STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225398	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devereux Skilled Nursing & Rehabilitation Center	39 Lafayette Street Marblehead, MA 01945

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review and interview the facility failed to ensure the Physician/Nurse Practitioner were notified of recommendations made by a Wound Physician for one Resident (#1) out of a total sample of 15 residents. Specifically, for Resident #1 who had facility acquired pressure injuries, the facility failed to ensure the Physician/Nurse Practitioner were notified of recommendations made by the Wound Physician on 10/6/23 and 10/11/23, and the Resident was subsequently hospitalized on [DATE] with a wound infection. Findings include: Resident #1 was admitted to the facility in June 2023 and current diagnoses include dementia and facility acquired pressure ulcer of the right heel. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/7/24, indicated Resident #1 was assessed by staff to have severely impaired cognition. Review of the MDS, dated [DATE], indicated the following: -Resident has a stage 1 or greater, a scar over a bony prominence, or a non removable dressing/device. -Has one or more unhealed pressure ulcers. -Has one stage 2 pressure ulcer. Review of the current care plan for Resident #1 indicated a diagnoses list that included the diagnosis: Pressure ulcer of right heel, stage 4. The care plan fails to indicate a care plan for a stage 4 pressure ulcer of the right heel. Review of the Wound Physician visit note, dated 10/6/23, indicated the following recommendation: - Recommend X-ray of right foot. -Encounter: subsequent, progress, improving. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan of Care: Plan of care discussed with facility staff. Review of the Wound Physician visit note, dated 10/11/23, indicated the following recommendation: -Periwound: (+)dry/scaly -Note: flaky periwound +pain. -Encounter: subsequent, progress, improving. The Physician indicated the following recommendation in bold font and in a bold box on the report: - X-ray- Recommend to right foot. Plan of Care: Plan of care discussed with facility staff. Review of Resident #1's medical record failed to ensure the Physician/Nurse Practitioner were notified of recommendations made by a Wound Physician on 10/6/23 and 10/11/23. Review of the medical record indicated a Physician progress note, dated as created 12/2/23 as a late entry for a visit on 10/11/23, written by the Nurse Practitioner, that indicated the following: Note text included: New right heel blister and start of comfort meds d/t (due to) significant pain from ulcer. Assessment: Pressure ulcer of right heel, stage 2. - Pressure ulcer of right heel, started 9/20/2023. - Pressure ulcer of right heel, stage 2. - skin prep, off load. - appears worse->? XR (X-ray). -wound care provider consult -start APAP tid (medication used to treat pain three times a day). -monitor Further review of the medical record failed to indicate that nursing made the Physician/Nurse Practitioner aware that the Wound Physician recommendations for his/her x-ray was ever completed. Review of the October 2023 Physician orders indicated an order, dated 10/12/23, Send out to hospital for right heel evaluation one time for right heel infection. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospital Emergency Department note, dated 10/12/23, indicated: Noted to have purulent drainage from the right heel ulcer, and he was admitted with concern for osteomyelitis (as infection in the bone). Review of the Hospital discharge summary indicated Resident #1 was treated for Pressure ulcers with superadded infection right heel, MSSA infection. Review of a MD progress, dated 10/19/23, indicated: Assessment and Plan: This is a patient with pressure ulcer of left and right heels, for which he/she was sent to the hospital. Recommendation was made by the wound doctors in the hospital for both sides for dressing ad boot, the patient was back and continued the same. Continue to apply the dressing and also the boot. During an interview on 8/21/24 at 11:12 A.M., with Nurse (#1) he said that the Wound physician comes into the facility weekly and rounds with a nurse to see all residents with wounds. Nurse #1 said that at the end of the visit the Wound physician gives the nurse notes with any new recommendations they have. Nurse #1 said that it is the nurse's responsibility to notify the physician/nurse practitioner of any new recommendations and write a progress note in the clinical record indicating that this was done. During an interview on 8/21/24 at 11:46 A.M., the Director of Nursing (DON) she said that the nurses are expected to notify the Nurse Practitioner with any new recommendation by the Wound Physician and they should write a note in the clinical record indicating that this was done. During an interview on 8/21/24 at 1:24 P.M., the Nurse Practitioner (NP) she said that she could not recall if she was ever told that the Wound Physician recommended an X-ray of Resident #1's right heel on 10/6/24 or 10/11/24, and that she did not document in her notes what had occurred at that time, but that Resident #1 was hospitalized for a right heel wound infection on 10/12/23. The NP said she reviewed her progress note for Resident #1 from 10/11/23 and said she still cannot recall if she was made aware there were recommendations for an X-ray.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43846 Based on observations, record review and interview the facility failed to implement resident centered care plans for seven Residents (#31, #34, #41, #6, #19,#14 and #38) out of a total sample of 15 residents. Specifically, 1a. For Resident #31, the facility failed to ensure his/her Prevalon boots (soft boots that help reduce the risk of pressure ulcers) were applied as per the plan of care, 1b. For Resident #31, the facility failed to ensure nursing staff supervised the Resident during meals as per the plan of care, 2a. For Resident #34, the facility failed to ensure his/her Prevalon boots were applied and offload the Resident's heels as per the plan of care, 2b. For Resident #34, the facility failed to ensure nursing staff supervised the Resident who is at risk for aspiration during meals as per the plan of care, 3. For Resident #41, the facility failed to ensure nursing staff supervised the Resident during meals as per the plan of care, 4. For Resident #6, the facility failed to ensure nursing staff supervised the Resident during meals as per the plan of care, 5. For Resident #19, the facility failed to ensure nursing staff supervised the Resident during meals as per the plan of care, 6. For Resident #14, the facility failed to ensure nursing staff supervised the Resident during meals as per the plan of care, 7. For Resident #38, the facility failed to ensure nursing staff supervised the Resident during meals as per the plan of care. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs), dated 1/1/15, indicated a program of ADLs is provided to residents by the following method: The ability of each resident to meet the demands of daily living is assessed by a licensed nurse and/or member of the interdisciplinary team. A program of assistance and instruction in ADL skills is implemented. 1a. Review of Resident #31's most recent Minimum Data Set (MDS) assessment, dated 5/31/24, indicated Resident #31 scored a 13 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated Resident #31 is at risk for developing pressure ulcers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #31 was admitted to the facility in May 2020 with diagnoses that included dysphagia, end stage renal disease, and peripheral vascular disease. On 8/20/24 at 9:12 A.M. and 2:06 P.M., the surveyor observed Resident #31 in bed with his/her heels directly on the mattress with out Prevalon boots on. On 8/21/24 at 7:37 A.M. and 8:04 A.M., the surveyor observed Resident #31 in bed with his/her heels directly on the mattress with out Prevalon boots on. Review of Resident #31's skin care plan, dated 8/24/22, indicated an intervention for Resident #31 to wear Prevalon boots when in bed. Review of Resident #31's Norton Scale for Predicting Risk of Pressure Ulcer, dated 8/19/24, indicated he/she was at high risk, scoring a 9. During an interview on 8/21/24 at 10:37 A.M., Nurse #2 said if a resident has a care plan stating they are to wear Prevalon boots when in bed then they should be on. Nurse #2 said she was unaware Resident #31 was care planned to have Prevalon boots on. 1b. Resident #31 was admitted to the facility in May 2020 with diagnoses that included dysphagia, end stage renal disease, and peripheral vascular disease. Review of Resident #31's most recent Minimum Data Set (MDS) assessment, dated 5/31/24, indicated Resident #31 scored a 13 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated Resident #31 required supervision or touching assistance for meals. On 8/20/24 from 8:03 A.M. to 8:15 A.M., the surveyor observed Resident #31 in bed with his/her breakfast tray not initiating eating. No staff were present to provide supervision or touching assistance. On 8/21/24 from 8:18 A.M. to 8:24 A.M., the surveyor observed Resident #31 in bed with his/her breakfast tray not initiating eating. No staff were present to provide supervision or touching assistance. Review of Resident #31's nutrition care plan, dated 2/13/23, indicated continuous supervision with eating 1:8 ratio. Review of Resident #31's ADL care plan, dated 12/29/23, indicated Resident #31 eats with supervision. Review of Resident #31's active Certified Nurse Aide (CNA) Kardex (document that explains each resident's plan of care to the CNAs), indicated eating: continual supervision 1:8. During an interview on 8/21/24 at 9:56 A.M., the Speech Therapist said if a Residents' Kardex or care plan states supervision that means staff member should be in the room at all times. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24 at 10:37 A.M., Nurse #2 said if a resident has a care plan or Kardex stating they should be supervised at meal time then that means staff should be in the room at all times to supervise the resident while they eat. During an interview on 8/21/24 at 10:41 A.M., CNA #2 said if a resident's Kardex states the resident needs supervision then that means a nurse or a CNA needs to be in the resident's room while the resident eats. 2a. Resident #34 was admitted to the facility in April 2022 with diagnoses that included dysphagia following cerebral infarction, hemiplegia and hemiparesis, and contracture of the left hand. Review of Resident #34's most recent Minimum Data Set (MDS) assessment, dated 6/07/24, indicated Resident #34 was assessed by staff to have memory issues. The MDS further indicated Resident #34 is at risk for developing pressure ulcers. On 8/20/24 at 8:40 A.M.,12:04 P.M., and 2:06 P.M., the surveyor observed Resident #34 in bed with his/her heels directly on the mattress with out Prevalon boots on. On 8/21/24 at 8:02 A.M., the surveyor observed Resident #34 in bed with his/her heels directly on the mattress with out Prevalon boots on. Review of Resident #34's skin care plan, dated 8/24/22, indicated Resident #34 is to wear Prevalon boots at all times. Review of Resident #34's skin care plan, dated 9/15/22, indicated Resident #34 should off load his/her heels while in bed. Review of Resident #34's Norton Scale for Predicting Risk of Pressure Ulcer, dated 6/07/24, indicated Resident #34 was at high risk, scoring a 9. During an interview on 8/21/24 at 10:37 A.M., Nurse #2 said if a resident has a care plan that indicates they need Prevalon boots on at all times then they should be on the resident at all times. Nurse #2 said Resident #34 does not have boots anymore but his/her heels should be offloaded at all times because the Resident's heels are red. 2b. Resident #34 was admitted to the facility in April 2022 with diagnoses that included dysphagia following cerebral infarction, hemiplegia and hemiparesis, and contracture of the left hand. Review of Resident #34's most recent Minimum Data Set (MDS) assessment, dated 6/07/24, indicated Resident #34 was assessed by staff to have memory issues. The MDS further indicated Resident #34 required supervision or touching assistance for meals and complaints of difficulty or pain when swallowing while eating. The MDS also indicated the Resident also receives nutrition via a feeding tube. On 8/20/24 from 11:59 A.M. to 12:04 P.M., the surveyor observed Resident #34 laying in bed consuming his/her lunch behind the privacy curtain unable to be seen from the hallway. No staff were present in the room to provide supervision or touching assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 from 8:04 A.M. to 8:21 A.M., the surveyor observed Resident #34 laying in bed consuming his/her breakfast behind the privacy curtain unable to be seen from the hallway. No staff were present in the room to provide supervision or touching assistance. Review of Resident #34's ADLs care plan, dated 8/02/23, indicated that for eating Resident #34 requires continual supervision for PO (by mouth) intake. Review of Resident #34's dysphagia care plan, dated 4/06/23, indicated an intervention to maintain aspiration precaution every shift. Review of Resident #34's active Certified Nurse Aide (CNA) Kardex (document that explains each resident's plan of care to the CNAs), indicated aspiration precautions. During an interview on 8/21/24 at 9:56 A.M., the Speech Therapist said if a Residents' Kardex or care plan states continual supervision that means staff member should be in the room at all times. During an interview on 8/21/24 at 10:37 A.M., Nurse #2 said if a resident has a care plan or Kardex stating they should be supervised at meal time then that means staff should be in the room at all times to supervise the resident while they eat. Nurse #2 said Resident #34 is on aspiration precautions and needs to be supervised at all times when eating. During an interview on 8/21/24 at 10:41 A.M., CNA #2 said if a resident's Kardex states the resident needs supervision then that means a nurse or a CNA needs to be in the resident's room while they eat. 3. Resident #41 was admitted to the facility in July 2023 with diagnoses that included dementia, chronic kidney disease, and nutritional deficiencies. Review of Resident #41's most recent Minimum Data Set (MDS) assessment, dated 7/05/24, indicated Resident #41 scored a 9 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. The MDS further indicated Resident #41 required supervision or touching assistance with meals. Review of Resident #41's ADL care plan, dated 10/18/23, indicated Eating: Supervision. Review of Resident #41's quarterly nursing assessment, dated 7/05/24, indicated Eating: Supervision or touching assistance. Review of Resident #41's active Certified Nurse Aide (CNA) Kardex (document that explains each resident's plan of care to CNA), indicated eating: continual supervision 1:8. On 8/20/24 from 7:58 A.M. to 8:23 A.M., the surveyor observed Resident #41 laying in bed with a breakfast tray directly in front of him/her. Resident #41 was not initiating eating and there were no staff present to provide supervision or touching assistance. On 8/20/24 from 11:57 A.M. to 12:04 P.M., the surveyor observed Resident #41 laying in bed. There was a lunch tray in the room however it was not set up to consume and there were no staff present to set up the tray, provide supervision or touching assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 from 8:05 A.M. to 8:21 A.M., the surveyor observed Resident #41 laying in bed eating his/her breakfast. There were no staff present to provide supervision or touching assistance. During an interview on 8/21/24 at 9:56 A.M., the Speech Therapist said if a Residents' Kardex or care plan states continual supervision that means staff member should be in the room at all times. During an interview on 8/21/24 at 10:37 A.M., Nurse #2 said if a resident has a care plan or Kardex stating they should be supervised at meal time then that means staff should be in the room at all times to supervise the resident while they eat. During an interview on 8/21/24 at 10:41 A.M., CNA #2 said if a resident's Kardex states the resident needs supervision then that means a nurse or a CNA needs to be in the resident's room while they eat. 4. Resident #6 was admitted to the facility in February 2022 with diagnoses that included chronic respiratory failure with hypoxia, heart failure, and dementia. Review of Resident #6's most recent Minimum Data Set (MDS) assessment, dated 7/19/24, indicated Resident #6 scored a 12 out of a possible 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairment. The MDS further indicated Resident #6 required supervision or touching assistance with meals. On 8/20/24 from 8:12 A.M. to 8:23 A.M., the surveyor observed Resident #6 in bed with his/her breakfast tray directly in from of him/her. Resident #6 was not initiating eating and there were no staff present to provide supervision or cueing assistance. On 8/21/24 from 8:06 A.M. to 8:23 A.M., the surveyor observed Resident #6 with his/her breakfast tray directly in from of him/her. Resident #6 was not initiating eating and there were no staff present to provide supervision or cueing assistance. Review of Resident #6's nursing quarterly assessment, dated 7/19/24, indicated Eating: Supervision or touching assistance. Review of Resident #6's ADL care plan, dated 5/3/24, indicated Eating: supervision. Review of Resident #6's active Certified Nurse Aide (CNA) Kardex (document that explains each resident's plan of care to the CNAs), indicated eating: continual supervision 1:8. During an interview on 8/21/24 at 9:56 A.M., the Speech Therapist said if a Residents' Kardex or care plan states supervision that means staff member should be in the room at all times. During an interview on 8/21/24 at 10:37 A.M., Nurse #2 said if a resident has a care plan or Kardex stating they should be supervised at meal time then that means staff should be in the room at all times to supervise the resident while they eat. During an interview on 8/21/24 at 10:41 A.M., CNA #2 said if a resident's Kardex states the resident needs supervision then that means a nurse or a CNA needs to be in the resident's room while they eat. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41105 5. Resident #19 was admitted to the facility in October 2022 and has diagnoses that include Severe Vascular Dementia with Agitation. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/05/24, indicated that on the Brief Interview for Mental Status exam Resident #19 scored a 6 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated Resident #19 had no behavior of rejecting care, required supervision or touching assistance with eating and had complaints of difficulty or pain when swallowing. Review of the Quarterly Nursing Assessment, dated 7/05/24, indicated Resident #19 requires supervision or touching assistance for eating. Review of the current CNA (Certified Nursing Assistant) Kardex (document that explains each resident's plan of care to the CNAs), indicated Resident #19 requires continual supervision for eating and is on Aspiration (when food or drink goes into your airway rather than your esophagus) Precautions. Review of Resident #19 ADL care plan included the following intervention: Eating: continual supervision. Review of the Speech and Language Pathologist discharge report, dated 7/18/24, indicated the following: Pt. is tolerating downgraded diet to liquefied puree with thin liquids without overt s/s (signs or symptoms) of aspiration or difficulty noted. PO (by mouth) intake varies secondary to decreased cognition; however, he/she benefits from a quiet, 1:1 environment. D/C skilled SLP services as per MD order. Pt has reached max potential at this time. On 8/20/24 at 8:02 A.M., Resident #19 was observed alone in his/her room with breakfast on a tray table directly in front of him/her. There were no staff present to provide supervision or touching assistance. On 8/20/24 at approximately 11:45 A.M., Resident #19 was observed to approach the unit dining room and a staff person told Resident #19 it was lunch time and redirected him/her back to his/her room. The surveyor continued to make the following observation: -At 12:08 P.M., Resident #19 was observed seated alone in his/her room, with the lights off, and lunch had been placed on the tray table directly in front of him/her. There were no staff present to provide continual supervision or touching assistance. On 8/21/24 at 7:47 A.M., Resident #19 was observed seated in his/her room with a breakfast tray directly in front of him/her. There were no staff present to provide continual supervision or touching assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24 at 8:52 A.M., with Resident #19's CNA (#1) she said that she has access to the CNA Kardex and that the Kardex tells her how much care a resident needs. CNA #1 said that continual supervision means she has to be with the resident for the entire meal. CNA #1 said that Resident #19 requires someone with him/her to supervise the entire meal but that morning she was assisting another resident. She said that when she is with another resident the nurse should watch Resident #19. During an interview on 8/21/24 at 9:00 A.M., with Resident #19's Nurse (#1), he said that if the CNA Kardex and the care plan indicate that a resident requires continual supervision with meals that means that the resident should either be eating in the dining room with staff supervision or if the resident eats in their room, staff should stay in the room with the resident for the entire meal. Nurse #1 said that Resident #19 had his/her diet downgraded because he/she pockets food but he doesn't think he/she needs continual supervision anymore. During an interview 8/21/24 at 9:42 A.M., with the Rehab Director, she reviewed the most recent Speech Therapy notes with the surveyor and said that Resident #19 was on service 7/8/24-7/18/24 and upon discharge required a liquefied diet and a quiet 1:1 environment for meals. During an interview on 8/21/24 at 9:52 A.M., with the Speech Therapist (ST) #1 she said that continual supervision means that staff should be with a resident for the entire meal. ST #1 said that Resident #19 used to eat in the main dining room but that it was too distracting for him/her and during meals Resident #19 needs staff to encourage him/her to to keep eating. During an interview on 8/21/24 at 10:25 A.M., with the Director of Nursing (DON) she said it is her expectation that the Kardex and care plan be accurate and up to date. The DON said that if the Kardex and care plan say a resident requires continual supervision that means that staff go up and down the hall checking on the residents. 45343 6. Resident #14 was admitted to the facility in March 2020 with diagnoses including hemiplegia and hemiparesis following unspecified cerebral vascular disease affecting left non-dominant side, dysphagia (difficulty swallowing), and unspecified severe protein-calorie malnutrition. Review of Resident #14's most recent Minimum Data Set (MDS) assessment, dated 5/31/24, indicated Resident #14 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #14 requires supervision/touching assistance for eating. On 8/20/24 at 7:59 A.M., and 12:00 P.M., and 8/21/24 at 8:16 A.M., 12:19 P.M. and 12:23 P.M., Resident #14 was observed eating in his/her room. There were no staff present to provide supervision. During a record review on 8/21/24 at 9:00 A.M., Resident #14's care plan indicated the following: -Eating: Supervision, revised 3/23/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Devereux Skilled Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 39 Lafayette Street Marblehead, MA 01945	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nutrition: Monitor/document/report to MD PRN for s/sx (signs/symptoms) of dysphagia, pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals, initiated 3/23/24. Review of Resident #14's Kardex (document that explains each resident's plan of care to the CNAs), indicated the following: Eating: Continual Supervision (1:8). Review of Resident #14's Speech Language Pathology discharge summary, dated 4/1/24, indicated a concluding status for swallowing as follows: Patient uses safe swallowing strategies with 80% accuracy with min verbal cues from caregivers. During an interview on 8/21/24 at 12:45 P.M., Nurse #2 said staff set-up Resident #14's meal trays and should be providing Resident #14 with direct supervision for the entire meal due to Resident #14's swallowing issues. During an interview on 8/21/24 at 1:25 P.M., Corporate Nurse #1 said she would expect nursing to follow Resident #14's plan of care and provide supervision with meals. 7. Resident #38 was admitted to the facility in January 2024 with diagnoses including Cerebral Palsy, dysphagia (difficulty swallowing), and legal blindness. Review of Resident #38's most recent Minimum Data Set (MDS) assessment, dated 6/26/24, indicated Resident #38 had Brief Interview for Mental Status exam score of 15 out of a possible 15 indicating intact cognition. The MDS further indicated Resident #38 requires supervision/touching assistance for eating. On 8/20/24 at 8:20 A.M., 11:59 A.M., and 12:04 P.M., and 8/21/24 at 8:09 A.M., and 8:17 A.M., Resident #38 was observed eating in his/her room. There were no staff present to provide supervision and Resident was not visible from the hallway. During a record review on 8/20/24 at 12:13 P.M., Resident #38's care plan indicated the following: -Eating: Continual supervision, revised 10/18/23. -Nutrition: Maintain aspiration precautions every shift, initiated 4/17/24. Review of Resident #38's Kardex (document that explains each resident's plan of care to the CNAs), indicated the following: Eating: Continual Supervision (1:8). During an interview on 8/21/24 at 12:45 P.M., Nurse #2 said staff set-up Resident #38's tray and tell him/her where all the food items are on the meal tray. Nurse #2 said Resident #38 is on aspiration precautions and requires continual supervision during all meals. During an interview on 8/21/24 at 1:25 P.M., Corporate Nurse #1 said she would expect nursing to follow Resident #38's plan of care and provide supervision with meals.

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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. 43846 Based on record review, observations and interviews, the facility failed to ensure a physician's order was implemented for one Resident (#6) out of a total sample of 15 residents. Specifically, for Resident #6, the facility failed to ensure his/her weight was obtained weekly, as ordered. Findings Include: Resident #6 was admitted to the facility in February 2022 with diagnoses that included chronic respiratory failure with hypoxia, heart failure, and dementia. Review of Resident #6's most recent Minimum Data Set (MDS) assessment, dated 7/19/24, indicated Resident #6 scored a 12 out of a possible 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairment. The MDS further indicated Resident #6 is on a physician prescribed weight gain regimen. Review of Resident #6's weights indicated; - 8/02/24: 120.6 Lbs (pounds) - 7/23/24: 119.6 Lbs - 7/01/24: 119.6 Lbs - 6/10/24: 120.2 Lbs Further review of the medical record failed to indicate any other weights were obtained in June, July and August 2024. Review of Resident #6's current physician order, dated 10/17/22, indicated weekly weights every Monday day shift. Review of Resident #6's antidepressant care plan, dated 4/12/23, indicated monitor weight weekly. Review of Resident #6's nutrition care plan, dated 5/26/23, indicated weights per MD order. During an interview on 8/21/24 at 1:39 P.M., Nurse (#2) said Resident #6 has an order for weekly weights to be done every Monday and they should be done as ordered. Nurse #2 said the staff document weights in the electronic medical record. During an interview on 8/21/24 at 2:06 P.M., the Director of Nurses (DON) said she reviewed Resident #6's weights and said Resident #6 has not been consistently weighed weekly. The DON said she expects the nursing staff to follow doctors orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review and interview the facility failed to ensure Wound Physician recommendations were followed for one Resident (#1) out of a total sample of 15 residents. Specifically, for Resident #1 who had facility acquired pressure injuries, the facility failed to implement recommendations made by the Wound Physician on 10/6/23 and 10/11/23, and the Resident's wound worsened and Resident #1 was subsequently hospitalized on [DATE] with a wound infection. Findings include: The policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, undated, indicated the following: - The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusives, absorbtive, etc.) and application of topical agents. Resident #1 was admitted to the facility in June 2023 and current diagnoses nclude dementia and facility acquired pressure ulcer of the right heel. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/7/24, indicated Resident #1 was assessed by staff to have severely impaired cognition. Review of the MDS, dated [DATE], indicated the following: -Resident has a stage 1 or greater, a scar over a bony prominence, or a non removable dressing/device. -Has one or more unhealed pressure ulcers. -Has one stage 2 pressure ulcer. Review of the current care plan for Resident #1 indicated a diagnoses list that included the diagnosis: Pressure ulcer of right heel, stage 4. The care plan fails to indicate a care plan for a stage 4 pressure ulcer of the right heel. Review of Resident #1's current Physician orders include the following order: - Start date 9/29/23: Right Heel clean with normal saline apply Medi honey to wound bed cover with ABD (abdominal pad) pad then wrap with kerlix daily and PRN (as needed) every day shift. Review of the Wound Physician visit note, dated 10/6/23, indicated the following recommendation: - Recommend X-ray of right foot. -Encounter: subsequent, progress, improving. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan of Care: Plan of care discussed with facility staff. Review of the Wound Physician visit note, dated 10/11/23, indicated the following recommendation: -Periwound: (+)dry/scaly -Note: flaky periwound +pain. -Encounter: subsequent, progress, improving. The Physician indicated the following recommendation in bold font and in a bold box on the report: - X-ray- Recommend to right foot. Plan of Care: Plan of care discussed with facility staff. Review of the medical record indicated a Physician progress note, dated as created 12/2/23 as a late entry for a visit on 10/11/23, written by the Nurse Practitioner indicated the following: - Pressure ulcer of right heel, stage 2 started 9/20/23. - Pressure ulcer of right heel, stage 2. - skin prep, off load. - appears worse->? XR (X-ray). -wound care provider consult -start APAP tid (medication used to treat pain three times a day). -monitor Review of Resident #1's October 2023 Physician orders: - Failed to indicate a written or telephone order was obtained from Resident #1's Physician for an x-ray on 10/6/23 and 10/11/23. - Indicated an order dated 10/12/23, Send out to hospital for right heel evaluation one time for right heel infection. Review of the clinical record failed to indicate an X-ray was ordered or obtained on 10/6/23 or 10/11/23. Review of the nursing progress notes from 10/6/23 through 10/12/23 failed to indicate that nursing was aware of the new wound recommendations for the right heel x-ray. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospital Emergency Department note, dated 10/12/23, indicated: Noted to have purulent drainage from the right heel ulcer, and he was admitted with concern for osteomyelitis (an infection in the bone). Review of the Hospital discharge summary indicated Resident #1 was treated for Pressure ulcers with superadded infection right heel, MSSA infection. Review of the facility readmission note from the hospital indicated: Pt on antibiotics (Amoxicillin Clavulanate 875.125 mg) for right heel infection. During an interview on 8/21/24 at 11:12 A.M., with Nurse (#1) he said the following: - The X-ray company that comes to the facility is very reliable and when an X-ray is ordered the X-ray company comes to the facility the same day and nursing typically get the results within 4 hours maximum. - The Wound Physician comes into the facility weekly and rounds with a nurse to see all residents with wounds. At the end of the visit the Wound Physician gives the nurses notes with any new recommendations they have. Nurse #1 said it is the nurse's responsibility to notify the Physician/Nurse Practitioner of any new recommendations and write a progress note in the clinical record indicating that this was done and what the Physician/Nurse Practitioner said. - X-ray results are kept in the residents chart and uploaded into the electronic medical record. Nurse #1 indicated that there is no indication that the X-rays were ever done on 10/6/23 or 10/11/23, and that Resident #1 was hospitalized on [DATE] with an infected right heel. During an interview on 8/21/24 at 11:46 A.M., the Director of Nursing (DON) she said that the nurses are expected to notify the Nurse Practitioner with any new recommendation by the Wound Physician and they should write a note in the clinical record indicating that this was done. The DON said that she would look into what happened on 10/6/23 and 10/11/23 but by the end of survey was unable to find any documentation indicating that the Physician/Nurse Practitioner were notified of the recommendations or that they were followed. During an interview on 8/21/24 at 1:24 P.M., with the Nurse Practitioner she said that she could not recall if she was ever told that the Wound Physician recommended an X-ray of Resident #1's right heel on 10/06/24 or 10/11/24, and that she did not document in her notes what had occurred at that time, but that Resident #1 was hospitalized for a right heel wound infection on 10/12/23. The NP said she reviewed her progress note for Resident #1 from 10/11/23 and said she still cannot recall if she was aware there were recommendations for an X-ray and that they were never done.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48671 Based on observation, record review, interview and policy review, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure medications were not left on top of the medication cart unsupervised during medication pass. Findings include: Review of the facility policy titled Medication Storage, dated 2017, indicated the following: - The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. - Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. During a medication observation on 8/21/24 at 8:29 A.M., the surveyor observed Nurse (#1) remove medications from the medication cart and place them on top of the medication cart. The surveyor then observed Nurse #1 leave six medications on top of the medication cart and walk down the hallway to obtain items from the kitchenette. The medications were left accessible and unattended in the hall and two residents were observed near the medication cart and one housekeeping staff member was a short distance from the medication cart. During an interview on 8/21/24 at 8:46 A.M., Nurse #1 said he should not have left the medications on top of the medication cart unattended and walked away. During an interview on 8/21/24 at 9:44 A.M., the Director of Nursing said medications should not be left on top of the medication cart or left unattended and must be stored properly.

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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. 45343 Based on observations, record reviews and interviews, the facility failed to ensure accurate medical records were maintained for two Residents (#14 and #38) out of a total sample of 15 residents. Specifically, for Resident #14 and #32, the facility failed to accurately document the level of supervision received during meals. Findings Included: 1. Resident #14 was admitted to the facility in March 2020 with diagnoses including hemiplegia and hemiparesis following unspecified cerebral vascular disease affecting left non-dominant side, dysphagia (difficulty swallowing) and unspecified severe protein-calorie malnutrition. Review of Resident #14's most recent Minimum Data Set (MDS) assessment, dated 5/31/24, indicated Resident #14 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #14 currently requires supervision/touching assistance for eating. On 8/20/24 at 7:59 A.M., and 12:00 P.M., and 8/21/24 at 8:16 A.M., 12:19 P.M. and 12:23 P.M., Resident #14 was observed eating in his/her room. There were no staff present to provide supervision or touching assistance. During a record review on 8/21/24 at 9:00 A.M., Resident #14's care plan indicated the following: - Eating: Supervision, revised 3/23/24. - Nutrition: Monitor/document/report to MD PRN (as needed) for s/sx (signs/symptoms) of dysphagia, pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals, initiated 3/23/24. Review of Resident #14's Kardex (a form indicating level of assistance a resident requires) indicated the following: Eating: Continual Supervision (1:8). Review of Resident #14's Speech Language Pathology discharge summary dated 4/1/24 indicated a concluding status for swallowing as follows: Patient uses safe swallowing strategies with 80% accuracy with min verbal cues from caregivers. Review of Resident #14's Nursing Assistant Daily Flow Record for August 2024 indicated staff had signed off that Resident #14 had received supervision during all his/her meals, contrary to the surveyors observations on 8/20/24 and 8/21/24. During an interview on 8/21/24 at 12:45 P.M., Nurse #2 said staff are expected document accurately on the daily flow sheet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 1:25 P.M., Corporate Nurse #1 said she would expect staff to document accurately on the nursing assistant flow sheet. 2. Resident #38 was admitted to the facility in January 2024 with diagnoses including Cerebral Palsy, dysphagia (difficulty swallowing) and legal blindness. Review of Resident #38's most recent Minimum Data Set (MDS) assessment, dated 6/26/24, indicated Resident #38 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #38 requires supervision/touching assistance for eating. On 8/20/24 at 8:20 A.M., 11:59 A.M., and 12:04 P.M., and 8/21/24 at 8:09 A.M., and 8:17 A.M., Resident #38 was observed eating in his/her room. There were no staff present to provide supervision or touching assistance. Resident #38 was not visible from the hallway. During a record review on 8/20/24 at 12:13 P.M., Resident #38's care plan indicated the following: -Eating: Continual supervision, revised 10/18/23. -Nutrition: Maintain aspiration precautions every shift, initiated 4/17/24. Further review of Resident #38's Kardex (document that explains each resident's plan of care to the CNAs), indicated the following: Eating: Continual Supervision (1:8). Review of Resident #38's Nursing Assistant Daily Flow Record for August indicated staff had signed off that Resident #38 had received supervision during all his/her meals, contrary to the surveyor's observations on 8/20/24 and 8/21/24. During an interview on 8/21/24 at 12:45 P.M., Nurse #2 said staff are expected document accurately on the daily flow sheet. During an interview on 8/21/24 at 1:25 P.M., Corporate Nurse #1 said she would expect staff to document accurately on the nursing assistant flow sheet.

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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. 48671 Based on observations, policy review, and interview, the facility failed to ensure infection control standards of practice for the prevention of infections were implemented. Specifically, the facility failed to: 1. ensure nursing staff performed hand hygiene appropriately during the medication administration task; and 2. ensure infection control practices were maintained to prevent the spread of infection during medication administration. Findings include: Review of the facility policy titled Infection Control, dated as reviewed 10/14/22, indicated the following: - The facility require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. - All personnel shall follow the handwashing /hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitor. Review of the facility document titled Protocol for Hand Hygiene, dated 8/17, indicated the following: - Examples of situation when hand hygiene is indicated: 1. Before and after direct patient/resident contact. 2. After completing tasks at one patient/resident area before moving to another station. 6. After contact with items/surfaces at patient/resident areas. 1. During a medication administration observation on 8/21/24 at 7:50 A.M., the surveyor observed Nurse (#2) doffing (removing) her gloves, touch the contaminated glove with her bare hand and discard the contaminated gloves. Then, without performing hand hygiene, Nurse #2 exited the resident's room and touched items on top of the medication cart located in the hall. During a medication observation on 8/21/24 at 8:17 A.M., the surveyor observed Nurse #2 administer eardrops to a resident and then doff her gloves, touch the contaminated glove with her bare hand and discard the contaminated gloves. Then, without performing hand hygiene, Nurse #2 exited the resident's room and touched the eardrop medication bottle with her bare hand and touched the overbed tray table in another resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 9:20 A.M., Nurse #2 said she should not touch the contaminated glove with her bare hand and said she should have used hand sanitizer or soap and water before and after she removed her gloves. During an interview on 8/21/24 at 9:29 A.M., the Director of Nursing said she expects staff to follow infection control guidelines, perform proper glove removal and perform hand hygiene before and after glove use. 2. During a medication observation on 8/21/24 at 8:29 A.M., the surveyor observed Nurse #1 remove medications for administration and place medication pills into three separate medication cups, the nurse then stacked the medications cups on top of one another causing the contaminated bottom each medication cup to be in contact with the loose medications inside each cup. Nurse #1 was observed picking up the three stacked medication cups and placed them into the top drawer of the medication cart and closed the drawer to the medication cart. During an interview on 8/21/24 at 8:45 A.M., Nurse #1 said he should not have stacked the medication cups together contaminating the medication because the top of the medication cart is contaminated. During an interview on 8/21/24 at 9:45 A.M., the Director of Nursing said medication cups should not be stacked together contaminating the medication inside and she expects infection control measures to be followed.