STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225395	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lanessa Extended Care	751 School Street Webster, MA 01570

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 51466 Based on record review, and interview, the facility failed to provide notification to the invoked Health Care Proxy (HCP) and obtain consent for the use of psychotropic medications for one Resident (#23) out of a total sample of 18 residents. Specifically, the facility failed to obtain informed consent and provide information regarding the risks and benefits of the medication use to Resident #23's HCP prior to the administration of Ativan (psychotropic medication used for anxiety). Findings include: Review of the facility's Psychotropic Medication Informed Consent Policy, dated February 2016 indicated the following: -Prior to administering psychotropic medication, the facility shall obtain the informed written consent of the resident, the resident's health care proxy or the resident's guardian. Informed written consent shall be obtained on a form approved by the DPH. The written consent form shall be kept in the resident's medical record. -Informed written consent shall include the following information: >The purpose of administering the psychotropic medication, >The prescribed dosage and >Any known effect or side effect of the psychotropic medication. -Documentation of informed consent for prescribing psychotropic medication including but not limited to, drugs that treat depression, anxiety disorders, or attention deficit/hyperactivity disorder. -These procedures are required each time a new or renewed prescription falls outside the dosage range to which the resident or resident's representative previously consented, or once a year, whichever is shorter. Resident #23 was admitted to the facility in January 2024, with diagnoses including Idiopathic Gout, Chronic Kidney Disease Stage 3B and Major Depressive Disorder. (continued on next page)

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's Physician orders for November 2024, indicated the following: -Physician's order obtained on 11/2/24 for Ativan 0.5 mg by mouth every six hours as needed (PRN) for anxiety or agitation. -Ativan was administered on 11/9/24 for agitation. Review of Resident #23's Medical Record indicated the following: -the Health Care Proxy (HCP) was invoked on 7/20/24. -no evidence of Psychotropic Medication consent from the HCP for the medication Ativan. During an interview on 1/30/25 at 1:20 P.M., Unit Manager (UM) #1 said that every psychotropic medication requires consent from the responsible party prior to being administered. UM #1 further said that there was no consent located in the medical record and the Ativan medication was given without consent. During an interview on 1/30/25 at 2:04 P.M., the Director of Nursing (DON) said Resident #23 did not have the necessary consent for Ativan, prior to administration of the medication. The DON said that the facility policy includes obtaining consent prior to giving the medication and this did not occur.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 47901 Based on interview, and record review, the facility failed to assess one Resident (#79) out of a total sample of 18 residents, for the clinical appropriateness to self-administer medications. Specifically, for Resident #79, the facility failed to complete an assessment for the appropriateness and safety of self-administration of medications when an order was received to leave a Benadryl cream at the Resident's bedside. Findings include: Review of the facility's policy titled Self-Administration of Medications, dated July 2015 indicated: -Evaluate the resident's cognitive, physical, and visual ability to self-administer medications. -Complete the Self Administration Evaluation and document whether the resident can safely self-medicate or is unable to safely self-medicate. If the resident can't safely self-medicate, document the reason why. -Inform the resident/responsible party of the decision. -Update the care plan for self-medication to include where the medication will be stored, documentation of self-administration, and location of the drug administration. -Perform resident education of all required self-medication protocols and document any education. -Mark the MAR (Medication Administration Record) for each medication being self-administered for daily compliance monitoring purposes. (Indicate that the resident has self-administered). -If there is a change in the resident's status, re-evaluate his/her ability to continue self-administration of medications, as this right may be withdrawn if the resident can no longer safely self-administer medications. Resident #79 was admitted to the facility in September 2024 with diagnoses including Asthma and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) Assessment, dated 12/6/24, indicated Resident #79 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. Review of Resident #79's January 2025 Physician's orders indicated: -Obtain a consult for genital issues, dated 1/24/25. -Benadryl Cream 1% to genital area every 6 hours as needed (PRN), may leave at bedside, dated 12/19/24. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated no documented evidence that an evaluation was completed initially and thereafter to assess Resident #79 for the self-administration of the Benadryl cream. On 1/30/25 at 8:57 A.M., the surveyor and Unit Manager (UM) #1 reviewed Resident #79's clinical record. UM #1 said he was unable to find an evaluation for Resident #79 to self-administer the Benadryl cream. UM #1 further said if a resident requested to self-administer medications, an evaluation would be completed by the nursing staff before a Physician's order was obtained for the specific medications to be self-administered. UM #1 said a self-administration of medications assessment should have been completed before the order was obtained to leave the Benadryl cream at the Resident's bedside, but this was not done. During an interview on 1/31/25 at 2:18 P.M., the Clinical Nurse Specialist said a self-administration medication assessment should been completed for Resident #79 for the Benadryl cream, but it was not.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 48206 Based on interview, and record review, the facility failed to act upon, provide timely responses, and document written responses and rationale to grievances of resident care and services brought to facility administration by the Resident Council. Specifically, the facility failed to: A) address grievances related to staffing levels on the 11:00 P.M.- 7:00 A.M. shift when reported in Resident Council Meeting on 12/18/24. B) document response and rationale when concerns with staffing levels on 11:00 P.M.- 7:00 A.M. shift were reported in Resident Council Meeting on 1/21/25. Findings include: Review of the facility Grievance Policy, undated, indicated the following: -The facility will make prompt efforts to resolve any grievances . -The facility will appoint a grievance officer who will be responsible for overseeing the grievance process including: >Receiving and tracking grievances to conclusion >Conducting any necessary investigations >Issuing written grievance decisions to the resident if requested Residents will be notified individually or through postings in prominent locations through the facility of the following: >The right to file a grievance orally or in writing >A reasonable expected time frame for completing review of the grievance >The right to obtain a written decision regarding his or her grievances >Contact information of independent entities with whom grievances may be filed .(i.e Ombudsman [a person who investigates, reports on, and helps settle complaints]) -The grievance officer shall begin the grievance process by logging a summary of the grievance (if oral), the date the grievance was received and by initiating an investigation. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of any grievances filed should be completed within seven days. If the review cannot be completed within this timeframe, the grievance officer should communicate the status of the review and an updated time in which it is expected the review will be completed. -Upon completion of the review, the grievance officer should document the following: a. The date the grievance was received. b. A summary of the resident's grievance. c. Steps taken to investigate the grievance. d. A summary of the pertinent findings or conclusions regarding the grievance. e. A statement as to whether the grievance was confirmed or not. f. Any corrective action taken or to be taken in response. During an interview on 1/28/25 at 8:49 A.M., the Ombudsman said that he recently attended a Resident Council Meeting and residents said there were not enough nursing staff on the 11:00 P.M.- 7:00 A.M. shift and that the residents had to wait to be changed or cleaned up. Review of the Resident Council Minutes on 12/18/24 indicated the following: -Nine residents were in attendance -The Ombudsman was in attendance -Residents stated that on the 11:00 P.M.- 7:00 A.M. shift they do not get changed all night except right before their A [sic] shift is over in the morning. -Meeting minutes were reviewed and signed by the Activities Director and the facility Administrator. -Review of the Resident Council Minutes for 12/18/24 provided to the survey team failed to indicate evidence of a Resident Council Concern Follow Up Form or additional response relative to the staffing concerns on the 11:00 P.M.- 7:00 A.M. shift. Review of the Resident Council Minutes on 1/21/25 indicated the following: -Ten residents were in attendance -Residents stated that their medication is passed late sometimes and they need more CNAs, there are not enough. -Meeting minutes were reviewed and signed by the Activities Director and the facility Administrator. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Council Concern Follow Up Form, dated 1/21/25, indicated: -Concern was for Nursing -Nature of the concern: Residents stated their meds are passed late and they need more CNAs. -Department Head solution: Staff shortage, working to get more staff. -Form was signed by the Resident Council President, Department Head, Activities Director, and Administrator on 1/22/25 -Further review of the Resident Council Concern Follow Up Form did not indicate that a response and rationale for the response was provided to the Resident Council as required. During a group interview with the Resident Council members on 1/28/25 at 10:07 A.M., nine residents participated in the meeting from the Windsor Unit and stated the following: -The Activities Director takes notes regarding grievances or concerns from Resident Council meetings and provides the notes to the Department Heads and the Administrator. -The Department Heads will respond to the Activities Director and the Administrator signs off on the concern. -The Ombudsman was responsive, involved, and attended Resident Council Meetings. -On the 11:00 P.M.- 7:00 A.M. shift, the facility usually only has two staff members on each unit. -The facility had tried to hire people but Residents were told that the positions were hard to fill. -The 11:00 P.M.- 7:00 A.M. staff were often regularly scheduled staff, not agency staff. -Residents felt the staffing issue was ongoing and unresolved. -4 out of the 9 residents stated they had waited for more than 30 minutes for assistance from CNAs (Certified Nursing Assistants) on the 11:00 P.M.- 7:00 A.M. shift at times. -3 out of the 9 residents stated they had waited for more than 60 minutes for assistance from CNAs on the 11:00 P.M.- 7:00 A.M. shift at times. Review of actual worked nursing schedules with daily unit census data (number of residents residing on a given unit on a given day) provided to the survey team indicated the following staffing levels: -1/13/25: Total Census 86 A) Elmwood Unit: Census- 41. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	> 11:00 P.M.- 7:00 A.M. shift: 1 CNA and 1 Nurse B) Windsor Unit: Census- 45. > 11:00 P.M.- 7:00 A.M. shift: 2 CNAs and 1 Nurse - 1/16/25: Total Census 85 A) Elmwood Unit: Census- 43 > 11:00 P.M.- 7:00 A.M. shift: 1 CNA and 1 Nurse B) Windsor Unit: Census- 42 > 11:00 P.M.- 7:00 A.M. shift: 2 CNAs and 1 Nurse - 1/19/25: Total Census 84 A) Elmwood Unit: Census- 42 > 11:00 P.M.- 7:00 A.M. shift: 1 CNA from 11:00 P.M. to 5:45 A.M., and 1 Nurse B) Windsor Unit: Census- 42 > 11:00 P.M.- 7:00 A.M. shift: 2 CNAs and 1 Nurse During an interview on 1/18/25 at 4:09 P.M., The Activities Director (AD) said that she will complete a Resident Council Concern Form documenting any issues or grievances brought up in the Resident Council Meeting. The AD said she gives the forms to the department heads right away to notify them of the issue and to get a response. The AD said that she recalled filling out a Resident Council Concern Form on 12/18/24 about the staffing concern on the 11:00 P.M.- 7:00 A.M. shift, but she was unable to locate the form. During an interview on 1/29/25 at 10:02 A.M., the surveyor met with the Clinical Nurse Specialist (CNS) and the Administrator. The CNS said that they have received grievances relative to staffing and that staffing had come up a couple of times in Resident Council. The CNS further said the facility responded to the Resident Concern on 1/22/25 and that the issues were mostly during morning time medication pass, and the facility adjusted their staffing model in response to cover medication administration by Nursing. At the time, the surveyor, the Administrator, and the CNS reviewed the staffing information on 1/13/25, 1/16/25, and 1/19/25. The CNS said they staff for two CNAs on each unit (Elmwood and Windsor, total of 4 CNAs) for the 11:00 P.M.- 7:00 A.M. shift and that the Elmwood unit has residents who have more acute needs and require a higher level of care. The CNS said that three CNAs in the facility from 11:00 P.M. to 7:00 A.M. is not appropriate for a census of 84 and the staffing plan is for four CNAs in the facility. During an interview at the time, the Administrator said that she was aware that a CNA had no-called, no-showed on 1/13/25, 1/16/25, and 1/19/25. The Administrator further said she was not aware that only 3 CNAs had worked the 11:00 P.M.- 7:00 A.M. shift those days or that the shifts had not been filled. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor requested any evidence of the response to the 12/18/24 Resident Council concern relative to the 11:00 P.M.- 7:00 A.M. shift staffing. During an interview on 1/29/25 at 4:04 P.M., the Administrator said that she does not have evidence that the staffing concern from the 12/18/24 Resident Council was addressed. The Administrator said she treats the Resident Council concerns as grievances, and the staffing concern should have been addressed and was not. No additional evidence was provided to the survey team at time of survey exit relative to response to the Resident Council concerns on 12/18/24 or 1/21/25. Please refer to F725

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45429 Based on record review, and interview, the facility failed to accurately execute Advance Directives for two Residents (#41 and #234) out of a total sample of 18 residents. Specifically, the facility failed to: 1. For Resident # 41, ensure that the MOLST (Massachusetts Medical Order for Life-Sustaining Treatment) form was valid and reflected the signature of Resident #41's invoked (made active by a Physician) Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) after the Physician had determined that the Resident lacked the capacity for informed medical decision making. 2. For Resident #234, ensure that the MOLST form was valid and reflected the signature of the Resident who maintained his/her capacity for informed medical decision making. Findings include: Review of the facility policy for MOLST, dated August 2015, indicated: -the admitting nurse will note the existence of the MOLST form on the admissions assessment and review the form for completeness (e.g. signed by the resident/patient or legally recognized health care agent, and by a qualified health care provider) and confirm with the resident/patient, if possible, or the resident's legally recognized health care agent, the MOLST form in hand has not been revoked or superseded by a subsequent MOLST form. A completed, fully executed MOLST form is a valid medical order, and is immediately actionable. -a qualified health care provider, preferably a registered nurse or social worker, may conduct an initial review of the MOLST with the resident/patient, or if the resident/patient lacks decision-making capacity the legally recognized health care agent, within the first required 14 day assessment period as part of the comprehensive assessment and care planning process. -The MOLST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference, anytime there is a significant change in the resident's condition, or if the resident/patient lacks decision making capacity, if the legally recognized health care agent requests it. 1. Resident #41 was admitted to the facility in November 2022, with diagnoses including toxic encephalopathy and seizure disorder. Review of Resident #41's clinical record indicated: -a MOLST form signed on 3/14/23 by Resident #41's HCP. -a HCP activation form dated 8/23/24 after the MOLST form had been signed by the HCP. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-no evidence that the MOLST form had been re-addressed with Resident #41's HCP after their facility admission and before the surveyor brought it to the attention of the facility. During an interview on 1/28/25 at 3:41 P.M., Social Worker (SW) #1 said that the MOLST form for Resident #41 was not valid as it had been signed by the HCP before the Resident had been deemed incapacitated by his/her Physician. 2. Resident #234 was admitted to the facility in January 2025 with diagnoses including Psychosis and Hypertension. Review of Resident #234's clinical record indicated: -a MOLST form signed on 5/16/22 by Resident #234's HCP prior to his/her admission to the facility. -no evidence of a HCP activation form or Physician's order for HCP activation to validate the HCP's signing of the MOLST form. -no evidence that the MOLST form had been re-addressed with Resident #234 after his/her facility admission and before the surveyor brought it to the attention of the facility. During an interview on 1/28/25 at 3:36 P.M., SW #1 said the MOLST form from 5/16/22 was not valid and that a new MOLST form should have been completed with Resident #234 and it had not been.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 51466 Based on interview, and record review, the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC: notice issued to a resident who is receiving benefits under Medicare Part A when all covered services end) and/or Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN: notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) were accurately issued for three Residents (#483, #63, #34) out of a total sample of 18 residents. Specifically, the facility failed to: 1. For Resident #483: >issue a NOMNC with Provider contact information inserted above the title of form. >provide the NOMNC two days prior to discharge. 2. For Resident #63: >provide a NOMNC with Provider contact information inserted above the title of form. >provide paper copies of NOMNC to responsible party. >obtain signature on the SNF ABN form, indicating the responsible party received and understood the information. 3. For Resident #34: >provide the NOMNC with Provider contact information inserted above the title of form. >provide paper copies of NOMNC to the responsible party. >obtain signature on the SNF ABN form, indicating the responsible party received and understood the information. Findings include: Review of Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) Centers for Medicare and Medicaid Services (CMS -10123), indicated the following: -The name, address, and telephone number, of the provider that delivers the notice must appear above the title of the form. The provider's registered logo may be used. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. -Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of electronic notice delivery. -The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. Review of the Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566, indicated the following: -The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. -The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain a copy of the ABN delivered to the beneficiary on file. -The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out representative in parentheses after his or her signature. The representative's name should be clearly legible or noted in print. -The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier. 1. Resident #483 was admitted to the facility in December 2024. Review of Resident #483's clinical record indicated: -the Resident was his/her own responsible party. -the Resident was discharged home on 12/16/24. -the Resident had a planned discharge to home, as evidenced by a nursing progress note dated 12/13/24, that indicated: >the Resident's family member asked to speak with staff about discharge planning. >the interdisciplinary team was working on setting up services for discharge. Review of the NOMNC form for Resident #483 indicated: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #483's last covered day (LCD) of Medicare Part A service was on 12/16/24. -Resident #483 had a planned discharge to home which was initiated by the facility. -Provider contact information did not appear above the title of the form. -Resident #483 was not given the NOMNC form two calendar days prior to LCD and signed the NOMNC form on 12/16/24, the same day as discharge. 2. Resident #63 was admitted to the facility in October 2023 Review of Resident #63's medical record indicated: -The Resident's HCP was invoked on 10/27/23. -Resident #63 received Medicare Part A Skilled Services which started on 12/24/24. -Resident #63 had a LCD of Part A Services on 1/16/25. -Resident #63 remained in the facility after the LCD on 1/16/25. Review of the NOMNC form for Resident #63 indicated: -Resident #63's LCD of Medicare Part A Services was on 1/16/25. -Provider contact information did not appear above the title of the form. -Resident #63's Responsible party was notified of LCD on 1/14/25 by phone and a message was left. -Provider emailed the NOMNC form to the Responsible Party on 1/14/25. -Provider did not mail the NOMNC form or request return receipt by mail. Review of the Skilled Nursing Facility SNF ABN form indicated the following: -The signature box for Patient or Authorized Representative indicating they had received and understand the notice, was unsigned. 3. Resident #34 was admitted to the facility in November 2024. Review of Resident #34's medical record indicated: -Resident #34 had a legal Guardian who was their responsible party. -Resident #34 received Medicare Part A Skilled Services Episode which started on 12/19/24. -Resident #34 had a LCD of Part A Services on 1/5/25. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident remained in the facility after the completion of his/her Medicare Part A stay. Review of NOMNC form indicated: -Medicare Part A Services ended on 1/5/25. -Provider contact information did not appear above the title of the form. -Provider staff person called the Resident's Responsible party on 1/3/25 at 2:00 P.M. to notify them of the Resident's LCD of 1/5/25. -Provider staff person emailed the NOMNC form. -Provider staff person did not mail the NOMNC form. Review of the Skilled Nursing Facility SNF ABN form indicated the following: -The signature box for Patient or Authorized Representative indicating they had received and understand the notice, was unsigned. During an interview on 1/28/25 at 3:57 P.M, the Social Worker (SW) said that she should have filled out the Provider information at the top of the NOMNC forms for Residents #483 and #63, but she did not. The SW said she did not realize the facility needed to provide the Resident or Responsible Party with a copy of the NOMNC form and did not mail a copy of the NOMNC forms to the responsible parties for Resident #63 and #34 but had emailed them instead. The SW said she did not receive a signed copy of the NOMNC forms from the responsible parties for Resident's #63 and #34. The SW said she was not aware the Patient or Responsible Party needed to sign the SNF ABN form and could not provide evidence this was done for Resident's #63 and #34. The SW said that she refers to the CMS guidelines for NOMNC and ABN completion to ensure that they are done properly.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, record review, and interview, the facility failed to maintain a clean, comfortable, and homelike environment for one Resident (#54) out of a total sample size of 18 residents. Specifically, the facility failed to maintain Resident's #54 wheelchair in a clean and sanitary manner when the Resident was dependent on the wheelchair for mobility and the wheelchair was visibly soiled. Findings include: Resident #54 was admitted to the facility in October 2023 with diagnoses including Unspecified Abnormalities of Gait, Mobility and Weakness. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #54: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 00 out of a total possible score of 15. -was dependent for wheelchair mobility. Review of the Comprehensive Person-Centered Care Plan for Resident #54 indicated: -Resident #54 had impaired mobility and required intervention of a wheelchair for a mobility device. On 1/27/25 at 11:12 A.M., the surveyor observed Resident #54 seated in the day room in his/her wheelchair with the bilateral arm rests coated in a white splattered substance and dried brown debris. On 1/29/25 at 11:29 A.M., the surveyor observed Resident #54 seated in his/her wheelchair while in the small multipurpose room. The wheelchair remained with the bilateral arm rests coated in a white splattered substance and dried brown debris. On 1/30/25 at 8:57 A.M., the surveyor observed Resident #54 seated in the day room in his/her wheelchair and the bilateral arm rests remained coated in a white splattered substance and dried brown debris. During an interview on 1/30/25 at 3:00 P.M., Certified Nurses Aide (CNA) #5 said he was assigned to the Resident today. The surveyor and CNA #5 observed Resident #54's wheelchair and CNA #5 said the wheelchair was dirty. CNA #5 said that wheelchairs should be cleaned weekly by housekeeping. CNA #5 said that all staff could and should wipe up spills when they occur. CNA #5 said that housekeeping services would come and clean any equipment if asked but that he had not contacted housekeeping during his shift to clean the wheelchair and should have. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/25 at 3:20 P.M., the Housekeeping Director (HD) said that wheelchair cleaning should be performed weekly on Wednesdays. The HD said that wheelchair cleaning had not been done in the past week due to staff illness and no replacement staff had been assigned to complete wheelchair cleaning last week. The surveyor and the HD observed Resident #54's wheelchair and the HD said the wheelchair was dirty and in need of cleaning. The HD was unable to provide evidence that Resident #54's wheelchair had been cleaned over the past 30 days. The HD said that she has tried to promote a clean, home-like, and comfortable environment for all Residents, but the wheelchair was not okay, and she would not want to sit in it. During an interview on 2/3/25 at 2:00 P.M., the Administrator said that there was no facility policy for wheelchair cleaning, but that wheelchair cleaning should be done every two weeks and/or when needed.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 42761 Based on interview, and record review, the facility failed to complete a Minimum Data Set (MDS) Assessment in a timely manner for one Resident (#82) out of three Residents reviewed in a closed record sample. Specifically, the facility failed to complete a significant change in status assessment (SCSA) by the fourteenth calendar day after the determination that a significant change in the Resident's status had occurred. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, indicated the following relative to timing for a SCSA: -An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program. -The ARD (Assessment Reference Date) must be less than or equal to 14 days after the determination that the criteria for an SCSA are met (determination date plus 14 calendar days). -The MDS completion date could be no later than the fourteenth calendar day after determination that significant change in resident's status occurred (determination date plus 14 calendar days). Resident #82 was admitted to the facility in January 2023 with diagnoses including End Stage Renal Disease (ESRD) and Dementia. Review of Resident #82's clinical record indicated the following: -The Resident was admitted to Hospice on 12/16/24 resulting in a significant change in status and change in plan of treatment. -A SCSA with an ARD of 12/18/24 was completed on 1/5/25. -Review of the SCSA demonstrated that the assessment was completed 20 days after determination that a significant change in the Resident's status occurred on 12/16/24. During an interview on 2/3/25 at 11:45 AM, MDS Nurse #1 said that the SCSA was not completed until 1/5/25 and that the Assessment was completed late. MDS Nurse #1 said that the Assessment should have been completed timely to ensure services provided to the Resident to meet the Resident's needs.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interview, and record review, the facility failed to accurately complete Minimum Data Set (MDS) Assessments for one discharged Resident (#82) out of three closed records reviewed, and for four Residents (#235, #38, #54, and #51) out of a total sample of 18 active resident records reviewed. Specifically, the facility failed to: 1. For Resident #82, code Hospice services on the Resident's Significant Change in Status Assessment (SCSA) when the Resident received Hospice services while at the facility. 2. For Resident #235, code that the Resident was taking antipsychotic, antidepressant, antianxiety, and anticoagulant medications when staff administered these medications to the Resident during the observation period for the MDS Assessment, while the Resident was at the facility. 3. For Resident #38, code that the Resident was taking an opioid medication when staff administered the medication to the Resident during the observation period for the MDS Assessment. 4. For Resident #54, ensure that the Minimum Data Set (MDS) Assessment was accurately coded related to Resident #54's use of psychotropic medication. 5. For Resident #51, code that the Resident was taking an antidepressant medication when staff administered the medication to the Resident during the observation period for the MDS Assessment. Findings include: 1. Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2023, indicated the following: -Special treatments, procedures, and programs included Hospice services. -Special treatments, procedures, and programs performed for a resident, while the resident was in the facility and within the previous 14 days, were to be recorded on the MDS assessment. Resident #82 was admitted to the facility in January 2023 with diagnoses of Dementia and End Stage Renal Disease (ESRD). Review of Resident #82's clinical record indicated the Resident was admitted to Hospice Services on 12/16/24. Review of Resident #82's SCSA, dated 12/18/24, did not indicate that the Resident received Hospice Services while in the facility and within the previous 14 days of the 12/18/24 ARD (Assessment Reference Date). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/3/25 at 11:45 A.M., MDS Nurse #1 said that Resident #82's SCSA was not accurately coded. MDS Nurse #1 said that the Resident's SCSA should have indicated that Hospice Services were provided to Resident #82 during the observation period for the assessment. MDS Nurse #1 said that the MDS Assessment should have been accurately coded to ensure appropriate delivery of care for the Resident's needs. 2. Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, indicated the following relative to medications: -The intent of the items in this section is to record the number of days, during the last seven days (or since admission/entry or reentry if less than seven days) that . select medications were received by the resident. -Review the resident's medication administration records for the seven day look-back period (or since admission/entry or reentry if less than seven days). Resident #235 was admitted to the facility in January 2025 with diagnoses including delirium, Compression Fracture, Acute Embolism and Thrombosis of Deep Veins, and Traumatic Brain Injury (TBI). Review of Resident #235's MDS Assessment, dated 1/15/25, did not indicate the Resident took anticoagulant, antidepressant, antipsychotic, and antianxiety medications during the look-back period for the MDS Assessment. Review of Resident #235's January 2025 Medication Administration Record (MAR) indicated the Resident received the following medications during the seven day look back period between his/her admission to the facility and the ARD of the MDS assessment dated [DATE]: -Apixaban (anticoagulant medication), six days. -Trazodone (antidepressant medication,) six days. -Haloperidol (antipsychotic medication,) six days. -Lorazepam (antianxiety medication), four days. During an interview on 1/29/25 at 3:41 P.M., MDS Nurse #2 said that Resident #235 received anticoagulant, antidepressant, antipsychotic, and antianxiety medications during the look-back period for the MDS assessment dated [DATE]. MDS Nurse #2 said that the Resident's MDS Assessment was coded inaccurately and should have been coded to indicate that the Resident received anticoagulant, antidepressant, antipsychotic, and antianxiety medications during the look-back period for the Assessment. 44337 3. Resident #38 was admitted to the facility in August 2024 with diagnoses including chronic back pain and Neuropathy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #38 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. Review of the January 2025 Physician's orders for Resident #38 indicated: -Tramadol HCL (opioid medication used to treat moderate to severe pain) tab 100 mg (milligrams) - two half tabs (100 mg) by mouth every six hours, initiated 12/13/24. Review of the January 2025 Medication Administration Record (MAR) indicated Resident #38 was administered Tramadol HCL as ordered by the Physician. Further review of the MDS assessment dated [DATE] did not indicate Resident #38 had been accurately coded for the prescribed Tramadol HCL medication. During an interview on 1/29/25 at 2:06 P.M., MDS Nurse #2 said that the MDS dated [DATE] had been coded inaccurately. MDS Nurse #2 said that Resident #38 had been receiving Tramadol HCL and the MDS should have been coded for use of the opioid medication. MDS Nurse #2 said she would modify the 1/10/25 MDS information to reflect the opioid medication for Resident #38. 50138 4. Resident #54 was admitted to the facility in October 2023 with diagnoses including Dementia with other behavioral disturbances, Mood Disturbance and Anxiety. Review of Resident #54's Comprehensive Person-Centered Care Plan, last revised 11/11/24, indicated: -The Resident used psychotropic medications (medications that affect a person's mental status). Review of the Resident's clinical medical record indicated: -The Resident was prescribed and administered Trazodone (antidepressant medication) 25 mg (milligrams) by mouth daily at bedtime, effective 10/21/23. -The Resident was prescribed and administered Prozac (antidepressant medication) 20 mg by mouth daily, effective 10/31/23. -The Resident was prescribed and administered Seroquel (antipsychotic medication) 12.5 mg by mouth daily at bedtime, effective 9/10/24. Review of Resident #54's most recent Minimum Data Set (MDS) assessment dated [DATE], did not indicate that the Resident utilized psychotropic medications. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 8:00 A.M., MDS Nurse #1 said the facility followed the RAI Manual for coding and was aware that Resident #54 was prescribed psychotropics. MDS Nurse #1 said she did not believe the psychotropic medications needed to be coded as the psychotropic medications had not been newly prescribed in the last seven days. MDS Nurse #1 said that she would need to consult with her supervisor to clarify. During an interview on 1/30/25 at 4:30 P.M., the Clinical Nurse Specialist (CNS) said the 1/10/25 MDS Assessment for Resident #54 was not coded correctly as the prescribed psychotropic medications should have been included but they were not. The CNS said that MDS coding should be accurate as it is an assessment which assists in developing the plan of care and services required for the Resident. 50320 5. Resident #51 was admitted to the facility in July 2021 with diagnoses including Cerebral Vascular Accident (CVA), Major Depressive Disorder, and Generalized Anxiety Disorder. Review of Resident #51's January 2025 Physician's orders indicated the Resident: -was ordered Cymbalta (antidepressant) 20 mg one capsule by mouth, twice daily, initiated 7/31/21. Review of Resident #51's January 2025 MAR indicated the Resident was administered the Cymbalta medication as ordered by the Physician during the month of January. Review of the Physician Progress Note dated 1/3/25, indicated the Resident should continue with Cymbalta as part of the treatment plan for Depression. Review of the Resident's most recent MDS dated [DATE], indicated the Resident was not taking an antidepressant medication. During an interview on 2/3/25 at 8:50 A.M., MDS Coordinator #1 said the MDS Assessment completed in January 2025 should have been coded yes for antidepressants and it was not.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on record review, and interview, the facility failed to provide care and services that met professional standards of practice for two Residents (#56 and #51) out of a total sample of 18 residents. Specifically, the facility failed to: 1. For Resident #56, schedule a urology appointment when the Resident had been discharged back to the facility from the hospital with a kidney stone and related infection. 2. For Resident #51, implement a Physician order for a Pulmonary Consultation to evaluate the Resident for clinical symptoms and Chronic Obstructive Pulmonary Disease (COPD). 3. For Resident #51, implement the Physician's orders for weekly weight monitoring. Findings include: Review of the facilty Policy and Procedure for Consultant Services dated April 2015, indicated: >The organization will identify and facilitate consultant services to meet the Resident's needs, to ensure optimum care for each resident/patient through their consultant services. >The licensed charge nurse will obtain an order for the consultant. All Consultation orders should specify why the order is being requested. >Once the consultant has been identified by the MD and after the family has been notified and given permission for the consult, the staff will call the consultant to notify him/her of the request and document response in the medical record. Review of the Board of Registration in Nursing Advisory, Ruling on Nursing Practice, titled: Accepting, Verifying, Transcribing and implementing Prescriber orders. Issued 9/22/93, revised 4/11/18, indicated: -Nurse's Responsibility and Accountability: >Licensed Nurses accept, verify, transcribe, and implement orders from duly authorized Prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. >Licensed Nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. >The paramount importance of patient safety must be reflected in practices that are specific to the setting and circumstance. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #56 was admitted to the facility in March 2022 with diagnoses including Major Neurocognitive Disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #56: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of a total possible score of 15. Review of Resident 56's hospital discharge summary indicated a primary diagnosis of kidney stone and antibiotics were prescribed. Further review of the hospital discharge summary indicated that an appointment should be scheduled with the Urologist as soon as possible for a diagnosis of left kidney stone. Review of a Nursing Admission Progress Note dated 12/25/24 at 8:13 P.M., indicated Resident #56 returned from the hospital with a diagnosis of a left kidney infection due to the presence of a kidney stone and had been prescribed antibiotic therapy. Further review of the Nursing Admission Progress Note indicated that medications and laboratory orders had been verified with the on-call Medical Provider. Review of a Nursing Admission Progress Note dated 12/25/24 at 9:38 P.M., indicated that a follow-up appointment should be scheduled as soon as possible to see the Urologist per hospital report. Further review of Resident #56's clinical record did not indicate that the urology appointment had been scheduled as required for the Resident. During an interview on 1/30/25 at 11:19 A.M., Nurse #5 said when a Resident returns from the hospital, the Physician is notified and all medications, orders, and recommendations are reviewed at that time and documented by the Nurse in the admission progress notes. Nurse #5 said that any appointments listed in the hospital discharge summary are scheduled one to two days after a Resident returns from the hospital and entered into the unit appointment book once they are scheduled. Nurse #5 said that she could not find any evidence in the clinical record that the urology appointment had been addressed with the Physician or scheduled for follow-up. Nurse #5 said that Resident #56's urology appointment had been overlooked. 50320 2. Resident #51 was admitted to the facility in July 2021, with diagnoses including Cerebral Vascular Accident (CVA), Hypertension (HTN), Morbid Obesity, and Diabetes Mellitus Type 2 (DM II). Review of the most recent Minimum Data Set (MDS) Assessment indicated Resident #51 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points. Review of Resident #51's clinical record included a Nursing Progress Note dated 5/28/24, that indicated the Resident: -complained of coughing a lot (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-cough was reported to the Nurse Practitioner (NP) -new order obtained for Prednisone (corticosteroid) 40 milligrams (mg) by mouth (PO) BID x 5 days -start Mucinex (expectorant) 400 mg PO every 8 hours as needed for cough for 3 days -may have a pulmonary consult due to Chronic Obstructive Pulmonary Disease (COPD) and worsening needs Review of the NP progress note dated 5/28/24 indicated: -History: the patient requested cough medicine and reports chronic cough I have COPD -Physical Exam Respiratory: Diminished B/L (bilaterally), faint expiratory wheezes, no crackles -Plan: for cough - patient reports a history of COPD but no documentation of this diagnosis in the past >start Prednisone 40 mg a day for question of asthma or COPD >Pulmonary Consult for question of a diagnosis of COPD >not on medications Review of Resident #51's January 2025 Physician's orders indicated in the consult section, undated, the following: -Pulmonary Consult for Chronic Obstructive Pulmonary Disease (COPD) >Further review of the clinical record indicated no evidence that a Pulmonary Consult was obtained for Resident #51 as ordered. During an interview on 2/3/25 at 10:44 A.M., the Clinical Nurse Specialist (CNS) said she spoke with the NP on 1/31/25 regarding a follow-up on the Pulmonology Consult and the NP recommended the Resident be scheduled for a non-emergent Pulmonary Consult. The CNS said someone should have followed through with the original recommendation on 5/28/24 but they did not. 3. Review of the facility policy, Weights, dated August 2015, indicated the following: >Residents are weighed weekly x4: residents/patients with MD order for weekly weights. >Residents will be weighed monthly, unless clinically indicated. >Weights are documented in the resident's/patient's medical record and/or weight book. Resident #51 was admitted to the facility in July 2021 with diagnoses including Cerebral Vascular Accident (CVA), Hypertension (HTN), Morbid Obesity, and Diabetes Mellitus Type II (DM II). (continued on next page)

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Lanessa Extended Care	751 School Street Webster, MA 01570

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points. -had diagnoses of Hypertension, Morbid Obesity, and Diabetes. -was prescribed a Diuretic (medication to help the body get rid of extra fluids, used to treat high blood pressure, edema, and other conditions). Review of the Resident #51's Nutrition Care Plan, initiated 11/3/21 and revised 1/2/25, indicated: >Monitor/evaluate weight/weight changes date, initiated 11/3/21. >Obtain weights as ordered and record date, initiated 5/11/22. Review of Resident #51's December 2024 Physician's orders indicated the Resident was prescribed the following Diuretic medications: >Lasix 20 milligrams (mg) three tablets (60 mg) daily by mouth, once daily, initiated 5/21/24 (increase in lower extremity edema) >Hydrochlorothiazide 25 mg tablet by mouth, once daily, initiated 7/23/21 Review of the Resident's December 2024 Medication Administration Record (MAR) indicated the Resident was administered the medications as ordered by the Physician from 12/1/24 - 12/31/24. Further review of the Resident's clinical record indicated the following Physician's orders: -Weigh weekly, initiated 12/2/24 Review of Resident #51's December 2024 MAR and Treatment Administration Record (TAR) indicated no documentation of weekly weights as ordered by the Physician on 12/2/24. Review of Resident #51's Weight Report for December 2024 indicated the Resident had one recorded weight: -12/10/24: weight 345.6 pounds. Review of the January 2025 Physician's orders for Resident #51 indicated: >Weight daily, notify Nurse Practitioner (NP) if greater than 3 pounds, order not dated >Lasix 20 milligrams (mg) three tablets (60 mg) daily by mouth, once daily, initiated 5/21/24 >Hydrochlorothiazide 25 mg tablet by mouth, once daily, initiated 7/23/21 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's Physician Progress Note dated 1/3/25, indicated the plan for Hypertension, Heart disease with CHF and Lower Extremity Edema was to: - .continue with Hydrochlorothiazide 25 mg daily - .continue with Furosemide (Lasix) 60 mg daily -continue to monitor vital signs. Review of the January 2025 MAR and January 2025 TAR indicated that no weights had been recorded for the month. Review of the January 2025 Weight Report indicated the Resident had one recorded weight: -1/17/25: weight 349.3 pounds. During an interview on 2/3/25 at 8:02 A.M., the Director of Nursing (DON) said the Certified Nurses Aides (CNA) weigh the Residents and report the weight to the Resident's Nurse. The DON said the Nurse should then record the weight in the electronic medical record (EMR) or on the MAR/TAR. The DON said these are the only two places resident weights are recorded. The surveyor and the DON reviewed Resident #51's clinical record, and the DON said she was unaware Resident #51 had a current Physician's order for daily weights or a past order for weekly weights in December 2024. The DON said whatever the Resident's current Physician's order for weights is, that it should be completed as ordered by the Physician and documented on the MAR/TAR or in the electronic medical record. The DON said based on the current orders in Resident #51's medical record, staff were not weighing the Resident as ordered. During an interview on 2/3/25 at 10:32 A.M., the Clinical Nurse Specialist (CNS) said she was unable to determine where the order for daily weights had come from on the January 2025 orders. The CNS said the NP had updated the order in December 2024 for weekly weights. The CNS said she had spoken to the NP who would evaluate the Resident and determine what weights were appropriate for the Resident. During an interview on 2/3/25 at 10:46 A.M., the NP said she believed she had requested weekly weights for Resident #51 in December 2024 to assess for any weight changes but did not remember writing an order for daily weights in January 2025. The NP said she was going to assess the Resident to establish the appropriate weighing schedule for him/her.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50138 Based on observation, record review, and interview, the facility failed to provide a smoking environment that was free of accidental hazards for one Resident (#62), out of a total sample size of 18 residents. Specifically, the facility failed to ensure that Resident #62 was appropriately supervised during smoking activity when the Resident was assessed as needing supervision, placing the Resident at risk of accident and/or injury. Findings include: Review of the facility policy titled Smoking; revised November 2020 indicated but was not limited to the following: -It is the policy of the facility to provide a healthy and safe environment for residents, staff, and visitors by limiting the use of tobacco smoking materials on its campus. -Purpose is to afford residents the privilege of smoking while maintain a safe and clean environment within the policy of this facility, that also is respectful to the non-smoker. <Residents who smoke will be evaluated for their ability to smoke safely upon admission, quarterly, and as dictated by any significant change in condition, to ensure that they continue to be capable of smoking and use smoking materials without presenting a danger to themselves or others. The need for assistive and/or safety devices will be identified and noted on the resident's individualized care plan. <Smoking will be permitted at scheduled times .The facility reserves the right to make changes to the designated times if/or when necessary, residents will be notified of such. <Smoking will take place under the supervision of a staff member. Resident #62 was admitted to the facility in August 2023 with diagnoses including nicotine dependence and Dementia. Review of Resident #62's most recent Smoking Evaluation and Safety Screen dated 10/22/24, indicated: -The Resident required routine supervision during scheduled smoking activity to ensure the Resident was safe during smoking. Review of Resident #62's Comprehensive Person-Centered Care Plan, last revised 2/27/24, indicated: -The Resident was assessed for smoking and was assessed for supervision level: Supervised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident will smoke safely at the designated areas and a scheduled time. -The Resident required monitoring for safety during smoking. On 1/27/25 at 11:15 A.M., the surveyor observed Resident #62 was seated in a chair and smoking a cigarette outside of the building in the designated smoking area at the front of the facility. The surveyor observed a male staff member was present outside in the designated smoking area. During an interview at the time, the male staff member identified himself as the facility's resident smoking supervisor. The smoking supervisor said that the Residents who smoke always required supervision during the scheduled smoking times for safety reasons. The smoking supervisor was then observed leaving the smoking area to assist another resident in a wheelchair back to the nursing unit, leaving Resident #62 unsupervised while he/she was actively smoking a cigarette. Upon returning to the smoking area, the smoking supervisor said that the resident in the wheelchair needed assistance to get back to the nursing unit because it was cold outside. On 1/28/25 at 9:10 A.M., the surveyor observed Resident #62 seated in a chair in the smoking area holding a burning cigarette and smoking without any staff member present in the designated smoking area. The surveyor observed the smoking supervisor exit the facility via the front door and enter the smoking area thereafter. During an interview at the time, the smoking supervisor said that he was the staff member assigned to the 9:00 A.M. smoking time. During a follow-up interview on 1/29/25 at 9:23 A.M., the smoking supervisor said that smoke times are about 15 minutes long. The smoking supervisor said that his main responsibility is to supervise the smoking supplies and the residents for the whole time, so the residents do not get hurt, such as a burn or fall. During an interview on 1/29/25 at 12:05 P.M., the Administrator and Director of Nursing (DON) said that routine supervision for smoking meant that a Resident required supervision by a staff member at all times while cigarettes were being smoked. The Administrator said it was her expectation that the smoking supervisor was to monitor the entire duration of the smoking time and not leave residents unattended.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42761 Based on observation, interview, and record review, the facility failed to provide treatment in accordance with professional standards of practice relative to an indwelling urinary catheter for one Resident (#34) out of a total sample of 18 residents. Specifically, the facility failed to: -reassess Resident #34's indwelling catheter status upon re-admission when the Resident was hospitalized with indwelling urinary catheter associated complications. -obtain a Physician order to include the current indwelling urinary catheter size required for the Resident. -update the Resident's Indwelling Catheter Care Plan to reflect the Resident's current indwelling catheter status. Findings include: Review of the facility's policy titled Urinary Catheter Insertion (Indwelling), dated April 2015, indicated an indwelling urinary catheter would be inserted when the resident's clinical condition demonstrates necessity by a licensed nurse, as ordered by the physician. Resident #34 was admitted to the facility in February 2023 with diagnoses including Dementia, Obstructive and Reflux Uropathy, Benign Prostatic Hypertrophy (BPH), other Hydronephrosis, and Stage Four Chronic Kidney Disease. Review of Resident #34's Indwelling Urinary Catheter Care Plan, initiated 7/29/24 and revised 11/27/24, indicated: -The Resident had an indwelling urinary catheter, size 14 French (Fr: French scale or system used to size catheters) with a 10 milliliter (ml) balloon. -Change Foley (type of indwelling urinary catheter) . per MD (physician) order. Review of Resident #34's Minimum Data Set (MDS) Assessment, dated 12/23/24, indicated: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of four out of 15 total possible points. -The Resident required partial/moderate assistance for perineal hygiene. -The Resident had an indwelling urinary catheter. Review of Resident #34's January 2025 Physician orders, dated 1/13/25, indicated: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Foley Cath (catheter) # (size) 16 Fr -Balloon 10 ml. -Change Foley Catheter (Coude [type of catheter with a curved tip]) once a month . -Irrigate Foley Catheter with 60 ml NS (normal saline) as needed for blockage or leakage. -Replace Foley Catheter as needed for blockage or leakage. Review of Resident #34's January 2025 Treatment Administration Record (TAR) indicated staff changed the Resident's indwelling urinary catheter on 1/22/25 as follows: -Coude cath (catheter). -16 Fr, 10 ml balloon. Review of Resident #34's Nursing Progress Note, dated 1/24/25, indicated: -The Resident's Foley bag was full and draining bloody drainage. -Foley was flashed [sic]. -A new Foley was changed. -The new Foley was not patent. -The Resident was confused and started shaking. -A new order was obtained to send the Resident to the ER (emergency room). Review of Resident #34's Hospital Discharge Summary, dated 1/27/25, indicated: -The Resident had experienced hematuria (blood in the urine). -The Resident's indwelling catheter was changed to a size 24 Fr with a 10 ml balloon. Review of Resident #34's Nursing Progress Note, dated 1/27/25, indicated: -The Resident returned to the facility from the hospital. -The Resident was diagnosed with a urinary tract infection (UTI) and was being treated with antibiotic medication. -The facility staff updated the Nurse Practitioner (NP) on the Resident's return to the facility and his/her medication. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Nursing Progress Note did not include any evidence that the Resident's current indwelling urinary catheter status had been assessed. On 1/31/25 at 2:00 P.M., the surveyor observed Nurse #3 exit Resident #34's room. During an interview at the time, Nurse #3 said that he had observed Resident #34's indwelling urinary catheter and the Resident currently had a size 24 Fr with 10 ml balloon indwelling urinary catheter in place. Nurse #3 said that staff would be required to change the Resident's indwelling urinary catheter if the catheter became blocked or if it leaked and was not able to be flushed. Nurse #3 further said if the urinary catheter needed to be changed, it would have to be changed to a size 16 Fr with 10 ml balloon because that was what was indicated in the Physician order. Nurse #3 also said that information in the Resident's care plan relative to catheter size should match the information on the Physician order. Nurse #3 said that the Unit Manager (UM) was responsible to review the Resident's Hospital Discharge Summary, obtain new orders relative to the urinary catheter, and complete an indwelling urinary catheter assessment. When the surveyor requested to speak to UM #2, Nurse #3 said that UM #2 was not working at the facility on 1/31/25. During an interview on 1/31/25 at 3:05 P.M., the Clinical Nurse Specialist (CNS) said that no re-admission assessment and no indwelling urinary catheter assessment had been completed for Resident #34 when the Resident returned from the hospital on 1/27/25. The CNS also said there were no orders in place for Resident #34's current indwelling urinary catheter size. The CNS said that it was important to ensure the proper size urinary catheter was ordered for the Resident and that changing the urinary catheter from a size 24 Fr to a size 16 Fr could result in complications, such as obstruction.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48206 Based on interview and record review, the facility failed to maintain sufficient nursing staff to provide care to residents on one unit (Elmwood) out of two sampled nursing units, when no staffing waivers were in place. Specifically, the facility failed to: -ensure sufficient qualified nursing staff were available to provide care and respond to resident's basic needs on the 11:00 P.M. to 7:00 A.M. (night) shift. -ensure that positions are filled timely when there are staff call outs. -schedule the type and level of staff that reflect the expectations described in the facility assessment. Findings include: Review of the Facility Assessment, dated July 2024, indicated: -Total Number of beds: 96 -Windsor Unit: >Short term rehab unit/long term care with 49 Beds. >Residents on the unit are short term rehab services, medication management. >Some residents do transition to long term care and are at a higher functioning level. -Elmwood Unit: >Secure long term care unit with 47 beds. >Residents often transition to this unit for long term care. >Most residents have advanced cognitive loss such as dementia, Alzheimer's and are total care for ADLs (Activities of Daily Living- activities related to personal care which include bathing, dressing, grooming and eating). -Staffing Needs: A) Licensed nurses providing direct care: the facility will make every effort to meet the CMS required 3.58 ppd (hours of direct care per patient per day) for direct care nursing staffing levels taking into consideration resident acuity and need to the extent possible. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B) Nurses Aides: the facility will make every effort to meet the CMS required 3.58 ppd for direct care nursing staffing levels taking into consideration resident acuity and need to the extent possible. During the Entrance Conference on 1/27/25 at 8:51 A.M., the Administrator and Clinical Nurse Specialist (CNS) said there were no nurse staffing waivers in place. Review of the Resident Council Minutes on 12/18/24 indicated: -Residents stated that on the 11:00 P.M. - 7:00 A.M. (night) shift they do not get changed all night except right before their A [sic] shift is over in the morning. Review of the Resident Council Minutes on 1/21/25 indicated: -Residents stated that their medication is passed late sometimes and they need more CNAs (Certified Nurses Aides), there are not enough CNAs. Review of the Resident Council Concern Follow Up form, dated 1/21/25, indicated: -Nature of the concern: Residents stated their meds are passed late and they need more CNAs. -Department Head solution: Staff shortage, working to get more staff. During a group interview with the Resident Council members on 1/28/25 at 10:07 A.M, nine Residents from the Windsor Unit participated in the meeting and stated the following: -On the 11:00 P.M.- 7:00 A.M. shift, the facility usually only has two staff members on each unit. -The facility had tried to hire people but Residents were told that the positions were hard to fill. -The 11:00 P.M.- 7:00 A.M. staff were often regularly scheduled staff, not agency staff. -Residents felt the staffing issue was ongoing and unresolved. -4 out of 9 Residents said they had waited for more than 30 minutes for assistance from CNAs on the 11:00 P.M.- 7:00 A.M. shift. -3 out of 9 Residents said they had waited for more than 60 minutes for assistance from CNAs on the 11:00 P.M.- 7:00 A.M. shift. Review of actual worked nursing schedules with daily unit census data (number of residents residing on a given unit on a given day) provided to the survey team indicated the following staffing levels: -1/13/25: Total Census 86 A) Elmwood Unit: Census- 41. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>11:00 P.M.- 7:00 A.M. shift: 1 CNA and 1 Nurse B) Windsor Unit: Census- 45. >11:00 P.M.- 7:00 A.M. shift: 2 CNAs and 1 Nurse -1/16/25: Total Census 85 A) Elmwood Unit: Census- 43 >11:00 P.M.- 7:00 A.M. shift: 1 CNA and 1 Nurse B) Windsor Unit: Census- 42 >11:00 P.M.- 7:00 A.M. shift: 2 CNAs and 1 Nurse -1/19/25: Total Census 84 A) Elmwood Unit: Census- 42 >11:00 P.M.- 7:00 A.M. shift: 1 CNA from 11:00 P.M. to 5:45 A.M., and 1 Nurse B) Windsor Unit: Census- 42 >11:00 P.M.- 7:00 A.M. shift: 2 CNAs and 1 Nurse Review of the Census and Conditions of Residents Report dated 1/29/25, indicated: -91 residents in total. -35 (38%) residents were dependent for toilet use. -22 (24%) residents were dependent for transferring. -30 (33%) residents were dependent for dressing. -18 (20%) residents were dependent for bathing. -66 (73%) residents were occasionally or frequently incontinent of bladder. -34 (37%) residents were occasionally or frequently incontinent of bowel. -45 (49%) residents had diagnoses of Dementia or Alzheimer's Disease. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 3:15 P.M., the facility Scheduler said that she bases staffing on the facility census and the residents' acuity of care. The Scheduler said the Elmwood Unit is a dementia unit and residents there are more acute, and she will staff an extra CNA on that unit to assist. The Scheduler said she staffs the facility for four CNAs per unit (8 total in house) for the 7:00 A.M. to 3:00 P.M. and 3:00 P.M. to 11:00 P.M. shifts, and two CNA's on each unit (4 total in house) for the 11:00 P.M. to 7:00 A.M. shift. The surveyor and the Scheduler reviewed staffing schedules for 1/13/25, 1/16/25, and 1/19/25. The Scheduler said that on those three shifts, four CNA's were originally scheduled, but one CNA staff was a no-call/no-show on each of those shifts and only three CNAs worked. The Scheduler said she was alerted to the no-call/no-shows and staff absences the day after they occurred. The Scheduler further said that if staff call out with enough notice to her, she will attempt to fill the shift by asking to see if staff could stay late or come in early to cover. The Scheduler said she ends her day at 3:30 P.M. and if she is not available in the facility to assist when a call out occurs outside of her hours, she said that Nurses would try to see if someone from the second shift could remain and assist. The Scheduler further said that the staff members that were no-call/no-shows on the identified dates were facility staff, not agency or contracted staff. Review of the staffing schedules indicated CNA #2 worked 11:00 P.M. to 7:00 A.M. shift on the Windsor unit on 1/13/25 and 1/19/25. During an interview on 1/19/25 at 6:33 A.M., CNA #2 said that usually there are two CNA's assigned to each unit on the 11:00 P.M. to 7:00 A.M. shift. CNA #2 said recently there have been CNA call outs or no-call/no-show on the Elmwood unit. CNA #2 said when that happens, they will float a CNA between the two units, and that CNA will help and change the heavy wetters and then they will try to keep everyone safe. CNA #2 said if there are two CNA's on each unit, on the 11:00 P.M. to 7:00 A.M. shift they will do two rounds of assist at night, but if there is only one CNA on the unit, the CNA's will only change the heavy wetters. CNA #2 said that staff call outs on the 11:00 P.M. to 7:00 A.M. shift happen late at night around 10:30 P.M. and staff in house are unable to find coverage. Review of the staffing schedules indicated CNA #1 worked 11:00 P.M. to 7:00 A.M. shift on the Elmwood Unit on 1/16/25. During an interview on 1/29/25 at 6:39 A.M., CNA #1 said she usually works on the 11:00 P. M. to 7:00 A.M. shift on the Elmwood unit. CNA #1 said that many residents are not able to make their needs known and need staff assistance with bathing, toileting, and dressing. CNA #1 said that she has worked with only one CNA overnight on the Elmwood unit. CNA #1 said when there is a no-call/no-show, they try to have staff from the prior shift stay late or make calls to see if staff can pick up (shifts). CNA #1 said if they are unable to get a CNA to come in, CNA staff from the other unit will float and help do resident rounds overnight to toilet and change residents as needed. CNA #1 further said that working with only 1 CNA is very difficult. Review of the staffing schedules indicated Nurse #1 worked 11:00 P.M. to 7:00 A.M. shift on the Windsor Unit on 1/13/25 and 1/19/25 and the Elmwood Unit on 1/16/25. During an interview on 1/29/25 at 6:43 A.M., Nurse #1 said that she often works on the Elmwood unit and typically for 11:00 P.M. to 7:00 A.M. shifts on both units. Nurse #1 said there were several times recently where a CNA no-called/no-showed and they were unable to get replacement coverage. Nurse #1 said that when it was her and one CNA, they would each take a hallway to monitor. Nurse #1 said that it was difficult to provide care to residents on the Elmwood Unit with only one Nurse and one CNA, and they try to make sure that residents are safe and monitor them as able to prevent falls and respond to call lights. Nurse #1 said that they have had issues recently with specific staff that continue to call out or no-show. Nurse #1 said that she has not seen management staff come into the facility during off hours or that staffing practices have changed to address the call-outs/no-shows. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 10:02 A.M., with the Clinical Nurse Specialist (CNS) and the Administrator, the CNS said that they have received grievances relative to staffing and that staffing had come up a couple of times in Resident Council. The CNS further said the facility responded to the Resident Concern on 1/22/25 and that the issues were mostly during morning time medication pass. The CNS said the facility adjusted their staffing model in response to cover medication administration by Nursing. The surveyor, Administrator, and CNS reviewed the staffing information on 1/13/25, 1/16/25, and 1/19/25. The CNS said they staff for two CNAs on each unit (Elmwood and Windsor, total of 4 CNAs) for the 11:00 P.M.- 7:00 A.M. shift and that the Elmwood Unit has residents who have more acute needs and require a higher level of care. The CNS said that three CNAs in the facility from 11:00 P.M. to 7:00 A.M. is not appropriate for a census of 84 and the staffing plan is for four CNAs in the facility. The surveyor, the CNS, and the Administrator, reviewed the Facility Assessment staffing data indicating 3.58 ppd staffing levels for Nurses and CNAs and the CNS said that the assessment was accurate relative to resident acuity levels and staffing needs. The surveyor requested evidence of the ppd staffing levels for 1/13/25, 1/16/25, and 1/19/25. At the time, the Administrator said that she was aware that a CNA had no-called no-showed on 1/13/25, 1/16/25, and 1/19/25, but she was not aware that only 3 CNAs had worked the 11:00 P.M.- 7:00 A.M. shift those days or that the shifts had not been filled. The facility did not provide evidence of the facility ppd staffing level calculation for 1/13/25, 1/16/25, and 1/19/25 to the survey team at time of the survey exit.

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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. 48206 Based on interview, and record review, the facility failed to ensure that competency in skills and techniques necessary to provide resident care were demonstrated for one Certified Nurses Aide (CNA [#3]), out of a total of five staff reviewed. Specifically, for CNA #3, the facility failed to ensure that annual competency training with demonstrated competency in the skills and techniques necessary to care for residents' needs was completed for 2024 as required. Findings include: Review of the Facility Assessment Tool, dated July 2024, indicated but was not limited to the following: -Staff training/education and competencies: Required in-service training for nurses' aides. In-service training must: >Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. >Include dementia management training and resident abuse prevention training >Address areas of weakness as determined in nurses' aides performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff. >For nurses' aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. Review of CNA #3's employee record did not indicate that a CNA competency evaluation for 2024 was completed as required. During an interview on 1/19/25 at 4:06 P.M., the Administrator said she was unable to provide evidence that CNA #3 had completed a CNA competency evaluation. The surveyor requested the facility policy relative to CNA competency evaluations from the Administrator. The facility did not provide any evidence of a CNA Annual Competency policy to the survey team at time of survey exit.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48206 Based on observation, and interview, the facility failed to post nursing staff data daily, at the start of each shift, relative to licensed and unlicensed nursing staff directly responsible for resident care per shift. Specifically, the facility failed to post nursing staff data that included: -total number and the actual hours worked for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nurse Aides (CNAs) -resident census. Findings include: On 1/28/25 at 8:13 A.M., the surveyor observed the daily staffing information dated 1/28/25 posted on a dry-erase board mounted on the wall next to the front desk and in the lobby area by the front door and accessible to residents and visitors. The staffing information posted on the dry-erase board indicated the following: Day: RN -1, LPN-3, CNA - 8 Afternoon: RN - 1, LPN-3, CNA-8 Night: RN -1, LPN - 1, CNA - 4 Further review of the daily staffing information posted did not indicate the total number and the actual hours worked for licensed and unlicensed staff and the facility resident census. During an interview on 1/28/25 at the time, the Receptionist said that she updated the staffing dry erase board every morning based on the daily staffing schedule provided to her by the Scheduler. During an interview on 1/28/25 at 3:15 P.M., the Scheduler said she provides staffing information to the receptionist on the number of RNs, LPNs, and CNAs that are scheduled from the printed facility staffing data maintained by the Scheduler. The surveyor and the Scheduler reviewed the regulatory requirements for documentation of staff postings to include the actual hours scheduled and the facility census and the Scheduler said that she was not aware of the regulation to include hours worked and facility census, and would include that information in the daily staff posting moving forward.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50320 Based on record review, and interview, the facility failed to provide the necessary Behavioral Health care and services to attain or maintain the highest practicable mental, and psychosocial well-being for two Residents (#51 and #23) out of a total sample size of 18 residents. Specifically, the facility failed to ensure that the Residents (#51 and #23) received follow-up Behavioral Health Services after recommendations for continued follow-up visits were made by the Provider. Findings include: Review of the facilities policy on consultant services dated April 2015 indicated: >The facility will identify and facilitate consultant services to meet the resident's need, to ensure optimum care for each resident/patient consultant services. 1. Resident #51 was admitted to the facility in July 2021 with diagnoses including Cerebral Vascular Accident (CVA), Major Depressive Disorder, and Generalized Anxiety Disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated: -The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points. -The Resident reported he/she had little interest or pleasure in doing things nearly every day and feeling down or depressed nearly every day. -The Resident had verbal behaviors 1-3 days and other behavioral symptoms 1-3 days. Review of Resident #51's plan of care, initiated 7/26/21 and last revised 1/2/25, indicated: -The Resident had episodes of anxiety/history of anxiety with intervention for Psych evaluation and follow-up as needed for medication management and counseling, initiated 7/26/21. -The Resident had behavioral problems of being verbally abusive, history of sexually inappropriate behaviors, socially inappropriate behaviors and rejection of care, initiated 7/15/22. -The Resident used psychotropic medications related to pain and depression, with interventions to consult Psych services as needed, initiated 9/19/22. -The Resident had diagnoses of depression and anxiety and was at risk for alteration in mood with intervention to refer to Psych services PRN (as needed), initiated 1/17/23. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident had an alteration in psychosocial well being related to loss of past roles and withdrawn from care and activities with intervention for Psych consult PRN, initiated 7/20/24. Review of the initial Psychiatric Evaluation dated 3/12/24 indicated the following: -Resident had diagnoses including Anxiety Disorder and Major Depressive Disorder -Resident was prescribed Neurontin (anti-convulsant used as a mood stabilizer) and Duloxetine (anti-depressant medication). -Resident demonstrated behaviors with staff including yelling and swearing. -Resident reported low motivation and named his/her current situation to be the trigger. -Clinician will follow and remain supportive. -Plan: 1. Continue with current medications. 2. Monitor, document for depression. 3. Will follow for medication management every 3 months and as needed. Review of the Social Service Progress Note dated 1/23/25, indicated the Resident was last seen by Psychiatric Services in April 2024 and Social Work followed up regarding another visit and the Resident refused. During an interview on 1/30/25 at 11:36 A.M., Resident #51 said he/she remembered seeing someone from Behavioral Health Services sometime around last March (2024), but he/she does not remember them ever coming back. During an interview on 1/30/25 at 1:02 P.M., the Social Worker (SW) said a Psychiatric Service Consultant comes to the facility every Tuesday. The SW said the referral process for Psychiatric Services is to have nursing tell the SW of the need for referral, and the SW maintains a list of who needs to be seen, and reviews the list with the Psychiatric Services Provider when they come in the facility. The SW said she spoke with Resident #51 on 1/23/25 about receiving Psychiatric Services and the Resident declined. The SW said she would review her paperwork for evidence any further Psych Services were offered to the Resident prior to her meeting with Resident #51 on 1/23/25. The SW further said that the note about the Resident being seen in April 2024 was incorrect, and the Resident was seen in March 2024. During an interview on 2/3/24 at 11:13 A.M., the SW said she had no evidence Resident #51 had any follow-up Psychiatric Services after his/her initial evaluation on 3/12/24. The SW said the Resident should have been seen or offered to be seen by Psychiatric Services before 1/23/25, to address the recommendations for 3-month follow-up from the initial evaluation, but he/she had not been offered additional Psychiatric Services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45429 2. Resident #23 was admitted to the facility in June 2024 with diagnoses including Major Depressive Disorder and Congestive Heart Failure (CHF). Review of the Resident #23's clinical record indicated: -care planning for depression and psychosocial well-being and coping related to accepting their own limitations, adjustment to nursing center placement, loss of past roles/status and withdrawal from care and activities, with the intervention for psychiatric consultation and follow-up as needed, last revised 11/11/24. -a Physician's Progress Note dated 12/18/24, with the recommendation to have the Resident followed up by the in-house Psychiatric team for Depression. -a Social Worker Progress Note dated 12/27/24, indicating that the Resident has had thoughts of hurting him/herself a few times in the past two weeks, thoughts of allowing themselves to fall, expressing anger towards their family and that a referral would be made to the Psychiatric team by the Social Worker. -Physician's orders for January 2025 listing the following: Sertraline (anti-depressant medication) 50 milligrams (mg) every morning, Remeron (anti-depressant medication) 7.5 mg at bedtime and Ativan (anti-anxiety medication) 0.5 mg every 6 hours as needed and a standing order for Psychiatry Consult as needed. -no documented evidence at the time of survey that the Resident had been seen by the Psychiatric team since the Physician's recommendation or Social Worker recommendations were documented in December 2024. Review of Resident #23's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -was cognitively intact as evidenced by a score of 14 out of 15 points on the Brief Interview for Mental Status (BIMS) assessment. -reported symptoms of Depression, trouble sleeping, fatigue, feeling bad about themselves and thoughts of being better off dead/self-harm. -had been experiencing verbal behaviors towards others, other behaviors (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), wandering and rejection of care. During an interview on 1/29/25 at 2:55 P.M., Social Worker (SW) #1 said that Resident #23 should have been referred for Behavioral Health follow-up as she had indicated in the Social Work Progress Note and as indicated by the Physician in his progress note but the Resident was not followed up. The SW also said that she had reviewed notes by the facility's Consulting Psychiatric Team and mobile crisis team and Resident #23 had not been seen since the recommendation had been made in December 2024 to the time of survey.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47901 Based on record review, and interview, the facility failed to maintain accurate records of controlled substance medications management and reconciliation for four locked medication carts on two Units (Elmwood Unit and Windsor Unit). Specifically, the facility failed to: -maintain accurate records of controlled substance medications that had been removed from locked medication carts and stored in the DON's office while awaiting disposal/ destruction. -maintain accurate records of controlled substance medications that were awaiting disposal/destruction for a period of six months. Findings include: Review of the facility policy titled, Disposal of Medications and Medication Related Supplies, revised December 2019, indicated: -Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations. -All controlled substances remaining in the facility after a resident has been discharged , or the order is discontinued, are disposed of in the facility by the administrator, director of nursing and/or consultant pharmacist. -Accountability records for controlled substances that are disposed of or destroyed are maintained with the unused supply until it is destroyed or disposed of and then stored for five years or per applicable law or regulation. On 1/28/25 at 10:15 A.M., during a medication administration observation of the Elmwood Unit medication cart one, the surveyor reviewed the controlled substance medication documentation labeled Book #1 with Unit Manager (UM) #2. The surveyor observed that narcotic medications had been removed from the controlled substance medication book and had been signed by two staff members as removed from count since 8/16/24. Further review of the controlled substance documentation in Book #1 did not indicate that the controlled substance medications had been destroyed. On 1/28/25 at 11:00 A.M., on the Elmwood Unit on the medication cart two, the surveyor and UM #2 observed the controlled substance medication documentation Book #2, which indicated twenty (20) entries of controlled substance medications that had been removed from medication cart two by two Nurses from 8/16/24 - 11/24/24. Further review of the controlled substance documentation in Book #2 did not indicate that the controlled substance medications had been destroyed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/28/25 at 12:15 P.M., on the Windsor Unit, the surveyor and UM #1 reviewed a medication cart and the controlled substance medication documentation labeled Book #3. UM #1 said the documentation in the controlled substance medication book indicated that controlled substance medications had been released from the medication cart by the Nurse on duty to the Director of Nursing (DON) for destruction. Further review of the controlled substance medication documentation in Book #3 did not indicate when the controlled substance medications had been destroyed. On 1/28/25 at 12:19 P.M., the surveyor and UM #1 reviewed the second medication cart on the Windsor unit where the controlled substance medication documentation book was labeled Book #4. The controlled substance medication book was worn in appearance and the book reference number was unable to be identified. The surveyor observed there were four pages in the controlled substance medication documentation book that indicated the controlled substance medications had been released from the medication cart and signed off by the DON on 11/26/24. Further review of the controlled substance medication documentation in Book #4 did not indicate that the controlled substance medications had been documented as being destroyed. During an interview on 1/28/25 at 12:38 P.M., the DON said the controlled substance medications had been removed from the medication carts for destruction and remained under double lock and key in her office. The DON further said she was unsure how long the controlled substance medications in her office had been waiting for destruction. During an interview on 1/28/25 at 1:05 P.M., the Clinical Nurse Specialist (CNS) said the controlled substance medications had been removed from the medication carts for destruction and that the controlled substance medications were under double lock and key but had not been destroyed for six months. The CNS said the last time controlled substance medications were destroyed by the facility was 5/31/24. During an interview on 1/29/25 at 10:00 A.M., with the CNS, the DON, and the Administrator, the CNS said the controlled substance medications were in bags but there was no record of the controlled substance medications that had been removed from the Nurse's controlled substance medication carts. The CNS said the controlled substance medications that were removed from the Nurses' medication carts had not been recorded on a controlled substance disposal record. During an observation at the time, the surveyor observed five large bags containing controlled substance medications in the DON's office. The surveyor observed the following total of 80 different controlled substance medications in the five large bags in the DON's office: -multiple cards of Tramadol (opioid pain medication) for multiple residents -multiple vials of Lorazepam (antianxiety medication) for multiple residents -multiple cards of Oxycodone (opioid pain medication) for multiple residents -multiple vials of Morphine Sulfate liquid (opiate narcotic pain medication) for multiple residents -multiple cards of Lorazepam tablets for multiple residents -multiple tablets of Hydromorphone (opioid pain medication) for multiple residents (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-multiple cards of Phenobarbital (barbiturate medication) for multiple residents -multiple doses of Lyrica (used to treat nerve pain) for multiple residents -multiple doses of Clonazepam (antianxiety) for multiple residents -Fentanyl patches (opiod pain medication) for multiple residents -multiple doses of Ambien medication (sedative medication) for multiple residents -multiple doses of Dilaudid medications (opioid medication) for multiple residents During a follow-up interview on 1/29/25 at 3:15 P.M., the CNS said the controlled substance medications that were removed from the medication carts should have been recorded on the controlled substance medication disposal record with the dates of removal from the medication cart, the amount of medication removed per resident, the resident's name, and the type of medication removed. The CNS said the facility did not have a controlled substance medication disposal record in place.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on interview, and record review, the facility failed to ensure that psychotropic medications (medication that affect the mind, emotions and behavior) administered were necessary for one Resident (#27) out of five applicable residents reviewed, out of a total sample of 18 residents. Specifically, the facility failed to ensure: -For Resident #27, that the obtained consent from the Resident's Health Care Proxy (HCP) for the use of psychotropic medications was necessary when the Informed Consent for Psychotropic Administration was obtained from and signed by another residents' HCP. Findings include: Review of the facility policy titled Psychotropic Medication Management, dated April 2015, indicated: -Each resident's drug regimen will be free from unnecessary drugs. Administration of psychoactive medications will focus on the individual needs of the resident and will be prescribed only when necessary and clinically indicated to treat specific conditions and symptoms as diagnosed and documented. -Notify resident or responsible party of initiation of psychoactive medication. Ensure that supportive diagnoses and target behaviors are documented and clearly identify the use of the medication is necessary and warranted. -Notify resident or responsible party of initiation of psychoactive medications, and with any changes to dose, and document in record. -Review should include verification that adequate indications for use of the psychotropic medication exist, the medications are not being used for extended duration and residents are free of duplicate therapy. Resident #27 was admitted to the facility in October 2023, with diagnoses including Post Traumatic Stress Disorder (PTSD), Cirrhosis, increased ammonia level, hallucinations and Altered Mental Status. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #27: -was moderately, cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of a total possible score of 15. -had a diagnosis of Delusional Disorder and Bipolar Disorder. -had a Health Care Proxy (HCP). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-HCP was invoked (evaluation of capacity by a Physician that indicates a resident is unable to make medical decisions) prior to the Resident's admission to the facility. -was taking anti-psychotic and anti-depressant medications. -was taking anti-psychotic medication on a routine basis. Review of the Physician Documentation for Resident Incapacity, dated 9/22/23, indicated: -Resident #27 lacked capacity to make medication decisions due to Progressive Dementia. -Duration of the incapacity was indefinite. Review of Resident #27's January 2025 Medication Administration Record (MAR) indicated that the Resident had received: -Trazodone (antidepressant medication) 100 milligram (mg) tablets daily at bedtime, initiated 12/24/24. -Buspirone (antianxiety medication) 20 mg three times a day, initiated 12/24/24. Review of Resident #27's Informed Consent for Psychotropic Administration indicated that the consent for Trazodone and Buspirone medications were signed by an individual other than the HCP on 11/21/24. During an interview on 1/29/25 at 11:01 A.M., Unit Manager (UM) #2 said she was unsure who had signed the consents for the Trazodone and Buspirone medications. During an interview on 1/30/25 at 3:02 P.M., the surveyor and the Clinical Nurse Specialist (CNS) reviewed Resident #27's consents. The CNS said the consent for Trazodone and Buspirone was signed by another residents' HCP, and not Resident #27's HCP. The CNS said that the consents should have been signed by the appropriate HCP, but they were not.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 51466 Based on interview, and record review, the facility failed to ensure that one Resident (#23) out of a total sample of 18 residents, was free from a significant medication error when an order for twice daily Allopurinol (medication used to prevent Gout pain - caused by a high uric acid level in the blood, leading to joint pain and inflammation) was not accurately transcribed to a new monthly Medication Administration Record (MAR). Specifically, for Resident #23, the facility failed to ensure that the Allopurinol medication order for twice daily administration was accurately transcribed to a new month's MAR, resulting in decreased Allopurinol medication administration to once a day, and increasing the Resident's risk for gout pain not being appropriately managed. Findings include: Review of the Facility policy titled Physician Orders- Transcription, dated April 2015, indicated: -All written physician's orders or telephone orders must be duly noted and accurately transcribed by licensed nursing staff. -Carefully transcribe orders as written to MAR and/or Treatment Administration Record (TAR). Resident #23 was admitted to the facility in January 2024, with diagnoses including Idiopathic Gout and Major Depressive Disorder. Review of Resident #23's Pain Care Plan, initiated on 1/15/24, indicated the Resident had potential for pain related to decreased mobility and included the following interventions: -Administer pain medications as ordered. -Assess characteristics of pain: location, severity of a scale from 0-10. -Discuss with resident factors that precipitate pain and what may reduce it. Review of Resident #23's Gout Care Plan, initiated on 7/25/24, indicated the Resident had a diagnosis of Gout and had potential for pain and decreased mobility, with the following interventions initiated: -Medications as prescribed. Observe for effectiveness and side effects, report to MD (Medical Doctor) as needed. -Observe for joint swelling, decreased mobility. Review of the Hospice Care Plan, initiated on 9/11/24, indicated the following interventions initiated: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Administer pain medication and other medications per MD orders. Review of the Resident #23's Hospice record indicated: -The Resident was admitted to Hospice Services on 9/14/24. -The Hospice Nursing assessment, dated 12/27/24, indicated the Resident had complaints of increased Gout pain and recommended the Allopurinol be increased to twice a day. -The Hospice Interdisciplinary Note, dated 12/31/24, indicated that the Resident had been having increased Gout pain in bilateral (both) heels and recommended increasing the Resident's Allopurinol to 100 mg twice a day. -Physician's orders, dated 12/27/24, indicated Allopurinol 100 mg po (by mouth) twice a day. Review of the Minimum Data Set (MDS) Assessment, dated 12/27/24, indicated Resident #23: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of 15. -was able to make his/herself understood. -was receiving Hospice services. Review of Resident #23's December 2024 MAR indicated: -Allopurinol 100 mg once a day was administered from 12/1/24 -12/27/24. -Allopurinol 100 mg once a day was discontinued on 12/27/24, and was increased to Allopurinol 100 mg twice day. -Allopurinol 100 mg twice a day was administered from 12/27/24 -12/31/24. Review of the January 2025 MAR indicated: -Allopurinol 100 mg once a day was administered from 1/1/25 through 1/29/25. During an interview on 1/30/24 at 12:10 P.M., with Nurse #4 present, Resident #23 said he/she was having 4 out of 10 (4/10) gout pain in the left leg, and the gout pain would come and go, but had been worse lately. Resident #23 said the gout pain was quiet. During an interview at the time, Nurse #4 said that Resident #23 was receiving Allopurinol for gout pain once a day and that she was not aware the Allopurinol medication had been increased to twice a day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lanessa Extended Care	751 School Street Webster, MA 01570

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 12:23 P.M., Unit Manager (UM) #1 said a new Physician's order written on 12/27/24 to increase Allopurinol to twice a day was posted (transcribed) on the December 2024 MAR but was not posted on the January 2025 MAR that was available from the pharmacy for editing. UM #1 further said the reason the new order was not posted on the January 2025 MAR was because the double check system for editing did not occur but should have. UM #1 said it was a medication error. UM #1 said that Resident #23 is on the Allopurinol medication for gout pain and could potentially have worsening pain if this medication was not given as ordered. During an interview on 1/30/25 at 2:04 P.M., the Clinical Nurse Specialist (CNS) said the Allopurinol medication error occurred because of a transcription error that occurred during the end of month editing in December 2024. The CNS said it is the responsibility of the Nurse receiving a Physician's order, to double post the orders on the old MAR and new MAR, and it is the responsibility of the UM's to double check for accuracy, but this did not occur.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 44337 Based on observation, interview, and record review, the facility failed to ensure four of four residents with a Physician ' s order for pureed texture diet received chicken at the lunch meal that was a pureed consistency (altered diet in which foods are ground and strained to a smooth soft pudding like consistency free of lumps or texture making them easier to chew and swallow). Findings include: Review of the facility US Foods Diet Guide last updated 3/19/21, indicated the following: -National Dysphagia Diet (NDD) Level 1: Pureed is designed for people who have moderate to severe dysphagia and reduced ability to protect their airway. -NDD Level 1 diet consists of pureed and cohesive foods in pudding-like consistency. Review of the facility Dining Services Assistant Job Description dated April 2013, indicated the following: -The primary purpose of your position is to provide assistance in all dining service functions as directed and in accordance with established dining services policies and procedures. -Major Duties and responsibilities include to follow therapeutic diet cards as ordered by the Physician. Review of the facility's [NAME] Job Description, dated April 2013, indicated the following: -The [NAME] was required to prepare food in accordance with current applicable Federal, State and Local standards, guidelines and regulations . -Must be able to cook a variety of foods in large quantities. -Follow therapeutic diets ordered by the Physician. Review of the Facility Assessment, dated July 2024, indicated services and care for nutrition were provided by the facility and included: -Individualized dietary requirements. -Specialized diets. Review of the facility's lunch menu for 1/28/25 indicated baked chicken was the main entree to be served for the noon time lunch meal. On 1/28/25 at 12:21 P.M., surveyor #2 observed the following in the Windsor Unit Dining Room: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two containers of the same white ground meat and one container of whole chicken on the steam table. During an interview at the time, Dietary Aide (DA) #1 said that one container of the white ground meat was for residents requiring a ground diet and the other container of white ground meat was supposed to be pureed. DA #1 said the meat that was supposed to be pureed was not pureed, that it should have been more soupy and should not look ground. The white ground meat that was supposed to be pureed was served to the residents. On 1/28/25 at 12:28 P.M., surveyor #1 observed the following in the facility's Main Dining Room: -The FSD placed covered metal containers of food into the steam table. -One of the metal containers was approximately half full of finely shredded white meat. During an interview at the time, the FSD said that the container of finely shredded white meat was pureed chicken. During an interview on 1/28/25 at 12:53 P.M., on the Windsor Unit, the Regional FSD said that the pureed chicken had not been prepared correctly, and that it was more ground consistency than it was pureed. During an interview on 1/28/25 at 4:22 P.M., the FSD said that there were four residents at the facility who required puree textured foods and the FSD provided a list of the residents to the survey team. The FSD said the chicken prepared and served for residents requiring puree textured foods at the noon time meal that same day should have been checked prior to the food being sent from the kitchen and being provided to the residents. The FSD said that the chicken prepared and served to residents requiring puree textured foods was not prepared and served in a form that was pureed. The FSD also said that the chicken should not have been served to residents requiring puree textured foods, but the chicken was served to the residents. Review of the list of residents requiring puree textured foods provided to the survey team by the FSD on 1/28/25 indicated Resident's #7, #16, #32, and #234 required pureed textured foods. During an interview on 1/29/25 at 9:52 A.M., the [NAME] said that as the Cook, she was responsible to ensure that all foods were prepared to the proper texture prior to leaving the kitchen. The [NAME] said that she did not check the consistency of the pureed chicken after it was prepared and before it was delivered to the residents. The [NAME] said that the pureed food should be the consistency of baby food. During an interview on 1/29/25 at 10:16 A.M., the Speech Therapist (ST) said that puree textured food was the most restrctive texture and was to be prepared as a blenderized baby food texture. The ST said that puree textured food was prepared for some residents at the facility with decreased ability to process food in their mouths. The ST said that puree textured food should be smooth, moist, and should not come apart. The ST said the puree textured chicken prepared for lunch on 1/28/25 should have been a moist baby food consistency.

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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. 44337 Based on observation, and interview, the facility failed to maintain sanitary conditions in the facility kitchen and dining areas and follow safe sanitation and food handling practices while storing and serving food to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Specifically the facility failed to: 1. Ensure staff stored a multi use thickening agent in the facility's main kitchen in a safe and sanitary manner. 2. Ensure staff stored food at the proper and safe holding temperature on the steam table prior to serving the food to residents on the Windsor Unit. 3. Ensure staff labeled and stored food in a sanitary and safe manner in the facility kitchen and unit nourishment kitchens and maintained the facility dishwasher at the proper temperature for sanitization of dishware. Findings include: Review of the facility policy titled Dietary Department Guidelines, revised 1/2014, indicated: -The facility must store, prepare and distribute food under sanitary conditions. -The Dietary Department Supervisor will oversee the entire dietary program in collaboration with the dietician, including the purchase, storage, preparation, and serving of food to residents, employees and visitors as indicated. She or he also will supervise the cleaning and sanitizing of dishware and utensils, as well as the cleaning of the physical dietary plant. -The dietary department will be maintained in a clean and sanitary manner to prevent foodborne illness. -Food items should be labeled and dated to allow for rotation of supplies. -All items stored in the refrigerator will be covered, labeled with the contents and the date. All potentially hazardous foods must be discarded within 3 calendar days after the date prepared. -Refrigerator temperatures will be monitored regularly, and logs will be maintained of all temperatures. -All frozen food will be stored below 0 degrees. Freezer temperatures will be monitored regularly, and logs will be maintained of all temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Steam tables will keep foods at proper temperature and will be maintained in a safe, sanitary condition. -All food preparation equipment, dishes, and utensils must be maintained in a clean, sanitary and safe manner and used and repaired according to the manufacturer's recommendations. -Dishwasher will not be overfilled and will reach wash temperatures of at least 160 degrees, or according to the manufacturer specifications/instructions. Rinse temperatures will reach at least 180 degrees, or according to the manufacturer specifications/instructions. -Ice machines will be sanitized during manufacture and dispensing of ice and will be cleaned as per manufacturer's recommendations. -All areas of the Dietary Department will be cleaned on a regular schedule. Logs/schedules will be kept of cleaning tasks as they are completed. Review of the facility policy titled Use & Storage of Food Brought in by family or visitors, dated November 2016, indicated: -All food items that are already prepared by the family or visitor brought in, must be labeled with content and date. >The facility may refrigerate, label and date prepared items in the nourishment refrigerator. >The prepared food must be consumed by the resident within 3 days. Review of the facility policy titled Personal Food Policy, dated November 2016, indicated: -Dietary aides are responsible for monitoring the temperatures of all nourishment refrigerators daily to ensure they are at 41 degrees or below. Freezers must be cold enough to keep food frozen solid to the touch (approximately 0 degrees F). If temperatures are noted to be out of range, staff must immediately notify maintenance and dispose of any items that may be contaminated. -Dietary aides are responsible for checking nourishment refrigerators daily and discarding any unused refrigerated food after 3 days. 50138 1. Review of the facility policy titled Dietary Department Guidelines, revision date 1/2014 indicated: -The facility must store .food under sanitary conditions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial main kitchen tour on 1/27/25 at 7:15 A.M., the surveyor observed a large, wheeled, white plastic container approximately half full of a white powder. The large, wheeled, white plastic container had a clear plastic sliding lid that was slid back into the open position exposing white powder and light brown debris scattered on the surface of the white powder. The large, wheeled, white container also had a carboard box that contained black trash bags on top of the clear plastic sliding door that was open. During an interview at the time, the surveyor and the [NAME] observed the open container of white powder with brown debris on the surface and the [NAME] said that the white powder was Thick-It (a cornstarch-based powder used to thicken liquids for residents with swallowing difficulty) and was used to thicken liquids which are served from the kitchen at all meal times. The [NAME] said that the scattered brown debris on the surface of the Thick-It were pieces of cardboard from the cardboard box stored above that must have fallen in while the container lid was open. The [NAME] said she was unaware of how long the container lid had been left open but that the Thick-It was contaminated and should be discarded immediately. During a follow-up observation and interview on 1/27/25 at 1:11 P.M., the surveyor and the FSD observed the white, wheeled, container of Thick-it with cardboard scattered on the surface. The FSD said that the Thick-It should have been covered to prevent contamination from the cardboard. The FSD said he was made aware of the contaminated Thick-it earlier in the day but had not yet discarded it but probably should do it soon. The FSD said that the cardboard might be dangerous if ingested by a Resident. 2. Review of the Facility Policy titled Dietary Department Guidelines, revision date 1/2014, indicated: -The facility must store, prepare and distribute food under sanitary conditions. <Hot cooked foods will be held at temperatures above 140 Fahrenheit (F). Food temperatures will be monitored regularly, and logs maintained of temperatures. <Any food item that becomes contaminated .or when held at unsafe temperatures, etc., will be immediately discarded. Review of the dietary service food menu titled Fall/Winter 2024 - 2025, dated 11/14/24, indicated: -Lunch service Main Entree was Meat Lasagna on Monday 1/27/25. During an interview and observation in the main kitchen on 1/27/25 at 1:11 P.M., the FSD said that the main entree served for lunch was a meat lasagna. The surveyor and the FSD observed the meal temperature tracking sheet from the Windsor Unit steam table dated 1/27/25. The meal temperature tracking sheet from the steam table on the Windsor Unit indicated that the beginning service temperature of the main entree meat lasagna was 134 Fahrenheit (F). The FSD said that the residents had been served the meat lasagna on the Windsor Unit at lunch time. The FSD said that the main entree should only have been served between 135 -140 F and the Dietary Aide should have returned the meat lasagna to the kitchen to reheat but did not. The FSD said that when foods are not held at the proper temperature, it was a concern due to food safety. 51466 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 1/28/25 at 11:45 A.M., the surveyor observed the following in the facility's Main Kitchen: -The stand-up freezer and refrigerator had crumbs and dried frozen substances on the bottom shelves. -Movable carts that contained clean silverware, boxes of bread, and clean water pitchers, had visible crumbs, drips and dried substances on the shelf surfaces and the outside of the carts. -The ice machine had a broken vent with a thick, brown, crusted, dust-like substance adhering to the vent. -Dry storage containers holding oats and Thick-It powder with crusted, dried brown substances on the clear top, under the lid, and in the lid slider. -The dry storage room had a black substance on the floor underneath the food. -A bag of egg noodles on a shelf in the dry storage area, opened and undated. -The walk-in refrigerator had a large puddle of liquid on the floor. -Movable carts transporting food from the kitchen to the dining areas had visible crumbs, spatter, drips and dried substances on the shelf surfaces, underneath food trays and on the outside of the carts. -Steam tables on the two Units and in the Main Dining Room had crusted and dried substances on the inside of steam tables, and on the front glass. -Dried debris and crumbs were in the cabinet door runner, underneath the steam table. During an interview on 1/28/25 at 11:45 A.M., the FSD said the dietary staff should be wiping out and cleaning the refrigerator and freezer weekly or as needed, but a cleaning log is not kept. The FSD said the ice machine should be kept clean, the outside wiped down by dietary staff as needed, cleaned monthly by the dietary staff, then professionally every three months. The FSD said he was not sure what the black substance was on the floor in the dry storage area, but said it looked like mold spots and he was unsure how long it had been there. The FSD said the bag of egg noodles should not have been left opened and undated and he was unsure of how long the egg noodles had been left open. The FSD also said that the walk-in refrigerator has had some standing liquid on the floor, on and off for a few months, and he did not think it had been reported to maintenance or an outside company for evaluation. The FSD said the dietary staff are responsible for wiping down the portable food carts in between uses, but the carts that were transporting food and holding clean items did not appear very clean and he could see the visible drips, crumbs and debris. The FSD further said there was no cleaning schedule in place. The FSD said that no cleaning schedule had been developed, and no cleaning logs had been maintained to indicate when equipment in the facility's main kitchen, main dining room, unit dining rooms and unit kitchenettes had been cleaned. On 1/28/25 at 2:20 P.M., the surveyor observed DA #2 was using the high temperature hot water sanitizer machine and running dishes through the machine. There was a wash in progress and temperature for two observed wash cycles was 139 degrees. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/25 at 2:30 P.M., DA #2 said that she has always been told the wash cycle should not be less than 137 degrees. During an interview on 1/28/25 at 2:32 P.M., the Regional FSD said the dish machine's wash cycle should be a minimum of 150 degrees. The Regional FSD said he did not know where the current dishwasher temperature log was located and provided the surveyor with temperature logs dated from 2023. On 1/28/25 at 4:49 P.M., the surveyor and the FSD observed the unit kitchenettes and found the following: >Windsor Unit: -The refrigerator temperature was 47 degrees and had milk, yogurts, and health shakes stored in the refrigerator. During an interview at the time, the FSD said the refrigerator temperatures should be kept below 42 degrees but was not. The FSD said that it is the dietary department's responsibility to maintain/stock the kitchenettes and to check the refrigerator and freezer temperatures. The FSD said the temperature logs are kept in the dietary office and that he would alert the maintenance department that the refrigerator/freezer temperatures were not in required ranges. On 1/29/25 at 2:45 P.M., the surveyor and Regional FSD observed the unit kitchenettes and found the following: >Windsor Unit: -Refrigerator temperature was 48 degrees with milk products and health shakes in the refrigerator. During an interview at the time, the Regional FSD said he was unaware the refrigerator and freezer temperatures were out of range from the previous day. The Regional FSD said they should have been looked at by maintenance, and food products/ drinks should have been removed and checked right away. The Regional FSD placed a new thermometer in the refrigerator and adjusted the temperature dial. The Regional FSD said the refrigerator should be kept at or below 41 degrees but was not. The surveyor observed that the refrigerator temperature decreased to 41 degrees but the Regional FSD was unable to say if the temperature decrease was due to the adjusted refrigerator temperature dial or if the thermometer was incorrect.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47901 Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records for one Resident (#24) out of a total sample of 18 residents. Specifically, the facility failed to maintain accurate documentation of meal intake percentages by Certified Nurse Aides (CNAs) when Resident #24 was identified as being at risk for weight loss. Findings include: Review of the facility policy titled, Nursing Documentation, dated 2/2016 indicated: -The nursing personnel documents information related to the resident's condition and care provided in the resident's medical record. Resident #24 was admitted to the facility in April 2023 with diagnoses including Alcohol Dependence, Traumatic Fracture, COPD and Muscle Weakness. Review of Resident #24's Clinical Progress notes indicated: -11/27/24 - Dietary Risk Meeting: >Resident admitted to risk on 11/20/24 .weight 153.6, weight loss 8.5% over 30 days and 10.9% over 90 days, >Resident re-weight 11/20/24: 159.4, weight loss 5% over 30 days . -12/11/24 - Dietary Risk Meeting: >Resident admitted to risk on 11/20/24 .weight 153.6, weight loss 8.5%, re-weigh completed, clarified weight 159.4 on 11/20/24, weight loss 5% over 30 days >weight completed 12/4/24 -163.2, stable, continue care planning . Review of Resident #24's Weights Tab in PCC (Point Click Care) indicated the following: -9/1/24: weight 169.3 pounds (lbs.) -11/20/24: 159.4 lbs. -12/4/24: 163.2 lbs. -12/25/24: 151.2 lbs. (weight loss of 18.1 lbs. from 9/1/24). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's Documentation Survey Reports v2 (Certified Nurses Aides [CNA] flowsheets) for November 2024 through January 2025 indicated the following Meal Intake Documentation: -November 2024: 39 out of 90 opportunities for meal documentation were left blank. -December 2024: 35 out of 93 opportunities for meal documentation were left blank. -January 2025: 25 out of 90 opportunities for meal intake documentation were left blank. During an interview on 1/31/25 at 9:41 A.M., Unit Manager (UM) #2 said CNAs are expected to document meal intakes after every meal, but this was not done. During an interview on 1/31/25 at 11:14 A.M., the Dietician said he would review the meal intake documentation for residents identified with weight loss. The Dietician further said he would interview the residents and ask staff about how the Residents ate. The Dietician said he would not base his interventions solely on the meal intake documentation since the meal intake documentation had not been completely documented.

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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** 50138 Based on observation, interview, and record review, the facility staff failed to maintain infection control practices per professional standards for three Residents (#7, #47 and #11) out of a total sample of 18 residents. Specifically, the facility failed to: 1. For Resident #7, appropriately provide care for a urinary drainage bag that was not in use when the Resident interchanged the urinary drainage bags for daytime and nighttime use, placing him/her at risk for contamination and infection. 2. For Resident #47, assist with hand hygiene prior to eating, following the Resident's participation in a group activity when his/her hands were visibly soiled, placing the Resident at risk for contamination and infection. 3. For Resident #11, maintain Enhanced Barrier Precautions (EBP) while providing high contact care during a bolus feeding (administering a dose of formula through a feeding tube using a catheter syringe [syringe without a needle]) procedure, placing the Resident at risk for transmission of organisms. Findings include: 1. Review of the Wound, Ostomy and Continence Nurses Society Resource Guide 2015 -Care and Management of Patients with Urinary Catheters: A Clinical Guide ([NAME] et al., 2012; Gould et al., 2009; [NAME] et al., 2010, pg 15), indicated: -Urinary Drainage Bag Decontamination: >A closed system is considered the best way to prevent infection but if a closed system is interrupted, replace it with a new drainage bag or refer to facility policies for decontamination of the drainage bag. >There is insufficient evidence to support either daily single use or multiuse drainage bags for the reduction of CAUTI (catheter-associated urinary tract infection) rates > After cleaning drainage bag, air-dry the bag. After disinfection, cap the drainage bag tubing between uses, and disinfect the end of the tubing before reconnecting it to the catheter. Resident #7 was admitted to the facility in April 2011 with diagnoses including Obstructive Uropathy, and Urinary Tract Infection. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #7: -was cognitively intact as indicated by a score of 15 out of a total score of 15 on the Brief Interview for Mental Status (BIMS) assessment. (continued on next page)

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	225395	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lanessa Extended Care	751 School Street Webster, MA 01570

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was dependent for hygiene as well as toileting. -had an indwelling urinary catheter. Review of Resident #7's February 2024 Physician's orders indicated: -The Resident had a Foley catheter (type of urinary catheter) 16 French (Fr) with 30 ml (milliliter) balloon. -The Resident may use leg bag (a small drainage bag worn on the leg to collect urine from the Foley Catheter). -The Resident required Foley catheter care every shift and as needed (PRN). -The Resident required drainage bag changes weekly on Wednesday. Review of Resident #7's Care Plan last revised on 11/21/24, indicated: -The Resident had a Foley catheter. -The Resident used a leg bag when out of bed. -The Resident was at risk for infection due to catheter use. -Staff were to provide the Resident with Foley catheter care per policy. On 1/27/25 at 8:59 A.M., the surveyor observed two urinary drainage bags containing small quantities of yellow liquid and dated 1/22/25, hanging on the left sided handrail next to the toilet bowl in Resident #7's bathroom. Both drainage bags were observed to be making contact with the bathroom wall and were not secured in a storage bag. On 1/30/25 at 2:46 P.M., the surveyor observed one urinary drainage bag dated 1/29/25, hanging on the left sided handrail and making contact with the wall in Resident #7's bathroom. The urinary drainage bag was observed to contain a small volume of yellow liquid in the tubing and was not secured in a storage bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 8:35 A.M., the surveyor and Certified Nurses Aide (CNA) #5 observed a urinary drainage bag dated 1/29/25, which contained a small volume of red liquid in the tubing in Resident #7's bathroom. The urinary drainage bag was hanging on the left sided handrail making contact with the wall and not secured in a storage bag. During an interview at the time, CNA #5 said that he was caring for Resident #7, that the urinary drainage bag hanging in the bathroom belonged to Resident #7, and the urinary drainage bag was touching the wall and contained red urine. CNA #5 said that Resident #7 uses a smaller urinary drainage bag during the day and the larger urinary drainage bag, which is used at night, is kept in the bathroom when not in use. CNA #5 said that Resident #7 was dependent on staff to care for the urinary drainage bags. CNA #5 said that before the urinary drainage bag was hung on the handrail in the bathroom, he had wiped the tip with alcohol and replaced the cap for storage. CNA #5 said that the CNA staff do not rinse out the urinary drainage bags or tubing before hanging them in the bathroom when not in use. CNA #5 said that a storage bag should be used when storing the urinary drainage bag so that germs cannot get on the urinary drainage bag. CNA #5 said he did not use a storage bag today but should have. On 2/3/25 at 9:17 A.M., the surveyor and Nurse #3 observed a urinary drainage bag dated 1/29/25, which contained a small volume of red liquid in the tubing in Resident #7's bathroom. The urinary drainage bag was hanging on the left sided handrail and in a clear plastic storage bag. During an interview at the time, Nurse #3 said that the urinary drainage bag/tubing contained red urine, and that he was the Nurse caring for Resident #7 today. Nurse #3 said that the urinary drainage bag and its tubing should have been rinsed with soap and water before being put into the clear plastic storage bag because the residual urine could cause bacteria to grow and create a possible infection. During an interview on 2/3/25 at 9:22 A.M., the Infection Preventionist (IP) said that urinary drainage bags, when not in use, should be cleaned with soap and water, allowed to dry and then placed in a storage bag to prevent contamination with bacteria. During an interview on 2/3/25 at 10:09 A.M., the Clinical Nurse Consultant said the facility did not have a policy or procedure for urinary drainage bag cleaning and storage, but the standard of practice would be to rinse with soap and water, allow to dry, and then store in plastic bag for protection against contaminants. 2. Resident #47 was admitted to the facility in June 2021 with diagnoses including Dementia and Weakness. Review of Resident #47's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #47: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of a total possible score of 15. -required supervision level assistance for eating. -was dependent on facility staff for personal hygiene which included hand washing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 12:04 P.M., the surveyor observed Resident #47 participating in a group activity board game with two other residents and Activity Aide (AA) #2. Resident #47 was observed to be touching game pieces and the game board with his/her hands that were coated with a dried brown substance around and under the nail beds of both hands and down the index finger of the right hand. On 1/28/25 at 12:10 P.M., the surveyor observed AA #1 serve Resident #47 a beverage mug that was accepted by the Resident. Resident #47 was observed sipping the beverage from the mug at the time. On 1/28/25 at 1:10 P.M., the surveyor observed AA #1 serve Resident #47 his/her lunch meal. Resident #47 was observed to pick up the fork via the right hand which remained coated with a dried brown substance around and under the nail beds and down the index finger. When the surveyor asked AA #1 whether Resident #47 was in need of hand hygiene prior to eating the meal, AA #1 said that facility staff never cleans a Residents' hands before a meal because the Residents get washed up with morning care only. AA #1 said that Resident #47 had gone directly to meal service following the group activity without being assisted with hand hygiene and that the Resident's hands were visibly soiled with an unidentifiable brown substance. AA #1 said that the Resident's hands should have been cleaned before eating because germs and bacteria could get into Resident #47's mouth and make him/her sick. During an interview on 1/28/25 at 2:02 P.M., the Director of Nursing (DON) said that she would expect hand hygiene to be provided prior to meals for all residents with alcohol hand sanitizer or if hands were visibly soiled hands should be washed with soap and water. The DON said that hand hygiene prior to meals is important in the prevention of nosocomial infections. 3. Review of the facility policy for Enhance Barrier Precautions (EBP), undated, indicated the following: -Enhanced Barrier Precautions require the use of gown and gloves for certain residents during specific high contact resident care activities in which there is an increased risk for transmission of multidrug-resistant organisms. -High contact resident care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting device care and wound care. -Signage will be posted on the door or wall outside of the resident room indicating the need for enhanced barrier precautions, the required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. -carts with appropriate PPE will be placed outside the resident's room. Resident #11 was admitted to the facility in December 2019, with diagnoses including Cerebral Palsy and Dysphagia. Review of Resident #11's Comprehensive Person-Centered Care Plan last revised 1/24/24, indicated: -the Resident had an increased susceptibility for infection related to G-tube (feeding tube) -educate resident/family regarding reason for enhanced barrier precautions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Enhanced Barrier Precautions as ordered Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #11: -was severely cognitively impaired and unable to complete the Brief Interview for Mental Status (BIMS) exam. -was dependent on staff for all Activities of Daily Living (ADL's). -required artificial feeding. Review of Resident #11's January 2025 Physician's orders indicated: -Jevity 1.5 calorie, 474 milliliters (ml) bolus via PEG (feeding tube) three times daily -Enhanced Barrier Precautions every shift On 1/29/25 at 12:00 P.M., the surveyor observed that there was no PPE cart located outside of Resident #11's room. The surveyor also observed there was EBP signage posted outside of Resident #11's room which indicated: >for Everyone: -to cleanse hands before entering and when leaving the room. >for Providers and Staff: -wear gloves and a gown for high contact resident care activities including device care or use: central line, urinary catheter, feeding tube, tracheostomy. On 1/29/25 at 12:08 P.M., the surveyor observed the following during a bolus feeding procedure to Resident #11 performed by Nurse #2 in the Resident's room: -Nurse #2 transferred the Resident in his/her wheelchair into the room without wearing gloves or a gown. -Nurse #2 lifted up the Resident's shirt and touched the feeding tube without wearing gloves. -Nurse #2 put on gloves after performing hand hygiene and performed the remainder of the bolus feeding without wearing a gown while providing feeding tube care to the Resident. During an interview on 1/29/25 at 1:08 P.M., Nurse #2 said that she should have worn a gown and gloves before entering the room as instructed on the EBP sign and she did not. During an interview on 1/29/25 at 1:11 P.M., Unit Manager (UM) #1 said that for residents on EBP all staff should perform hand hygiene, wear a gown and put on gloves prior to entering the resident's room.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 42761 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure that the facility was free of pests on one Unit (Windsor) and the facility's Main Dining Room. Specifically, the facility failed to: -obtain routine pest control services. -obtain pest control services when staff and residents at the facility identified fruit flies in the facility's Main Dining Room and on the Windsor Unit. Findings include: Review of the facility's Pest Control Services Agreement with [Contracted Pest Control Company], dated 1/15/20, indicated the following: -Inspection and treatment for pests would be provided at least 12 times per year. -Areas of service included the exterior perimeter of the facility, common areas, kitchen and food preparation areas, dining areas, storage areas, restrooms, laundry, and resident rooms upon request. -The technician was to check in on each visit and maintain the pest control log book. Review of the facility's Pest Control Service Reports indicated: -Pest control services were provided to the facility 11 times during 2024 (not 12 times as indicated in the Pest Control Services Agreement). -The last pest control service visit to the facility was on 10/29/24 to re-treat the kitchen and dishwasher areas for fruit fly prevention. Review of the facility's Pest Control Log indicated: -the Administrator had observed fruit flies in the facility's Main Dining Room and Main Kitchen on 11/19/24. -no evidence that pest control services were obtained relative to fruit flies in the facility's Main Dining Room and Main Kitchen. On 1/27/25, between 9:45 A.M. and 9:51 A.M., surveyor #5 observed a few small, winged insects, lying dead on towels on the windowsill in Resident #25's room. During an interview at the time, Resident #25 said he/she had noticed small flies in the room and that the small flies would come and go. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/28/25, between 11:20 A.M. and 11:47 A.M., surveyor #1 observed the following in the facility's Main Kitchen: -a small, winged fly flying in front of the stand-up freezer. -a small, winged fly flying in the hallway between the food preparation area and the dry storage room. -a small, winged fly flying over egg salad sandwiches being made by the Cook. -The [NAME] waved her hand at the small, winged fly and said, Get out of here!. During an interview at the time with the Food Service Director (FSD) and the Cook, the FSD said that the facility had a problem with fruit flies a few months prior, and he didn't notice any problems with fruit flies currently in the Main Kitchen. The [NAME] then said that she did not see fruit flies often in the Main Kitchen. On 1/28/25 at 2:20 P.M., surveyor #1 observed a small, winged fly flying in the FSD's office, located in the facility's Main Kitchen and one small, winged fly flying in the hallway, just outside of the FSD's office (in the hallway between the food preparation area and the dry storage room). During an interview on 1/28/25 at 3:29 P.M., the Administrator said that the facility did not have a policy for pest control and that the facility did have a pest control agreement with a pest control company. The Administrator said that routine pest control services were supposed to be provided monthly and that the facility could call the pest control company for additional visits as needed, if pests were observed in the facility. The Administrator said that the last date the pest control company had been to the facility was on 10/29/24 and that the pest control company had provided treatment for fruit flies on that date. The Administrator said that she observed fruit flies in the facility's Main Kitchen and Main Dining Room in November 2024 and that she entered the observations into the Pest Control Log. The Administrator further said that no one at the facility followed up with the pest control company relative to the sightings of fruit flies and that no pest control services had been obtained by the facility since 10/29/24.