STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225380	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Westfield LLC	60 East Silver Street Westfield, MA 01085

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 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. 42761 Based on observation, interview, and record review, the facility failed to provide care consistent with professional standards of practice relative to the use of compression stockings for one Resident (#51) out of a total sample of 17 residents. Specifically, the facility failed to: -Assess Resident #51 for the proper use of compression stockings for the Resident's lower extremities when the Resident had lower extremity swelling and staff applied improperly fitted compression stockings, which increased the Resident's risk for impaired skin integrity and blood circulation. Findings include: Review of the Cardinal Health document titled T.E.D. (thrombo-embolic-deterrent: type of hosiery used to prevent blood clots) Anti-Embolism (obstruction of an artery, typically by a clot of blood or an air bubble) Stockings, dated 2020 and located at https://www.cardinalhealth.com/content/dam/corp/web/documents/brochure/cardinal-health-ted-anti-embolism-stockings-for-acute-care-brochure.pdf indicated: -T.E.D. Anti-Embolism Stockings have been clinically proven to reduce the risk of developing deep vein thrombosis (DVT: blood clot that forms in a vein) in physician reviewed, published studies on hospitalized patients and to promote increased blood flow velocity in the legs. -For knee length stockings, measure in standing position if possible. -Measure calf circumference at greatest portion to determine size. -Measure the distance from bend of knee to bottom of heel to determine length. -T.E.D. stocking precautions: Proper sizing and application must be assured for optimal benefit of stockings. -It is important to measure the patient's leg size to assure that the appropriate pressure pattern is applied. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51 was admitted to the facility in December 2024 with diagnoses including Fracture of Neck of Left Femur (thigh bone) and Personal History of Pulmonary Embolism. Review of Resident #51's Minimum Data Set Assessment, dated 12/19/24, indicated the Resident: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) of 15 out of 15 total possible points. -had a hip fracture. -demonstrated no rejection of care. -required substantial/maximal assistance to transition from sitting to standing. -required the use of a wheelchair. -required substantial/maximal assistance for lower body dressing. Review of Resident #51's Provider Encounter Note, dated 12/19/24, indicated the Resident had non-pitting (not impacted by pressure) edema (accumulation of excess fluid in soft tissues, causing swelling) to his/her left lower extremity. Review of Resident #51's Provider Encounter Note, dated 12/23/24, indicated the Resident had trace (small amount) edema in his/her right and left lower extremities. Review of Resident #51's Nursing Progress Note, dated 12/24/24, indicated the Resident had 1+ (one plus: 2 millimeter indent with rapid return to normal) pitting (when an external force causes an indentation) edema in his/her lower extremities. Review of Resident #51's Provider Encounter Note, dated 12/27/24, indicated the Resident had trace edema in his/her right and left lower extremities. Review of Resident #51's Activities of Daily Living (ADL) Care Plan, revised 12/30/24, indicated: -The Resident required assistance with ADLs due to decreased strength and endurance, recent left femur fracture, weakness, and pain. -The Resident required substantial/maximal assistance for lower body dressing. -The Resident required substantial/maximal assistance for putting on/taking off footwear. On 1/2/25 at 9:52 A.M., the surveyor observed the following: -Resident #51 was sitting in a wheelchair beside his/her bed. -The Resident's feet were positioned off the floor and resting on the wheelchair foot rests. -The Resident wore full length pants and slipper socks. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The surveyor observed that the Resident's pants were tight around his/her lower legs, below the knees bilaterally and the slipper socks were tight over the Resident's feet and creased over the tops of the Resident's ankles. During an interview at the time, Resident #51 said that he/she had been experiencing swelling in his/her bilateral lower legs and that the swelling had been present prior to being admitted to the facility. The Resident then pulled his/her pant legs up to knee level bilaterally and the surveyor observed T.E.D. stockings on both of the Resident's lower legs. The surveyor further observed both stockings were rolled down under the Resident's knees, forming an indentation directly below both knees, around the full circumference of each of the Resident's lower legs. Resident #51 said that the stockings felt tight right below his/her knees and that he/she did not know why, but the stockings always rolled down. On 1/2/25 at 4:50 P.M., the surveyor observed the following: -Resident #51 was sitting in a wheelchair beside his/her bed. -The Resident's feet were positioned on the wheelchair footrests and the Resident wore the same full length pants observed earlier in the day and slipper socks. -The surveyor observed that the Resident's pants remained tight around his/her lower legs, below the knees bilaterally and the slipper socks were tight over the Resident's feet and creased over the tops of the Resident's ankles. During an interview at the time, Resident #51 said that he/she required assistance from staff for lower body dressing and that due to his/her hip fracture, he/she was unable to put on his/her own pants and socks. Resident #51 said that staff who assisted him/her to get dressed in the morning applied the T.E.D. stockings to help with his/her swelling and that he/she had been wearing the stockings daily for a couple of weeks. At this time, Resident #51 pulled his/her pant legs up to knee level and the surveyor observed the T.E.D. stockings on the Resident's lower legs. The surveyor observed the tops of the stockings were rolled down directly under the Resident's knees, and formed an indentation directly below both knees and around the full circumference of each of the Resident's lower legs. Review of Resident #51's Lower Body Dressing Flow Sheet indicated: -The Resident required substantial/maximal assistance for lower body dressing on 1/2/25. -The Resident required dependence on staff for lower body dressing on 1/3/25. Review of Resident #51's Kardex Report indicated the following for dressing as of 1/3/25: -Substantial/maximal assistance for clothing management. -May need dependent assist if fatigued. During an interview on 1/3/25 at 7:50 A.M., Certified Nurses Aide (CNA) #2 said Resident #51 wore T.E.D stockings every day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/25 at 9:06 A.M., Nurse #3 said she overheard the surveyor speaking with CNA #2 earlier that morning regarding Resident #51 and the use of compression stockings, so she reviewed the Resident's Physician orders and Treatment Administration Records (TARs) to identify whether the Resident had a treatment order for the use of compression stockings. Nurse #3 said that all residents requiring the use of compression stockings needed to have a Physician's order for the stockings. Nurse #3 also said that when compression stockings were ordered by the Physician, the Nurse was required to measure the resident's legs to ensure the proper size stocking was used. Nurse #3 said that when she reviewed Resident #51's Physician's orders and TARs, there was no order for compression stockings. Nurse #3 further said that the compression stockings would only be applied if ordered by the Physician. Nurse #3 said that the facility did not use T.E.D. stockings for any residents and that the facility only used MediGrip Support and Compression Stockings, unless a different stocking was ordered by the Physician. During a follow-up interview on 1/3/25 at 9:22 A.M., Nurse #3 said Resident #51 did have T.E.D. stockings, so the stockings must have come with the Resident when he/she was admitted from the hospital. Nurse #3 said that the Resident needed to be assessed for the use of the compression stockings to ensure the stockings were appropriate for the Resident's condition and an order would need to be obtained. Nurse #3 also said residents need to be measured for the proper size compression stockings to ensure proper fit and that compression stockings should never be rolled down below the knees. Nurse #3 further said that Resident #51 was not able to put on his/her own socks and depended on staff to complete his/her lower body dressing. During an interview on 1/3/25 at 9:51 A.M., the Unit Manager (UM) said that a Physician's order was required for implementing the use of compression stockings for a resident and that the Nurse was required to measure the resident's legs to ensure the proper size stockings were used. The UM said that compression stockings should not be rolled down under a resident's knees and that the top of the stockings should be flat around the circumference of the lower legs. The UM said that Resident #51's compression socks rolling down under his/her knees and causing indentation in the tissue increased the Resident's risk for alteration in skin integrity and impaired circulation due to prolonged pressure.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42761 Based on observation, interview, and record review, the facility failed to provide care according to professional standards of practice for one Resident (#14) out of a total sample of 17 Residents, relative to nutrition interventions and weight monitoring when the Resident was identified as being at nutritional risk and had severe weight loss. Specifically, for Resident #14, the facility failed to: -Implement Provider recommendations in a timely manner for a nutrition consult. -Implement weekly weight monitoring, as recommended by the Physician Assistant (PA) when the Resident was identified with greater than 20 pounds weight loss over a period of two weeks. -Accurately monitor and record the Resident's meal intake percentage. -Accurately assess the Resident for weight loss when the Resident had a severe weight loss of greater than 10% in less than six months. Findings Include: Review of the facility's Policy titled, Weight Assessment and Intervention, dated 2001 and last reviewed March 2022, indicated: -Residents are weighed upon admission and at intervals established by the interdisciplinary team. -Weights are recorded in each unit's weight record chart and in the individual's medical record. -Any weight change of 5% (percentage) or more since the last weight assessment is retaken the next day for confirmation. >If the weight is verified, nursing will immediately notify the dietician in writing. -The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual)/ (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe c. 6 months - 10% weight loss is significant; greater than 10% is severe Review of the Dietary Intake Guide, undated, provided by the facility indicated: -The Dietary Intake Guide was a resource to help measure meals, liquids, . consumed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Record amount of the total meal . consumed using the following guidelines: -Refused - 0% (refused meal completely or consumed only one or two bites of each item). -Poor - 25% (approximately 25% of entree or 50% of one item consumed). -Fair - 50% (approximately half of food is consumed, [e.g., 50% of entree, 25% of vegetable and soup left]. If total entree is consumed but no other food is touched, record as Poor/25%, not Fair/50%). -Good - 75% (majority of meal is consumed but a significant amount of one or more items is left [e.g., 25% of entree or 75% of vegetable left]). -All - 100% (entire meal is consumed except for a minimal amount of food [e.g., less than 25% of vegetable left]). Resident #14 was admitted to the facility in August 2024, with diagnoses including Dementia, Type 2 Diabetes Mellitus, Pure hypercholesterolemia, and Dysphagia. Review of Resident #14's Minimum Data Set (MDS) Assessment, dated 10/31/24, indicated that the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of nine out of 15. Review of Resident #14's Weights and Vitals Summary Report indicated the Resident weighed 195.3 pounds (lbs) on 8/1/24. Further review of Resident #14's Weights and Vitals Summary indicated: -8/8/24: weight of 192.4 lbs -8/15/24: weight of 172.3 lbs -8/15/24: a re-weigh of 170.8 lbs -9/5/24: weight of 171.4 lbs -10/4/24: weight of 165.6 lbs -11/4/24: weight of 168.2 lbs -12/3/24: weight of 166.2 lbs -1/1/25: weight of 165.4 lbs Review of Resident #14's Physician order, dated 8/1/24, indicated: -Monthly weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's Speech Therapy Evaluation, dated 8/2/24, indicated: -The Resident had dysphagia. -Treatment plan included interventions for swallowing dysfunction and/or oral function for feeding. -The Resident required a dysphagia advanced (food that is soft, moist, and easy mashed with a fork) diet texture. Review of Resident #14's Nutritional Care Plan, initiated 8/6/24, indicated: -The Resident had a nutritional problem/potential nutritional problem. -Registered Dietician (RD) to evaluate and make diet change recommendations PRN (as needed) -Provide, serve diet as ordered. -Monitor intake and record every meal. -Weigh as ordered, at same time of day and record. Review of Resident #14's Nursing Progress Note, dated 8/2/24, indicated: -Currently receiving dysphagia diet and in [sic] working with SLP (Speech Language Pathologist). Review of Resident #14's Nutrition Assessment, dated 8/6/24, indicated: -The Resident's usual body weight was not known. -The Resident weighed 195.3 lbs. (weight documented on 8/1/24) -The Resident's body mass index (BMI: numerical value that indicates weight status and estimates body fat) was 31.8. -The Resident was considered as obese, and obesity was not a concern due to advanced age and diagnoses. -The Resident had not experienced significant/severe weight loss or gain. -The Resident was eating well, per documentation. -The nutrition plan included routine surveillance of weight per facility protocol and physician orders, ., offer snacks between meals . -The Registered Dietician (RD) was available as needed. Review of Resident #14's Change in Condition (CIC) Note, dated 8/13/24, indicated the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts). -Functional decline (worsening function and/or mobility). -Other change in condition with recommendations for speech screen. Review of Resident #14's Nursing Progress Note, dated 8/14/24, indicated the following: -The Resident ate less than 25% of two meals. -Staff reported increased coughing during meals. -Speech evaluation requested. Review of the Resident's clinical record indicated the Resident was actively receiving therapy for Speech and Language services on 8/14/24. Review of Resident #14's Weights and Vitals Summary indicated the Resident weighed 172.3 lbs on 8/15/24 (weight loss of 20.1 lbs. from the 8/8/24 weight). Further review of the Resident's Weights and Vitals Summary indicated a re-weigh was obtained on 8/15/24 and the Resident's weight was 170.8 lbs. Review of Resident #14's CIC Form, dated 8/16/24, indicated: -Significant weight loss of approximately 20 lbs. was noted. -Facility staff notified the Physician Assistant (PA) of the weight loss. -The PA recommended: >Supplement drinks three times daily. >Dietician consult. >Weekly weight monitoring. Review of Resident #14's Nursing Alert Progress Note, dated 8/16/24, indicated: -Dietician notified via email. States she (Dietician) will assess Resident. Review of Resident #14's Physician Assistant (PA) Encounter Note, dated 8/27/24, indicated: -Weight loss. -RN (Registered Nurse) reports 20 lbs weight loss over 2 weeks. -Will order health shakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dietary evaluation. -House Supplement three times daily. Review of Resident #14's Weights and Vitals Summary indicated the Resident weighed 171.4 lbs on 9/5/24. Review of Resident #14's Physician Encounter Note, dated 9/17/24, indicated: -Continue health shakes. -Dietician to follow. Review of Resident #14's Speech Therapy Discharge Summary, dated 9/27/24, indicated: -The Resident had met his/her goal for swallowing. -The Resident's diet had been upgraded to regular texture with thin liquids. Review of Resident #14's Physician order, dated 9/27/24, indicated: -CCHO (Consistent Carbohydrate Diet) diet, Regular Texture, Thin Liquids consistency. Review of Resident #14's Weights and Vitals Summary indicated the Resident weighed 165.6 lbs on 10/4/24. Review of Resident #14's Minimum Data Set (MDS) Assessment, dated 10/31/24, indicated: -The Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. -The Resident weighed 166 lbs. -Weight loss of 5% or more in last month or 10% or more in last six months was marked as: -No or unknown. Review of Resident #14's clinical record did not indicate that weekly weights as ordered on 8/1/24, were implemented and were being done consistently for Resident #14. Further review of the Resident's clinical record indicated a nutrition assessment recommended by the PA on 8/16/24, was not completed until 11/1/24 (approximately 2.5 months after the PA recommendation). Review of the Nutrition Assessment, dated 11/1/24, indicated: -The Resident's usual body weight was not known. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident was at potential nutritional risk due to advanced age, varied intake, and triggered for significant weight loss trends. -The Resident's current weight loss was -13.9% over three months (severe). -The Resident weighed 165.6 lbs. -The Resident's BMI was 27. -The Resident started on dietary supplement shakes in August 2024 which may have slowed the Resident's weight loss trend. -No new recommendations were made. Review of Resident #14's Weights and Vitals Summary indicated the Resident weighed 165.4 lbs on 1/1/25. On 1/3/25 between 12:05 P.M. and 12:45 P.M., the surveyor observed the following in the facility's main dining room: -Resident #14 was seated in a wheelchair at a table with one other resident. -Resident #14 was served a meal which included chicken breast, cooked carrots, rice, one dinner roll, and one bowl of pineapple wedges. -The Resident fed him/herself during the meal. -At the end of mealtime, Resident #14 had consumed most of the chicken breast (leaving a few small pieces on the plate) and most of the cooked carrots (leaving a few carrots on the plate). -The Resident did not eat any of the rice and dinner roll and left both food items on the plate. -The Resident did not eat any of the pineapple wedges. During an interview on 1/3/25 at 12:30 P.M., the Resident said that he/she did not have a big appetite, and did not eat much. During an interview on 1/3/25 at 1:45 P.M., Activity Assistant (AA) #1 said that she picked up Resident #14's lunch meal tray on 1/3/25 and that the Resident ate 80% of the meal. Review of the CNA (Certified Nursing Assistant) tasks sheet, dated 1/3/25, indicated meal percentage documented as follows: -51-75% of lunch meal consumed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 8:41 A.M., the surveyor observed Resident #14 eating breakfast. The Resident's meal included one biscuit with jelly, scrambled eggs, cream of wheat, one glass of orange juice, one glass of milk, and one cup of coffee. The surveyor observed that the Resident ate all of the biscuit and jelly, drank all of the orange juice and coffee and ate a few bites of the scrambled eggs. At the end of the meal, the Resident left the rest of the scrambled eggs uneaten, ate no cream of wheat, and drank none of the milk. The surveyor further observed the Resident request that staff remove his/her breakfast meal. During an interview on 1/7/25 at 9:47 A.M., the Unit Manager (UM) said residents at the facility were weighed monthly and some residents required daily and weekly weights. The UM said CNAs weighed residents according to the required frequency determined by the Physician and that after the CNAs obtained resident weights, the weights were to be reviewed by the Nurse. The UM said if there was a change in weight of three to five pounds, a re-weight would be required, and if the weight change was validated, the Nurse would be required to complete a Change in Condition (CIC) form. The UM said that the Nurse would also be responsible to notify the Physician of the weight change. The UM said that she was responsible to notify the Registered Dietician (RD) of the weight change. The UM also said that recommendations made by the Physician when notified of a change in weight would be implemented by the Nurse who obtained the recommendations. The surveyor and the UM reviewed Resident #14's clinical record, and the UM said that facility staff identified Resident #14 as having had a significant change in weight between 8/1/24 and 8/15/24. The UM said that based on the CIC form completed on 8/16/24, facility staff had notified the Physician Assistant (PA) of the weight change, and that the PA recommended implementing dietary supplements, weekly weights, and a consult by the RD. The UM said that she would have to look into whether the weekly weights had been implemented and whether a consult with the RD had occurred. During a follow-up interview on 1/7/25 at 11:52 A.M., the UM said that she was unable to locate any evidence of follow-up with the Physician regarding Resident #14's weight changes and was unable to locate any weekly weight assessments in the Resident's clinical records. The UM further said that there should have been follow-up with the RD to ensure the dietary evaluation was completed and whether any new interventions were recommended. The UM also said that weekly weights should have been implemented for Resident #14 on 8/16/24, but the weekly weights had not been implemented. During an interview on 1/7/25 at 10:20 A.M., the RD said that she recently started working at the facility and that she had recently identified Resident #14 as having had severe weight loss. The RD said that Resident #14 had been identified as having had a greater than 10 percent weight loss over the previous five months. The RD said that she had also identified other residents with significant weight changes and was in the process of evaluating them. The RD said that she had not yet evaluated Resident #14. The RD said that accuracy for monitoring meal percentages was important because meal intake percentages need to be compared with the estimated needs for each resident's nutrition. The surveyor and the RD reviewed Resident #14's clinical record and the RD said that no dietary consult had been provided for Resident #14 when the severe weight change was identified, and the dietary consult was ordered by the PA. The RD further said that the dietary consult was not completed until 11/1/24, and was not completed relative to weight loss, but for a routine quarterly assessment. The RD also said that a dietary consult should have been completed within a week of the 8/16/24 PA request for a consult. (continued on next page)

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Vantage at Westfield LLC	60 East Silver Street Westfield, MA 01085

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 1/7/25 at 11:08 A.M., the RD said the standard for measuring meal intake percentage relative to the items Resident #14 consumed at lunch time on 1/3/25 should have been recorded as 25%-50%. The RD then provided the surveyor with the Dietary Intake Guide used to measure the amounts of meals consumed. During a telephone interview on 1/7/25 at 11:37 A.M., the PA said that she did not work in the facility from July 2024 to November 2024, and that when she returned, she evaluated Resident #14 on 11/13/24. The PA said that a covering PA worked in the facility at that time (July 2024 to November 2024), and Resident #14 would have been assessed in August 2024 by the covering PA. The PA further said that the recommendations ordered by the covering PA for weekly weights and a dietary consult on 8/16/24, should have been implemented for Resident #14 at that same time. During an interview on 1/7/25 at 11:52 A.M., the UM said that weekly weights had not been implemented as ordered by the PA on 8/16/24. The UM also said no dietary consult had been completed until 11/1/24 after being ordered by the PA on 8/16/24. The UM said that facility staff should have followed-up with the RD relative to the ordered dietary consult and any recommended interventions. During an interview on 1/7/25 at 1:31 P.M., the RD said that a higher body mass index (BMI) was considered protective for the nursing facility population and that she would not want to see Resident #14 with a lower BMI than what it was currently (27). During an interview on 1/7/25 at 1:42 P.M., the Physician said that she attended QAPI meetings monthly at the facility and that resident weight variances were discussed at the QAPI meetings. The Physician said that she did not recall the facility discussing weight loss concerns for Resident #14. The Physician said that she was not sure that the facility's initial weight of 195.3 lbs for Resident #14 was accurate, but that there was no information available to indicate that the weight was inaccurate. Please refer to F726.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42761 Based on observation, interview, and record review, the facility failed to ensure that staff competencies were assessed for three employees (Certified Nurses Aides [CNAs #7 and #8], and Activities Assistant [AA #1]) out of three employees reviewed and relative to meal monitoring and documentation for one Resident (#14). Specifically, the facility failed to: -Assess competency for Activities Assistant (AA) #1 relative to accurately monitoring meal percentage intakes when AA #1 was tasked with monitoring and recording resident meal percentage intakes in the facility's main dining room and AA #1 monitored and recorded an inaccurate meal intake for Resident #14. -Assess nursing assistant competencies, identified by the facility for assessment, for CNAs #7 and #8 upon hire, and since working at the facility, when CNAs #7 and #8 were working in the facility and providing direct care to residents. Findings include: Review of the Facility Assessment Work Document, dated 8/5/24, indicated the following: -The facility provided care for residents with cognitive impairments. -The facility provided care for residents requiring assistance with activities of daily living (ADLs). -The facility provided care relative to nutrition for residents. -Staff training/education programs were conducted to provide the level and types of support and care needed for the resident population. -Training programs applied to all facility staff to include direct care staff, managers, supervisors, contracted staff, and volunteers, as appropriate. -Training programs, as appropriate were provided as part of the facility's orientation process for new and newly assigned staff, annually, and/or as needed. -Training programs contain learning objectives, performance standards, and evaluation criteria. Review of the facility policy titled Staffing, Sufficient and Competent Nursing, dated 2001, indicated but was not limited to the following: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. - . the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments, and the facility assessment. -Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles . -Staff must demonstrate the skills and techniques necessary to care for resident needs . -Competency requirements . for nursing staff are established and monitored by nursing leadership . to ensure that gaps in education are identified and addressed . Review of the facility's document titled Facility Orientation Competency: Nursing Assistant, undated, indicated the following: -The evaluator will place their initials in the appropriate column on the line that corresponds to the skill after competency in the area is achieved by employee. -All evaluators are to sign the bottom of this form identifying their signature, title, initials, and date. -Checklist must be complete and handed in prior to coming off orientation. -Topics requiring competency assessment included meal percentage monitoring. Review of the Dietary Intake Guide, undated, provided by the facility indicated but was not limited to the following: -The Dietary Intake Guide was a resource to help measure meals, liquids, . consumed. -Record amount of the total meal . consumed using the following guidelines: >Refused - 0% (refused meal completely or consumed only one or two bites of each item). >Poor - 25% (approximately 25% of entree or 50% of one item consumed). >Fair - 50% (approximately half of food is consumed, [e.g., 50% of entree, 25% of vegetable and soup left]. If total entree is consumed but no other food is touched, record as Poor/25%, not Fair/50%). >Good - 75% (majority of meal is consumed but a significant amount of one or more items is left [e.g., 25% of entree or 75% of vegetable left]). >All - 100% (entire meal is consumed except for a minimal amount of food [e.g., less than 25% of vegetable left]). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14 was admitted to the facility in August 2024 with a diagnoses of Dementia and Dysphagia. Review of Resident #14's Minimum Data Set (MDS) Assessment, dated 10/31/24, indicated the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) of nine out of 15 total possible points. Review of Resident #14's Nutrition Care Plan, revised 11/5/24, indicated: -Diet as ordered (monitor and record). On 1/3/25 between 12:05 P.M. and 12:45 P.M., the surveyor observed the following in the facility's main dining room: -Resident #14 was seated in a wheelchair at a table with one other resident. -Resident #14 was served a meal which included chicken breast, cooked carrots, rice, one dinner roll, and one bowl of pineapple wedges. -The Resident fed him/herself during the meal. -At the end of mealtime, Resident #14 had consumed most of the chicken breast (leaving a few small pieces on the plate) and most of the cooked carrots (leaving a few carrots on the plate). The Resident did not eat any of the rice and dinner roll, or any of the pineapple wedges. During an interview on 1/3/25 at 12:30 P.M., Resident #14 said that he/she liked the food and that he/she just did not have a big appetite. At the same time, the surveyor observed AA #1 approach Resident #14's table, ask the Resident if he/she was done eating, and removed the Resident's meal plate. Review of the facility's Lunch Meal Intake Sheet, dated 1/3/25 and completed by AA #1, indicated Resident #14 consumed 80% of his/her lunch meal that same day. During an interview on 1/3/25 at 1:45 P.M., AA #1 said she recorded meal percentage intakes for residents who ate lunch in the facility's main dining room that same day and that she recorded Resident #14's lunch meal intake percentage. AA #1 said that when she records resident meal intakes, she looks at the residents' plates and estimates how much of the total meal the resident consumed. AA #1 said she recorded Resident #14's lunch meal intake as 80% consumed. AA #1 said that after she completes the Meal Intake Sheet, she leaves the sheet at the nurses station and the meal percentages documented on the sheet are then entered into the residents meal records on the computer by the CNAs. At the time, the surveyor and AA #1 reviewed the Lunch Meal Intake Sheet and discussed the lunch meal observation for Resident #14. AA #1 said that the meal percentage she recorded on the Meal Intake Sheet may have been inaccurate. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/25 at 1:54 P.M., with CNA #7 and CNA #8, CNA #8 said that all resident meal intake percentages are entered into the computer. CNA #7 said that when meal percentages are recorded from staff in the main dining room, the staff bring the completed meal percentage sheet to the nurses station and a CNA enters the meal percentages recorded into the resident meal records on the computer. Review of Resident #14's electronic meal intake record for 1/3/25 indicated Resident #14 consumed 51% -75% of his/her lunch time meal on 1/3/25. During an interview on 1/7/25 at 10:20 A.M., the Registered Dietician (RD) said it was important to have accurate information relative to meal percentage intakes to ensure residents consume percentages of food that matches their estimated dietary needs. The RD said that she was not sure how staff had been trained to monitor and record meal percentages, and offered that the surveyor should ask the Staff Development Coordinator (SDC). During a follow-up interview on 1/7/25 at 11:08 A.M., the RD said the standard for measuring meal intake percentage relative to the items Resident #14 consumed at lunch time on 1/3/25 should have been recorded as 25%-50%. The RD then provided the surveyor with the Dietary Intake Guide used to measure meals consumed. During an interview on 1/7/25 at 11:58 A.M., the SDC said nursing staff competencies were completed during orientation, when staff were newly hired, and annually. The SDC said that competency assessments were recorded on the competency checklists and maintained in the employee education files. The SDC said that meal percentage monitoring was included in topics requiring competency assessment for CNAs and that there was no competency assessment checklist for activities staff. The SDC said that AA #1 does record meal percentages for residents who eat in the main dining room and that AA #1 would have needed to be trained to ensure she was recording meal percentages accurately. The SDC said that she would provide the survey team with evidence that the required competencies had been completed. During a follow-up interview on 1/7/25 at 4:22 P.M., the SDC said CNA #7 began working at the facility on 11/1/23, CNA #8 began working at the facility on 4/29/24, and AA #1 began working at the facility on 7/31/24. The SDC said there was no evidence that any competency assessments had been completed for CNA #7 and CNA #8. The SDC also said there was no evidence competency had been assessed for AA #1 relative to monitoring and recording resident meal percentages.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 50138 Based on record review, and interview, the facility failed to complete a performance review at least once every 12 months for five Certified Nurses Aides ([CNA's] #1, #2, #3, #4 and #5) out of five employee records reviewed. Specifically, the facility failed to complete annual performance evaluations for CNA's #1, #2, #3, #4 and #5 as required, to address areas of weakness identified in the evaluation and the special needs of the facility residents. Findings include: Review of the facility employee records indicated that: -CNA #1 was hired on 1/21/22 -CNA #2 was hired on 5/15/18 -CNA #3 was hired on 10/16/23 -CNA #4 was hired on 12/19/17 -CNA #5 was hired on 11/27/18 Further review of the employee records did not indicate that performance evaluations had been completed for the employees for the past 12 months. During an interview on 1/7/25 at 11:22 A.M., CNA #1 said that she had worked at the facility for over a year and had never received an employee performance evaluation since being employed at the facility. During an interview on 1/7/25 at 2:28 P.M., the Director of Nursing (DON) said that she was responsible to complete performance reviews for all CNA staff. The DON said that CNA's #1, #2, #3, #4 and #5 had not been given a performance review in the past 12 months but should have. The DON further said employee performance reviews should be done every year on the employees' anniversary date of hire to evaluate the CNA performance and opportunities for improvement if needed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on interview and record review, the facility failed to ensure that one Resident (#366) out of a total sample of 17 residents, was free from unnecessary medication administration. Specifically, for Resident #366, the facility failed to ensure that the Resident had adequate indication for the use of an antibiotic medication (Clarithromycin - used to treat chest and skin infections) that was ordered by the Physician to be administered for twenty-nine days. Findings include: Review of the facility policy titled Medication Monitoring and Management, dated 1/1/21, indicated: >When a resident receives a new medication, the medication order is evaluated for the following: -The dose, route of administration, duration, and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use. -A written diagnosis, an indication, and/or documented objective findings support each medication. -The prescriber documents the clinical rationale in the resident's active record for using a medication outside these stated guidelines. Resident #366 was admitted to the facility in December 2024 with diagnoses of Crohn's Disease, Muscle Weakness and Wedge Compression Fractures of the Vertebra. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #366 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. During an interview on 1/3/25 at 9:42 A.M., Resident #366 said he/she was taking Clarithromycin medication for a bacterial infection called Mycobacterium Chelonae (severe skin infection that causes prolonged skin lesions that is resistant to standard antibiotic therapy) to the skin. Review of Resident #366's January 2025 Physician's orders indicated: -Clarithromycin Oral Tablet 500 milligram (mg), give one table by mouth every 12 hours for infection for 29 days, start date of 12/22/24. During an interview on 1/3/24 at 1:48 P.M., Nurse #4 said Resident #366 was taking the Clarithromycin medication for an infection but was unsure what type of infection. The surveyor and Nurse #4 reviewed the Resident's clinical records and Nurse #4 said there was no documented diagnoses for the use of the Clarithromycin medication. During an interview on 1/3/25 at 1:56 P.M., the Director of Nursing (DON) said she thought the Resident was being treated for a Urinary Tract Infection (UTI - infection in the bladder) but would review the Resident's clinical record and update the surveyor. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/25 at 2:09 P.M., the Infection Preventionist (IP) said she knew Resident #366 was receiving the Clarithromycin medication but was unsure why the Resident was taking the Clarithromycin medication. During a follow-up interview on 1/3/25 at 2:45 P.M., the DON said all medications administered should have an indication for use. The DON said Resident #366 had no documented indication for the use of the prescribed Clarithromycin medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45435 Based on observation, record review, and interview, the facility failed to ensure that it was free of a medication error rate of five percent (5%), or greater when one Nurse (#1) out of three Nurses observed during the medication pass procedure, made two errors in 27 total opportunities, for a medication error rate of 7.41%, impacting one Resident (#45) out of five residents observed, out of a total sample of 19 residents. Specifically, for Resident #45, the facility failed to ensure that: -Nurse #1 did not crush medications that were not ordered to be crushed. -Nurse #1 properly administered two Extended Release (ER) medications. Findings include: Review of the facility policy titled Medication Administration-General Guidelines, dated 1/1/21, indicated: -Tablet Crushing/Capsule Opening: Crushing tablets may require a Physician's order, per facility policy. -Long acting or enteric coated dosage forms should not be crushed, an alternative should be sought. -Consult with the Pharmacist for an alternative medication. -The Pharmacist should be contacted to review all medications being considered for crushing, whether a Physician's order is present or not. The Pharmacist can assist in finding appropriate alternatives to medications that should not be crushed. When identified, the Prescriber shall be contacted for an order change. -Instructions for crushing medications should be included on the resident's orders and the medication administration record (MAR) so that all personnel administering medications are aware of this need. -Please consult with product literature or Do Not Crush lists which the facility may have or with the Pharmacist if there is a question about medications to be crushed when crushing multiple medications for the same resident. Review of the facility policy titled Crushing Medications, dated April 2018, indicated: -The nursing staff and/or Consultant Pharmacist shall notify any attending Physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long-acting or enteric coated medications). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The attending Physician or Consultant Pharmacist must identify an alternative medication and/or dosage form; or b. The attending Physician must document (or provide the nurses with a clinically pertinent reason to document) why crushing the medication will not adversely affect the resident; or c. The facility or Practitioner must provide literature from the manufacturer or peer-reviewed journal to justify why modification of the dosage form will not compromise resident care . Resident #45 was admitted to the facility December 2024 with diagnoses including Hypertensive Heart Disease with Heart Failure and Atherosclerotic Heart Disease of Native Coronary Artery. Review of the Physician's orders, dated January 2025, indicated the following: -Isorbide Mononitrate ER (medication used to prevent chest pain) Oral Tablet Extended Release, give 30 mg by mouth one time a day for Heart Failure, initiated 12/10/24. -Metoprolol Succinate ER (medication used to treat chest pain and high blood pressure) Oral Tablet Extended Release, give 25 mg by mouth one time a day for HTN (hypertension), date initiated 12/10/24. Further review of the Physician's orders did not indicate the Isorbide Mononitrate ER 30 mg and/or Metoprolol Succinate ER 25 mg medications should be crushed. Review of Resident #45's clinical record showed no documented evidence that the Pharmacy had been consulted relative to the crushing of the two extended-release medications. On 1/3/25 at 8:15 A.M., during a medication pass observation on the B wing unit, the surveyor observed Nurse #1 crush, mix in applesauce, and administer the following medications to Resident #45: -Isorbide Mononitrate ER Oral Tablet 30 mg, one tablet, crushed, mixed with applesauce and given by mouth. -Metoprolol Succinate ER Oral Tablet 25 mg, one tablet, crushed, mixed with applesauce and given by mouth. During an interview on 1/3/25 at 8:50 A.M., Nurse #1 said that she had crushed the medications very fine because the Resident had difficulty swallowing them. The surveyor and Nurse #1 reviewed Resident #45's individual medication cards for Isorbide Mononitrate ER 30 mg and Metoprolol Succinate ER 25 mg and Nurse #1 said she should not have crushed the extended-release medications. Nurse #1 said that she would notify the Physician that she had crushed and administered the medications. During an interview on 1/3/25 at 11:49 A.M., the Director of Nursing (DON) said Isorbide Mononitrate ER and Metoprolol Succinate ER should not have been crushed. The DON further said Nurse #1 had been instructed to complete a Medication Error Report. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/25 at 1:34 P.M, the Consultant Pharmacist said Isorbide Mononitrate ER and Metoprolol Succinate ER should not be crushed. The Consultant Pharmacist said the pharmacy would have no way to know that a Resident needed crushed medications unless the pharmacy had been notified by the facility, and he had no evidence of this notification for Resident #45. The Consultant Pharmacist said it is the responsibility of the facility to follow the instructions for medication administration. The Consultant Pharmacist further said that nursing staff could call the pharmacy 24 hours a day for instructions if there were any questions regarding the crushing of medications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45435 Based on observation, interview, and record review, the facility failed to ensure that one Resident (#45) out of a total sample of 19 residents were free from significant medication errors. Specifically, the facility failed to ensure the proper administration of Isorbide Mononitrate ER (an extended release [ER] medication used to prevent chest pain) and Metoprolol Succinate ER (an extended-release medication used to treat chest pain and high blood pressure) when the manufacturer's specifications regarding the preparation and administration of both medications were not followed, putting the resident at risk for worsening cardiac symptoms. Findings include: Review of the facility policy titled Medication Administration-General Guidelines, dated 1/1/21, indicated: -Tablet Crushing/Capsule Opening: Crushing tablets may require a Physician's order, per facility policy. -Long acting or enteric coated dosage forms should not be crushed, an alternative should be sought. -Consult with the Pharmacist for an alternative medication. -The Pharmacist should be contacted to review all medications being considered for crushing, whether a Physician's order is present or not. The Pharmacist can assist in finding appropriate alternatives to medications that should not be crushed. When identified, the Prescriber shall be contacted for an order change. -Instructions for crushing medications should be included on the resident's orders and the medication administration record (MAR) so that all personnel administering medications are aware of this need. -Please consult with product literature or Do Not Crush lists which the facility may have or with the Pharmacist if there is a question about medications to be crushed when crushing multiple medications for the same resident. Review of the facility policy titled Crushing Medications, dated April 2018, indicated: -The nursing staff and/or Consultant Pharmacist shall notify any attending Physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long-acting or enteric coated medications). a. The attending Physician or Consultant Pharmacist must identify an alternative medication and/or dosage form; or (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The attending Physician must document (or provide the Nurses with a clinically pertinent reason to document) why crushing the medication will not adversely affect the resident; or c. The facility or Practitioner must provide literature from the manufacturer or peer-reviewed journal to justify why modification of the dosage form will not compromise resident care . Review of Davis's Drug Guide for Nurses, 19th edition, Copyright 2025, Vallerand, A. H. and Sanoski, C.A. indicated the following: -Isosorbide Mononitrate - Swallow extended-release tablets whole; do not break, crush, or chew. -Metoprolol - **Do not crush** High Alert Medication: This medication bears a heightened risk of causing significant patient harm when it is used in error. Extended-release tablets may be broken in half; do not crush or chew. Resident #45 was admitted to the facility December 2024 with diagnoses including Hypertensive Heart Disease with Heart Failure and Atherosclerotic Heart Disease of Native Coronary Artery. Review of Resident #45's Physician's orders, dated January 2025, indicated: -Isorbide Mononitrate ER Oral Tablet Extended Release, give 30 mg by mouth one time a day for Heart Failure, initiated 12/10/24. -Metoprolol Succinate ER Oral Tablet Extended Release give 25 mg by mouth one time a day for HTN (hypertension), initiated 12/10/24. Further review of Resident #45's Physician's orders did not indicate to crush the Isorbide Mononitrate ER and/or Metoprolol Succinate ER medications. Review of Resident #45's clinical record showed no documented evidence that the Pharmacy had been consulted relative to the crushing of the extended-release medications. On 1/3/25 at 8:15 A.M., during a medication pass observation on the B wing unit, the surveyor observed Nurse #1 crush, mix in applesauce, and administer the following medications to Resident #45: -Isorbide Mononitrate ER Oral Tablet 30 mg, one tablet, given by mouth. -Metoprolol Succinate ER Oral Tablet 25 mg, one tablet, given by mouth. During an interview on 1/3/25 at 8:50 A.M., Nurse #1 said that she had crushed the ER medications because the Resident had difficulty swallowing the medications. The surveyor and Nurse #1 reviewed the individual medication cards for Isorbide Mononitrate ER 30 mg and Metoprolol Succinate ER 25 mg. Nurse #1 said she should not have crushed the extended-release medications and she would notify the Physician that she had crushed and administered the medications. During an interview on 1/3/25 at 10:31 A.M, Nurse #2 said that there should be a list of medications that cannot be crushed, but she was not sure where the list was and that she would check with the Unit Manager (UM). (continued on next page)

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	225380	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Westfield LLC	60 East Silver Street Westfield, MA 01085

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/25 at 10:49 A.M., Nurse #3 said that she is not sure if there was a list of do not crush medications, but if a medication cannot be crushed, it would be indicated on the medication card. During an interview on 1/3/25 at 10:53 A.M., UM #1 said that extended-release, delayed release and enteric coated medication should not be crushed. UM #1 said that the facility used to have a list of medications that cannot be crushed located on each medication cart, but she was unable to locate any of these lists. The surveyor and UM #1 reviewed Resident #45's medication cards for Isorbide Mononitrate ER and Metoprolol Succinate ER and found no instructions relative to crushing the medications was indicated on the medication card. During an interview on 1/3/25 at 11:49 A.M., the Director of Nursing (DON) said Resident #45's Isorbide Mononitrate ER and Metoprolol Succinate ER medications should not have been crushed by Nurse #1. During an interview on 1/3/25 at 1:34 P.M, the Consultant Pharmacist said Isorbide Mononitrate ER and Metoprolol Succinate ER should not have been crushed. The Consultant Pharmacist said the pharmacy had no evidence of a facility notification that Resident #45 needed his/her medications crushed. The Consultant Pharmacist further said it is the responsibility of the facility to follow the instructions for medication administration and that the pharmacy does not print administration instructions on the label unless it is part of the Physician's order. The Consultant Pharmacist said that nursing staff could call the pharmacy 24 hours a day for instructions if there were any questions regarding the crushing of medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice for one Resident (#25) out of a total sample of 18 residents, increasing the risk of contamination and the spread of infections to the Resident and other residents within the facility. Specifically, for Resident #25, the facility staff failed to appropriately follow Enhanced Barrier Precautions (EBP's: the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), while providing: -high contact care to the Resident when performing ADLs (Activities of Daily Living such as bathing, dressing, grooming, personal hygiene). -administration of an Intravenous (IV- method of delivering medication through the vein) medication to the Resident. Finding include: Review of the facility policy titled Enhanced Barrier Precautions, revised March 2024, indicated: -Enhanced barrier precautions (EBPs)are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistance organisms (MDROs) to residents. -EBPs employ targeted gown and glove use in addition to standard precautions during high contact care activities. -Examples of high contact care activities requiring the use of gown and gloves for EBPs include: >dressing >bathing/showering >transferring >changing linens >changing briefs or assisting with toileting >device care or use (central line, urinary catheter, feeding tube (a flexible tube that provides nutrition and hydration when a person is unable to eat or drink safely by mouth), tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person breathe) /ventilator (a mechanical device that helps people breathe by moving air in and out of their lungs), etc) >wound care (any skin opening require a dressing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. >Wounds generally include chronic wounds (i.e pressure ulcers, diabetic foot ulcers .) >Indwelling medication devices include central lines, urinary catheters, feeding tubes and tracheostomies. Resident #25 was admitted to the facility in November 2024 with diagnoses including Acute Osteomyelitis and Pressure Ulcers to the left and right heels. Review of the MDS (Minimum Data Set) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out a total possible score of 15. Review of Resident #25's Physician's orders for January 2025 indicated: -PICC (Peripherally Inserted Central Catheter) NonValved: BRAND Bard Power PICC Provena Gauge 4 FR total Length 37 cm (centimeters). Double lumen-use purple lumen for med administration, active 11/29/24 -Normal Saline Flush, use 10 milliliters (ml) intravenously two times a day for SASH/SAS (Saline, Antibiotic, Saline and Heparin/ Saline, Antibiotic, Saline - procedure based on device type) technique prior to med administration, initiated 11/29/24 -Vancomycin HCL Intravenous Solution Reconstituted 1 GM, use 1 gram intravenously two times a day for bilateral Calcaneus Osteomyelitis, to administer via: (Device type) [sic] Single lumen to be used Diluent/volume per manufactures recommendation utilize SASH/SAS technique, initiated 11/29/24 -Normal Saline Flush, use 10 ml intravenously two times a day for SASH/SAS technique after med administration, initiated 11/29/24 -Heparin Lock Flush solution 10 Unit/ML, use 5 ml intravenously two times a day for SASH technique after administration of Saline, initiated 11/29/24. Review of Resident #25's Plan of Care, initiated 11/29/24 and revised 12/5/24, indicated: -Resident #25 needed assistance with his/her ADLs (activities of daily living, includes bathing, dressing, hygiene, personal care) due to decreased strength and endurance, bilateral heel ulcers with osteomyelitis, pain, non-weight bearing, weakness. -Intervention for Enhanced Barrier Precautions, initiated 12/3/24 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/2/25 at 10:02 A.M., Resident #25 was observed lying in bed next to the window with the head of the bed elevated. Resident #25 was observed to have left and right heels wrapped in gauze and elevated off the bed. The surveyor observed an Intravenous (IV) machine pump running and attached to his/her left arm via a PICC IV line. The Resident said that he/she was receiving the IV antibiotic to treat Osteomyelitis in his/her heals. Resident #25 further said that he/she received wound treatments to both his/her heels and to another area on his/her buttock (sacrum). On 1/2/25 from 10:02 A.M. to 10:33 A.M., the surveyor observed the following: -Signage outside of Resident #25's room, below the room name plate, indicating Enhanced Barrier Precautions (EBP). The EBP sign indicated: >Perform hand hygiene before and after patient contact, contact with environment, and after removal of PPE (Personal Protective Equipment). >Wear gown and gloves prior to these activities: *During High Contact Care Activities: *Dressing *Bathing/Showering *Transferring *Providing hygiene *Changing linens *Changing briefs or assisting with toileting *Device Care or use of a device (i.e central lines, urinary catheters, feeding tubes, tracheostomies, ventilators). -Clear storage bin with PPE including gloves and clean reuseable yellow gowns outside of the room. -Black Bin labeled for dirty reuseable gowns. -10:05 A.M.- CNA #6 donned gloves, did not don a gown, entered Resident #25's room and closed the door for privacy. -10:09 A.M.- Nurse #4 did not don gloves or gown, entered Resident #25's room with medications in a cup to be dispensed, and closed the door. -10:11 A.M.- Nurse #4 exited the room, and CNA #6 remained in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10:33 A.M.- CNA #6 exited the room holding a clear bag of dirty linens, was not wearing a gown or gloves, and walked down the hall to the dispose of the bag of dirty linens. CNA #6 was not observed disposing of any used PPE in the bin outside the room upon exiting the room. During an interview on 1/2/25 at 10:11 A.M., Nurse #4 said that the EBP sign outside of Resident #25's room indicated that staff should wear gloves and gowns when providing direct care for Resident #25. Nurse #4 said EBP is needed when Residents have wounds, catheters, or other open areas which are a risk for infection. Nurse #4 said that Resident #25 had the EBP in place because of his/her wounds and IV line. Nurse #4 said that the facility has an Infection Preventionist (IP) who monitors and oversees any infection control needs. Nurse #4 said the facility was well stocked with PPE. Nurse #4 further said that when removing PPE, there are plastic bags available inside the Resident rooms so that staff can remove the gowns, place dirty gowns in the bag, and place bags in the bin outside of the room labeled for soiled gowns. During an interview on 1/2/25 at 10:36 A.M, the surveyor and CNA #6 reviewed the EBP signage outside of Resident #25's room. The CNA said when the sign is hung above or below the room number, it indicates which bed in the room. CNA #6 said that the sign hanging under the room number would indicate Resident #25's bed. CNA #6 said that the sign indicated staff should wear a gown and gloves when giving direct care to the Resident. CNA #6 said when she leaves the room and removes PPE, she would remove the gown, place the dirty gown in the bag, remove her gloves, do hand hygiene, and then place the dirty bagged gown into the bin outside of the room. CNA #6 said that she should have been wearing a gown when providing direct care to Resident #25 and had not been. On 1/3/25 at 8:34 A.M., the surveyor observed the following: -Nurse #4 performed hand hygiene, donned gloves, and prepared the infusion IV machine to administer Vancomycin medication to Resident #25 at 100 ml/hr. -Nurse #4 doffed gloves, performed hand hygiene, and donned new gloves. Nurse #4 was not observed to don a gown. -Nurse #4 cleansed the central line lumens (access device attached to the IV line) of Resident #25's PICC line with alcohol wipes, opened the sealed syringe package, prepared 10 ml saline solution in a syringe, administered saline via the purple IV lumen, checked blood return, and demonstrated the IV line was patent (open and unobstructed). -Nurse #4 connected Vancomycin to the infusion pump, and demonstrated that the IV was running as ordered. During an interview at the time, Nurse #4 said that the medication would run about 90 minutes total and after the infusion was finished, she would administer the second doses of saline and then Heparin as ordered per the SASH technique. During an interview on 1/3/25 at 1:25 P.M., the Unit Manager (UM) said that EBP is to prevent infections and that residents with catheters, wounds, or those on IV medications have EBP in place. The UM said that staff are expected to wear a gown and gloves when providing direct care to a resident with EBP precautions. The UM said that CNA #6 and Nurse #4 should have been wearing gowns when providing care for Resident #25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/25 at 1:40 P.M., the Infection Preventionist (IP) said that CNA #6 should have been wearing a gown during direct care. The IP further said that Nurse #4 should have been wearing a gown when administering IV medications. During a follow-up interview on 1/3/25 at 2:12 P.M., Nurse #4 said that she should have been wearing a gown when she administered the IV medication earlier, and had not been.