STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225389	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sacred Heart Nursing Home	359 Summer Street New Bedford, MA 02740

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 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. 43935 Based on record review and interviews, the facility failed to develop and implement a person-centered plan of care which included care for residents who had experienced trauma and the identification of potential triggers to be avoided to help prevent potential re-traumatization for two Residents (#120 and #30), out of a total sample of 24 residents. Findings include: 1. Resident #120 was admitted to the facility in March 2024 with diagnoses including Parkinson's disease. Review of the most recent Brief interview for Mental Status (BIMS), dated 3/27/24, indicated the Resident was cognitively intact with a score of 15 out of 15. During an interview on 6/21/24 at 10:52 A.M., Resident #120 said he/she had a trauma in which he/she was robbed and sexually assaulted that occurred quite a few years ago. The Resident said the event had a lasting impact on him/her and he/she can be jumpy or reactive at times. The Resident said he/she shared the trauma with the facility. During an interview on 6/21/24 at 11:06 A.M., Certified Nurse Aide (CNA) #2 said she was familiar with Resident #120 but was not aware of any behaviors, traumas or potential triggers the Resident may have that would cause a behavior or reaction. During an interview on 6/21/24 at 11:31 A.M., CNA #1 said she knows Resident #120 well and cares for them frequently. She said she had never known the Resident to have behaviors or a history of trauma and she was unaware of any triggers or things that should be avoided to help prevent the Resident from having a negative reaction. Review of the Social History and Assessment for Resident #120, dated 3/27/24, indicated but was not limited to the following: - Resident is alert and oriented and able to communicate their needs and desires - Resident does not exhibit any behaviors - Resident enjoys sharing stories about their life (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Mental health history: Resident reports being robbed and sexually assaulted in the past - Trauma: Does the Resident report or the record reflect any history of trauma: No - Does the Resident have disturbing memories or thoughts from a stressful experience in the past: No Review of the current care plans for Resident #120, as of 6/21/24, indicated, but were not limited to the following: PROBLEM: Mood/Behavior: I have a history of depression, can be stubborn and want things done a particular way, and it makes me upset if things go differently. I have a diagnosis of insomnia and am visually impaired with dry eyes. (6/21/24) GOAL: I would like to be free of acute emotional distress and feel safe and comfortable in my environment by evidence of no crying, sadness, or unacceptance of placement during the next 90 days. (6/21/24) INTERVENTIONS: Administer medications at the lowest effective dose, monitor for side effects of antidepressants and report significant findings, encourage me to participate in activities, if I appear upset talk to me to find out where I am from, I enjoy attending mass and family friends on the same unit, I have a tablet I play games on, refer to social services and psych services as needed, use a slow calm approach introduce yourself tell me what you are going to do and allow me to express myself and process what you have said (6/21/24) The current active care plans failed to indicate the Resident had suffered a trauma, or that his/her mental health history included a traumatic event or to identify any potential triggers to be avoided to help prevent potential re-traumatization to the Resident. During an interview on 6/21/24 at 4:32 P.M., Nurse #2 said she was not aware of any traumas in Resident #120's past, or any behaviors or potential triggers to be avoided while caring for the Resident. During an interview on 6/21/24 at 4:34 P.M., Nurse #3 said she knows the Resident well and cares for them often. She said she was unaware the Resident had any trauma or mental health history and she does not know of any behaviors the Resident has or any triggers to be avoided to ensure the Resident does not have a negative reaction. (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 6/21/24 at 4:40 P.M., the Director of Social Services said residents have a social history and assessment completed upon admission and residents with a known trauma or history of a trauma would have a care plan developed and implemented to alert the staff to the concern and potential things to be avoided or behaviors to monitor. She reviewed the assessment for Resident #120 and said although the Resident indicated a history of sexual assault and being robbed, they declined psychotherapy. She said she did not indicate the Resident's experiences of sexual assault or being robbed as a trauma and that was an error. She reviewed the care plans for Resident #120 and said a care plan should have been developed and implemented to alert staff to the trauma and things to avoid or behaviors to be on the look out for but that did not happen. She said it is imperative that staff understand potential triggers to avoid any potential re-traumatization to the Resident and that process was not implemented for this Resident as it should have been. 2. Resident #30 was admitted to the facility in November 2019 with diagnoses including: schizoaffective disorder, bipolar disorder and generalized anxiety. Review of the most recent BIMS, dated 5/14/24, indicated the Resident was cognitively intact with a score of 14 out of 15. Review of the medical record for Resident #30 indicated but was not limited to the following: - a recent hospitalization in April of 2024 in which he/she had reported a history of trauma, but due to being in the hallway at the hospital chose not to elaborate - Resident was on services and received psychotherapy routinely at the facility During an interview on 6/18/24 at 9:17 A.M., the Resident said he/she has a history of trauma and bad thoughts that come up regarding that trauma but he/she did not want to speak to the surveyor about it in detail at that time and appeared suspicious of the surveyor. Review of the psychotherapy notes from May 2024 indicated, but were not limited to the following: - 5/10/24: Diagnoses: post-traumatic stress disorder (PTSD); precipitants and triggers of feelings and behaviors were explored, others report a suspicious demeanor and paranoia - 5/24/24: Diagnoses: PTSD; others have observed a suspicious demeanor, paranoia has improved, precipitants and triggers for feelings and behaviors were explored Review of the current care plans for Resident #30, as of 6/21/24, indicated, but were not limited to the following: PROBLEM: Mood/Behavior: I have schizoaffective disorder, manic episodes, bipolar disorder, anxiety, depression and insomnia. I am visually impaired and hard of hearing. I can be obsessed with my health and any changes that occur. My last severe manic episode was in 2023; in 2024 I have been more paranoid and hearing things from my inner voice. There are times I want to stay up late at night to watch television, eat snacks and write letters. (edited: 6/11/24) GOAL: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I would like to be free of acute emotional distress and feel safe and comfortable in my environment as evidenced by not packing my items and no excessive worrying over my health conditions during the next 90 days. (edited: 5/13/24) INTERVENTIONS: Administer medications at the lowest effective dose, monitor for side effects of antidepressants, anxiolytics, mood stabilizers, and antipsychotics and report significant findings, encourage me to participate in activities, I enjoy attending mass, I often like to have a confessional to bring me comfort when my negative thoughts are overpowering, I see a psychotherapist, monitor me during times of excessive charity as it may be a sign of mania, reassure me that we are monitoring my health, refer to psych services and social services as needed (5/13/24); remind me the importance of having a good wake-sleep cycle (6/11/24) Review of the current care plans for Resident #30 failed to indicate the Resident had a trauma history, what the trauma entailed or what triggers should be avoided to help avoid potential behaviors and feelings or re-traumatization to the Resident. During an interview on 6/21/24 at 4:32 P.M., Nurse #2 said she knows Resident #30 and was aware the Resident had an extensive psychiatric history. She said she was not aware of any trauma or potential triggers that should be avoided to help the Resident avoid a negative reaction or behavior. During an interview on 6/21/24 at 4:34 P.M., Nurse #3 said she knows the Resident well and cares for him/her often. She said the Resident had delusional behaviors and a recent psych hospitalization . She said she was not aware of any trauma or any potential triggers to avoid when caring for the Resident to help potentially eliminate behaviors or negative feelings on the Resident's part. During an interview on 6/21/24 at 4:50 P.M., the Director of Social Services said she knows the Resident well and is aware the Resident has a history of trauma related to abandonment and not feeling good enough. She reviewed the current care plans for Resident #30 and said there was no indication of the trauma, potential triggers and what should be avoided to potentially prevent a behavior or re-traumatization to the Resident. She said there should be a care plan in place and it is not. During an interview on 6/25/24 at 11:58 A.M., the Director of Nurses (DON) said the facility should be developing and implementing a care plan for any resident with a known history of trauma which includes any triggers or potential triggers to help mitigate a potential negative consequence or outcome for the resident in the future.

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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. 42742 Based on observation, interview, and record review, the facility failed to provide services that met professional standards of practice for one Resident (#57), out of a total sample of 24 residents. Specifically, the facility failed to ensure the Resident's foam dressing to the left heel unstageable deep tissue injury (DTI-pressure injury where the depth of the ulcer is obscured by a layer of dead tissue, or slough and/or eschar, covering the wound bed) was changed in accordance with the physician's order. Findings include: Review of the facility's policy titled Dressing Changes and Changing a Clean Dressing, revised November 2023, indicated but was not limited to the following: Purpose: -To promote wound healing. -Cleanse and rinse wound as ordered. Resident #57 was admitted to the facility in April 2024 and had diagnoses including peripheral vascular disease, displaced articular fracture of head of the right femur, and bilateral paralytic syndrome following cerebral infarction. Review of the Minimum Data Set (MDS) assessment, dated 4/19/24, indicated that Resident #57 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, was at risk for developing pressure ulcers, was dependent on staff for mobility, and had two unstageable DTIs present upon admission. Review of the Skin Issue care plan, initiated 6/19/24, indicated Resident #57 had an unstageable area on the left heel upon admission which had gotten smaller in size. Care planned interventions included applying Allevyn foam dressing (used to keep the wound moist and clean, providing an optimal environment for healing) as ordered (6/19/24). Review of current Physician's Orders indicated the following: -Foam dressing -Cleanse left heel with normal saline, pat dry, cover with foam dressing, change every three days, and as needed for intactness/soilage. Monitor for pain with every dressing change, once a day every three days 7:00 A.M. - 3:00 P.M. (6/5/24) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 8:29 A.M., the surveyor observed Nurse #5 perform a dressing change to Resident #57's left heel unstageable DTI who was lying in bed. Nurse #5 removed the old dressing exposing the Resident's wound for observation. The wound was approximately 2 centimeters (cm) in length x 1 cm width with a dark wound bed in the center. There was no drainage or open areas. The surrounding skin was pink. Resident #57 denied any pain or discomfort. Nurse #5 measured the wound then applied a new foam dressing. Nurse #5 did not cleanse the wound with normal saline or pat dry prior to applying the new foam dressing per physician's orders. Nurse #5 said she performed the dressing change that was due for the night. During an interview on 6/25/24 at 8:35 A.M., the surveyor reviewed Resident #57's medical record with Nurse #5 who said the physician's order said to cleanse the wound with normal saline and pat dry before applying the foam dressing. She said she did not do that but should have and would have to go back and do it over again. During an interview on 6/25/24 at 12:43 P.M., the Director of Nursing (DON) said Resident #57 came in with heel issues and discoloration. The Assistant Director of Nursing (ADON) said she was the facility's wound care nurse, and the Resident came in with a left heel DTI. The ADON said the foam dressing was started on 6/4/24. She said the Resident was at risk for developing pressures because he/she did not move and was dependent on care. The ADON said wound dressing changes should be done per physician's orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42742 Based on observation, interview, and record review, the facility failed to ensure two Residents (#57 and #96), out of a total sample of 24 residents, received care and treatment to prevent and to promote the healing of pressure injuries consistent with professional standards of practice. Specifically, the facility failed: 1. For Resident #57, who had an existing left heel unstageable deep tissue injury (DTI- pressure injury where the depth of the ulcer is obscured by a layer of dead tissue, or slough and/or eschar, covering the wound bed), to consistently implement physician's orders to offload the Resident's heels and adjust the low air loss (LAL) mattress (distributes body weight over a broad surface area to help prevent skin breakdown) per physician's orders and care planned interventions; and 2. For Resident #96, who had an existing unstageable DTI on his/her coccyx, to ensure the Resident's LAL mattress settings were programmed in accordance with the physician's order. Findings include: Pressure Injury Care: -Make sure the patient's heels don't rest on the bed. Apply heel protection devices, as required, to prevent heel pressure injuries. The devices should completely offload pressure from the heels. If you're placing pillows under the patient's calves to decrease pressure, place each pillow longitudinally underneath the calf with the heel suspended in the air. Wolters Kluwer. Lippincott Nursing Procedures, Eighth edition, [Philadelphia: Wolters Kluwer, [2019]. Page 632. Review of the facility's policy titled Wound and Skin Protocol Policy, revised January 2024, indicated but was not limited to the following: -Interventions must be care planned and implemented during the admission process and revised as needed. Review of the facility's policy titled Low Air Loss Mattress, last reviewed March 2024, indicated but was not limited to the following: Purpose: -To treat and prevent wounds by facilitating blood circulation and decreasing pressure of each tissue's contact area. -If determined that the resident requires a low air mattress an order will be obtained by the physician to include low air loss mattress: Check accuracy of weight setting. Monitor for bottoming out. Check that the static button is set in the off position. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Check the resident's weight and adjust the low air loss mattress accordingly. This should be done weekly with the weekly weights and documented. -Caregivers should always perform a hand check by placing their hands underneath patient's pelvis area to check if there is sufficient air support to ensure the patient is not bottoming out. 1. Resident #57 was admitted to the facility in April 2024 and had diagnoses including peripheral vascular disease, displaced articular fracture of head of the right femur, and bilateral paralytic syndrome following cerebral infarction. Review of the Minimum Data Set (MDS) assessment, dated 4/19/24, indicated that Resident #57 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, was at risk for developing pressure ulcers, was dependent on staff for mobility, and had two unstageable DTIs present upon admission. Review of the Skin care plan, initiated 4/25/24, indicated Resident #57 was at risk for skin problems secondary to his/her incontinence and decreased mobility and was admitted with areas of DTI on the heels and buttock. Care planned interventions included the following: -Offload the heels, 4/24/24 -Low air loss mattress on the bed, 4/23/24 Review of current Physician's Orders indicated the following: -Offload the heels every shift three times a day, 7:00 A.M.-3:00 P.M., 3:00 P.M.-11:00 P.M., and 11:00 P.M. -7:00 A.M., 4/13/24 -Low air loss mattress, check accuracy of weight setting. Monitor for bottoming out. Check that static button is set in off position every shift 7:00 A.M.-3:00 P.M., 3:00 P.M.-11:00 P.M., and 11:00 P.M.-7:00 A.M., 4/18/24 During an observation with interview on 6/18/24 at 8:55 A.M., the surveyor observed Resident #57 lying in bed with a pillow underneath the left calf. The Resident's left heel was in contact with the mattress and not offloaded per physician's orders. The Resident's LAL mattress static mode button was in the on position indicating the mattress was distributing a constant level of air pressure evenly distributed across the mattress surface. Resident #57 said he/she had a sore on the left heel but wasn't sure how it got there and described his/her current pain level as a 7 out of 10 and stinging. The Resident said he/she had a history of a stroke and had limited range of motion in the upper extremities and difficulty speaking. During an interview on 6/18/24 at 12:35 P.M., Resident Representative #1 said Resident #57 had a bedsore on the back of his/her left heel. Resident Representative #1 said it was better, but still sore, and said sometimes he/she comes to visit in the middle of the night and the Resident's heels are flat on the bed, not elevated, so he/she will put a pillow or something underneath. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/20/24 at 9:53 A.M., Nurse #5 said the Resident had a 1.0 centimeter (cm) x 1.5 cm DTI on the left heel and interventions included to keep the heels offloaded. She said the Resident had not complained of pain. On 6/24/24 at 9:03 A.M., the surveyor observed Resident #57 lying in bed with a pillow underneath the left calf. The Resident's left heel was in contact with the mattress and not offloaded per physician's orders. The Resident's LAL mattress static mode button was in the on position. During an interview on 6/25/24 at 8:23 A.M., Certified Nursing Assistant (CNA) #5 said she was assigned to the Resident this day but didn't know if he/she had any wounds. CNA #5 asked CNA #4 who said he/she didn't have any wounds or pressure areas that she knew of but said the Resident was at risk for developing pressure ulcers. CNA #4 said the Resident had an air mattress and his/her heels were supposed to be elevated while in bed. On 6/25/24 at 8:17 A.M., the surveyor observed Resident #57 lying in bed with a pillow underneath the left and right calves. The Resident's left heel was in contact with the mattress and the right heel in contact with the pillow. The heels were not offloaded per physician's orders. The Resident's LAL mattress static mode button was in the on position. During an observation with interview on 6/25/24 at 8:27 A.M., the surveyor and Nurse #5 observed Resident #57 lying in bed. The Resident's LAL mattress static mode button was in the on position. The surveyor observed the Resident's left heel wound with Nurse #5. The wound was approximately 2 centimeters (cm) in length x 1 cm width with a dark wound bed in the center. There was no drainage or open areas. The surrounding skin was pink. Resident #57 denied any pain or discomfort. Nurse #5 said it was a DTI. She said the mattress was set at 200 pounds on static pressure and wasn't sure if that was the order but would check. She said the Resident's heels should be offloaded to treat the current left heel DTI and to prevent others from forming. She said the Resident was at risk for developing pressure ulcers. During an interview on 6/25/24 at 8:35 A.M., the surveyor reviewed the medical record with Nurse #5 who said the LAL mattress should not have been on static mode and said she didn't know the difference between static mode and alternating mode for air pressure or the benefit to the static mode being turned off. She said mattresses should be set per physician's orders but wasn't sure how to adjust the settings. During an interview on 6/25/24 at 12:42 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said the Resident was admitted with a left heel DTI and was at risk for developing pressure ulcers due to immobility and dependence on staff for care. The DON and ADON said care planned interventions should be consistently implemented. They further said the static pressure cycle holds the air pressure, it doesn't alternate it, and should have been turned off per physician's orders. They further said the Resident's heels should have been consistently offloaded while in bed. The DON and ADON said nursing or maintenance sets up the air mattresses, but nursing adjusts the settings. 2. Resident #96 was admitted to the facility in May 2024 and had diagnoses including muscle weakness, abnormalities of gait and mobility, and altered mental status. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment, dated 5/11/24, indicated Resident #96 had severe cognitive impairment as evidenced by a BIMS score of 0 out of 15, was dependent on staff for mobility, was at risk for developing pressure injuries, and had one unhealed unstageable DTI present upon admission. Review of a Nursing Progress Note, dated 5/6/24, indicated but was not limited to the following: -coccyx 1.0 x 2 cm open area, new Allevyn dressing applied, right buttock 3 x 1 cm excoriation, coccyx 7 x 10 cm dark pink/purplish in color. Review of current Physician's Orders indicated the following: -Low air loss mattress: Check accuracy of weight setting. Monitor for bottoming out. Check that static button is set in off position, 5/6/24 Review of the Skin care plan, initiated 5/20/24, indicated Resident #96 was at risk for skin problems secondary to incontinence and decreased mobility. Interventions included a low air loss mattress on his/her bed (5/8/24). Review of the Vitals Summary indicated the following weights for Resident #96: 6/12/24 - 130.0 pounds (lbs.) 6/19/24 - 133.0 lbs. On 6/20/24 at 9:48 A.M., the surveyor observed Resident #96 sitting in a recliner in his/her room. A LAL mattress was inflated on the bed with the weight setting programmed at 325 pounds. The static mode button was in the on position. On 6/24/24 at 8:49 A.M., the surveyor observed Resident #96 lying in bed. The LAL mattress weight setting was programmed at 325 pounds. The static mode button was in the on position. On 6/25/24 at 8:09 A.M., the surveyor observed Resident #96 lying in bed. The LAL mattress weight setting was programmed at 150 pounds. The static mode button was in the on position. Resident #96 was non-verbal but shook his/her head yes when asked if there was a wound on his/her coccyx. During an interview on 6/25/24 at 8:51 A.M., Certified Nursing Assistant (CNA) #4 said she was familiar with the Resident who didn't have any wounds or pressure injuries she knew of. She said other than repositioning, there were no other interventions to prevent pressure injuries that she knew of. During an observation with interview on 6/25/24 at 8:55 A.M., the surveyor entered the Resident's room with Nurse #7 and observed the LAL mattress settings programmed at 150 pounds, static pressure. Nurse #7 said the Resident had a small open area on his/her coccyx and was getting a wound treatment to the area. She said she wasn't sure what the correct settings would be for the mattress but would look. Nurse #7 said Resident #96 was at risk for developing pressure ulcers and interventions included the LAL mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 9:15 A.M., the surveyor reviewed the medical record with Nurse #7 who said Resident #96 had an unstageable wound on his/her coccyx and the physician's order was to make sure the air mattress was not bottoming out, check the weight settings, and make sure the static mode setting was off. She said the Resident's current weight was 133.0 pounds. She said the weight setting should be adjusted to the Resident's weight with the static mode button in the off position per physician's orders. During an interview on 6/25/24 at 9:46 A.M., the Maintenance Director said nursing is responsible for adjusting the settings on the air mattresses because maintenance staff doesn't know what the residents' needs are, so they always defer back to nursing if the settings need to be adjusted. During an interview on 06/25/24 at 12:59 P.M., the DON and ADON said the Resident had a pressure ulcer on his/her coccyx when admitted from the hospital, but it was healing. They said the Resident was at risk of developing pressure ulcers and had a LAL mattress on the bed. They said the Resident's weight is considered when adjusting the settings and the weight should have been set per physician's orders and static mode turned off.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sacred Heart Nursing Home	359 Summer Street New Bedford, MA 02740

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 43935 Based on record review and interviews, the facility failed to identify the potential triggers to be avoided in two Residents (#120 and #30), with a history of trauma, to help prevent potential re-traumatization out of a total sample of 24 residents. Findings include: During an interview on 6/24/24 at 3:33 P.M., the Director of Nurses (DON) and Administrator said the facility does not have a policy on trauma informed care and there is no specific policy or procedure they follow. 1. Resident #120 was admitted to the facility in March 2024 with diagnoses including Parkinson's disease. Review of the most recent Brief interview for Mental Status (BIMS), dated 3/27/24, indicated the Resident was cognitively intact with a score of 15 out of 15. During an interview on 6/21/24 at 10:52 A.M., Resident #120 said he/she had a trauma in which he/she was robbed and sexually assaulted that occurred quite a few years ago. The Resident said the event had a lasting impact on him/her and he/she can be jumpy or reactive at times. The Resident believes a trigger would be someone coming up from behind him/her quietly or touching him/her from behind which would cause him/her to be frightened and likely lash out physically. The Resident said he/she shared the trauma with the facility but no one else had asked him/her about potential triggers that could cause upset. The Resident said it would be good for the facility to know his/her trigger so it can be avoided. During an interview on 6/21/24 at 11:06 A.M., Certified Nurse Aide (CNA) #2 said she was familiar with Resident #120 but was not aware of any behaviors, traumas or potential triggers the Resident may have that would cause a behavior or reaction. During an interview on 6/21/24 at 11:31 A.M., CNA #1 said she knows Resident #120 well and cares for them frequently. She said she had never known the Resident to have behaviors or a history of trauma and she was unaware of any triggers or things that should be avoided to help prevent the Resident from having a negative reaction. Review of the Social History and Assessment for Resident #120, dated 3/27/24, indicated but was not limited to the following: - Resident is alert and oriented and able to communicate their needs and desires - Resident does not exhibit any behaviors - Resident enjoys sharing stories about their life - Mental health history: Resident reports being robbed and sexually assaulted in the past - Trauma: Does the Resident report or the record reflect any history of trauma: No (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Does the Resident have disturbing memories or thoughts from a stressful experience in the past: No Review of the current care plans for Resident #120, as of 6/21/24, failed to indicate the Resident had suffered a trauma, or that his/her mental health history included a traumatic event or to identify any potential triggers to be avoided to help prevent potential re-traumatization to the Resident. During an interview on 6/21/24 at 4:32 P.M., Nurse #2 said she was not aware of any traumas in Resident #120's past, or any behaviors or potential triggers to be avoided while caring for the Resident. During an interview on 6/21/24 at 4:34 P.M., Nurse #3 said she knows the Resident well and cares for them often. She said she was unaware the Resident had any trauma or mental health history and she does not know of any behaviors the Resident has or any triggers to be avoided to ensure the Resident does not have a negative reaction. During an interview on 6/21/24 at 4:40 P.M., the Director of Social Services said residents have a social history and assessment completed upon admission and residents with a known trauma or history of a trauma would have a care plan developed and implemented to alert the staff to the concern and potential things to be avoided or behaviors to monitor. She reviewed the assessment for Resident #120 and said although the Resident indicated a history of sexual assault and being robbed, they declined psychotherapy. She said the facility psychotherapist would typically help any trauma residents with psychotherapy sessions. She said she did not indicate the Resident's experiences of sexual assault or being robbed as a trauma and that was an error. She said since that was not documented, the Resident was not asked if he/she had any potential triggers. She reviewed the care plans for Resident #120 and said a care plan should have been developed and implemented to alert staff to the trauma and things to avoid or behaviors to be on the look out for but that did not happen. She said it is imperative that staff understand potential triggers to avoid any potential re-traumatization to the Resident and that process was not implemented for this Resident as it should have been. 2. Resident #30 was admitted to the facility in November 2019 with diagnoses including: schizoaffective disorder, bipolar disorder and generalized anxiety. Review of the most recent BIMS, dated 5/14/24, indicated the Resident was cognitively intact with a score of 14 out of 15. Review of the medical record for Resident #30 indicated but was not limited to the following: - a recent hospitalization in April of 2024 in which he/she had reported a history of trauma, but due to being in the hallway at the hospital chose not to elaborate - the last social services assessment had been completed since November of 2019 at the time of the Resident being admitted and failed to indicate a history of trauma or potential triggers - Resident was on services and received psychotherapy routinely at the facility During an interview on 6/18/24 at 9:17 A.M., the Resident said he/she has a history of trauma and bad thoughts that come up regarding that trauma but he/she did not want to speak to the surveyor about it in detail at that time and appeared suspicious of the surveyor. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the psychotherapy notes from May 2024 indicated, but were not limited to the following: - 5/10/24: Diagnoses: post-traumatic stress disorder (PTSD); precipitants and triggers of feelings and behaviors were explored, others report a suspicious demeanor and paranoia - 5/24/24: Diagnoses: PTSD; others have observed a suspicious demeanor, paranoia has improved, precipitants and triggers for feelings and behaviors were explored Review of the current care plans for Resident #30 failed to indicate the Resident had a trauma history, what the trauma entailed or what triggers should be avoided to help avoid potential behaviors and feelings or re-traumatization to the Resident. During an interview on 6/21/24 at 4:32 P.M., Nurse #2 said she knows Resident #30 and was aware the Resident had an extensive psychiatric history. She said she was not aware of any trauma or potential triggers that should be avoided to help the Resident avoid a negative reaction or behavior. During an interview on 6/21/24 at 4:34 P.M., Nurse #3 said she knows the Resident well and cares for him/her often. She said the Resident had delusional behaviors and a recent psych hospitalization . She said she was not aware of any trauma or any potential triggers to avoid when caring for the Resident to help potentially eliminate behaviors or negative feelings on the Resident's part. During an interview on 6/21/24 at 4:50 P.M., the Director of Social Services said she knows the Resident well and the Resident recently requested to be hospitalized psychiatrically related to paranoia and delusions that were felt to be uncontrolled. She said she checks in regularly with the Resident and is aware the Resident has a history of trauma related to abandonment and not feeling good enough. She reviewed the medical record and said there were no available social history and assessments completed since admission. She said the Resident is followed by psychotherapy who she believes manages the Resident's trauma and is aware of the Resident's triggers. She reviewed the current care plans for Resident #30 and said there was no indication of the trauma, potential triggers and what should be avoided to potentially prevent a behavior or re-traumatization to the Resident. She said there should be a care plan in place and it is not. On 6/25/24 at 9:06 A.M., the surveyor called and left a message for the facility psychotherapist to discuss the Resident's care but the call was not returned. During an interview on 6/25/24 at 11:58 A.M., the DON said the facility usually performs social history and assessments on admission and they need to consider a reassessment period to determine if things may have occurred or if the residents are triggered by an old trauma they now wish to share. She said the facility should be care planning for any resident with a known history of trauma and any triggers or potential triggers to help mitigate a potential negative consequence or outcome for the resident in the future. She confirmed the facility did not have a policy on trauma informed care or the care of residents with PTSD.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49425 Based on observation, record review, and interview, the facility failed to follow 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 maintain safe and clean equipment and ensured that food was stored properly, in three out of four kitchenettes. Findings include: Review of the facility's policy titled Kitchen/Pantry Cleaning Schedule, undated, indicated but was not limited to the following: -Check/Clean & sanitize microwave (inside & out) -Check all cabinets, shelving, drawers in good repair -If any equipment is in need of repair, please inform supervisor On 6/20/24 at 9:49 A.M., the surveyor observed the following in the Third Floor Unit kitchenette: -Inside the microwave, the bottom outer panel of the microwave was rusted, and peeling off. -Inside the microwave, on the right-side wall, there was food particle spatter and a dark brown stain. -Inside the microwave on the bottom left front corner was a brownish, sticky, crusted substance. -A toaster, three clear plastic serving bowls, a coffee machine, and two packages of drinking cups were stored under the sink next to plumbing piping. On 6/24/24 at 8:03 A.M., the surveyor observed the following in the Saint Michael's Unit kitchenette: -Inside the microwave on the upper left side wall was a brownish, orange crusted stain. -Inside the microwave on the back top right and left corners were areas of rust. -An aluminum foil food serving pan, one bottle of prune juice, and one plastic coffee mug were stored under the sink next to plumbing piping. On 6/24/24 at 11:27 A.M., the surveyor observed the following in the Saint Joseph's Unit kitchenette: -Inside the microwave on the top center, there were two areas of rust peeling off, food particle spatter and dark brown stains. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Inside the microwave on the top right and left corners were areas of rust. -A coffee pot and multiple bags of coffee in a bucket were under the sink next to plumbing piping. During an interview with observation of the Saint Michael's Unit kitchenette on 6/25/24 at 8:26 A.M., Unit Manager #1 said the dietary staff were responsible for stocking and cleaning the kitchenettes. UM #1 and the surveyor observed the microwave and she said she has never noticed the rusted areas before and will notify maintenance. The surveyor and UM #1 observed the cabinet under the sink and noted an aluminum foil food serving pan, one bottle of prune juice, one plastic coffee mug. She said nothing is supposed to be stored under the sink and removed the items. During an interview with observation of the Saint Joseph's Unit kitchenette on 6/25/24 at 8:39 A.M., the Food Service Director (FSD) said the microwaves are supposed to be cleaned and sanitized daily. The surveyor and FSD observed the microwave, and he said the areas on the top of the microwave appear to be rusted and flaking off, and it needed to be replaced. The FSD and surveyor observed the cabinet under the sink and noted a coffee pot, and multiple bags of coffee stored in a bucket. He said no food items should ever be stored under the sink due to the high risk of contamination. FSD said the dietary staff are responsible to check the cabinets daily and ensure nothing is placed in the cabinet, under the sink. During an interview with observation of the Saint Michael's Unit kitchenette on 6/25/24 at 8:48 A.M., the FSD and surveyor observed the microwave. He said the microwave appears to be rusted and needed to be replaced. The FSD and surveyor looked in the cabinet under the sink, and all items had been removed. The surveyor informed the FSD of the findings on 6/24/24 and 6/25/24 earlier in the morning, and he said no items are to be stored under the sink. During an interview with observation of the Third-Floor kitchenette on 6/25/24 at 8:48 A.M., the FSD and surveyor observed the microwave and noted that the inside, bottom outer panel was rusted, and peeling off, and continued to have food particle spatter and a dark brown stain on the right inside wall. He said it was in disrepair and should not be in use. He said the dietary staff never made him aware, and it needs to be replaced. The FSD and surveyor looked in the cabinet under the sink and noted a toaster, three clear plastic serving bowls, coffee machine, two packages of drinking cups. He said nothing is supposed to be stored under the sink, and the dietary staff should have removed the items when they do the daily cleaning of the kitchenette.

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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. 43935 Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program. Findings include: Review of the facility's policy titled Antibiotic Stewardship Program Policy, last revised 11/2023, indicated but was not limited to the following: - it is the policy of the health facility to implement an antibiotic stewardship program which will promote the appropriate use of antibiotics while optimizing treatment of infections - facility action: an antibiotic review process, also known as a time out for all antibiotics prescribed in the facility - antibiotic time out (ATO) prompts clinicians to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer - ATO can be considering a stop order of an antibiotic when diagnostic test results or symptoms of the resident do not support the diagnosis of infection During an interview on 6/20/24 at 10:45 A.M., the Infection Preventionist (IP) said the facility uses the pre-defined McGeer criteria to determine if an illness or set of symptoms rise to the level of an infection. She said antibiotic usage is tracked on the facility illness surveillance sheets which also indicate whether or not an illness meets infection criteria. Review of the facility surveillance sheets for April and May 2024 indicated but were not limited to the following: APRIL: Resident #73 had a skin concern with an onset date of 4/30/24, the surveillance indicated the issue did not rise to the level of an infection as determined by the facility criteria, however an antibiotic was prescribed for 7 days. Review of the progress notes, including physician and nurse practitioner notes for Resident #73 from 4/25/24 through 5/20/24, failed to indicate an ATO was performed for Resident #73's continued antibiotic use, even though the symptoms did not meet infection criteria. MAY: Resident #106 had a urinary issue with an onset date of 5/11/24, the surveillance indicated the issue did not rise to the level of an infection as determined by the facility criteria, however an antibiotic was prescribed for 7 days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes, including physician and nurse practitioner notes for Resident #106 from 5/5/24 through 5/25/24, failed to indicate an ATO was performed for Resident #106's continued antibiotic use, even though the symptoms did not meet infection criteria. Further review of Resident #106's medical record indicated a urinalysis and culture was obtained related to a fall the Resident had and there were no symptoms of a potential illness or infection prior to the diagnostic test being obtained and the Resident completed a 7-day course of antibiotics and remained without urinary symptoms for the entirety of the treatment. During an interview on 6/20/24 at 3:29 P.M., the IP said the facility is supposed to complete a time out and document that in the medical record for all residents on antibiotics in the facility that do not meet infection criteria. She reviewed the information for Resident #73 and Resident #106 and said there was no evidence that an ATO had occurred for either Resident as it should have. She said neither Resident #73 or #106 met McGeer infection criteria and an ATO should have been documented in their medical records in accordance with the facility policy and it was not. During an interview on 6/25/24 at 11:54 A.M., the Director of Nurses said residents on antibiotic therapy are discussed daily in morning meeting. She said she was aware of the concerns discussed with the IP regarding the antibiotic stewardship. She said the expectation is that the policy is followed and an ATO is completed as it is required to be and it is not being done in accordance with the facility policy at this time.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation and interview, the facility failed to ensure a functional, safe, and clean environment on two (2PY and 3PY) of four units in the facility. Specifically, the facility failed to ensure sharps containers were replaced when two thirds to three-quarters full to decrease the risk of needlestick injuries and exposure to bloodborne pathogens. Findings include: Review of the facility's policy titled Sharps Container Weekly Check Policy/Procedure, revised July 2018, indicated but was not limited to the following: -It will be the responsibility of the maintenance and nursing department to inspect and dispose of any sharps containers that are two thirds to three-quarters full. -Sharps containers will be checked weekly and disposed of according to department policy. -The maintenance department will routinely check/replace containers on a scheduled day, usually Monday, once a week -Sharps containers in resident rooms will be replaced on an as needed basis. Nursing staff will submit a request to the maintenance department indicating which rooms need new containers. Review of the Occupational Safety and Health Administration (OSHA) web-based fact sheet titled, Protecting Yourself When Handling Contaminated Sharps, indicated but was not limited to the following: - A needlestick or a cut from a contaminated sharp can result in a worker being infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and other bloodborne pathogens. The standard specifies measures to reduce these types of injuries and the risk of infection. Careful handling of contaminated sharps can prevent injury and reduce the risk of infection. Employers must ensure that workers follow these work practices to decrease the workers' chances of contracting bloodborne diseases. Sharps Containers: - The containers must be replaced routinely and not be overfilled, which can increase the risk of needlesticks or cuts. Occupational Safety and Health Administration. (2011, January). Protecting Yourself When Handling Contaminated Sharps. https://www.osha.gov/sites/default/files/publications/bbfact02.pdf On 6/25/24, during a tour of the 2PY and 3PY Units, the surveyors observed wall mounted sharps containers in the following residents' rooms filled above the three-fourths (3/4) full line marking with various sharps inside including but not limited to contaminated syringes, needles, and razors: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3PY Unit: 9:50 A.M. room [ROOM NUMBER] 2PY Unit: 10:33 A.M. room [ROOM NUMBER] (unoccupied after terminal clean) 10:34 A.M. room [ROOM NUMBER] 10:35 A.M. room [ROOM NUMBER] 10:37 A.M. room [ROOM NUMBER] 10:40 A.M. room [ROOM NUMBER] The sharps containers were all filled above the three-fourths (3/4) full line marking increasing the potential for needlestick injuries and exposure to bloodborne pathogens. Review of the Monthly Facility Inspection document, provided by the Maintenance Director, indicated monthly resident room checks were last completed in May 2024. No other documents were provided by the Maintenance Director including a sharps container weekly checklist to indicate that maintenance was routinely checking the containers on a scheduled day, once a week, per facility policy. During an interview on 6/25/24 at 9:59 A.M., Nurse #1 said maintenance was responsible for changing the sharps containers and, as far as she knows, it is not done on a schedule. She said the staff either verbally tell maintenance if they are on the unit or the staff can complete a maintenance slip to notify maintenance of the need for a needle box change. She said they request a change from maintenance if they notice it's at the line or if they use it and it seems that the needle doesn't fall freely, or if they have to jiggle it. During an interview on 6/25/24 at 10:35 A.M., Nurse #5 said if a sharps container is full, they would notify maintenance to replace it. She said a repair slip is completed then attached to a clip outside the maintenance office. She said the containers should not be filled above the fill line as it could be a potential hazard. She said she was aware the sharps container in room [ROOM NUMBER] was full yesterday but didn't notify maintenance yet. During an interview on 6/25/24 at 10:42 A.M., Certified Nursing Assistant (CNA) #3 said she wasn't sure who she would notify if the containers were full. She said the aides and nurses monitor them and said she had not seen any that were full this day. During an interview on 6/25/24 at 11:06 A.M., the Maintenance Director said nursing monitors the sharps containers on the units and if one is full and needs to be replaced then nursing makes out a request for maintenance to empty it. He said if maintenance staff are in a room and notice a container is full, they'll switch it out. The surveyor reviewed the repair slips with the Maintenance Director and Maintenance Staff #1 who said they had not received any for the observed rooms. The Maintenance Director said if the containers are too full there is a potential for needlestick injuries. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/25/24 at 1:09 P.M., the Maintenance Director said sharps containers should also be replaced if full during a terminal room clean or on an as needed basis. He said maintenance doesn't routinely check the residents' rooms, just once a month for the most part. He said he only has two staff for the whole facility, so they are not doing weekly checks. During an interview on 6/25/24 at 1:17 P.M., the surveyor reviewed the Monthly Facility Inspection document with the Maintenance Director and Maintenance Staff #1 who said resident room checks were last completed in May but wasn't sure what day.