policy titled Training & Identification and Reporting Incidents that may be indicative of abuse and neglect, dated as revised 7/2017, indicated but was not limited to the following: - To provide training and direction for identifying and reporting incidents/events that may be incidents of abuse and/or neglect. - All staff, residents and families will be provided training and will be knowledgeable in the definition of abuse, including mental abuse. - Training on abuse prevention will be provided during on hire orientation, annually and whenever there is a need for re-education. - Supervise/monitor staff to identify possible inappropriate behaviors, such as use of derogatory language, rough handling, or not meeting residents needs or requests. - Facility staff will receive in-service training at least annually on abuse prohibition. The in-service training will include, but not to be limited to: - Reporting and investigation requirements for any allegation of abuse, mistreatment or neglect. - All reports will be forwarded to the Director of Nursing. - The Director of Nursing (or his/her designee) will review all known or unexplained findings to further determine patterns or trends being vigilant to the possibility of abuse. - Notification of state agencies will occur per State and federal requirements. Review of the facility's policy titled Investigation Guidelines for Allegations of Abuse or Neglect, dated as revised 7/17, indicated but was not limited to the following: - All reports of resident abuse, neglect, mental abuse, mistreatment, and injuries of an unknown origin (bruises, skin tears) shall be investigated thoroughly and promptly by facility management. - Analysis of the incident and investigation will be conducted to determine what changes are needed, if any, to policies and procedures to deter further occurrences. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Administrator and Director of Nursing will keep the resident and his/her representative informed of the progress of the investigation. - A copy of the completed investigation and report will be provided to the Administrator and the Department of Public Health within five working days of the reported incident per State and federal requirements. - Any alleged violations and all substantiated incidents of any form of abuse will be reported to the state agency and to all other agencies as required by State and federal regulations, and corrective actions will be taken as necessary pending on the results of the investigation. Resident #57 was admitted to the facility in July 2024 with diagnoses which included left hip hemiarthroplasty (partial hip replacement). Review of the Minimum Data Set (MDS) assessment, dated 7/22/24, indicated Resident #57 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. During an interview on 8/6/24 at 12:18 P.M., Resident #57 said a Certified Nursing Assistant (CNA) was assisting him/her onto the bed pan and pushed him/her over very roughly, and it really hurt. Resident #57 said he/she reported the incident to a nurse the night it occurred and to the Social Worker the next day. Resident #57 said no one updated her on the outcome of her complaint. Review of the Grievance/Concern form indicated on 7/25/24, Resident #57 reported the CNA came to help him/her use the bed pan, and the CNA shoved me over. The summary of pertinent findings indicated: -Nurse statement from Resident #57 -CNA statement differs from resident concerns -Director of Social Services statement from Resident #57 -Former Administrator interview with Resident #57 -What action was taken to resolve the concern: CNA put on administrative leave as further investigation ongoing. CNA will be removed from Resident #57's assignment if she returns. -Grievance was confirmed: blank -Grievance was not confirmed: blank -Recommended corrective action: blank -Was grievance/concern resolved: blank -Resident notified by staff member: blank (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-This form was completed by: blank -Administrator review/Signature: blank During an interview on 8/7/24 at 10:35 A.M., the surveyor reviewed the grievance with the Director of Social Services. She said it was her responsibility to track and follow up on resolutions of grievances and she did not complete the investigation as she should of, and it was incomplete. During an interview on 8/7/24 at 10:57 A.M., the Director of Nursing (DON) reviewed Resident #57's grievance with the surveyor and said it was an allegation of abuse, and the investigation was incomplete. She said it was missing interviews and resolutions, and a thorough investigation was not conducted in accordance with the facility Abuse Policy. Additionally, she said the allegation was not reported to the state as required.

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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. 49425 Based on interview and record review, the facility failed to ensure an allegation of physical abuse by a Certified Nursing Assistant (CNA) was reported timely to the state agency as required for one Resident (#57), of a total sample of 17 residents Findings include: Review of the facility's policy titled Investigation guidelines for allegations of abuse or neglect, dated as revised 7/17, indicated, but was not limited to the following: - When an alleged or suspected case of abuse, mistreatment, neglect, exploitation, misappropriation of resident property, or injuries of unknown origin is reported, the Administrator, or designee, will immediately notify the State Agency but no later than 2 hours after the allegation is made if the events that cause the allegation of abuse or result in serious bodily injury - Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Agency and all other persons or agencies in accordance by State law through established procedures. - Reports to the state agency will be submitted electronically through the HCFRS (Health Care Facility Reporting System). Resident #57 was admitted to the facility in July 2024 with diagnoses which included left hip hemiarthroplasty (partial hip replacement). Review of the most recent Minimum Data Set (MDS) assessment, dated 7/22/24, indicated Resident #57 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. During an interview on 8/6/24 at 12:18 P.M., Resident #57 said a CNA was assisting him/her onto the bed pan and pushed him/her over very roughly, and it really hurt. Resident # 57 said he/she reported the incident to a nurse the night it occurred and to the Social Worker the next day. Resident #57 said no one updated her on the outcome of her complaint. Review of the Grievance/Concern form indicated on 7/25/24, Resident #57 reported the CNA came to help him/her use the bed pan, and the CNA shoved me over. The summary of pertinent findings indicated: -Nurse statement from Resident #57 -CNA statement differs from resident concerns -Director of Social Services statement from Resident #57 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Former Administrator interview with Resident #57 -What action was taken to resolve the concern: CNA put on administrative leave as further investigation ongoing. CNA will be removed from Resident #57's assignment if she returns. -Grievance was confirmed: blank -Grievance was not confirmed: blank -Recommended corrective action: blank -Was grievance/concern resolved: blank -Resident notified by staff member: blank -This form was completed by: blank -Administrator review/Signature: blank Review of HCFRS on 8/6/24 at 12:05 P.M., failed to indicate the allegation of physical abuse by a CNA was reported as required. During an interview on 8/7/24 at 10:57 A.M., the Director of Nursing (DON) reviewed Resident #57's grievance with the surveyor and said it was an allegation of abuse, and the investigation is incomplete. She said her expectation was for an allegation of abuse to be reported through HCFRS within two hours of receiving the complaint.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49425 Based on record review, interview and policy review, the facility failed to ensure that allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated for one Resident (#57), out of a total sample of 17 residents. Specifically, the facility failed to ensure an allegation of physical abuse by a Certified Nursing Assistant (CNA) was thoroughly investigated in accordance with the facility's abuse policy. Findings include: Review of the facility's policy titled Investigation Guidelines for Allegations of Abuse or Neglect, dated as revised 7/17, indicated, but was not limited to the following: - All reports of resident abuse, neglect, mental abuse, mistreatment, and injuries of an unknown origin (bruises, skin tears) shall be investigated thoroughly and promptly by facility management. - The Administrator, Director of Nursing or her/his designee will coordinate gathering of information for purposes of investigation on all alleged incidents. - The Investigator will obtain a complete report outlining the event. Interviews will be conducted as directed by Director of Nursing/Administrator. - The individual conducting the investigation will identify and interview all individuals who are relevant to the incident. In addition the individual will: - Review the reported allegation. - Review the resident's medical record to determine events leading up to the incident. - Interview the person reporting the incident. - Interview the resident (as medically appropriate). - Interview any staff (on all shifts) who had contact with the resident during the period of the alleged incident. - Interview the resident's roommate, family members, and visitors. - Interview other residents whom the accused employee provides care or services. - Review the events and circumstances leading up to the alleged incident and interview any individuals who may be relevant. Resident #57 was admitted to the facility in July 2024 with diagnoses which included left hip hemiarthroplasty (partial hip replacement). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 7/22/24, indicated Resident #57 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the Resident was cognitively intact. During an interview on 8/6/24 at 12:18 P.M., Resident #57 said a CNA was assisting him/her onto the bed pan and pushed him/her over very roughly, and it really hurt. Resident #57 said he/she reported the incident to a nurse the night it occurred and to the Social Worker the next day. Resident #57 said no one updated her on the outcome of her complaint. Review of the Grievance/Concern form indicated on 7/25/24, Resident #57 reported the CNA came to help him/her use the bed pan, and the CNA shoved me over. The summary of pertinent findings indicated: -Nurse statement from Resident #57 -CNA statement differs from resident concerns -Director of Social Services statement from Resident #57 -Former Administrator interview with Resident #57 -What action was taken to resolve the concern: CNA put on administrative leave as further investigation ongoing. CNA will be removed from Resident #57's assignment if she returns. -Grievance was confirmed: blank. -Grievance was not confirmed: blank. -Recommended corrective action: blank. -Was grievance/concern resolved: blank. -Resident notified by staff member: blank. -This form was completed by: blank. -Administrator review/Signature: blank. Review of the full investigation included the following: - Nurse statement from Resident #57. - CNA statement differs from resident concerns. - Director of Social Services statement from Resident #57. - Former Administrator interview with Resident #57 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Situation, Background, Assessment, Recommendation (SBAR) Communication Tool which indicated the following: - Situation: CNA request recommendation for next step - Background: Coaching and Counseling - Assessment: No conclusion at this time - Recommendation: Other statements may be provided from co-workers that have had concerns regarding CNA. Not available at this time - No further documentation was included in investigation Further review of the investigation failed to indicate the facility thoroughly investigated the Resident's report of physical mistreatment as an allegation of potential abuse. During an interview on 8/7/24 at 10:35 A.M., the Director of Social Services said she informed the former Administrator of Resident #57's complaint. She said the former Administrator was handling the investigation. She said she did not investigate the complaint and it was incomplete. During an interview on 8/7/24 at 10:57 A.M., the Director of Nursing (DON) reviewed the investigation with the surveyor of Resident #57's allegation of abuse, and said it was incomplete. She said the investigation was missing interviews and resolutions, and a thorough investigation was not conducted in accordance with the facility Abuse Policy.

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NAME OF PROVIDER OR SUPPLIER Mayflower Place Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 579 Buck Island Road West Yarmouth, MA 02673	

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 31830 Based on observation and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the status for one Resident (#19), out of a total sample of 17 residents. Findings include: Resident #19 was admitted to the facility in January 2023 with diagnoses which included major depressive disorder and chronic congestive heart failure. Review of the MDS assessments, dated 3/13/24 and 6/12/24, indicated in Section O-Special Treatments and Programs, Resident #12 received Hospice services. Further review of the paper and electronic medical record failed to indicate a Physician's order, documentation, or care plans to reflect Resident #19 received Hospice services. During an interview on 8/7/24 at 2:19 P.M., MDS Nurse #2 and the surveyor reviewed the MDS assessments, dated 3/13/24 and 6/12/24. MDS Nurse #2 said Resident #19 did not receive Hospice services during those assessment dates and the MDSs were not accurate. MDS Nurse #2 said Hospice services were checked in error.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31830 Based on observation, interview, and record review, the facility failed for one Resident (#12), out of a total sample of 17 residents, to develop and implement individualized person-centered care plans to meet the resident's physical, psychosocial and functional needs. Specifically, the facility failed to ensure comprehensive care plans, including measurable objectives and timeframes were implemented. Findings include: Review of the facility's policy titled Comprehensive Care Plans, dated July 2023, indicated but was not limited to the following: -Facility will develop and implement an individualized interdisciplinary plan of care for each resident that includes instructions needed to provide effective and person-centered care. -The Comprehensive Care Plan will be reviewed and revised on a quarterly basis, with a significant change in condition, on re-admission from inpatient hospital stay, and as requested by the Resident/Representative. -The Comprehensive Care Plan will be ongoing, focusing on each individual resident as a unitary being. -Residents and their representatives will play an active role in the development of goals and implementation of the residents' Comprehensive Care Plan, where practicable. -The interdisciplinary team will develop and implement the Comprehensive Care Plan within 21 days of admission. The comprehensive care plan will address measurable resident goals, actual and potential problems, needs, strengths, and individual preferences of the resident. -Each discipline will be responsible for the initiation and ongoing follow-up for care plans as related to their area of expertise. Resident #12 was admitted to the facility in July 2024 with diagnoses which included heart failure, urinary retention, anxiety, glaucoma, and difficulty walking. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 7/9/24, indicated in Section V: Care Area Assessments, the following Care Areas were triggered: Cognitive loss/dementia, visual function, communication, ADL functioning/rehabilitation potential, urinary incontinence, behavioral symptoms, falls, nutritional status, and pressure ulcers. Subsequent review of Resident #12's paper and electronic medical record failed to include any comprehensive care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 1:55 P.M., MDS Nurse #1 reviewed the medical record with the surveyor and was unable to locate any comprehensive care plans. The MDS Nurse said once the comprehensive MDS was completed, and care areas were triggered, the care plans should have been developed but were not.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43935 Based on document review and interview, the facility failed to follow physician's orders and ensure diagnostic tests were completed timely, as ordered, for two Residents (#20 and #13), out of a sample of 17 residents. Findings include: Review of the facility's policy titled Physician Orders, dated as revised 11/2005, indicated but was not limited to the following: - physician's orders are to be transcribed by licensed personnel only - the nurse transcribing the order is responsible for ensuring that needed labs are obtained and shall indicate that each order has been noted Review of the facility's policy titled Diagnostic Services Guidelines, dated 1/2014, indicated but was not limited to the following: - the purpose is to provide laboratory and other diagnostic studies for the residents in the facility as ordered - physicians order the diagnostic service to be performed - laboratory and other diagnostic services are available 24 hours per day 7 days per week - diagnostic results are to be obtained and included in the medical record Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #20 was admitted to the facility in April 2018 and had diagnoses including: hypertension, chronic obstructive pulmonary disease, and anemia. Review of the monthly medication regimen reviews for Resident #20 indicated but was not limited to the following: - 5/15/24: Resident receives Lasix, a diuretic medication, and has not had a basic metabolic panel (BMP) documented in the medical record in the previous six months, please monitor a BMP on the next convenient lab day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician signed the recommendation in agreement on 5/20/24 and wrote ordered on the pharmacy recommendation. - 6/12/24: Resident had orders for labs on 5/20/24 but they were not available in the medical record, please ensure the ordered labs are obtained. The physician initialed the pharmacy recommendation, it was undated. Review of Resident #20's Physician's Orders from May 2024 indicated but were not limited to the following: - 5/20/24 CMP (complete metabolic panel), CBC (complete blood count), TSH (thyroid stimulating hormone) on Wednesday. This order was handwritten and signed by the Physician and noted by the Nurse. Review of the medical record including lab results and progress notes failed to indicate the labs ordered on 5/20/24 had been completed and results were available. During an interview on 8/7/24 at 8:02 A.M., Unit Manager (UM) #1 said the Lab Provider routinely comes to the facility on Mondays, Wednesdays, and Fridays. She reviewed the medical record for Resident #20 and also the Lab Provider's patient portal and said there were no lab results for the month of May for the ordered CMP, CBC, or TSH for the Resident. She said there is no indication in the medical record as to why the labs were not completed and she does not know why they were missed but it was an error. UM #1 said it appears they were completed on 7/3/24, six weeks after they were originally ordered by the physician. During an interview on 8/7/24 at 12:02 P.M., Physician #1 said his expectation is that labs ordered for a resident are completed when they are ordered. He said the labs for Resident #20 were ordered in May and should have been completed the Wednesday after they were ordered, but they were missed and not obtained until July which was a long time from the original order and that should not have occurred. During an interview on 8/7/24 at 1:28 P.M., the Director of Nurses (DON) said she was made aware of the missing labs ordered in May as a result of a pharmacy recommendation for Resident #20. She said she was unsure how the error could have occurred since the nurse noted the order, but she felt it was a long time in between the order being written and the labs being obtained and did not meet the standard of practice for following physician orders as written. 2. Resident #13 was admitted to the facility in November 2019 and had diagnoses including: dementia, hypertension, and urinary tract infection (UTI). Review of the Nurse Practitioner's (NP) note from 8/2/24 indicated but was not limited to the following: - Resident status post fall from bed, no injury, reports not feeling well but non-specific other than tired. Plan to obtain Urinalysis (U/A) culture and sensitivity (C&S) rule out (R/O) UTI (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the active current Physician's Orders for Resident #13 on 8/7/24 indicated but were not limited to the following: - U/A C&S R/O UTI - may straight cath (8/2/24) - this order was handwritten by the NP and noted by a nurse - Obtain urine sample to rule out UTI, may straight cath, discontinue (d/c) this order once collected (8/3/24) Review of the medical record, including progress notes, failed to indicate the urine sample had been collected, the staff were experiencing problems collecting the sample, or any results were available. During an interview on 8/7/24 at 8:22 A.M., UM #1 said the urine had been ordered on 8/2/24 but there were no results available in the Lab Provider's system and no evidence that the specimen had been collected yet. She reviewed the progress notes for Resident #13 and said there was no evidence that the staff were having issues obtaining the urine. During an interview on 8/7/24 at 12:03 P.M., Physician #1 said when an order is provided to the facility for a urine specimen to be obtained and it is a regular lab specimen to look for a potential UTI and the order contains a clause that the staff may straight cath the resident, then he expects the urine to be obtained by the next day at the latest. He said beyond that timeframe there should be documentation of behaviors and the staff attempting to collect the specimen numerous times and by the second day he would expect a call for an alternative order. He said that Resident #13 should not be waiting for almost five days for a urine specimen to be obtained and that is too long between the order date and the staff completing the order. He said in general when orders are written he expects them to be completed without delay. During an interview on 8/7/24 at 2:13 P.M., Family Member #2 said the facility notified her of the orders to obtain a urine specimen to R/O a UTI a few days ago but she has not been informed of the results yet. She said if the specimen hasn't been collected yet she would consider that an unacceptable amount of time to be waiting to get a urine sample since they usually get it through a straight cath. She said Resident #13 has frequent UTIs and she would not be happy if there was a delay in checking for the potential infection and beyond two days to get the sample feels to be an excessive timeframe. During an interview on 8/7/24 at 4:02 P.M., the DON said she is aware that there was a delay on the part of the staff collecting a urine sample for Resident #13. She said she expects a urine sample should be able to be collected and sent pretty quickly, in about a day or two but if it was not for any reason that the reasons would be documented and the physician would be notified of the issue and that did not occur. She said the expectation is that nurses are following physician's orders as written and urine specimens are obtained within two days and said in this instance that expectation was not met.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43935

Based on observation, interview, and record review, the facility failed to consistently implement approaches to prevent falls and provide adequate oversight to prevent future falls for one Resident (#50) who was considered a fall risk and had suffered nine falls between January 2024 and June 5, 2024 resulting in three injuries on 3/3/24, 5/3/24, and 5/8/24 including one hospitalization , out of 17 sampled residents.

Findings include:

Review of the facility's policy titled Incidents Falls, dated as reviewed 2/2018, indicated but was not limited to the following:

- it is the policy of the facility to implement preventative measures to reduce residents' fall risk and risk of injury related to the same, and

- all falls will be investigated as to their cause and interventions will be in place to prevent further falls.

Review of the facility's policy titled Purposeful Rounding, dated as revised 4/2024, indicated but was not limited to the following:

- purpose of the policy is to ensure resident needs are met and reduce the number of falls due to preventable interventions

- residents may be designated for purposeful rounding if they have a history of falls that are bathroom or environment related or at the discretion of the Nurse, Unit Manager (UM), Supervisor or Director of Nurses (DON)

- purposeful rounding will address hydration, toileting, safety and other needs and the Nurse is responsible for ensuring unlicensed staff follows purposeful rounding policies and procedures

- an orange purposeful rounding form will be hung on the door of the designated resident with a start time of midnight (12:00 A.M.)

- residents are to be rounded on by staff every one to two hours and documented on the purposeful rounding form

- the form is intended to assist the staff in addressing resident needs

- the staff will indicate the time of the round and which items were addressed with their initials

Review of the purposeful rounding sheets in use by the facility indicated but were not limited to the following:

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Purposeful rounding is a structured means of promoting resident centered communication between staff, residents and their families and improves the resident experience - reduces resident falls and improves a resident's perception of their care - gives nursing staff more time for patient care tasks and more control of their time by being proactive rather than reactive, meaning less call bells - please initial in each box when you round and check on a resident Time across the top of the form: 12:00 A.M., 2:00 A.M., 4:00 A.M., 6:00 A.M., 8:00 A.M., 10:00 A.M., 12:00 P.M., 2:00 P.M., 4:00 P.M., 6:00 P.M., 8:00 P.M., 10:00 P.M. Patient care tasks/prompts: Does the resident have pain? If yes, notify the nurse; Does the resident need to use the bathroom?; Does the resident need repositioning?; Are personal items in reach?; Does the resident have water? Resident #50 was admitted to the facility in September 2023 and had diagnoses including: cerebrovascular disease (medical condition that affects the blood vessels of the brain and its circulation), ataxia (impaired coordination), polyneuropathy (illness affecting peripheral nerves on each side of the body causing numbness, pain, or weakness), and restlessness and agitation. Review of the Minimum Data Set (MDS) assessment, dated 6/12/24, for Resident #50 indicated but was not limited to the following: - Section C (Cognitive patterns): Brief Interview for Mental Status score of 9 out of 15 indicating the Resident had moderately impaired cognition. - Section J (Health conditions): Resident has had 2 or more falls since prior assessment with minor injury and 2 or more falls since prior assessment with no injury. Review of the most recent fall risk assessment for Resident #50, dated 6/1/24, was a score of 13, indicating the Resident is at risk (score of 10 or higher represents a high risk for falls). The Resident also had six other fall risk assessments completed in 2024 indicating he/she was a high fall risk with scores over 10 on 1/16, 1/28, 3/3, 3/25, 5/3, and 5/28. Review of the medical record indicated Resident #50 had nine falls in 2024 on 1/16/24, 1/28/24, 3/3/24, 3/25/24, 5/3/24, 5/8/24, 5/28/24, 6/1/24 and 6/5/24. Review of the facility fall Incident/Accident reports for Resident #50 from January 2024 to August 2024 indicated the following: 1/16/24 at 11:15 A.M., Unwitnessed fall in Resident room; last seen at 10:00 A.M. in wheelchair, last toileted at 9:00 A.M., Resident said he/she slid out of wheelchair, no injury. Staff statements indicated Resident was lying on their back on the floor beside their bed, suggestions to prevent future falls included: dycem to wheelchair, chair alarm and new wheelchair. New interventions post investigation: dycem to wheelchair beneath Resident (on care plan). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/28/24 at 1:20 P.M., Unwitnessed fall in Resident room; last seen at 1:10 P.M. in wheelchair, last toileted at 1:00 P.M., Resident said he/she was trying to reach their glasses and water and lost their balance, no injury. Staff statements indicated Resident was lying on the floor in their room, suggestions to prevent future falls included: chair alarm. New intervention post investigation: keep table with personal items in reach when out of bed (on care plan, duplicate intervention from 9/14/23 - keep frequently used items in reach). 3/3/24 at 5:00 P.M., Unwitnessed fall in Resident's room; last seen at 4:30 P.M. in bed, last toileted at 2:00 P.M., Report indicated frequently used items and call bell were not in reach at the time of the fall, Resident said they were trying to stand up, fall resulted in skin tear/laceration on the nose with small amount of blood loss and moderate pain and Resident was sent to the hospital for further evaluation. Staff statements indicated Resident was lying face first on the floor half in and half out of the bed, suggestions to prevent future falls included: frequent safety checks and a bed alarm. New intervention post investigation: frequent safety checks (on care plan but resolved for purposeful rounding on 4/1/24) per care plan a scoop mattress was also added to the care plan. Resident returned from the hospital with no acute intercranial injury when a head CT was completed at the hospital. 3/25/24 at 3:30 A.M., Unwitnessed fall in Resident's room; last seen at 2:00 A.M. in bed, last toileted at 12:00 A.M., the Resident did not provide an explanation, no injury. Staff statements indicated Resident was found lying on his/her back on the floor, suggestions to prevent future falls did not include an idea for intervention, but did indicate the Resident is confused and impulsive and does not remember to ring for help. New intervention post investigation: safety checks every two hours on 11:00 P.M. to 7:00 A.M. shift (on care plan but resolved for purposeful rounding on 4/9/24). 5/3/24 at 3:30 P.M., Unwitnessed fall in Resident's room; last seen at 3:15 P.M. in bed, last toileted at 2:00 P.M., the Resident said he/she was trying to move, fall resulted in a 4 centimeter (cm) by 4 cm bruise on the left elbow with mild pain; licensed nurse note of incident indicated the Resident told the nurse he/she hit their head, but there was no obvious injury. Staff statements indicated the Resident was lying on the floor on his/her back next to the bed, suggestions to prevent future falls included: bed alarm and hospice consult for increased anxiety. New intervention post investigation: hospice consult related to increase anxiety (on care plan). Review of Hospice skilled note, dated 5/3/24, indicated but was not limited to: -Ativan (an anti-anxiety medication) recommended twice a day and as needed every 4 hours. Family describes increase restlessness as well and said if the Resident was less restless he/she would likely not have the urge to crawl out of bed or chair. 5/8/24 at 8:00 P.M., Unwitnessed fall in Resident's room; last seen at 7:30 P.M., in bed, last toileted at 7:00 P.M., Resident did not provide an explanation, fall resulted in skin tears/lacerations to right side of forehead, right side of nose, and left and right upper extremities (arms) with moderate blood loss and moderate pain. Staff statements indicated the Resident was lying on the floor beside the bed, was seen 20 minutes prior in passing and was lying calmly in bed, suggestions to prevent future falls included: 5 minute checks, private aide, toileting, fall alert pad, or something to make him/her more comfortable. New intervention post investigation: floor mats (on care plan). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/28/24 at 6:15 A.M., Unwitnessed fall in Resident room; last seen 6:00 A.M., in bed, last toileted at 5:45 A.M. , Resident denied attempting to get out of bed, no injury. Only one staff statement was available and indicated: Resident was sitting on the floor leaning against the bed and was calm and sleeping when last seen, with no suggestions for prevention of future falls. New intervention post investigation: Verbal cues, encourage the use of the call light prior to getting out of bed (not on the care plan). 6/1/24 at 9:03 P.M. [sic], Witnessed fall without head strike in Resident room; last toileted 8:12 A.M., witness indicated Resident slid out of wheelchair, no injury. Staff statements indicated: Resident was last seen prior to fall by staff at 8:10 A.M., calm and in his/her chair, suggestions to prevent future falls: applying dycem to Resident's seat at all times and needs 24 hour private aide. New intervention post investigation: Ensure dycem is on chair seat at all times when Resident is seated (on care plan, duplicate intervention from 1/16/24 - dycem to wheelchair beneath Resident). 6/5/24 at 5:00 P.M., Unwitnessed fall in Resident room; last seen at 4:50 P.M. resting in bed, last toileted 2:00 P.M., Resident said he/she wanted to get up, no injury. There was no investigation packet available for review and no evidence that an investigation was completed to determine the cause of the fall. New intervention on the care plan: Resident to be toileted and up out of bed prior to dinner at 4:45 P.M. (on care plan). Six of the nine falls between January 2024 and June 5, 2024 have occurred from the bed and three have been from the chair. One fall had been witnessed and three falls resulted in minor injuries, including a brief hospitalization on [DATE] for a laceration on the nose. Review of the Physician and Nurse Practitioner progress notes indicated but were not limited to the following: - 3/3/24: Patient fell out of bed bleeding from nose and nose deviating to the left side complained of moderate pain to nose, arm and leg, patient was sent to ER (emergency room) for evaluation. - 5/3/24: Fall - found lying on floor, poor historian, staff was able to safely Hoyer (mechanical lift) the resident into the Broda chair (positioning chair), positive restlessness in Broda chair, staff has noted increase in restlessness, hospice updated, would benefit from as needed ativan, may need to begin comfort meds. - 5/8/24: Unwitnessed fall with injury, found laying on the floor. Nurse states that resident is very restless, hospice was contacted. Head: no hematoma, blood noted to right (Rt) temple and Rt side of nose; skin tear to Rt lower arm 2 cm by 2 cm with two steri strips applied and left lower arm 0.5 cm by 2 cm with one steri strip applied. This is an acute new problem, the patient's condition is stable - 5/10/24: Fall - found on the floor on 5/8/24, initially reported shoulder pain but since then resolved without intervention, patient was started on Ativan and remains a fall risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/24 at 9:32 A.M., the surveyor observed Resident #50 in bed with a fall safety mat folded up and leaning against the wall, not on the floor beside the bed. On 8/8/24 the surveyor made the following observations of Resident #50: - 8:12 A.M., In bed with fall mat on the floor on the Resident's left side of the bed (none observed on the right), call light attached to side rail of the bed, Resident appears calm and comfortable, purposeful rounding sheet posted on the door but blank from 12:00 A.M. until 8:00 A.M., signed off at 8:00 A.M. - 9:02 A.M., In Broda chair with dycem on cushion, call light is not in reach but behind the Resident's chair draped over the bedside table, purposeful rounding sheet posted on the door but blank from 12:00 A.M. until 8:00 A.M. - 9:32 A.M., In Broda chair with dycem on cushion, purposeful rounding sheet posted on the door and signed as completed for 10:00 A.M., time slot, slipper socks on feet, call light not in reach but behind the Resident on the bedside table - 10:32 A.M., In Broda chair with dycem on cushion, purposeful rounding sheet posted on the door and signed as completed for 10:00 A.M., time slot, slipper socks on feet, call light not in reach but behind the Resident on the bedside table - 11:35 A.M., In Broda chair with dycem to chair, slipper socks on feet, purposeful rounding sheet posted on the door and signed as completed for 12:00 P.M., call light on bedside table behind Resident, out of reach. - 2:06 P.M., In Broda chair with dycem on chair and chair in a reclined position, call light is not in reach and is observed draped over the resident bedside table, purposeful rounding sheet posted on the door and signed as completed for 12:00 P.M. but not 2:00 P.M. - 2:43 P.M., In Broda chair, purposeful rounding sheet posted on the door and signed as completed for 12:00 P.M., but not 2:00 P.M., call light is behind the Resident on the bedside table - not in reach - 4:29 P.M., In Broda chair reclined, purposeful rounding sheet posted on the door and incomplete since 12:00 P.M., call light is behind the Resident on the bedside table - not in reach - 5:16 P.M., In Broda chair reclined awake and restless, but said he/she is comfortable, Resident said he/she did not know where the call light was when asked, it was observed behind the chair draped over the bedside table, overbed table in front of Resident with daily news sheet on it, purposeful rounding sheet posted on door is incomplete since 12:00 P.M. - 5:42 P.M., In Broda chair reclined, call light remains out of reach draped over the bedside table behind the Resident's chair, Resident is calm with eyes closed, purposeful rounding sheet posted on door is incomplete since 12:00 P.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Mayflower Place Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 579 Buck Island Road West Yarmouth, MA 02673	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Throughout 8/8/24 during the surveyors observations the Resident was never observed to have his/her call light in reach, and the purposeful rounding sheet from 8/8/24 was incomplete from 12:00 A.M., until 8:00 A.M. , and then incomplete again from 2:00 P.M., through 6:00 P.M., indicating the purposeful rounding was not implemented or complete for the Resident at those times as required. During an interview on 8/8/24 at 11:40 A.M., Certified nurse assistant (CNA) #5 said purposeful rounding is a new program in which residents who fall often are highlighted to the staff for more intense monitoring to ensure they have everything they need in an effort to help prevent falls. She said the night shift (11:00 P.M. to 7:00 A.M.) collect the old sheets and put a new one up each night and the process runs for the full 24 hour day. She said the staff is supposed to document at each two hour interval when they complete the rounds. She said she thinks the sheets just a reminder to all staff to pay closer attention to the residents. She said Resident #50 is a fall risk and on purposeful rounding because of frequent falls. During an interview on 8/8/24 at 11:43 A.M., CNA #4 said she is not exactly sure what purposeful rounding is, but does know that if a resident has an orange sheet on their door they need to have it signed off and staff have to make sure the resident has everything they need every two hours. She said the form is on the door for a whole day and all three shifts are required to complete the form. She said Resident #50 is a fall risk and sits in a chair in their room throughout the day. She said the Resident should have their call light in reach at all times, she said staff can tell what the Resident's fall interventions are by looking at the Kardex. She said the purposeful rounding form needs to be signed off by the staff every two hours. During an interview on 8/8/24 at 11:45 A.M., Nurse #5 said purposeful rounding is a newer program to the facility and it is for residents who are a high fall risk. She said the program puts a high focus on visually checking on the resident more often than just during normal care tasks. She said residents on the program have an orange sign off sheet posted on their door to alert staff to the need for a higher focus and let them know the resident is a potential safety hazard and risk of falls. She said the night shift posts the sheets each night and the process goes throughout all three shifts and staff are required to sign off each box at each allocated time to prove they saw the residents and addressed their needs. She said the UM may know how the forms are used. She said Resident #50 is a high fall risk and is on the purposeful rounding program as a fall intervention, she said additional interventions would be found on the care plan or in the Kardex. During an interview on 8/8/24 at 11:49 A.M., UM #1 said purposeful rounding is a newer process that has been implemented in the last few months in the facility for residents who are a higher risk for falls or have suffered from numerous falls and it is a care plan intervention for staff to visualize the resident more in an effort to prevent further falls by making sure the resident's have everything they need. She said the program would be on the care plan and Kardex as a fall intervention and the orange sheet is posted on the resident's door by the night shift each night and is to be completed by the staff on all three shifts, all staff have a responsibility to look at these residents more frequently. Review of the current care plans for Resident #50 indicated, but were not limited to the following: PROBLEM: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall risk/impaired mobility related to: decreased balance, strength, endurance, range of motion and coordination; non-ambulatory; muscle weakness; decreased safety awareness, psych medication use, as evidenced by fall risk assessment identifies risk factors. (9/14/23) APPROACHES: Move slowly and carefully with A.M. and P.M. care, wheelchair for independent mobility as needed, assist of one to far destinations as needed, monitor frequently for safe positioning and alignment, refer to Kardex for current level of assist, medications as ordered, keep environment clutter free, call bell in reach answer as soon as possible, keep frequently used items in reach, all disciplines monitor and intervene using interventions listed in the care plan, assess medications related to fall risk (9/14/23); remind spouse not to push wheelchair (11/26/23); rehab referral as needed for wheelchair positioning and safety, place dycem on top of wheelchair cushion, monitor post fall for injury for 72 hours after falls (1/16/24); Keep bedside table with personal items within reach when out of bed (1/30/24); Scoop mattress to bed (3/3/24); Add to purposeful rounding (4/1/24); Hospice consult for increase anxiety (5/3/24); Floor mats to both sides of the bed at all times when in bed (5/8/24); Dycem to Broda chair cushion to prevent slipping (6/1/24); Toilet and up out of bed prior to dinner at 4:45 P.M. (6/5/24) Review of the Kardex in place for Resident #50 indicated but was not limited to the following: Page one: Safety: 9/14/23: Fall Risk, Items and call bell within reach, encourage out of bed for meals, encourage activities Page two: 1/16/24: Fall - Dycem to wheelchair (w/c) seat; 1/28/24: Fall - from w/c no injury; 3/3/24: Fall from bed frequent safety checks; 3/3/24: scoop mattress status post fall; 3/25/24: Fall - no injuries out of bed, safety checks every 2 hours on night shift (discontinued 4/9/24); 4/9/24 add to hourly rounding Page three: 5/3/24: Fall in room consult hospice related to increase anxiety; 5/8/24: Mats placed on floor on both sides of bed with bed lowered at all times when in bed; 5/28/24: fall in room sitting on mat next to bed, intervention: (blank); 6/1/24: slid out of Broda chair intervention dycem (duplicate from 1/16/24); 6/5/24: Fall out of bed sitting on mat, intervention: toilet and out of bed prior to dinner at 4:45 P.M. 7/10/24: in & out of bed schedule Review of the current Physician's Orders as of 8/8/24 for Resident #50 indicated but were not limited to the following: - Healthcare proxy (HCP) invoked (activated) (12/21/23) - Add to hourly rounding (4/9/24) - Ensure dycem in wheelchair at all times when resident is seated (6/1/24) Review of the July 2024 and August 1-8, 2024 general nursing flow sheets indicated the following: - Add to hourly rounding (4/9/24) - this is an FYI and not signed off by the licensed nursing staff (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Ensure dycem in wheelchair at all times when resident is seated (6/1/24) - this has not been signed off by the licensed nurses throughout the month of July or in the first 22 shifts of the month of August 2024. During an interview on 8/8/24 at 2:49 P.M., Nurse #5 said the process should a fall occur on your shift is to assess the resident and complete a fall incident packet. She said the packet includes notification to the family and the doctor or Nurse practitioner (NP), then you speak with the staff and obtain statements, assess for pain and skin injury and the staff document notes for three days post incident. She said the staff try to determine the cause of the fall to put a new intervention in place to prevent another fall. She said the care plan and Kardex are then both updated with the new intervention so they can be implemented by all staff. She said if a duplicate intervention is put in place by the nurse on duty she would assume that the UM or office would come up with a new intervention since one is required. She said the care plan for falls safety should always be followed. During an interview on 8/8/24 at 5:00 P.M., Family Member #1 said Resident #50 has had a lot of falls and is forgetful and can be restless. She said the staff do contact her when a fall occurs but they do not tell her specifically what they will do to prevent another fall but say they will look into something to prevent another fall. She said the majority of the falls have been from the bed and she did not realize it was a total of nine falls in six months, which she said seemed like a lot. She said she knows and expects that the fall mats be on either side of the bed when the Resident is in bed, the call light is in reach next to or in his/her hand since they will use it and the staff are frequently checking on the Resident and if they were not doing these things consistently it would be unacceptable. On 8/9/24, the surveyor made the following observations at the following times of Resident #50: - 6:56 A.M., In bed with bed low to the ground and a fall mat on the Resident's left side (there was no fall mat observed on the right side), the call light is not in reach and is observed to be draped over the bedside table with the button on the far side by the wall, away from the Resident, there was no purposeful rounding sheet posted on the door or anywhere in the room. - 7:31 A.M., In bed with bed low to the ground and a fall mat on the Resident's left side (there was no fall mat observed on the right side), the call light is observed to be draped over the bedside table with the button on the far side by the wall not in the Resident's reach, there was no purposeful rounding sheet posted on the door or anywhere in the room. (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 with observation on 8/9/24 at 8:19 A.M., UM #1 observed Resident #50 who was in his/her bed. The Resident had the bed in a low position and there was one fall mat on the Resident's left side, but no fall mat on the right side. The UM said she was unsure as to why there was no purposeful rounding sheet on the Resident's door or in his/her room and confirmed the Resident was still on purposeful rounding. She said it was not good that the Resident did not have access to his/her call bell since it was draped over the bedside table out of reach. She said she was unaware of the Resident's need for bilateral fall mats and would have to check the care plan and Kardex. She said Resident #50 is a high risk for falls and all of his/her interventions should be in place per the care plan at all times in hopes of preventing further falls. She reviewed the 8/8/24 purposeful rounding sheet with the surveyor and said the sheet was incomplete and only completed at 8:00 A.M., 10:00 A.M., and 12:00 P.M., and should be completed at each interval to be a fully implemented and effective intervention and she does not know why it was not. She said there is no way to tell if the staff are rounding on the Resident and completing purposeful rounding as in intervention if they do not complete the sheet daily and the staff do not appear to be following the falls interventions and care plan as they should be. On 8/9/24 at 8:42 A.M., the surveyor observed Resident #50 out of bed in his/her Broda chair sitting in their room with their breakfast tray in front of them. The Resident said they needed assistance with their drink and usually had a sip cup. The Resident said he/she did not know where the call light was to call the staff for help. The call bell was observed to be draped over the bedside table behind the Resident's chair and out of their reach. The surveyor alerted staff to the Resident's need for assistance. During an interview with observation on 8/9/24 at 8:47 A.M., the DON entered Resident #50's room with the cup he/she requested. She said the Resident is a fall risk and is on purposeful rounding and that the program starts each day at midnight and the night shift staff put the sheets out each night. She said she is unsure as to why this Resident did not have a purposeful rounding sheet and she would have to check with the UM because one should be in place. She said the Resident should have his/her call light at all times as well and retrieved the call bell from behind the Resident over the bedside table and handed it to the Resident. She said the Resident should have been given their call light so they could contact staff if they needed anything. (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 8/9/24 at 9:46 A.M., UM #1 reviewed the medical record for Resident #50 including the care plans, fall incident reports and Kardex with the surveyor. She said there are instances in which interventions should have already been in place and were put on the care plan and Kardex a second time and that shouldn't have happened if they were already implemented as they should have been. She said the incident report from 3/3/24 indicated the Resident did not have their fall interventions in place and required a brief hospitalization and had a laceration to their nose from the fall. She said there is no interventions in place on the care plan for 3/25/24 and thinks it was likely resolved when purposeful rounding started since that would take the place of the every 2 hour night rounding. She said there is no evidence that a new intervention was implemented for the fall that occurred on 5/28/24 and there was no documentation on the care plan or the Kardex to show that a new intervention was implemented as it should have been. She said now that each fall is being broken down and looked at as a group she can see how the process is not working and interventions need to be specific to the cause of the fall, documented so they are known by all staff and implemented to improve the safety of the Resident and prevent further falls. She said it is apparent that interventions are not consistently implemented as they should be and it has appeared to cause further falls for the Resident. She said there is no fall packet or investigation for the 6/5/24 fall and she does not know why it cannot be located to show whether or not the fall investigation process was complete. She said the process for reviewing falls is that she checks the packets for completeness and then forwards them to the DON. She said they discuss the falls in general but not necessarily all the details or each new intervention. She said the Kardex is cluttered and difficult to read and that may be a factor in why she did not notice that interventions put in place should have already been in place. She said the process does not appear to be working as it is intended to and needs some work. She said she can confirm that the Resident was observed this morning by herself and the surveyor without all his/her safety interventions in place to prevent future falls in accordance with the care plan and the care plan was not implemented as it should have been. During an interview on 8/9/24 at 11:32 A.M., the DON said the expectation is that safety interventions for falls are consistently implemented and a new intervention is put in place related to the cause of the fall following each incident to ensure the Resident remains safe and in an effort to prevent further falls or injuries. She said the process had not been consistently followed as it should have been.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42742 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for the care of an indwelling catheter (tube inserted into the bladder to drain urine into a collection bag outside the body) for one Resident (#18), out of total sample of 17 residents. Specifically, the facility failed to ensure staff were consistently providing Foley catheter care and ongoing assessment to help prevent catheter-related urinary tract infections and any related problems. Findings include: Review of the facility's policy titled Catheter Care - Indwelling, revised July 2006, indicated but was not limited to the following: Purpose: -To ensure that indwelling catheters are patent. -To minimize the risk of catheter-associated urinary tract infections and its related problems. -To observe for increased sedimentation, mucous, crepitus, presence of hematuria or decreased drainage. Procedure: -Wash resident's perineal area with soap per-wash and warm water. -Roll catheter gently between fingers near the meatus to check for pressure of crepitus (feels like sand in the tubing and indicates the need for changing the catheter) -Observe the connection of the catheter to drainage bag for cracks in tubing. -Observe drainage tubing and bag for cracks or discoloration to indicate need for a new bag. -Observe urine flow for amount, color, odor, presence of sediment, mucous or blood. -Catheter care should be done at least twice daily. -Empty the catheter drainage bag at least every 8 hours or as necessary. -Cleanse the spigot on the drainage bag with an alcohol wipe before and after emptying. -Chart catheter care on appropriate nurse's notes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Note amount, color, and clarity or urine output and include any pertinent observations regarding the catheter. -An unobstructed urine flow and a closed sterile drainage system should be maintained. Resident #18 was readmitted to the facility in March 2024 and had diagnoses including urinary tract infection, benign prostatic hyperplasia (BPH-enlarged prostate), type 2 diabetes mellitus, obstructive and reflux uropathy, visual impairment, and infection and inflammatory reaction due to indwelling urethral catheter. Review of the Minimum Data Set (MDS) assessment, dated 6/5/24, indicated Resident #18 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had an indwelling urinary catheter, and had no unhealed wounds, or skin problems. The MDS also indicated the Resident required partial to moderate assistance by staff for personal hygiene and required substantial to maximum assistance by staff for toileting and bathing. Review of the Indwelling Urinary Catheter care plan, initiated 10/7/22, indicated but was not limited to the following: Problem: -Need for indwelling urinary catheter related to BPH, obstructive uropathy, status post transurethral resection of the prostate (TURP) (surgical procedure that involves removing part of the prostate gland through the urethra) 12/12/22 and lithotripsy on 9/19/22. Resident has Foley catheter changes monthly at urology. Goal: -The resident will have a patent indwelling urinary catheter without complication. Foley and bag changed monthly at urologist. Approach: -Consults as ordered, 4/11/23 -Assess and document complications and update physician as needed, 4/11/23 -Medications and treatments as ordered, 4/11/23 -Indwelling urinary catheter care as ordered, 4/11/23 Review of current Physician's Orders and the July and August 2024 Medication Administration Records (MAR)/Treatment Administration Records (TAR) did not indicate Resident #18 had a Foley catheter care order in place and failed to indicate orders for Foley catheter care, observation, and monitoring. Further review of the medical record failed to indicate Foley catheter care was being consistently provided by staff and documented in the appropriate nurses' notes twice daily per facility policy to minimize the risk of catheter-associated urinary tract infections and its related problems. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/24 at 11:08 A.M. and 8/6/24 at 11:42 A.M., the surveyor observed Resident #18 lying in bed. His/her Foley catheter was draining yellow urine into the urinary collection bag. During an observation with interview on 8/7/24 at 9:55 A.M., the surveyor observed Resident #18 lying in bed. His/her Foley catheter was draining yellow urine with sediment (can make the urine look cloudy, can be a sign of a number of conditions) into the urinary collection bag. Resident #18 denied signs or symptoms of a urinary tract infection (UTI) but said his/her UTIs come and go. When asked if he/she was currently being treated for a UTI, he/she said, I never know. Review of the Anti-Infective Agent report indicated Resident #18 was most recently treated for a UTI on 3/7/24 and 5/7/24. During an interview with Nurse #9 and Unit Manager (UM) #1 on 8/8/24 at 9:15 A.M., the surveyor reviewed the medical record with Nurse #9 who said Resident #18 did not currently have a UTI but did about a month ago. She said staff should be doing Foley care daily. She said the Resident was followed by urology monthly for catheter changes and had an appointment to have a suprapubic catheter (small incision into the abdomen where a medical device helps to drain urine from your bladder) but then didn't want to do it. Nurse #9 said the Resident's penis was bad, really bad because the catheter had been in place for so long. She said the Resident got frequent UTIs with the last being in June. She said the Resident got periods of inflammation at the Foley insertion site but was okay right now. Nurse #9 said there wasn't an order for Foley catheter care. UM #1 said the Resident was followed monthly by urology. UM #1 said there was nowhere to document catheter care on the MAR/TAR, but the Resident was good at telling staff if he/she had symptoms. During an interview on 8/8/24 at 10:31 A.M., UM #1 said she wasn't sure what type of care is needed for Foley catheter care or where it's documented but would review the policy. During an interview on 8/8/24 at 1:49 P.M., UM #1 said Foley catheter care should be done at least twice daily and documented per facility policy in nurses' notes. The surveyor reviewed the medical record with UM #1 who said that this was not being done consistently. She said Foley catheter care is needed to monitor for signs and symptoms of infection and to monitor for any changes that may occur. She said she could not show the surveyor that this was being done/documented consistently. During an interview on 8/12/24 at 10:19 A.M., the Director of Nursing (DON) said the Resident was admitted with a Foley catheter and had bleeding on/off at the catheter site and the whole penis was basically split in half which put him/her at higher risk for complications and had legal blindness so couldn't see it. She said the Resident was followed by urology monthly and the plan was for a suprapubic tube to minimize the risks. The DON said there's an order set they put in for Foley catheter care which would include catheter care each shift including emptying the drainage bag, changing the drainage bags, and looking at the urine to see how it looks. She said staff should be documenting it and nurses should be looking for sediment, signs and symptoms of infection, patency, flushing, all of that. She said the purpose is to monitor for signs and symptoms, urinary output, and hematuria (blood in the urine). The DON said there was no order set entered. She said catheter care should be done every shift and documented by nurses on the MAR, nurse progress notes, and CNA documentation in the electronic system, and should be consistently done. She said care plan interventions for the Resident's Foley catheter were not implemented consistently.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observation, record review, and staff interview, the facility failed to store, prepare and serve food in accordance with professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to properly label, date, and store food products in two of two nourishment kitchenettes. Findings include: Review of the facility's policy titled Safe Handling for Food Brought in From Visitors, dated effective , d+[DATE], indicated but was not limited to: - It is [Facility Name's] policy to assist residents in properly storing and safely consuming foods brought into the center for residents by visitors. - When food items are intended for later consumption, the responsible staff member will label foods with resident name and current date. - Refrigerator/freezers for storage of food brought in by visitors will be properly maintained. - Daily monitoring for refrigerated storage duration and discard of (sic) any food items that have been stored for maximum of 48 hours. On [DATE] at 4:07 P.M., the surveyor observed the following on the [NAME] Unit nourishment kitchenette: - Nectar thick lemon water opened and dated [DATE]. The manufacturer label on the container indicated the product should be discarded seven days after opening. - Nectar thick orange juice opened and dated [DATE]. The manufacturer label on the container indicated the product should be discarded seven days after opening. - Nectar thick cranberry juice opened and dated [DATE]. The manufacturer label on the container indicated the product should be discarded 10 days after opening. - Bologna and cheese sandwich in plastic container with no labeling or date. - A 12-ounce can of Wild Cherry Pepsi with no labeling or date. On [DATE] at 8:16 A.M., the surveyor observed the following on the [NAME] Unit nourishment kitchenette: - Nectar thick lemon water opened and dated [DATE]. The manufacturer label on the container indicated the product should be discarded seven days after opening. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Mayflower Place Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 579 Buck Island Road West Yarmouth, MA 02673	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Nectar thick orange juice opened and dated [DATE]. The manufacturer label on the container indicated the product should be discarded seven days after opening. - Nectar thick cranberry juice opened and dated [DATE]. The manufacturer label on the container indicated the product should be discarded 10 days after opening. - Bologna and cheese sandwich in plastic container with no labeling or date. - A 12-ounce can of Wild Cherry Pepsi with no labeling or date. On [DATE] at 8:21 A.M., the surveyor observed following on the [NAME] Unit nourishment kitchenette: - Nectar thick orange juice opened and dated [DATE]. The manufacturer label on the container indicated the product should be discarded seven days after opening. - Nectar thick apple juice opened with no date. The manufacturer label on the container indicated the product should be discarded 10 days after opening. - Honey consistency milk opened with no date. The manufacturer label on the container indicated the product should be discarded seven days after opening. During an interview on [DATE] at 12:00 P.M., Food Service Director (FSD) #2 said dietary staff are responsible for stocking and cleaning nourishment kitchenettes in the facility. During an interview on [DATE] at 1:39 P.M., FSD #1 said dietary aides are responsible for cleaning kitchenettes, including removal of expired products. The FSD #1 said all items should be labeled with a resident name and date. FSD #1 said all items brought in for residents from visitors should be discarded within 48 hours. FSD #1 said items outside the manufacturer's date should be discarded.

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F 0849

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48362

Based on interview and record review, the facility failed to ensure services were coordinated with the hospice provider to implement the resident's plan of care as required in the provider contract agreement for three Residents (#30, #21, #50), out of a total sample of 17 residents. Specifically, the facility failed:

1. For Resident #30, to provide on-going documentation, and maintain a complete medical record of services to ensure prompt and effective communication for continuity of care for the Resident;

2. For Resident #50, to ensure a current signed recertification statement for hospice eligibility and a schedule of hospice services were available in the medical record to maintain continuity of care; and

3. For Resident #21, to provide a schedule of hospice services, including involvement and collaboration of the coordinated plan of care.

Findings include:

Review of the facility's policy titled Palliative or Hospice Care, dated [DATE], indicated but was not limited to:

- To ensure that all residents who might benefit from palliative/hospice care and/or their designated health care agent are provided with information about, and access to, palliative/hospice care in order to prevent or relieve pain and suffering and to enhance the resident's quality of life, consistent with resident needs and preferences.

- Document the resident's acceptance or refusal to receive such services in his/her progress notes, as well as if/when such services are accessed, and any changes in services that are made.

- Include the need/choice for palliative/hospice care, if applicable, and all palliative/hospice-care related services on the resident's care plan.

- Provide on-going case management and monitoring of the resident and notify the Medical Provider of any abrupt or progressive changes.

1. Review of the facility's Hospice Agreement, dated [DATE], indicated but was not limited to the following:

- Records: Facility shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Inpatient Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines.

(continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Records: Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. Resident #30 was admitted to the facility in [DATE] with diagnoses including dementia, depression and anxiety. Review of the Physician's Orders failed to indicate an order for admission to hospice. Review of the black hospice binder for Resident #30 on the unit failed to included the following: - Current/active Hospice Certification and Plan of Care; - Documentation of any visits occurring after [DATE] by nursing, home health aides (HHA) or social services; and - A current schedule of services for nursing and/or HHA services provided to the Resident. During an interview on [DATE] at 12:50 P.M., Unit Manager (UM) #2 said the facility receives a schedule from Hospice providers. UM #2 said he was not sure where the Hospice schedule was posted on the unit. UM #2 looked for the posted schedule on the unit but was unable to locate. UM #2 said the Hospice provider usually has a schedule, but it was not posted on the unit. During an interview on [DATE] at 1:02 P.M., Nurse #2 said she was unaware of what information should be included in the Resident's Hospice binder. 49425 2. Resident #50 was admitted to the facility in [DATE] with diagnosis including Cerebral Vascular Accident (poor blood flow to the brain causes cell death) (CVA). Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #50 had moderate cognitive impairment as evidenced by score of 9 out of 15 on the Brief Interview for Mental Status (BIMS). Additionally, he/she was receiving Hospice services. Review of the Physician's Orders indicated Resident #50 had been admitted to Hospice services [DATE] with a diagnosis of CVA. Review of the Hospice Binder for Resident #50 had a recertification statement, dated [DATE], with a benefit period of [DATE] through [DATE]. The binder did not include the current recertification period as required. Additionally, there was no Hospice staff schedule located in the binder or on the unit, to provide continuity of care between the facility and the Hospice provider. (continued on next page)

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	225374	A. Building B. Wing	08/12/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with observation on [DATE] at 12:07 P.M., UM #1 said Hospice updates the binders with the documentation needed. She said the binder should have the current recertification period included. UM #1 said the recertification expired on [DATE], and the hospice record is incomplete. Additionally, she said the hospice schedule gets emailed weekly and gets posted in the nursing communication room. UM#1 and surveyor observed the communication room, and there was no schedule posted. She said the schedule is not posted as it should be. During an interview on [DATE] at 12:21 P.M., Social Worker #2 (SW) said the Hospice team updates all communications in the resident binders. She said she is responsible for checking the binders weekly to ensure all documentation is provided. SW #2 reviewed Resident #50's Hospice binder with surveyor and said the recertification period is not current. She said her expectation is for the binder to be up to date with the current recertification period. 31830 3. Resident #21 was admitted to the facility in [DATE] with diagnoses which included acute respiratory failure and adult failure to thrive. Review of the current Physician's Orders included: - Admit for Hospice, date ordered, [DATE] Review of the medical record indicated a Hospice Certification and Plan of Care with Certification period of [DATE] through [DATE]. The plan of care indicated frequency and duration of visits for the skilled nurse to be one time weekly for nine weeks and for the Home Health Aide, twice weekly for nine weeks. During an interview on [DATE] at 11:30 A.M., Nurse #5 said Resident #21 received hospice services but she was not aware of an official schedule of hospice services and not aware of the day or time services were provided to Resident #21. During an interview on [DATE] at 3:15 P.M., the Director of Nursing (DON) said she would expect the most recent Hospice certification to be in the record. The DON said she would expect all documentation including notes from Hospice nurse and HHA to be included in the record. The DON said she would expect a physician's order for admission to hospice to be present in the medical record. The DON said the Hospice provider schedule should be posted on the unit or in the Residents' record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections when the facility was currently experiencing an outbreak of COVID-19 infection. Specifically, the facility failed to: 1. Ensure proper COVID-19 outbreak testing procedures were implemented for 3 of 3 facility staff members reviewed representing 2 of 2 COVID-19 affected units; 2a. Ensure staff rapid antigen COVID-19 testing (BinaxNOW) was conducted in a manner that is consistent with current standards of practice and manufacturer's instructions for use for 3 of 3 staff members observed; and b. Ensure proper infection control practices were followed while conducting rapid COVID-19 outbreak testing of staff using BinaxNOW antigen testing cards; and 3. Ensure staff implemented appropriate use of personal protective equipment (PPE) for the care of COVID-19 positive residents to prevent unnecessary exposure and the potential spread of COVID-19 infection and ensure signage displayed outside resident rooms were accurate to reflect the type of transmission-based precaution and the PPE to be used. Findings include: Upon entrance to the facility on [DATE] at 7:30 A.M., the surveyor observed a COVID-19 outbreak posting that indicated that, as of 8/5/24, the facility had 23 total positive residents (four residents on the [NAME] Unit and 19 residents on the [NAME] Unit) and seven positive staff members. During an interview on 8/5/24 at 2:01 P.M., the Infection Preventionist (IP) said the facility was currently experiencing a COVID-19 outbreak which started on 7/13/24 when two staff members had tested positive. She said all residents and staff on the [NAME] Unit were being tested as part of outbreak testing procedures. She said the first resident tested positive on the [NAME] Unit on 7/23/24 and that the second unit ([NAME] Unit) became affected after a resident tested positive there on 7/28/24. The IP said the facility was currently performing outbreak testing of all staff and residents on the affected units starting within 48 hours after the potential exposure, then every 48 hours thereafter until the facility goes seven days without a new COVID-19 case. She said these criteria had not been met yet. The IP said the expectation was for staff to test prior to their shift or if symptomatic. During an interview on 8/7/24 at 7:44 A.M., the IP said the facility used Massachusetts Department of Public Health (DPH), Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS) guidance, whichever is the most recent. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Review of the Massachusetts Department of Public Health (DPH) Memorandum titled Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents, Including Visitation Conditions, Communal Dining, and Congregate Activities, dated May 10, 2023, indicated but was not limited to the following: - Long-term care facilities are required to perform outbreak testing of residents and staff as soon as possible when a case is identified. - If the long-term care facility identifies that the resident or staff member's first exposure occurred less than 24 hours ago, then they should wait until 24 hours after any exposure, if known. -Once a new case is identified in a facility, following outbreak testing, long-term care facilities should test exposed residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case unless the DPH epidemiologist directs otherwise. -Residents and staff who are recovered from COVID-19 in the last 30 days can be excluded from this testing. Review of the facility's policy titled Coronavirus Disease (COVID-19) - Testing Staff, undated, indicated but was not limited to the following: Staff in the facility, including all paid and unpaid individuals with potential for direct or indirect exposure to residents or infectious materials, are tested for SARS-CoV-2 virus as indicated to detect the presence of current infections (viral testing) and to help prevent the transmission of COVID-19 in the facility. -An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. Outbreak response is guided by the infection preventionist, in conjunction with the public health authority for the facility jurisdiction. -Viral testing of all staff (regardless of vaccination status) is conducted if there is an outbreak in the facility. Testing approaches may consist of contact tracing (focused testing) or broad-based (facility wide or group-level) testing. -When utilizing broad-based testing, all residents and staff identified as close contacts or on the affected unit(s) are tested , regardless of vaccination status. -As part of the broad-based approach, testing will continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), will be considered. On 8/7/24 at 4:45 P.M., the surveyor reviewed timecards and schedules worked for three randomly sampled staff (Staff #4, Staff #5, Staff #6) who were identified by the IP as being close contacts or on the affected units and were to be included in the facility's current COVID-19 outbreak testing protocol. The staff were as follows: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Review of Nurse #4's July and August 2024 timecard indicated that she had worked on the following days since the start of the current COVID-19 outbreak that occurred on 7/13/24 on the [NAME] Unit after a staff member had tested positive with the first resident testing positive on 7/23/24: -7/13, 7/17, 7/19, 7/20, 7/26, 7/27, 7/31, 8/2, and 8/3 on the [NAME] Unit -8/7 on the [NAME] Unit Review of the staff COVID-19 Positive Line Listing did not indicate Nurse #4 had recently recovered from COVID-19 in the past 30 days, therefore, would not be excluded from testing. Review of the staff July and August 2024 Testing Logs failed to indicated Nurse #4 conducted COVID-19 outbreak testing as required for any of the dates worked. During an interview on 8/7/24 at 8:07 A.M., Nurse #4 was observed on a medication cart in front of a resident's room on the [NAME] Unit. Nurse #4 said she tested prior to her shift that day in the library then said there were supplies on the unit. Nurse #4 then said, I didn't test and asked the IP who was nearby where she was supposed to test. Review of the resident COVID-19 Positive Line Listing provided by the IP on 8/7/24 at 12:04 P.M. indicated there were currently six residents residing on the [NAME] Unit that had active COVID-19 infection at that time. b. Review of Nurse #5's July and August 2024 timecard indicated that he/she had worked the following days on the [NAME] Unit: -7/13, 7/15, 7/18, 7/25, and 7/26 Review of the staff COVID-19 Positive Line Listing did not indicate Nurse #5 had recently recovered from COVID-19 in the past 30 days, therefore, would not be excluded from testing. Review of the staff July 2024 Testing Logs failed to indicate Nurse #4 conducted COVID-19 outbreak testing as required for any of the dates worked. c. Review of Nurse #6's July and August 2024 timecard indicated that he/she had worked on the following days after the first resident had tested positive for COVID-19 on the [NAME] Unit on 7/28/24: -7/28, 7/29, 7/30, 7/31, 8/3, 8/4, 8/5, 8/6, 8/7, all on the [NAME] Unit Review of the staff COVID-19 Positive Line Listing did not indicate Nurse #6 had recently recovered from COVID-19 in the past 30 days, therefore, would not be excluded from testing. Review of the staff July and August 2024 Testing Logs failed to indicated Nurse #6 conducted COVID-19 outbreak testing as required for any of the dates worked. Further review of the staff July and August 2024 Testing Logs failed to indicate any documentation of staff outbreak testing from 7/13/24 (start of outbreak) through 7/16/24 and 7/24/24 through 7/30/24 (continued outbreak). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2a. Review of the [NAME] BinaxNOW COVID-19 Ag Card product insert, revised April 2021, indicated but was not limited to the following: -The BinaxNOW COVID-19 Ag Card is a lateral flow immunoassay for the qualitative detection of the nucleocapsid protein antigen to SARS-CoV-2 directly from the anterior nasal (nares) swab specimens collected from individuals who are suspected of COVID-19 by their healthcare provider within seven days of the onset of symptoms. Precautions: -Proper sample collection, storage, and transport are essential for correct results. -Inadequate or inappropriate sample collection, storage, and transport may yield false test results. Test Procedure: -To collect a nasal swab sample, carefully insert the entire absorbent tip of the swab (usually 1/2 to 3/4 of an inch (1 to 1.5 cm) into the nostril. Firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall 5 times or more for a total of 15 seconds, then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril. -Read result in the window 15 minutes after closing the card. In order to ensure proper test performance, it is important to read the result promptly in 15 minutes, and not before. Results should not be read after 30 minutes. Review of COVID Testing Instructions, dated September 2023, displayed on the testing wall indicated but was not limited to the following: -Give both nostrils a shallow swab for about 15 seconds on each side. -Return to check your results after 15 minutes. -Interpret your results. -Record your test results next to your name on the sheet provided. -Throw away completed test once results are recorded. On 8/7/24 at 7:17 A.M., the surveyor observed Staff #1 conduct rapid antigen COVID-19 outbreak testing in the library (designated testing room). The surveyor observed Staff #1 insert the absorbent tip of the nasal swab in each nostril rotating the swab in a circular motion only 3 times in each nostril, not 5 times or more for a total of 15 seconds per manufacturer's instructions for use (IFU). There was no testing log available at the testing station for documentation. Staff #1 said he/she wasn't sure where the pad of paper went that had their names and dates at the top of it. Staff #1 said today was a staff testing day and they were required to do it every other day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation with interview on 8/7/24 at 7:21 A.M., the surveyor observed Staff #2 conduct rapid antigen COVID-19 outbreak testing in the library. Staff #2 closed and sealed the test card at 7:24 A.M. and did not label the card with the time. Staff #2 said staff are required to test every time they come in for work prior to their shift and before they go on the nursing floor. Upon completion of the test, Staff #2 said the IP usually checks the results and he/she just reports to the unit and doesn't wait for the results. Staff #2 exited the testing room and did not return within the required time frame to interpret the results or document them. On 8/7/24 at 7:25 A.M., the Infection Preventionist (IP) entered the library and placed the staff testing log on top of the testing cart for staff to document. On 8/7/24 at 7:25 A.M., the surveyor observed Staff #3 conduct rapid antigen COVID-19 outbreak testing in the library. The surveyor observed Staff #3 insert the absorbent tip of the nasal swab in each nostril rotating the swab in a circular motion only 3 times in each nostril, not 5 times or more for a total of 15 seconds per manufacturer's IFU. On 8/7/24 from 6:45 A.M. through 8:05 A.M., only three staff members had reported to the library to conduct COVID-19 outbreak testing prior to their shift. During an interview on 8/7/24 at 7:44 A.M., the IP said all staff were required to test prior to their shift today as it was a testing day but were not required to wait for their results prior to reporting to their assigned unit. She said staff could test at home as well prior to their shift and will just tell her if they're positive, that's how she monitors it. She said there was no oversight to ensure staff were conducting outbreak testing as required. The surveyor requested documentation of staff home testing results. The IP said she didn't have any. When asked how staff knew when to interpret results if there were no times written on the testing cards, she said she knew and the testing cards should be read at 15 minutes, but the results wouldn't change after that one way or the other. During an interview on 8/7/24 at 8:08 A.M., CNA #1 was observed working on the [NAME] Unit. He said he had not tested that day prior to his shift but was supposed to. During an interview on 8/7/24 at 8:12 A.M., Nurse #8 was at a medication cart on the [NAME] Unit and said he tested negative at home prior to his shift that day but did not document the results anywhere when he arrived to work or tell anyone, and no one had asked him. During an interview on 8/7/24 at 8:14 A.M., the Director of Nursing (DON) said she could not provide to the surveyor any documentation of at home staff testing this day. During an interview on 8/7/24 at 9:03 A.M., Housekeeping Staff #1 was observed working on the [NAME] Unit. She said she did not conduct COVID-19 outbreak testing that day and asked the surveyor if she was supposed to. During an interview on 8/8/24 at 8:41 A.M., the IP said she didn't have any other testing logs to provide to the surveyor upon request. She said they had not been good at documenting staff testing at home or in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. On 08/07/24 at 6:53 A.M., the surveyor observed the facility's staff COVID-19 testing station/cart in the library. There was an absorbent pad resting on top of the testing cart with three sealed BinaxNOW COVID-19 Ag Cards with the nasal swabs still inserted. All three testing cards were labeled with staffs' names and dated 8/6/24, the day prior. There were no times written. The BinaxNOW COVID-19 Ag testing cards were not properly disposed of after use per infection control standards of practice. During an interview on 8/7/24 at 7:26 A.M., the IP said the testing cards from the day prior should have been disposed of after use. 3. Review of the Centers for Disease Control and Prevention, Infection Control Guidance: SARS-CoV-2, dated 6/24/24 indicated the following: - HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Review of the Massachusetts Department of Public Health (DPH) Memorandum titled Comprehensive Personal Protective Equipment (PPE) Guidance, dated May 2023, indicated but was not limited to the following: -DPH recommends that a fit-tested N95 filtering facepiece respirator or alternative and eye protection be used when caring for patients with suspected or confirmed COVID-19. If there is any contact with potentially infectious material, an isolation gown and gloves should also be used. Review of the Massachusetts Department of Public Health (DPH) Memorandum titled Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents, Including Visitation Conditions, Communal Dining, and Congregate Activities, dated May 10, 2023, indicated but was not limited to the following: -Residents with COVID-19 may be released from isolation after five days from symptom onset, if afebrile for at least 24 hours, any symptoms have improved and they have a negative viral test collected on day five or late or, if asymptomatic, after five days from specimen collection date of the positive COVID19 test and have a negative viral test collected on day five or later. These residents must wear a mask around others through day 10. Recommended Sign for Resident Room: COVID-19 Positive Residents - Isolation Sign COVID-19 Suspected Residents (i.e. symptomatic, with test results pending) - Isolation Sign Review of the facility's policy titled Coronavirus Disease (COVID-19) - Using Personal Protective Equipment, undated, indicated but was not limited to the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Mayflower Place Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 579 Buck Island Road West Yarmouth, MA 02673	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-When caring for a resident with suspected or confirmed SARS-CoV-2 infection, personnel who enter the room of a resident will adhere to standard precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. -An N95 respirator is donned before entry into the resident room or care areas. -Disposable respirators are removed and discarded after exiting the resident's room or care area and closing the door. -Eye protection (goggles or face shield) is applied upon entry to the resident room or care area. -Non-sterile gloves are applied upon entry into the resident room or care area. -A clean isolation gown is donned upon entry into the resident room or area. Review of the facility's policy titled Isolation - Initiating Transmission-Based Precautions, undated, indicated but was not limited to the following: -When transmission-based precautions are implemented, the infection preventionist (or designee): a. clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used; and d. determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precaution: (1). The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. [NAME] Unit a. On 8/5/24 at 9:38 A.M., the surveyor observed CNA #6 enter a resident's room wearing a gown, gloves, and surgical facemask. An isolation contact/droplet precaution sign was posted outside the resident's room indicating that staff were required to wear eye protection, a gown, and gloves at the door. The sign also indicated staff must wear a fit tested N95 mask or higher when performing aerosol-generating procedures. CNA #6 did not don (to put on) an N95 respirator or eye protection prior to entering the room. A PPE cart was located directly outside the resident's room stocked with face shields and N95 respirators. Review of the resident COVID-19 Line Listing indicated the resident tested positive for COVID-19 on 8/4/24 and was still on isolation precautions. The type of transmission-based precaution sign displayed by the facility was not appropriate for the type of PPE required for use by staff upon entering the COVID-19 positive resident's room. During an interview on 8/5/24 at 3:13 P.M., CNA #6 said she didn't know she had to wear an N95 facemask and face shield in the room. She said it was a COVID-19 positive room but didn't know until after lunch so would wear them now. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. During an observation with interview on 8/5/24 at 9:39 A.M., the surveyor observed CNA #10 enter a resident's room wearing a gown, gloves, and surgical facemask. A quarantine droplet/contact precaution sign was posted outside the resident's room indicating eye protection, a gown, and gloves were required to enter the room. The sign also indicated a facemask was acceptable if an N95 mask was not available. CNA #10 did not don an N95 respirator or eye protection prior to entering the room to retrieve a breakfast tray. A PPE cart was located directly outside the resident's room stocked with face shields and N95 respirators. CNA #10 said he didn't wear an N95 or eye protection because he was just getting a tray. Review of the resident COVID-19 Testing Log indicated that the resident tested positive for COVID-19 on 7/31/24 and 8/5/24. The signage displayed was not accurate to reflect the type of precaution. c. On 8/5/24 at 9:54 A.M., the surveyor observed CNA #11 inside a residents' room wearing personal eyeglasses, a gown, gloves, and surgical mask. An isolation droplet/contact precaution sign was posted outside the room indicating that eye protection, a gown, and gloves must be worn to enter the room. The sign also indicated that an N95 respirator was required, but a facemask was acceptable if an N95 was not available; fit tested N95 or higher to be worn for aerosol generating procedures. CNA #11 did not don an N95 facemask or eye protection. A PPE cart was observed directly outside the room which contained N95 facemasks and disposable face shields. On 8/5/24 at 9:59 A.M., the surveyor observed CNA #8 hand CNA #11 clean linens through the plastic zip enclosure to the room. CNA #11 was still not wearing an N95 facemask or eye protection. CNA #8 told the surveyor that one of the residents in the room was COVID-19 positive. CNA #8 then donned a gown, gloves, and N95 to enter the room to assist CNA #11. CNA #8 did not don eye protection prior to entering the room. During an observation with interview on 8/5/4 at 10:25 A.M., the surveyor observed CNA #11 exit the resident's room (31 minutes after entering) still wearing her surgical facemask. CNA #11 said she wasn't sure which resident in the room had COVID-19 and didn't usually work on that unit so couldn't answer what the expectation for PPE was upon entering a COVID-19 positive resident's room. She asked CNA #1 who was across the hall and said she was supposed to be wearing full PPE with an N95 facemask upon entering the room. During an observation with interview on 8/5/24 at 10:28 A.M., the surveyor observed CNA #8 exit the resident's room (29 minutes after entering). CNA #8 said it was a COVID-19 positive room and she should have worn eye protection but did not. d. On 8/6/24 at 8:52 A.M., the surveyor observed CNA #2 enter Resident #52's room wearing a surgical mask, gown, gloves, and face shield. A quarantine droplet/contact precaution sign was posted outside the resident's room indicating eye protection, a gown, and gloves were required to enter the room. The sign also indicated a facemask was acceptable if an N95 mask was not available. CNA #2 did not don an N95 facemask. A PPE cart was located directly outside the resident's room stocked with face shields and N95 respirators. CNA #2 was observed to be wearing a surgical facemask throughout her time in the room assisting Resident #52. During an interview on 8/6/24 at 8:54 A.M., the surveyor observed CNA #2 exit the room. CNA #2 said the sign said quarantine, so she was unsure if she needed an N95 or a surgical mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident COVID-19 Line Listing indicated Resident #52 tested positive for COVID-19 on 8/1/24 and remained on isolation precautions. The signage displayed was not accurate to reflect the type of precaution. During an interview on 8/6/24 at 9:34 A.M., CNA #2 said the sign said quarantine, but the Resident was positive for COVID-19. She said she didn't know why the sign said quarantine and that it was ambiguous. During an interview on 8/6/24 at 11:12 A.M., the IP said Resident #19 was COVID-19 positive and should have had an isolation sign displayed, not a quarantine sign, and was in the process of changing it. She said the other sign was wrong. During an interview on 8/8/24 at 11:17 A.M. the surveyor reviewed the findings with the IP and Director of Nursing (DON). The IP said she oversees COVID-19 testing and that the facility was still conducting outbreak testing for residents and staff. She said staff are to test every 48 hours at home or in the facility prior to when their shift starts. She said if staff are testing at the facility, they are to wait 15 minutes, document their test results, then proceed with their day, but staff were masking and using standard precautions, so she wasn't terribly concerned about them waiting. The IP said it was a documentation thing so that's why they're now asking staff to wait. She said the testing log should be maintained, accurate, and complete. She said she could not provide evidence that this was being done. The IP said they started testing on the [NAME] Unit on 7/15/24 and the [NAME] Unit on 7/28/24 and all residents on the unit and staff were included per the facility's outbreak testing protocol. She said all residents and staff were included in outbreak testing regardless of vaccination status unless they were recovered from COVID-19 in the last 30 days and weren't symptomatic. The DON said the facility staff did not follow outbreak testing protocol. The IP and DON said the nostrils only needed to be swabbed 3 times each but then said the instructions posted on the wall said to give both nostrils a shallow swab for about 15 seconds on each side. The IP further said staff were required to wear full PPE including a gown, gloves, N95 facemask, and eye protection in COVID-19 positive rooms including when delivering or retrieving trays. She said the facility was not in a PPE crisis and was receiving a shipment of PPE the next day. She further said all the residents should have had isolation signs and not quarantine signs to reflect the appropriate type of precaution. The DON said there was some confusion with the roommates and that staff were getting very confused. The IP said if residents are still positive on day 5, then they are tested until day 10 and will remove precautions on day 11 as long as they are asymptomatic. The IP said if residents test negative for COVID-19 on day 6 and are asymptomatic, they can be removed from precautions but have to wear a mask outside the room until day 10.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 42742 Based on line listing review, interview, and policy review, the facility failed to implement their antibiotic stewardship program. Specifically, the facility failed to maintain complete surveillance line listing reports to ensure antibiotic use protocols were followed. Findings include: Review of the facility's policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, indicated but was not limited to the following: -Antibiotic usage and outcome data will be collected and documented using a surveillance tracking form. The data will be used to guide decisions for improvement of individual antibiotic prescribing practices and facility-wide antibiotic stewardship. -All resident antibiotic regimens will be documented on the facility tracking form. The information gathered will include: b. symptoms and start date of symptoms f. pathogen identified, if identified, and date identified Review of the facility's policy titled Antibiotic Stewardship - Orders for Antibiotics, revised December 2016, indicated but was not limited to the following: -Appropriate indications for use of antibiotics include: a. criteria met for clinical definition of active infection or suspected sepsis; and b. pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending) Review of the facility surveillance line listings on 8/8/24 at 7:28 A.M. for June 2024 through August 2024 failed to indicate the collection and documentation of signs and symptoms of infection for all residents listed or the date of onset to ensure the minimum criteria for initiation of antibiotics had been met. The line listings also failed to indicate the dates the pathogens were identified. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 12:10 P.M., the surveyor reviewed the line listings with the Infection Preventionist (IP) who said the facility uses the Loeb evidenced based surveillance criteria to define infections including the type of bacteria, what the treatment is, the duration of treatment, and if the infection is facility acquired or not. She said there was no symptom documentation on the facility's monthly tracking tools to determine whether any of the residents listed met the clinical criteria for the initiation of antibiotics. She said she had nothing else to show the surveyor that the residents met the criteria for antibiotic stewardship. The IP said the purpose of an antibiotic stewardship program is to ensure antibiotics are being prescribed in an appropriate manner and treating the appropriate thing, to limit the use of antibiotics, and to prevent multidrug-resistant organisms (MDROs). She said the providers had a little more work to do.