STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225400	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Wakefield LLC	One Bathol Street Wakefield, MA 01880

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49880 Based on observations, record review and interview, the facility failed to provide a dignified existence to one Resident (#43) out of a total sample of 29 residents. Specifically, for Resident #43 the facility failed to provide privacy and dignity while in his/her room. Findings Include: Review of facility policy, titled Quality of Life- Dignity, dated as revised 2009, indicated the following but not limited to: *Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self- esteem and self- worth. * The policy further indicated staff shall promote, maintain and protect resident privacy including bodily privacy during assistance with personal care. Resident #43 was admitted to the facility in August 2023 with diagnoses including multiple sclerosis, dementia, adult failure to thrive and neuromuscular dysfunction of the bladder. Review of the most recent Minimum Data Set (MDS) Assessment, dated 2/6/24, indicated that Resident #43 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that Resident #43 is cognitively intact. The MDS further indicated that Resident #43 is dependent for upper body and lower body dressing. On 2/27/24 at 7:56 A.M., the surveyor observed Resident #43 from the hallway lying in his/her bed. Resident #43 was uncovered, wearing a T-shirt, a brief (an adult incontinence product), socks and shoes. On 2/29/24 at 7:06 A.M., the surveyor observed Resident #43 from the hallway lying in bed, uncovered. Resident #43 was in a shirt, a brief, and his/her pants were pulled down to his/her knees. Resident #43 said that he/she did not want to be exposed and would prefer being fully dressed or covered up. Resident #43 said he/she was unable to pull up his/her own pants without assistance. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes from 2/10/24 through 2/29/24 failed to indicate that Resident #43 refused to be dressed or covered with blankets. During an Interview on 2/29/24 at 10:27 A.M. Nurse #2 said that Resident #43 is alert and oriented and requires assistance for bathing and dressing. Nurse #2 said that Resident #43 did not exhibit behaviors of disrobing on his/her own. Nurse #2 said that being visible from the hallway, undressed was not dignified, and that Resident #43 should have been covered up by staff, or had the curtain closed to provide privacy. During an interview on 2/29/24 at 10:41 A.M. Director of Nursing (DON) said that she observed Resident #43 at the same time as the surveyor on 2/29/24 at 7:06 A.M. and said that it was undignified for Resident #43 to be visualized from the hallway wearing a brief with his/her pants pulled down to his/her knees. The DON said she expects that all staff are maintaining a dignified experience for residents by providing privacy.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48990 Based on observations, interviews, and records reviewed, the facility failed to honor the right of self-determination to choose providers of health care services for one Resident (#81) out of 29 total sampled residents. Specifically, following alleged physical abuse, the facility failed to honor a request for Resident #81 to not have contact with the accused caregiver. Findings include: Resident #81 was admitted to the facility in February 2020 with diagnoses including a stroke with left sided hemiplegia (weakness). Review of the most recent Minimum Data Set (MDS) assessment, dated 2/7/24, indicated that Resident #81 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #81 was dependent on staff for assistance with transfers and personal hygiene. On 2/27/24 at 9:22 A.M., Resident #81 said he/she was injured by a nurse while she was removing his/her left arm brace and wouldn't stop even though he/she was screaming for her to stop. He/she identified the nurse as Unit Manager #1. Resident #81 said following the incident he/she told the Administrator he/she did not want Unit Manager #1 in his/her room and the Administrator said Resident #81 would have no further contact with Unit Manager #1. Resident #81 said Unit Manager #1 comes into his/her room to take care of him/her. Resident #81 said he/she feels anxious when Unit Manager #1 comes into his/her room. On 2/27/24 at 09:54 A.M., the surveyor observed Unit Manager #1 assisting Resident #81 with his/her breakfast tray and assisting to feed him/her. Review of Incident Investigation Final Report, which the facility reported in the Health Care Facility Reporting System (HCFRS), dated 1/17/23, indicated, but was not limited to: -Resident (#81) reported that approximately two to three weeks before, a staff member bent his/her fingers backwards. The Resident was asked if he/she was able to identify the staff member which he/she alleged Unit Manager #1. -In conclusion the facility is unable to substantiate any physical abuse on behalf of the facility. -The Resident requested to not have the accused caregiver moving forward and the request was honored. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/24 at 10:04 A.M., Resident #81 said Unit Manager #1 comes into his/her room almost every day. Resident #81 said he/she can't nap because he/she is afraid she would come into his/her room. Resident #81 said he/she has told staff multiple times he/she does not want Unit Manager #1 in his/her room, but since they said the abuse was not true there is nothing they can do. Resident #81 said the facility never offered him/her a room change, but that he/she would have wanted one to be away from Unit Manager #1. During an interview on 2/28/24 at 11:10 A.M., Unit Manager #1 said when the incident occurred a year ago, she was immediately suspended and returned after the allegation was not substantiated. Unit Manager #1 said she was never told not to care for Resident #81 and often is assigned to the medication cart on Resident #81's assignment. Unit Manager #1 said she gives Resident #81 medication and assists with non-direct care needs but does not wash him/her up or provide any care for the left hand contracture because Resident #81 did not feel comfortable with that. Review of Resident #81's medication administration record indicated Unit Manager #1 administered medication to Resident #81 on 2/5/24, 2/6/24, 2/12/24, 2/13/24, 2/14/24, 2/19/24, 2/20/24, 2/21/24, and 2/26/24. During an interview on 9:11 A.M., the Director of Nursing (DON) said that if any resident does not want a specific caregiver to care for them, the request should be honored. The DON said the Administrator, who no longer works at the facility, never communicated to the interdisciplinary team that Unit Manager #1 should not care for Resident #81, as indicated on the Incident Investigation Final Report, dated 1/17/23. The DON said that since this was not communicated, Unit Manager #1 had continued to care for Resident #81 since the incident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48990 Based on observation and interview, the facility failed to maintain a safe, clean, comfortable and homelike environment. Specifically: 1. The facility failed to maintain an environment free from physical disrepair, which included damaged walls, damaged ceilings, damaged floor, torn window screens, and broken window blinds on one of three resident units. 2. The facility failed to ensure that comfortable air temperatures were maintained on one of three resident units. 3. The facility failed to ensure a Resident room was free of bugs. Findings include: Review of the facility's policy titled 'Quality of Life Policy - Homelike Environment', undated, indicated, but was not limited to: -Residents are provided with a safe, clean, comfortable and homelike environment. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: g. Comfortable temperatures. 1) During a tour of the [NAME] Unit on 2/29/24 at 8:17 A.M., the surveyor observed the following: In room [ROOM NUMBER]E: -A crack in the bathroom ceiling measuring approximately three feet long. -The bathroom ceiling had peeling paint with brown stains. -Three dry brown drip-like marks on the wall above toilet, each measuring approximately three feet long. These stains start at the ceiling and end at the top of the wall tile. During an interview on 02/29/24 at 11:01 A.M, the Director of Maintenance said the brown stains appear to be dried feces. The Director of Maintenance said this should have been reported to be repaired, but he had not been made aware. In room [ROOM NUMBER]E: -The corner of the wall had chipped, peeling paint and a large gauge, measuring approximately two feet long by the bathroom door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Three broken blinds. -Three torn window screens. In room [ROOM NUMBER]E: -Two torn window screens. In room [ROOM NUMBER]W: - There was broken molding behind one of the beds. In room [ROOM NUMBER]E: -A torn window screen. In room [ROOM NUMBER]W: - 4 two-inch holes were in the bathroom ceiling. In a shared bathroom between room [ROOM NUMBER]E and 109E: -Brown, stained ceiling paint that is uneven with exposed plaster and screen-like patch. In room [ROOM NUMBER]W: - A bent curtain rod. During an interview on 2/29/24 at 11:23 A.M., a Resident said the ceiling had been leaking in the shared bathroom between room [ROOM NUMBER]E and 109E for a year. The Resident said housekeeping came this week to mop up the leak, but it has not been repaired. During an interview on 02/29/24 at 11:23 A.M., the Director of Maintenance said this should have been reported to be repaired, but he had not been made aware. During an interview on 2/29/24 at 11:40 A.M., Unit Manager #1 said there was a leak in the shared bathroom between room [ROOM NUMBER]E and 109E about a year ago that was reported to maintenance. Unit Manager #1 said she would have expected it to be fixed by now, but it was not. In room [ROOM NUMBER]E: -A cracked chair rail with sharp, jagged edges above 109E-A headboard. -Two broken blinds. -One broken screen. In room [ROOM NUMBER]E: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A broken baseboard next to the bathroom door. In the small dining room: -Broken wall covering above the radiator. In the hallway in front of the nurse's station: -One broken floor tile with large gauge in floor. During an interview on 02/29/24 at 11:23 A.M., the Director of Maintenance said the facility uses the TELS system (an electronic system to request maintenance services). The Director of Maintenance said if he receives a work order request from TELS he works on it promptly, but had not previously been notified of the surveyors concerns. The Director of Maintenance said it's expected that staff on all shifts use the TELS system to request any repairs needed such as if molding is falling off, floor concerns, chipped paint, leaks, broken screens, broken toilets, lights, cracks or anything related to safety or maintaining a homelike environment. 2. During an interview on 2/27/24 at 8:09 A.M., a Resident residing on the East wing of [NAME] Unit said the temperature in his/her room had been consistently cold during the winter months for the last three years. The Resident said he/she had complained multiple times and staff told him/her the facility can't turn up the heat further on the East wing because then it would get to be too hot for the [NAME] wing because it is the same heating zone for both East and [NAME] wings. During an interview on 2/28/24 at 09:21 A.M., a Resident residing on the [NAME] wing of [NAME] unit said his/her room gets too hot, so they have to leave their windows open all the time and sometimes put the air conditioner on. The windows were wide open in the room and there was a window air conditioner unit in the window. One Resident in this room was in bed without his/her shirt on because he/she felt hot. The Resident said it's too hot in this room without the window open. During an interview on 2/29/24 at 11:01 A.M., the Director of Maintenance said that the Resident room with the windows open would not affect the units temperatures because that room always kept the door closed and there was no thermostat in that room. During an interview on 2/27/24 at 9:05 A.M., the Director of Maintenance said that the East wing residents report being cold and the [NAME] wing residents report being hot. The Director of Maintenance said he tries to balance, but since the heat is on one circuit with only two thermometers there are large fluctuations in temperatures on the unit. During a tour of the [NAME] Unit on 2/27/24 at 9:05 A.M., the surveyor observed the Director of Maintenance measure temperatures using a handheld infrared thermometer gun (a device the measure environmental temperatures of rooms/objects). The outside temperature was 43 degrees Fahrenheit. The following results were observed: -room [ROOM NUMBER]E: 60 degrees -room [ROOM NUMBER]E: 66.5 degrees (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Activities department (on east wing hall): 67.2 degrees Fahrenheit -room [ROOM NUMBER]E: 65.3 degrees -Small dining: 82.5 degrees -Large dining room: 88.9 degrees -room [ROOM NUMBER]W: 85.9 degrees -West hallway: 88.9 degrees During an interview on 2/27/24 at 08:31 A.M., the Director of Maintenance was measuring the temperature in room [ROOM NUMBER]E, the thermometer was reading 57 degrees in the center of the room and at 60 degrees on the ceiling. The Resident in the room said he/she was very cold. The Director of Maintenance said the air felt cold around the Residents bed and that he could feel the cold floor in his feet. During a tour of the [NAME] Unit on 2/28/24 at 7:14 A.M., the surveyor observed the Director of Maintenance measure temperatures using a handheld infrared thermometer gun. The outside weather was 55 degrees. The Director of Maintenance said the weather had been mild and that there had not been extreme temperatures today or yesterday. The following results were observed: -Nurses station: 82.5 degrees -Small dining room: 83.8 degrees -Large dining room: 82.1 degrees -room [ROOM NUMBER]W: 81.3 degrees -room [ROOM NUMBER]W: 83.8 degrees -room [ROOM NUMBER]W: 81.7 degrees -room [ROOM NUMBER]W: 83.2 degrees -West hallway: 82.1 degrees During an interview on 2/29/24 at 8:39 A.M., CNA #2 said East wing is cold, and sometimes its bad cold. During an interview on 2/28/24 at 7:14 A.M, the Director of Maintenance said the [NAME] wing hallway felt too warm. The Director of Maintenance said the air temperature should be between 71 degrees and 81 degrees per regulations. He said a plumber came in in December and the temperatures are better than they were, but they are still not consistently within acceptable ranges. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 2/27/24 at 9:22 A.M., the surveyor observed over 40 tiny, black bugs flying around a Resident's breakfast tray. These bugs were landing on the Resident's cereal, banana, and juice cup. The Resident said the bugs are there every day. The Resident said he/she requested traps or sticky strips to be hung in his/her room but was told no by staff. On 2/27/24 at 9:54 A.M., Unit Manager #1 was observed assisting the Resident with his/her meal. Unit Manager was swatting the bugs away from herself and the Resident's food tray. During an interview on 2/27/24 at 9:58 A.M., Unit Manager #1 said there are often bugs in his/her room.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49880 Based on observations, record reviews and interviews the facility failed to implement a comprehensive person-centered care plan for one Resident (#60) out of a total sample of 29 residents. Specifically, the facility failed to implement the plan of care to apply heel lift booties (a boot to prevent skin breakdown) to bilateral feet while in bed for Resident #60. Findings Include: Resident #60 was admitted to the facility in November 2023 with diagnoses including fracture of unspecified part of neck of right femur, pain, protein calorie malnutrition, Alzheimer's disease, and muscle weakness. Review of Resident #60's most recent Minimum Data Set (MDS) Assessment, dated 1/21/24, indicated that Resident #60 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating that Resident #60 has severe cognitive impairment. The MDS Assessment further indicated that Resident #60 was at risk for developing pressure ulcers. On 2/28/24 at 6:58 A.M., the surveyor observed Resident #60 sleeping in his/her bed with his/her heels on the mattress. The surveyor observed heel lift booties in a box between the two bureaus in his/her room covered with clothing. On 2/29/24 at 7:07 A.M., the surveyor observed Resident #60 sleeping in his/her bed with his/her heels on the mattress. Resident #60 did not have heel booties on. Review of Resident #60's active physician's orders indicated, apply heel lift booties to bilateral feet while in bed. Remove for Care. Review of Resident #60's February Medication Administration Record (MAR), indicated that heel booties had been applied every shift. Review of progress notes from 2/21/24 through 2/29/24 did not indicate that Resident #60 refused application of heel lift booties. Review of Resident #60's at risk for skin breakdown care plan, dated 1/15/24, indicated apply heel lift booties to bilateral feet, remove for care. During an interview on 2/29/24 at 7:24 A.M., Nurse #3 said that he had just worked the overnight shift (11:00 P.M. - 7:00 A.M.) and that the heel lift booties should be applied as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 2/29/24 at 7:24 A.M., the Director of Nursing (DON) said that if there is an order to wear heel lift booties, they should be applied as ordered. If they are not applied, or Resident #60 refuses them, then it should be indicated on the MAR and in a progress note. The surveyor and the DON observed Resident #60 sleeping in bed without heel lift booties applied. The DON said it did not appear as though the heel lift booties had been applied as ordered, since the heel lift booties were not in the room.

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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. 46339 Based on observation, policy review and interviews the facility failed to ensure infection control practices were implemented during medication pass. Findings include: Review of facility policy titled 'Administering Oral Medications', revised October 2010, indicated the following but not limited to: Steps in the Procedure: *Wash hands *For tablets or capsules from a bottle, pour the desired number into the bottle cap and transfer to the medication cup. Do not touch the medication with your hands. Return extra capsules/tablets to the bottle. All medications to be given at the same time can be placed in the same cup except those that require assessment example vital signs prior to administration. During an observation on 2/29/24 at 7:45 A.M., the surveyor observed Nurse #1 pour medication out of a bottle the medication fell on top of the medication cart, Nurse #1 picked the medication with her bare hand and placed it in the medication cup. The surveyor continued to observe Nurse #1 pouring another medication from the bottle, a pill dropped in the medication cart, the nurse picked the medication with her bare hand and placed it back in the medication bottle. Nurse #1 continued preparing medication and was observed breaking a pill in half with her bare hands. During an interview on 2/29/24 at 7:50 A.M., Nurse #1 said she was not supposed to break the medication or touch the pills with her bare hands, due to infection control practices. During an interview on 2/29/24 at 12:26 P.M., the Director of Nursing said infection control practice should be adhered during medication pass.