| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 225400 | A. Building<br>B. Wing | 02/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Vantage at Wakefield LLC | One Bathol Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
| --- | --- |
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>36797<br><br>Based on observation, record review and interview, the facility failed to ensure a dignified existence for one Resident (#73) out of a total sample of 26 residents. Specifically, nursing pulled a patient backward down the hallway in his/her wheelchair, rather than forward facing.<br><br>Findings include:<br><br>Review of the facility policy titled Quality of Life-Dignity, dated as revised 2009, indicated that residents shall be treated with dignity and respect at all times.<br><br>Resident #73 was admitted to the facility in May 2024 with diagnoses including Alzheimer's dementia and adult failure to thrive.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/13/24, indicated that Resident #73 was unable to complete the Brief Interview for Mental Status exam and was assessed by staff to have moderately impaired cognition. The MDS further indicated that Resident #73 was dependent for mobility in a wheelchair.<br><br>On 1/28/25 at 1:09 P.M., the surveyor observed Nurse #1 wheel Resident #73 backwards out of the dining room on the Solana unit. Nurse #1 wheeled Resident #73 approximately 75 feet down the hall backwards, in a Geri-chair, to another dining room on the unit.<br><br>During an interview on 1/28/25 at 1:09 P.M., Nurse #1 said that she was not able to wheel the Resident facing forward because the Geri-chair was not functioning properly. Nurse #1 said that she informed the Maintenance department through the TELS system (computerized maintenance communication system) that the chair was broken. When the surveyor asked for the report, Nurse #1 said that she hadn't actually put the notification in the TELS system but rather reported it verbally to the Maintenance Director.<br><br>During an interview on 1/28/25 at 1:17 P.M., the Maintenance Director said he was unaware that Resident #73's Geri-chair needed to be fixed.<br><br>During a follow-up interview on 1/28/25 at 2:11 P.M., the Maintenance Director said that he had removed the wheels of the Geri-chair and found them to be in working order.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225400 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/04/2025 |
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| NAME OF PROVIDER OR SUPPLIER Vantage at Wakefield LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE One Bathol Street Wakefield, MA 01880 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/30/25 at 11:10 A.M. the Director of Nursing said that staff should not wheel a resident backwards as it was not dignified. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095<br><br>Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were consistently documented in the medical record for one Resident (#86), out of a total sample of 26 residents.<br><br>Findings include:<br><br>Review of the facility policy titled Advanced Directive, dated as revised [DATE], indicated that the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy.<br><br>(3) Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used.<br><br>If the Resident Has an Advance Directive<br><br>1. If the resident or the resident's representative has executed one or more advance directives), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff.<br><br>2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care.<br><br>Resident #86 was admitted to the facility in [DATE] with diagnoses including morbid obesity, alcohol abuse, and infection of the joint prosthesis.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated that Resident #86 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of a possible 15.<br><br>Review of Resident #86's plan of care related to advanced directives, dated as revised [DATE], indicated:<br><br>-Review contents and provide opportunity to update and/or make changes to Advance Directive with resident/patient and/or healthcare decision maker quarterly and as needed<br><br>On [DATE], the surveyor observed in the electronic health record, in the clinical dashboard, that Resident #86 was listed as both a DO NOT RESUSCITATE (DNR), and a FULL CODE.<br><br>Review of Resident #86's physician's order, dated [DATE], indicated:<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -FULL CODE.<br><br>Review of Resident #86's physician's order, dated [DATE], indicated:<br><br>-DO NOT RESUSCITATE (DNR).<br><br>Review of Resident #86's MOLST form, dated [DATE], indicated:<br><br>-Do Not Resuscitate.<br><br>Review of Resident #86's nurse practitioner note, dated [DATE], indicated:<br><br>-MOLST form discussed with patient tonight. Per hospital documentation patient adamantly wanted to be a DNR. This was confirmed with patient tonight and Do not Intubate was also added. MOLST form signed and updated and uploaded into miscellaneous documents section of electronic health record.<br><br>During an interview on [DATE] at 12:41 P.M., Nurse #5 reviewed the clinical dashboard and she said that she was not sure what Resident #86's code status was due to the conflicting information, indicating Resident #86 was both a full code status and a DNR.<br><br>During an interview on [DATE] at 12:41 P.M., Nurse #3 said the Resident #86's electronic health record has conflicting code status. Nurse #3 said that on [DATE] when the practitioner met with Resident #86, his/her code status for full code should have been discontinued from the physician's orders but was not resulting and two conflicting code status.<br><br>During an interview [DATE] at 3:09 P.M., the Director of Nursing said Resident #86's code status should consistently be documented in the medical record. |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>36797<br><br>Based on observations, interviews and record review, the facility failed to notify the physician of a significant change in status for one Resident (#72) out of a total sample of 26 residents. Specifically, the facility failed to notify the physician when Resident #72 verbalized Suicidal Ideation (SI) and acute psychological distress.<br><br>Findings include:<br><br>Review of the facility policy titled Change in a Resident's Condition of Status, dated as revised February 2021 indicated the following:<br><br>-The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition.<br><br>-The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.<br><br>Review of the facility policy titled Suicide Threats, undated, indicated the following:<br><br>-Staff shall report any resident threats of suicide immediately to the nurse supervisor/charge nurse.<br><br>-The nurse supervisor/charge nurse shall immediately assess the situation and shall notify Director of Nursing Services of such threats.<br><br>-After assessing the situation in detail the nurse supervisor/charge nurse shall notify the resident's attending physician and shall seek further direction from the physician.<br><br>Resident #72 was admitted to the facility in October 2023 and has diagnoses that include Suicidal Ideation, Major Depressive Disorder, Psychotic Disorder with Delusions, Anxiety Disorder, Bipolar disorder and Schizophrenia<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/15/24, indicated that Resident #72 has an active diagnosis of suicidal ideations. The MDS further indicated that Resident #72 scored a 6 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment and had expressed feelings of sadness/depression more than half of the time in the past week.<br><br>Review of the psychotherapy note dated 12/20/24 indicated the following: has a life long history do (sic) Schizophrenia and multiple suicide attempts and multiple psych hospitalization s.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 1/28/25, at 8:07 A.M., the surveyor observed Resident #72 crying in bed, yelling out to call an ambulance because he/she was having extreme suicidal thoughts. Resident #72 said he/she was afraid he/she was going to snap. Resident #72 was observed to be agitated and shaking, in acute psychological distress. The surveyor observed several staff members in the hallway and 2 nurses sitting at the nurse's station not responding to the distress calls from Resident #72. The surveyor informed Nurse #10 of Resident #72's verbalizations. Nurse #10 then went into the Resident's room and said this is Resident #72's normal behavior and brought Resident #72 to the dining room to eat.<br><br>On 1/29/25 at 8:00 A.M., the surveyor observed Resident #72 standing in his/her room doorway crying out I don't feel good inside, I want to kill myself. Resident #72 was observed to be agitated and shaking, in acute psychological distress. There were several staff members in the hallway however no one responded to Resident #72.<br><br>During an interview on 1/29/25 at 8:12 A.M. Nurse #11 said that he worked the 11 P.M.-7 A.M., shift last night and it had not been reported to him that Resident #72 had verbalized SI the previous day and had requested an ambulance be called. Nurse #11 said a physician should be notified if a resident verbalizes SI, and that a progress note should be in the clinical record indicating the physician's instructions.<br><br>Review of the clinical record failed to indicate that the physician had been notified of Resident #72's verbalization of SI on 1/28/25.<br><br>During an interview on 1/29/25 at 8:22 A.M., the Director of Nursing (DON) said that the physician should be notified immediately if a resident verbalizes SI, exhibits psychosocial distress and is requesting an ambulance be called. The DON said nursing should document in the clinical record that the physician has been notified and what the physician's instructions are regarding the plan to keep the resident safe.<br><br>During an interview on 1/30/25, at 10:20 A.M., the Medical Director said that she was not notified of Resident #72's verbalizations of SI on 1/28/25 and his/her request for an ambulance to be called. The Medical Director said that it is her expectation that she be notified whenever a resident verbalizes SI so that she can make a determination of a treatment plan that will ensure the resident's safety. In this case, the Medical Director said that the facility notified her of a verbalization of SI on 1/29/25, but that if she had been made aware that the verbalizations began on 1/28/25 and continued on 1/29/25 she would have ordered Resident #72 be sent to the hospital for evaluation and treatment. |

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| F 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>36797<br><br>Based on record review and interview, the facility failed to provide an accurate estimated cost of services to resident's or their representatives, for three out of three resident records reviewed, to ensure they were informed of their potential financial liabilities of the cost of items and services provided in addition to the daily per diem room rate.<br><br>Findings include:<br><br>The SNF ABN (CMS-10055) notice is administered to a Medicare recipient when the facility determines that the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all of the Medicare benefit days for that episode. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility.<br><br>Review of the notices provided to two residents who came off their Medicare Part-A Benefit, who had Medicare days remaining and remained at the facility, were provided Advanced Beneficiary Notices that did not include an accurate estimated cost of services should they choose to pay privately.<br><br>Review of the notices provided to one resident residents who came off their Medicare Part-A Benefit, who had Medicare days remaining and who was discharged from the facility, was provided an Advanced Beneficiary Notice that did not include an accurate estimated cost of services should they choose to pay privately.<br><br>During an interview on 1/29/25, at 1:28 P.M., The Business Office Manager said that she was not aware that the cost of the services received while a resident was utilizing their Medicare Part A benefit needed to be included on the SNF ABN form. |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797<br><br>Based on observations, record review and interview, the facility failed to protect two Residents (#72 and #17), from abuse and neglect, out of a total sample of 26 residents. Specifically:<br><br>1. For Resident #72 the facility neglected to provide psychosocial support including ongoing monitoring, intervention and notification of the physician timely in a Resident who has a known history of suicidal ideation (SI) and observed to be making statements of SI by multiple staff without intervention.<br><br>2. For Resident #17 the facility failed to prevent verbal abuse.<br><br>Findings include:<br><br>Review of the facility policy titled Abuse and Neglect-Clinical Protocol, dated revised 2018 indicated that abuse is defined as the deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being and it includes verbal abuse. Further review indicated that neglect is defined as the failure of the facility, its' employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.<br><br>1. Resident #72 was admitted to the facility in October 2023 with diagnoses that include Suicidal Ideation (SI), Major Depressive Disorder, Psychotic Disorder with Delusions, Anxiety Disorder, Bipolar disorder and Schizophrenia.<br><br>Review of the Minimum Data Set, dated dated dated [DATE], indicated that Resident #72 has a diagnosis of SI. Further review indicated that Resident #72 scored a 6 out of 15 on the Brief Interview for Mental Status exam indicating severe cognitive impairment. Further review indicated that Resident #72 expressed feelings of sadness/depression more than half of the time in the past week.<br><br>Review of Resident #72's medical record failed to indicate a care plan for suicidal ideation had been developed.<br><br>Review of the physician's orders dated January 2025 indicated the following psychotropic medications:<br><br>Clonazapam 0.5 MG (milligrams) give one tablet three times a day for anxiety.<br><br>Clozapine 25 MG give three tablets by mouth three times a day for schizophrenia.<br><br>Mirtazapine 45 MG give one tablet by mouth at bedtime for insomnia.<br><br>Risperdal 0.5 MG give one tablet by mouth one time a day for agitation.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Venlafaxiine HCL ER (extended release) 24 hour 75 MG give three capsules by mouth one time a day for anxiety.<br><br>Further review failed to indicate an order to monitor for SI.<br><br>Review of the behavior sheets dated January 2025 failed to indicate monitoring for SI.<br><br>Review of the medical record failed to indicate that an assessment of the timing of the administration of his/her psychotropic medications was effective in preventing severe mental anguish in the morning due to the continued mental anguish exhibited in the morning before medication administration.<br><br>Review of Resident #72's Behavioral Health Service notes indicate the following:<br><br>Review of the initial psychological evaluation 12/20/24, at 7:22 A.M., (8 days after re-admission to the facility), Psych Therapist #1, indicated the following: has a life long history do (sic) Schizophrenia and multiple suicide attempts and multiple psych hospitalization s. Resident #72 is requesting emotional support while in the facility. Further review indicated that Resident #72 informed Psych Therapist #1 that I am so upset with how I feel right now. I need my medication to kick in so I can feel good again. Further review indicated that Resident #72 is currently back to his/her emotional baseline in the mornings but shows great improvement after 10:00 A.M. Further review failed to indicate a review of psychotropic medications for efficacy.<br><br>Review of the psychotherapy note dated 12/23/24, Psych Therapist #2 indicated that tearfulness and anxiety is prominent in the mornings but subsides after morning medications are given. Further review failed to indicate a review of medications for efficacy.<br><br>Review of the psychotherapy note dated 1/13/25, Psych Therapist #2 indicated that Resident #72 is usually tearful and anxious in the morning before medication administration, and improved mood after. Further review failed to indicate a review of medications for efficacy prior to morning administration.<br><br>Review of the psychotherapy note dated 1/24/25, Psych Therapist #2 indicated Resident #72 said that I know I feel better now but I feel so terrible in the morning. Further review failed to indicate a review of medications for efficacy prior to morning administration.<br><br>On 1/28/25, at 8:07 A.M., the surveyor observed Resident #72 crying in bed, yelling out to call an ambulance because he/she was having extreme suicidal thoughts and was afraid he/she was going to snap. The surveyor observed several staff members in the hallway and 2 nurses sitting at the nurse's station, not responding to the distress calls from Resident #72. The surveyor also observed long call light cords and a bed adjustment cord hanging from the wall next to Resident #72's bed. The surveyor informed Nurse #10 of Resident #72's suicidal ideations. Nurse #10 said this is his/her normal behavior and brought Resident #72 to the dining room to eat. Nurse #10 neglected to address Resident #72's mental anguish.<br><br>On 1/29/25 at 8:00 A.M. the surveyor observed Resident #72 standing in his/her room doorway crying out I don't feel good inside, I want to kill myself. Resident #72 was observed to be agitated and shaking, in acute psychosocial distress. There were several staff members in the hallway, however none responded to Resident #72.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 1/29/25 at 8:12 A.M. Nurse #11 said that he worked the 11 P.M.-7 A.M. shift last night. Nurse #11 said that it had not been reported to him that Resident #72 had verbalized SI the previous day and had requested a ambulance be called. Nurse #11 said that the physician should be notified if a resident verbalizes SI, and that a progress note should be in the clinical record indicating the physician's instructions.<br><br>Review of the clinical record failed to indicate that the physician had been notified of Resident #72's verbalization of SI on 1/28/25 or that Psych Services had been notified or assessed the Resident's mood state to determine a plan to keep the Resident safe, resulting in continued mental anguish.<br><br>During an interview on 1/29/25 at 8:02 A.M., with Resident #72's Certified nurse's Aide (CNA) #7, she said that Resident #72 wakes up around 6:00 A.M. and often says he/she doesn't feel good inside, but she has never heard Resident #72 claim to want to commit suicide. CNA #7 said that Resident #72 usually feels better by lunch.<br><br>During an interview on 1/29/25 at 8:14 A.M., Nurse #4 said that Resident #72 just told her that he/she wanted to commit suicide. Nurse #4 then said that she would expect that a resident with active SI to have an active care plan in place.<br><br>During an interview on 1/29/25 at 8:22 A.M., the Director of Nursing (DON) said that the physician and psych services should be notified immediately if a resident verbalizes SI, exhibits psychosocial distress and is requesting an ambulance be called. The DON also said that she would expect that a progress note would have been entered into the medical record. The DON said that said nursing should document in the clinical record the plan to keep the resident safe. The DON said all residents with a history of SI should have a care plan, with resident specific triggers and interventions, to address the SI.<br><br>On 1/30/25 the surveyor observed the following:<br><br>At 7:58 A.M. Resident #72 yelled out I am going to kill myself (three times), I feel like I am suicidal, I don't feel good, I am going to do it. Nurse #12 was in the hallway however walked away and neglecting to acknowledge the Resident's verbalizations of SI, resulting in continued mental anguish. Housekeeping was in the room at the time and also, did not intervene.<br><br>At 8:01 A.M. Resident #72 yelled out I need help, I'm suicidal. I'm going to kill myself. Resident #72 was observed to be crying, and pleading with Nurse #12, who had briefly entered the room, not to leave him/her. Nurse #12 neglected to acknowledge the Resident's request and exited the room to resume working at his medication cart, resulting in his/her continued mental anguish.<br><br>At 8:05 A.M. Resident #72 said I feel suicidal, I need help. Nurse #12 went into the Resident's room and said give me 5 min. Resident #72 responded; I don't feel good inside, I am going to kill myself. The Resident was crying out begging the Nurse #12 for help from the doorway as Nurse #12 neglected to address Resident #72's verbalizations, resulting in his/her continued mental anguish.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | At 8:07 A.M. Resident #72 was observed tearful and crying as he/she said I am suicidal I want to kill myself. Nurse #12 entered Resident #12's room with a breakfast tray, then walked out closing the door shut to 3-4 inches behind him and exited, neglecting to address Resident #72's verbalizations. Resident #72 was left alone in the room crying, resulting in his/her continued mental anguish.<br><br>Between 8:08 and 8:41 A.M., the surveyor observed Resident #72 alone in his/her room, crying out feelings of SI and no staff intervened or checked on him/her. observed in bed moving, weeping, saying I am going to kill myself, I am suicidal please help me please. No staff responded, resulting in his/her continued mental anguish.<br><br>During an interview on 1/30/25 at 8:38 A.M., Resident #72 told the surveyor 'I'm having anxiety attacks, I put the call light on because mornings are difficult, I want to kill myself, I need help.<br><br>During an interview on 1/30/25 at 8:41 A.M., Nurse #12 said Resident #72 says I don't feel good inside all the time and explained it's a behavior thing, eventually he/she stops saying he/she wants to kill him/herself.<br><br>During an interview on 1/30/25 at 8:46 A.M., the Administrator was updated on the observations of Resident #72 since 1/28/25. The Administrator said Resident #72 should not be left alone after making threats to harm him/herself and a plan should have been established immediately to ensure his/her safety. The Administrator said that staff should be intervening to address Resident #72's cries for help.<br><br>During an interview on 1/30/25, at 10:20 A.M., the Medical Director said that she was. not notified of Resident #72's verbalizations of SI on 1/28/25 and his/her request for an ambulance to be called. The Medical Director said that it is her expectation that she be notified whenever a resident verbalizes SI so that she can make a determination of a treatment plan. In this case, the Medical Director said that the facility notified her of a verbalization of SI on 1/29/25 but they had ceased. She then said that if she had been made aware that the verbalizations began on 1/28/25 and continued on 1/29/25 she would have ordered Resident #72 be sent to the hospital for evaluation and treatment.<br><br>During an interview on 1/30/25 at 11:10 A.M. the Director of Nursing said that no plan had been put in place since she was notified of the Resident's SI yesterday. She said that she thought that the Resident was put on 1:1 supervision but couldn't be sure. The DON said that a plan should have been implemented immediately when the Resident exhibited mental anguish and made the acute statements of suicidal ideation. The DON then said that staff should never just walk away from a resident exhibiting SI.<br><br>During an interview on 1/30/25, at 11:18 A.M. Social Worker (SW) #1 said she was Informed on 1/29/25 that Resident #72 had verbalized SI and that she never heard him/her say this before. SW #1 said #72 should have immediately been offered behavioral health services.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 1/30/25 at 12:04 P.M., CNA #6, said she is Resident #72's regular CNA and that she was his CNA last night, 1/29/25 11 P.M.-7 A.M. CNA #6 said that she did not get a report that Resident #72 was having suicidal ideation's and that therefore no plan had been put in place to ensure his/her safety. CNA #6 said that Resident #72 always says he/she doesn't feel good inside and was very anxious last night and this morning. CNA #6 said that Resident #72 was more anxious last night and again this morning and just kept saying he/she doesn't feel good inside and needs his mother. he was not on 1:1 and was left alone in his room during the night. CNA #6 said she was upset that she was not told and said that that is not good if he/she was saying he/she was going to kill him/herself.<br><br>During an interview on 1/31/25 at 7:27 A.M. Psych Therapist #1 said there was a care plan that got erased on his/her last admission and clearly there was a mistake. He then said that Resident #72 is upset and says that all the time; that he/she is going to kill him/herself and that he/she is suicidal. Psych Therapist #1 then said that If you go back at 11 A.M. he/she will be much better. Resident #72 needs to be left alone not bothered, yes he/she can be left alone because he/she says he/she is going to kill him/herself all the time. Psych Therapist #1 then said that it was not possible to change Resident #72's medication to earlier in the morning because this is a nursing home you know.<br><br>Review of Nurse Practitioner (NP) #1's note dated 2/1/25, indicated that Resident #72 said he/she wanted to shoot him/herself with a gun. Resident #72 was transferred to the hospital for a psych evaluation. Resident #72 returned to the facility without changes to his/her plan of care.<br><br>Review of Psych Therapist #2's note dated 2/3/25, indicated to change morning medication administration timing to 6:00 A.M.<br><br>Review of the physician orders dated February 2025 indicated that all morning medications, including antipsychotic and antianxiety medication administration times were changed from 8:00 A.M. to 6:00 A.M.<br><br>On 2/4/25, at 7:05 A.M. the surveyor observed Resident #72 resting quietly in bed without observed psychosocial distress.<br><br>During an interview on 2/4/25, at 9:00 A.M., Nurse #10 said that Resident #72 is usually highly agitated in the mornings until around 10:00 A.M. (4 hours since waking up) when we are able to give him/her their medications, and today he/she is calm, not verbalizing anxiety or SI. Nurse #10 then said that he believes that changing the Resident's medication time to 6 A.M. has helped Resident #72 a lot as the Resident is no longer exhibiting signs of mental anguish in the morning.<br><br>48671<br><br>2. Resident #17 was admitted to the facility in August 2020 with diagnoses including major depressive disorder, bipolar disorder, and dementia.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/25, indicated Resident #17 had a Brief Interview for Mental Status exam score of 14 out of a possible 15, indicating intact cognition.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 1/31/25 at approximately 10:41 A.M., to 11:07 A.M., the surveyor was standing at the nurses station and Psych Therapist #1 and Resident #17 could be heard speaking to each other from the nurse's station. Resident #17 was calmly inquiring about lunch and could be heard asking Where is my lasagna? Is the lasagna here yet? As the discussion continued Psych Therapist #1 appeared to be irritated and in a harsh tone said Stop yelling or I will take it away again!.<br><br>On 1/31/25 at approximately 11:10 A.M., Resident #17 observed the surveyor standing at the nurses station, and continued to ask, where is my lasagna?. Psych Therapist #1 observed the surveyor and the exchange, and in a much different tone from moments earlier said It's on it's way honey and then he exited the unit.<br><br>On 1/31/25 at 11:49 A.M., the surveyor informed the Administrator of the interaction between Resident #17 and Psych Therapist #1. The Administrator said the Psych Therapist #1 should not have spoken that way to the Resident and said it could make him/her upset. While speaking with the Administrator the Medical Director introduced herself and said Psych Therapist #1 should not have threatened to withhold Resident #17's food.<br><br>During an interview on 1/31/25 at 12:07 P.M., with the Administrator and Medical Director and Psych Therapist #1, Psych Therapist #1 said Resident #17 is care planned for yelling and taking away his/her food is part of the care plan and said If he/she yells, then yes, I will take his/her food away so he/she will stop yelling The Psych Therapist #1 said Resident #17 has behaviors and said he/she needs to know his/her food will be removed if the behaviors continue. The Psych Therapist #1 said I can see why this could be upsetting and I probably should have said it differently.<br><br>Review of Resident #17 care plan failed to include documentation to support these Phych Therapist alleged behaviors<br><br>During a follow-up interview on 1/31/25 at 12:57 P.M., the Administrator said the interaction between Resident #17 and the Psych Therapist was a form of verbal abuse and must be reported to the State Agency as well. He indicated he implemented the facility's abuse policy and asked Psych Therapist #1 to leave the facility pending investigation. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>44095<br><br>Based on observation, record review, and interview the facility failed to implement care plans for two Residents (#66 and #63) out of a total sample of 26 residents. Specifically,<br><br>1. For Resident #66, the facility failed to implement fall mats.<br><br>2. For Resident #63, the facility failed to implement a care plan for heel protection booties.<br><br>Findings include:<br><br>Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated as revised March 2022, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.<br><br>3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.<br><br>1. Resident #66 was admitted to the facility in August 2023 with diagnoses including dementia, diabetes, and hemiplegia and hemiparesis following a cerebral infraction.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/14/24, indicated that Resident #66 had a memory problem. The MDS further indicated Resident #66 required assistance with transfers and bed mobility and had one fall since readmission.<br><br>Review of Resident #66's Fall (unwitnessed) Report, dated as 10/21/24, indicated:<br><br>-Certified Nurse Assistant (CNA) called this nurse to the room, resident was laying alert on the floor next to bed.<br><br>Review of Resident #66's physician's order, dated 10/21/24, indicated:<br><br>-Floor mat next to bed - WINDOW SIDE - while resident is in bed (status post fall), every shift.<br><br>Review of Resident #66's plan of care related to falls, dated 10/21/24, indicated:<br><br>-Floor mat next to the bed - WINDOW SIDE - while resident is in bed.<br><br>Review of Resident #66's care card, dated as current on 1/30/25, indicated:<br><br>-Floor mat next to the bed - WINDOW SIDE - while resident is in bed.<br><br>Review of Resident #66's Care Plan Evaluation note, dated 11/9/24, indicated:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Remains at risk for falls. Care plan is appropriate.<br><br>Review of Resident #66's Fall Risk Evaluation assessment, dated 1/21/25, indicated he/she was assessed by nursing to be at risk for falls as evidenced by a fall score of 19.<br><br>On 1/28/25 at 8:00 A.M., 9:01 A.M., 11:13 A.M., 12:43 P.M., 2:55 P.M., and 4:33 P.M., the surveyor observed Resident #66 in his/her bed. There was no fall mat on the side of the bed on the window side.<br><br>On 1/29/25 at 10:45 A.M., 1:09 P.M., and 4:05 P.M., the surveyor observed Resident #66 in his/her bed. There was no fall mat on the side of the bed on the window side.<br><br>On 1/30/25 at 2:12 P.M., the surveyor observed Resident #66 in his/her bed. There was no fall mat on the side of the bed on the window side.<br><br>During an interview on 1/30/25 at 3:25 P.M., CNA #2 and CNA #3 said Resident #66 is a fall risk. CNA #2 and CNA #3 said that staff use the fall mat during the night when he/she is sleeping.<br><br>During an interview on 1/31/25 at 7:18 A.M., Nurse #7 said Resident #66 is a high risk for falls and requires a fall mat.<br><br>During an interview on 1/30/25 at 3:17 P.M., the Director of Nursing said that nursing should use the floor mat according to the physician's orders and plan of care.<br><br>48671<br><br>2. Resident #63 was admitted to the facility in February 2020 with diagnoses including type two diabetes mellitus, hemiplegia (complete loss of strength) and hemiparesis (weakness) following cerebral infraction (stroke, lack of blood flow to the brain) affecting left non-dominant side.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/25, indicated that Resident #63 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. The MDS further indicated Resident #63 is dependent on staff for all mobility tasks.<br><br>Review of Resident #63's physician orders indicated the following orders:<br><br>-Apply heel lift [SIC] booties while in bed. Remove for care every shift. Document refusal in progress note every shift. Start date 10/03/24.<br><br>Review of Resident #63's risk for skin breakdown care plan, dated 10/3/24 indicated:<br><br>-Apply heel lift [SIC] (left) booties while in bed. Remove for care every shift. Refuses at times. Revised on 11/01/24.<br><br>Review of Resident #63's Kardex (resident specific care instructions) indicated: Apply heel lift [SIC] booties while in bed. Remove for care every shift. Refuses at times.<br><br>Review of the medical record failed to indicate Resident #63 refused left heel booties.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/28/25 at 8:01 A.M., the surveyor observed Resident #63 lying in bed. His/her bilateral heels were directly on the bed, and he/she was not wearing heel protection booties.<br><br>On 1/29/25 at 8:14 A.M., the surveyor observed Resident #63 lying in bed. His/her bilateral heels were directly on the bed, and he/she was not wearing heel protection booties.<br><br>On 1/29/25 at 11:30 A.M., the surveyor observed Resident #63 lying in bed. His/her bilateral heels were directly on the bed, and he/she was not wearing heel protection booties.<br><br>On 1/30/25 at 7:42 A.M., the surveyor observed Resident #63 lying in bed. His/her bilateral heels were directly on the bed, and he/she was not wearing heel protection booties.<br><br>During an interview on 1/30/25 at 8:03 A.M., Resident #63 said staff did not offer to put heel booties on his/her feet. Resident #63 said, I had them a while ago, but they don't put them on anymore.<br><br>During an interview on 1/30/25 at 8:30 A.M., Certified Nursing Assistant (CNA) #1 said she can check the Kardex to see what is needed. CNA #1 said Resident #3 had heel booties but refuses care and has always been this this way.<br><br>During an interview on 1/30/25 at 8:54 A.M., Nurse #9 said the Resident is at risk for skin breakdown and he/she should be wearing heel booties while in bed. Nurse #9 said she was unaware the Resident had not been wearing the protective heal booties.<br><br>During an interview on 1/30/25 at 11:30 A.M., the Director of Nursing said all physician orders should be followed, and any refusal of care should be documented in the medical record. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>36797<br><br>Based on observations, interviews, and record review the facility failed to ensure care plans were reviewed with the interdisciplinary team, as required, for one Residents (#51) out of a total sample of 26 residents. Specifically, for Resident #51 the facility failed to review and revise the care plan related to eating function during the comprehensive care plan review.<br><br>Findings include:<br><br>Review of the facility policy titled Care Planning-Interdisciplinary Team, dated as revised March 2022, failed to indicate that the care plan is revised with changes to a resident's condition or requirements.<br><br>Resident #51 was admitted to the facility in July 2021 with diagnoses including dementia, schizophrenia and diabetes.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/14/24, indicated that Resident #51 was unable to complete the Brief interview for Mental Status exam and was assessed by staff to have moderately impaired cognition. The MDS further indicated that Resident #51 requires set up/clean up help for eating.<br><br>Review of the care plan indicated Resident #51 requires supervision to touching assistance with eating.<br><br>Review of the documentation for Activities of Daily Living, eating, dated January 2025, indicated Resident #51 requires set up help only and is able to eat independently.<br><br>On 1/28/25 at 8:40 A.M., and 1:00 P.M., the surveyor observed Resident #51 eating alone in his/her room.<br><br>On 1/29/25 at 8:58 A.M., the surveyor observed Resident #51 eating alone in his/her room.<br><br>During an interview on 1/29/25 at 8:58 A.M., Certified Nurse's Assistant (CNA) #7 said that Resident #51 eats independently.<br><br>During an interview on 1/29/25 at 10:53 A.M., The MDS Nurse said that the care plan should reflect the current level of function and should have been revised at the time of the last comprehensive MDS. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>48671<br><br>Based on observation, interview, and records reviewed, the facility failed to meet professional standards of practice for one Resident (#14) out of a total of sample of 26 residents. Specifically, for Resident #14 the facility failed to obtain the dose of a Lidocaine patch (patch used to treat pain) prior to administration.<br><br>Findings include:<br><br>Review of the facility policy titled Administering Medications, dated April 2023, indicated the following:<br><br>8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.<br><br>10. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.<br><br>Resident #14 was admitted to the facility in February 2014 with diagnoses including fibromyalgia (chronic widespread pain), type two diabetes mellitus, osteoarthritis (joint pain and stiffness), and neuropathy (nerve pain).<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/18/24, indicated that Resident #14 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of a possible 15. The MDS further indicated pain was present, effecting sleep and interfering with therapy activities.<br><br>On 1/28/25 at 7:49 A.M., the surveyor observed Resident #14 propelling his/herself in a wheelchair in the hall. Resident #14 said he/she had lower back pain and said he/she was going to get the nurse for more medication.<br><br>Review of Resident #14's physician's order, dated 1/21/25, indicated:<br><br>-Lidocaine External Patch (Lidocaine) Apply to Lower back topically two times a day for Pain and remove per schedule. Start Date: 1/21/25.<br><br>Further review of the physician's order for the Lidocaine External Patch failed to indicate a dosage.<br><br>Review of Resident #14's Medication Administration Record, dated January 2025, indicated nursing administered Lidocaine External Patch as ordered between 1/21/25 and 1/30/25.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/30/25 at 11:33 A.M., Nurse #1 said that nursing should have clarified the strength of the Lidocaine order with the physician and said Resident #14 has been getting a Lidocaine 4% patch because that is what is available in the medication cart.<br><br>During an interview on 1/31/25 at 10:04 A.M., the Director of Nursing said nursing should have clarified the order for the Lidocaine External Patch with the physician. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>48671<br><br>Based on observations, interviews and records reviewed for one Resident (#63) out of 26 sampled residents, the facility failed to ensure an orthotic device was worn as ordered.<br><br>Findings include:<br><br>Resident #63 was admitted to the facility in February 2020 with diagnoses including type two diabetes mellitus, hemiplegia (complete loss of strength) and hemiparesis (weakness) following cerebral infraction (stroke, lack of blood flow to the brain) affecting left non-dominant side.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/25, indicated that Resident #63 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, and is dependent on staff for all mobility tasks. Further review of the MDS also indicated Resident #63 had an impairment in range of motion of one upper extremity.<br><br>On 1/28/25 at 8:01 A.M., the surveyor observed Resident #63 lying in bed with his/her left hand in a closed, fisted position. The Resident was not wearing a splint and there was no splint observed in his/her room. Resident #63 said he/she used to wear a splint on his/her left wrist but has not in a while.<br><br>On 1/28/25 at 12:18 P.M., the surveyor observed Resident #63 lying in bed with his/her left hand in a closed, fisted position. The Resident was not wearing a splint and there was no splint observed in his/her room.<br><br>On 1/29/25 at 8:14 A.M., the surveyor observed Resident #63 lying in bed with his/her left hand in a closed, fisted position. The Resident was not wearing a splint and there was no splint observed in his/her room.<br><br>On 1/29/25 at 11:30 A.M., the surveyor observed Resident #63 lying in bed with his/her left hand in a closed, fisted position. The Resident was not wearing a splint and there was no splint observed in his/her room.<br><br>Review of the physician orders indicated the following order:<br><br>- Left resting Hand splint. May remove for daily hygiene and skin inspection to ensure no redness/skin breakdown, every shift. Order Dated 8/2/24.<br><br>Review of the January 2025 Treatment Administration Record (TAR) indicated the following:<br><br>1/28/25 Documented as Administerd<br><br>1/29/25 Documented as Adminsterd<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #63's Kardex (a form indicating the care needs of a resident) indicated the following:<br><br>-Left resting Hand splint. May remove for daily hygiene and skin inspection to ensure no redness/skin breakdown.<br><br>Review of Resident #63's nursing notes for 1/28/25 and 1/29/25 failed to indicate Resident #63 refused the wearing of his/her left-hand splint.<br><br>During an interview on 1/29/25 at 1:22 P.M. Unit Manager #1 said Resident #63 should be wearing the left hand splint due to a contracture and said the physician's order should be followed.<br><br>During an interview on 1/30/25 at 7:43 A.M., Nurse #9 said the Resident has a left-hand splint but he/she usually refuses to wear it and said it should be documented in the medical chart that he/she does not wear it.<br><br>During an interview on 1/30/25 at 11:32 A.M., the Director of Nursing said the physician order for the left hand splint should be followed as ordered and said she expects staff to document and report refusal of care if the Resident refuses to wear the splint. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>44095<br><br>Based on interview and record review, the facility failed to provide care according to professional standards of practice for two Residents (#66 and #51) out of a total sample of 26 residents, relative to nutrition interventions and weight monitoring when the Resident was identified as being at nutritional risk and had weight loss. Specifically,<br><br>1. For Resident #66, who had weight loss, the facility failed to obtain weights according to current professional standards of practice.<br><br>2. For Resident #51 the facility failed to obtain a reweigh to determine weight loss.<br><br>Finding include:<br><br>Review of the facility policy titled Weight Assessment and Intervention, dated as revised March 2022, indicated that resident weights are monitored for undesirable or unintended weight loss or gain.<br><br>Weight Assessment:<br><br>1. Residents are weighted upon admission and at intervals established by the interdisciplinary team.<br><br>2. Weights are recorded in each units weight record chart and in the individual's medical record.<br><br>3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation.<br><br>a. If the weight is verified, nursing will immediately notify the dietitian in writing.<br><br>Review of the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, dated as revised 2/3/23, indicated the following:<br><br>-Current professional standards of practice recommend weighing the resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as slow and progressive weight loss. Weighing may also be pertinent if there is a significant change in condition, food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid and electrolyte imbalance. In some cases, weight monitoring is not indicated (e.g., the individual is terminally ill and requests only comfort care).<br><br>1. Resident #66 was admitted to the facility in August 2023 with diagnoses including dementia, diabetes, hemiplegia and hemiparesis following a cerebral infraction.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/14/24, indicated that Resident #66 had a memory problem.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #66's note weight change, dated 10/30/24, indicated:<br><br>-WEIGHT WARNING: Value: 86.8 pounds. Weight maintained in the mid 80s. House supplements increased to 2x/day.<br><br>Review of Resident #66's most recent weight recorded in the electronic health record, dated 11/4/24, indicated Resident #66 weighed 89 pounds (lbs).<br><br>Review of Resident #66's physician's note, dated 11/6/24 and 12/24/24, indicated:<br><br>-Weight fluctuations, optimize nutritional status maintain good sleep hygiene regular bowel movements adequate oral hydration. Ongoing follow-up with nutritionist, Physical Therapy (PT) and Occupational Therapy (OT) and monitor weights.<br><br>Review of Resident #66's nurse practitioner's notes, dated 11/6/24, 11/11/24, and 11/29/24, 12/15/24 indicated:<br><br>-Weight fluctuations, optimize nutritional status maintain good sleep hygiene regular bowel movements adequate oral hydration. Ongoing follow-up with nutritionist, PT OT and monitor weights<br><br>Review of Resident #66's nurse practitioner note, dated 1/18/25. indicated:<br><br>-Weight fluctuations, optimize nutritional status maintain good sleep hygiene regular bowel movements adequate oral hydration.<br><br>Review of Resident #66's nurse practitioners progress notes dated 1/22/25 and 1/24/25, indicated:<br><br>-Continue to monitor weight changes and optimize nutritional status.<br><br>Review of Resident #66's physician's progress note, dated 1/27/24, indicated:<br><br>-Continue to monitor weight changes and optimize nutritional status.<br><br>Review of Resident #66's plan of care titled Resident is at nutritional risk: related to weight loss, related to poor intake, dated as revised 1/4/25, indicated the following:<br><br>Goals:<br><br>-Resident will maintain a stabilized weight of 95 lbs to 101 lbs during the next 90 days.<br><br>Interventions:<br><br>-Weigh as ordered and alert Dietitian and physician to any significant loss or gain.<br><br>During an interview on 1/31/25 at 8:50 A.M., Certified Nursing Assistant (CNA) #4 said the previous Director of Nursing (DON) provided the CNAs with a list of residents that they needed to get weights on, but they no longer received a list.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/31/25 at 8:57 A.M., CNA #3 said that residents are weighed every month, and upon admission. CNA #3 said that Resident #66 has not been weighted in a while and he/she does not refuse care.<br><br>During an interview on 1/31/25 at 8:59 A.M., CNA #5 said the previous DON provided the CNAs with a list of residents who needed weights obtained, but they no longer received a list. CNA #5 said it has been a while since she obtained a weight for Resident #66.<br><br>During an interview on 1/31/25 at 7:28 A.M., Nurse #7 said that Residents who need weights are based on a list put out by the DON.<br><br>During an interview on 1/31/25 at 7:21 A.M., Nurse #3 said that weights are completed based on the physician's order. Nurse #3 said the previous DON would put out a weight list each month, and the CNAs would obtain the weights and once the weights were obtained the previous DON would put the weights into the electronic health record.<br><br>During an interview on 1/31/25 at 10:10 A.M., Nurse #8 said weights are supposed to be completed monthly. Nurse #8 said that Resident #66 had not had his/her weight completed in a while and Resident #66 does not refuse care. Nurse #8 said that when weights are obtained by CNAs, she will put the weight directly into the electronic health record and there is no weight logs kept on the unit.<br><br>During an interview on 1/30/25 at 1:06 P.M., the Registered Dietitian (RD) said nursing should be obtaining Resident #66's weight at minimum monthly. The RD said that she used to have a weekly risk meeting to review weights and skin with the DON, but that no longer happens. The RD said she reviews weights monthly and she sends a list of residents who need weights to the current DON, but does not receive a response. The RD shared an email sent to the DON on 1/10/25, indicating Resident #66 was without a weight. The RD said that the most recent weight for Resident #66 was obtained on 11/4/24, almost 90 days ago.<br><br>During an interview on 1/31/25 at 10:14 A.M., the DON said weights should be obtained monthly or more frequently. The DON said that the RD usually sends her an email requesting weights and she would address them. The DON said that since she had assumed the role in November there have been no risk meetings, but these meetings should be occurring. The DON reviewed Resident #66's weights in the electronic health record and said there has not been a weight obtained since 11/4/24 but there should have been.<br><br>36797<br><br>2. Resident #51 was admitted to the facility in July 2021 with diagnoses including dementia, schizophrenia and diabetes.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/14/24, indicated that Resident #51 was unable to complete the Brief interview for Mental Status exam and was assessed by staff to have moderately impaired cognition.<br><br>Review of the medical record indicated the following weights:<br><br>12/2/2024: 116.9 Lbs<br><br>(continued on next page) |

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|---|---|---|---|
| | 225400 | A. Building<br>B. Wing | 02/04/2025 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1/9/2025: 115.4 Lbs<br><br>1/9/2025: 110.6 Lbs (a significant weight loss of 5.39%) Taken the same day as the 115.4 lbs weight.<br><br>Review of the current care plan indicated a focus for nutrition with an intervention for weigh and alert dietitian and physician to any significant loss or gain.<br><br>Review of the dietitian's progress note dated 1/21/25 indicated the following: Resident with a significant weight loss trigger. Requested reweigh x 2. Will monitor reweigh and add interventions per RD (registered dietitian) discretion once weight is obtained.<br><br>During an interview on 1/30/25, at approximately 9:00 A.M. Nurse #12 said that all the weights are in the electronic medical record and there is no paper trail for weights. Nurse #12 then said that he had no idea why two weights were obtained for Resident #51 on the same day, or which weight was accurate.<br><br>During an interview on 1/30/25 at 1:06 P.M., the Registered Dietitian (RD) said that she expects a resident with a new significant weight loss to be re-weighed within 24 hours. The RD said that she still has not gotten a reweigh for Resident #51 despite repeatedly asking for one, 3 weeks later. The RD said that she checks three times a week but the weight has not been verified and that she cannot make changes to a resident's diet to address the weight loss until the weight has been determined to be accurate. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>44095<br><br>Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC: a flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV] ), consistent with professional standards of practice for one Resident (#86), out of a total sample of 26 residents. Specifically, for Resident #86, the facility failed to change the PICC line dressing once compromised, and nursing failed to obtain orders and implement recommendations for the removal of the PICC line.<br><br>Findings include:<br><br>Review of the facility policy titled Central Venous Catheter and Dressing Change, dated as revised March 2022, indicated the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings.<br><br>3. Change the dressing if it becomes damp, loosened or visibly soiled and:<br><br>a. at least every 7 days for TSM (transparent semi-permeable membrane) dressing;<br><br>b. at least every 2 days for sterile gauze dressing (including gauze under a transparent semi-permeable membrane [TSM] unless the site is not obscured); or<br><br>c. immediately if the dressing or site appear compromised.<br><br>Resident #86 was admitted to the facility in August 2024 with diagnoses including morbid obesity, alcohol abuse, and infection of the joint prosthesis.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/20/24, indicated that Resident #86 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of a possible 15. The MDS further indicated Resident #86 required IV medications.<br><br>During an interview on 1/28/25 at 7:43 A.M., Resident #86 said he/she has a PICC line in his/her left arm. Resident #86 showed the surveyor his/her right arm, the PICC line dressing was dated 1/22/25 and was peeling up and folded over onto itself. Resident #86 said the stupid nurses were supposed to take this (explicative) thing out on Sunday (1/26/25), but nobody has done it.<br><br>Review of Resident #86's physician's order, dated 9/11/24, indicated:<br><br>-Change Left arm PICC line dressing every 7 days and as needed (PRN), every day shift every 7 day(s) and as needed for dressing falls off/other reasons.<br><br>Review of Resident #86's physician's order, dated 10/13/24, indicated:<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Monitor Left Arm PICC line site for signs and symptoms (s/s) of infection/infiltration. Notify the provider if s/s occur every shift.<br><br>Review of Resident #86's plan of care related to PICC line, dated as reviewed 12/29/24, indicated:<br><br>-Sterile dressing change per policy and PRN.<br><br>Review of Resident #86's hospital discharge summary, dated 12/23/24, indicated:<br><br>Hospital Course by Problem:<br><br># Polymicrobial bacteremia associated with central line.<br><br>-Patient presented with suspected infected PICC line found to have Polymicrobial bacteremia with Methicillin-resistant Staphylococcus aureus (MRSA), staph hominis, and staph capitis found on blood cultures.<br><br>Review of Resident #86's physician's order, dated 12/24/24, indicated:<br><br>-Micafungin (antifungal medication) intravenous solution 100-0.9 milligrams/100 milliliter- (Micafungin Sodium in Sodium Chloride), use 100 mg intravenously one time a day for fungal infection until 1/26/25.<br><br>Review of Resident #86's nursing progress note, dated 1/22/25, indicated:<br><br>-Patient back from appointment with infectious disease clinic with order to continue with Micafungin until 1/26/25 then discontinue it and remove the PICC line on the same day 1/26/25.<br><br>Review of Resident #86's resident physician's visit form dated 1/22/25, indicated the following:<br><br>-Complete Micafungin course on 1/26/25 then remove the PICC line after micafungin course is complete.<br><br>During an interview on 1/28/25 at 12:31 P.M., Nurse #2 said that Resident #86 has a PICC line dressing that needs to be changed today because the dressing is peeling up.<br><br>On 1/29/25 at 11:00 A.M., the surveyor observed Resident #86's left arm PICC line dressing again and it was still dated 1/22/25 and the dressing was peeling up and still folded over onto itself.<br><br>During an interview on 1/29/25 at 11:07 A.M., Nurse #3 said Resident #86 has a PICC line used for IV antibiotics, and his/her last dose was given on Sunday. Nurse #3 said that he was aware the Resident #86's PICC line needed to be removed on Sunday, and he said it was probably still in because there was no Registered Nurse (RN) on the floor, and nobody was able to pull it out. Nurse #3 said he reviewed the consultation report from infectious disease, but he did not obtain orders for the removal. Nurse #3 looked at Resident #86's PICC line dressing and he said the dressing needed to be changed because of the compromised integrity (peeled and folded over on itself, same as the observation on 1/28/25).<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/29/25 at 3:11 P.M., the Director of Nursing (DON) said that nursing should have obtained an order to remove the PICC line on Sunday 1/26/25 based on the recommendations from infectious disease. The DON said that if Resident #86's PICC line dressing was peeling and potentially compromised the PICC line dressing should have been changed on 1/28/25. The surveyor reviewed Resident #86's most recent discharge summary from the hospital which indicated a history of potential PICC line infection and the DON said that there is even more reason to remove the PICC line as soon recommended. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>44095<br><br>Based on observation, interview, and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#57), out of a total sample of 26 residents. Specifically, for Resident #57, the facility failed to ensure that nursing changed Resident #57's oxygen tubing as ordered by the physician.<br><br>Findings include:<br><br>Review of the facility policy titled Oxygen Administration, dated as revised October 2010, indicated that the purpose of this procedure is to provide guidelines for safe oxygen administration.<br><br>1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.<br><br>2. Review the resident's care plan to assess for any special needs of the resident.<br><br>Resident #57 was admitted to the facility in August 2024 with diagnoses including diabetes, edema, heart failure, chronic kidney disease and dependence of renal dialysis.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/20/24, indicated that Resident #57 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of a possible 15. The MDS further indicated Resident #57 required continuous oxygen therapy.<br><br>On 1/28/25 at 7:55 A.M., 12:40 P.M., and 4:00 P.M., the surveyor observed Resident #57 receiving oxygen from an oxygen concentrator at 2 liters per minute via nasal cannula. The nasal cannula tubing was dated 1/6/25. There was also a portable oxygen cylinder in the room and the oxygen tubing for that device was undated.<br><br>On 1/29/25 at 6:46 A.M. and 9:35 A.M., the surveyor observed Resident #57 receiving oxygen from an oxygen concentrator at 2 liters per minute via nasal cannula. The nasal cannula tubing was dated 1/6/25. There was also a portable oxygen cylinder in the room and the oxygen tubing for that device was undated.<br><br>Review of Resident #57's plan of care related congestive heart failure, dated 8/16/24, indicated:<br><br>-Administer oxygen as ordered via nasal cannula.<br><br>Review of Resident #57's physician's order, dated 8/10/24, indicated:<br><br>-Oxygen tubing change weekly, label each component with date and initials, every night shift every Sunday. Label each component with date and initials.<br><br>-Oxygen at 2 liters per minute via nasal cannula, continuously, every shift.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #57's Treatment Administration Record (TAR), dated January 2025, indicated nursing changed the oxygen tubing on 1/5/25, 1/12/25, 1/19/25, and 1/26/25. However, based on the observation on 1/28/25 and on 1/29/25 the tubing was dated 1/6/25.<br><br>During an interview on 1/30/25 at 6:45 A.M., Nurse #7 said he works every Sunday into Monday, and he said it is his responsibility to change the oxygen tubing according to the physician's order. Nurse #7 said he dates the tubing for Monday when he changes the tubing. Nurse #7 said he has not changed the tubing for Resident #57 since 1/6/25.<br><br>During an interview on 1/29/25 at 3:16 P.M., the Director of Nursing (DON) said nursing should implement the physician's orders and change the tubing as ordered.<br><br>On 1/29/25 at 3:33 P.M., the DON observed the oxygen tubing connected to the concentrator dated as 1/6/25 (Monday). |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>44095<br><br>Based on observations, record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#57) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 26 residents. Specifically, the facility failed to ensure clamps were kept with the Resident in accordance with the plan of care and the physician's orders in case of emergency.<br><br>Findings include:<br><br>Review of the facility policy titled End-Stage Renal Disease, Care of a Resident with, dated as revised September 2010, indicated that residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.<br><br>1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents.<br><br>2. Education and training of staff includes, specifically:<br><br>d. how to recognize and intervene in medical emergencies such as hemorrhages and septic infections;<br><br>e. how to recognize and manage equipment failure or complications (according to the type of equipment used in the facility)<br><br>5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.<br><br>Resident #57 was admitted to the facility in August 2024 with diagnoses including chronic kidney disease and dependence of renal dialysis.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/20/24, indicated that Resident #57 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of a possible 15. The MDS indicated Resident #57 required dialysis.<br><br>Review of Resident #57's physician's order, dated 8/9/24, indicated:<br><br>-Maintain clamp at bedside, every shift for monitoring.<br><br>Review of Resident #57's plan of care related to Hemodialysis, dated 8/9/24, indicated:<br><br>-Maintain smooth catheter clamps at the bedside. Use clamps to clamp catheter if breakage or excessive bleeding from catheter.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/28/25 at 7:55 A.M., 12:40 P.M., and 4:00 P.M., the surveyor observed Resident #57 in his/her room and there was no emergency clamp at the bedside. There was a green thumb tack above Resident #57's bed with nothing hanging off the thumb tack. Resident #57 said he/she was not sure where the clamps were.<br><br>On 1/29/25 at 6:46 A.M. and 9:30 A.M., the surveyor observed Resident #57 in his/her room and there was no emergency clamp at the bedside. There was a green thumb tack above Resident #57's bed with nothing hanging off the tack.<br><br>On 1/29/25 at 9:35 A.M., the surveyor along with Nurse #3 attempted to locate the smooth clamps at Resident #57's bedside. There were no clamps available in the room. Nurse #3 pointed to a green tack on the wall and said that there should be a bag hanging off the green thumb tack with the clamps in there. Nurse #3 continued to say there was a second set on Resident #57's wheelchair. Nurse #3 looked all over Resident #57's room, including behind the bed, in drawers, and all over the wheelchair but he was unable to find the clamp.<br><br>During an interview on 1/29/25 at 3:15 P.M., the Director of Nursing (DON) said that Resident #57 should have a bag behind his/her bed with the clamps in it. The DON said nursing should ensure the clamps are present when signing off the physician's order. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225400 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/04/2025 |
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| NAME OF PROVIDER OR SUPPLIER Vantage at Wakefield LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE One Bathol Street Wakefield, MA 01880 | |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797<br><br>Based on record review and interview the facility failed to develop a comprehensive trauma informed care plan for one Resident (#72) out of a total sample of 26 residents. Specifically, Resident #72 has a known history of trauma and the facility failed to develop a care plan with resident specific triggers and interventions.<br><br>Findings include:<br><br>Review of the facility policy titled Trauma Informed Care and Culturally Competent Care, dated as revised August 2022, indicated the following:<br><br>Resident Care Planning:<br><br>1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate.<br><br>2. Identify and decrease exposure to triggers that may re-traumatize the resident.<br><br>3. recognize the relationship between past trauma and current health concerns (e.g , substance abuse, eating disorders, anxiety and depression.<br><br>4. Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values.<br><br>Resident #72 was admitted to the facility in October 2023 and had diagnoses that include Suicidal Ideation, Major Depressive Disorder, Psychotic Disorder with Delusions, Anxiety Disorder, Bipolar disorder and Schizophrenia<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/15/24, indicated that Resident #72 scored a 6 out of 15 on the Brief Interview for Mental Status exam. indicating severe cognitive impairment.<br><br>Review of the facility document titled GHC2-Social Services Assessment and Documentation, dated 10/24/23 indicated that Resident #72 has a history of post traumatic stress disorder (PTSD). Further review indicated Resident #72 was molested by a Priest at the age of 12.<br><br>At the time of admission in October 2023, a Trauma care plan to address Resident #72's history of sexual assault was developed however, it was resolved and removed from the plan of care on 12/13/24.<br><br>Review of the hospital discharge paperwork dated 12/12/24, indicated the following triggers:<br><br>1. Not being heard.<br><br>2. Being disappointed.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Loud noise/yelling<br><br>4. Perception of being belittled or put down.<br><br>5. Feeling disrespected.<br><br>6. Being touched.<br><br>7. Feeling overstimulated.<br><br>Further review indicated the following recommendations regarding care management:<br><br>1. Reassurance that he/she is safe.<br><br>2. Speak in a calm manner.<br><br>3. Predictable routines. Transition warnings when a change in routine is going to happen.<br><br>4. artwork/ carfts, wathcing tv/ music/resting in room.<br><br>However, none of the recommendations, or the Resident specific triggers, were put into Resident #72's plan of care upon his/her return to the facility on [DATE].<br><br>On 12/13/24 the facility social worker conducted a trauma assessment that indicated the following:<br><br>(scale: 1=not at all, 2=a little bit, 3=moderately)<br><br>Resident reported the following:<br><br>-Over the past month have you been experiencing repeated, disturbing memories, thoughts, or images of a stressful experience from the past=3<br><br>-Over the past month have you been experiencing repeated, disturbing dreams of a stressful experience from the past=3<br><br>-Over the past month have you noticed that you are suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)=3<br><br>-Over the past month have you been Feeling very upset when something reminded you of a stressful experience from the past=3<br><br>During an interview on 1/29/25 at 1:08 P.M., the Director of Nursing (DON) said that a PTSD care plan should have been developed and should include specific triggers and interventions. |

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F 0726

Level of Harm - Immediate jeopardy to resident health or safety

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.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797

Based on interviews, record review, staff education review, and Facility Assessment review, the facility failed to ensure the nursing staff were trained and demonstrated the competencies and skill sets necessary to provide the level and types of care and services needed as outlined in the Facility Assessment. Specifically: The facility failed to ensure licensed nursing staff who were on the schedule on 1/28/25, 1/29/25 and 1/30/25, were trained and competent to identify, assess, and intervene when one Resident (#72), who was admitted with Suicidal Ideation's, made repeated statements of wanting to commit suicide.

Findings include:

According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

Review of the facility policy titled Staffing, Sufficient Competent Nursing, dated 2001 indicated that the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.

Review of the facility policy titled Facility Assessment, dated revised December 2023 indicated that the facility assessment includes a breakdown of the training, licensure, education, skill level and measures of competency for all personnel.

Review of the document titled Facility Assessment, dated 8/1/2024, indicated that on a daily average 40 plus residents with behavioral symptoms reside in the facility. Further review indicated that the facility provides for residents with mental health and behavioral health needs that require intervention. Further review indicated that all personnel are required to be trained in behavioral health including but not limited to review of the behavioral health program's written policies, review of competencies and skills necessary to provide person-centered care and services that promote mental and psychosocial well-being.

Resident #72 was admitted to the facility in October 2023 with diagnoses that include Suicidal Ideation (SI), Major Depressive Disorder, Psychotic Disorder with Delusions, Anxiety Disorder, Bipolar disorder and Schizophrenia.

Review of the Minimum Data Set, dated dated dated [DATE], indicated that Resident #72 has a diagnosis of SI. Further review indicated that Resident #72 scored a 6 out of 15 on the Brief Interview for Mental Status exam indicating severe cognitive impairment. Further review indicated that Resident #72 expressed feelings of sadness/depression more than half of the time in the past week.

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #72's Behavioral Health Service notes indicate the following:<br><br>Review of the initial psychological evaluation 12/20/24, at 7:22 A.M., Psych Therapist #1, indicated the following: has a life long history do (sic) Schizophrenia and multiple suicide attempts and multiple psych hospitalization s.<br><br>On 1/28/25, at 8:07 A.M., the surveyor observed Resident #72 crying in bed, yelling out to call an ambulance because he/she was having extreme suicidal thoughts and was afraid he/she was going to snap. The surveyor observed several staff members in the hallway and 2 nurses sitting at the nurse's station, not responding to the distress calls from Resident #72. The surveyor also observed long call light cords and a bed adjustment cord hanging from the wall next to Resident #72's bed. The surveyor informed Nurse #10 of Resident #72's SI. Nurse #10 failed to demonstrate competency in behavioral health and said that this is his/her normal behavior. Nurse #10 failed to acknowledge Resident #72's continued expressions of mental distress.<br><br>On 1/29/25 at 8:00 A.M. the surveyor observed Resident #72 standing in his/her room doorway crying out I don't feel good inside, I want to kill myself. Resident #72 was observed to be agitated and shaking, in acute psychosocial distress. The several staff members in the hallway failed to demonstrate behavioral health competency as none of the staff responded to Resident #72's verbalizations of mental distress.<br><br>During an interview on 1/29/25 at 8:22 A.M., the Director of Nursing (DON) said that all nursing staff should be trained in behavioral health and nursing failed to respond to Resident #72 appropriately.<br><br>On 1/30/25 the surveyor observed the following:<br><br>At 7:58 A.M. Resident #72 yelled out I am going to kill myself (three times), I feel like I am suicidal, I don't feel good, I am going to do it. Nurse #12, who was in the hallway, failed to demonstrate competency in behavioral health when he walked away and did not acknowledge the Resident's verbalizations of SI. Housekeeping was in the room at the time and also, did not intervene.<br><br>At 8:01 A.M. Resident #72 yelled out I need help, I'm suicidal. I'm going to kill myself. Resident #72 was observed to be crying, and pleading with Nurse #12 not to leave him/her. Nurse #12, who had briefly entered the room, again failed to demonstrate competency in behavioral health when Nurse #12 did not acknowledge the Resident's request and exited the room to resume working at his medication cart.<br><br>At 8:05 A.M. Resident #72 said I feel suicidal, I need help. Nurse #12 went into the Resident's room and said give me 5 min. Resident #72 responded; I don't feel good inside, I am going to kill myself. The Resident was crying out begging the Nurse #12 for help from the doorway as Nurse #12 ignored Resident #72.<br><br>At 8:07 A.M. Resident #72 was observed tearful and crying as he/she said I am suicidal I want to kill myself. Nurse #12 entered Resident #12's room with a breakfast tray, then walked out closing the door shut to 3-4 inches behind him and exited. Resident #72 was left alone in the room crying.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Between 7:58 and 8:41 A.M., the surveyor observed Resident #72 to make multiple statements about wanting to kill him/herself, while no staff intervened or checked on him/her.<br><br>Review of all 24 of the licensed nursing staff training records, working in the facility on 1/28, 1/29 and 1/30/25, failed to indicate behavioral/mental health service training was completed.<br><br>During an interview on 1/31/25, at 12:55 P.M., the Administrator said that all staff should have been trained on behavioral health as indicated in the facility assessment as the facility has a significant number of residents that have behavioral health concerns. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095<br><br>Based on observations and interviews, the facility failed to post nursing staff data daily, at the start of each shift, as required. Specifically, the facility failed to ensure they consistently posted the staffing as required.<br><br>Findings include:<br><br>On 1/28/25 at 8:27 A.M., the surveyor observed a single sheet of paper in the clear plastic document holder, indicating the daily staffing dated as Monday 10/14/24.<br><br>On 1/29/25 at 7:54 A.M., and 9:04 A.M., surveyor observed a single sheet of paper in the clear plastic document holder, indicating the daily staffing dated as Tuesday 1/28/25.<br><br>During an interview on 1/29/25 at 2:44 P.M., the Scheduler said he is responsible for the daily postings and said he stopped posting the daily staffing as required back in the Fall of 2024 when the facility changed the schedule system. The Scheduler said that the new system calculated the staffing needs, and he posted the daily staffing by the employee time clock on the [NAME] Unit (approximately 30 feet away from the entrance of the building, and down a hallway not traveled by residents or visitors, especially for those residents and visitors for the Solana Unit and [NAME] Unit). The Scheduler said the time clock was not readily available to residents and visitors.<br><br>During an interview on 1/29/25 at 3:00 P.M., the Administrator said he was not aware that the Scheduler was no longer posting the daily staffing at the entrance to the facility, but the Scheduler should have. |

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| F 0740<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797<br><br>Based on observations, record review and interview, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two Residents (#72 and #80) with a history of suicidal ideation (SI) and depression, out of a total sample of 26 residents.<br><br>Specifically:<br><br>1. For Resident #72 the facility failed to provide Resident #72 with appropriate behavioral health services following verbalizations of SI and psychosocial distress.<br><br>2. for Resident #80 the facility failed to indicate any behavioral health care plan or interventions were implemented after identifying Resident #80's history of attempted suicide or suicidal ideations.<br><br>Findings include:<br><br>Review of the facility policy titled Behavioral Assessment, Intervention and Monitoring, dated revised March 2019 indicated that the facility will provide and the residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment. Further review indicated that the nursing staff will identify, document and inform the physician about specific details regarding changes in the individual's mental status, behavior and cognition.<br><br>Review of the document titled Facility Assessment, dated 8/1/2024, indicated that on a daily average, 40-47 residents with behavioral health needs reside in the facility. Further review indicated that the facility is able to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior and identify and implement interventions, including non-pharmacological interventions, to help support individuals with issues such as dealing with psychotic disorder, schizophrenia, anxiety, cognitive impairment, depression, trauma/PTSD, and other psychiatric diagnoses.<br><br>Resident #72 was admitted to the facility in October 2023 and had diagnoses that include Suicidal Ideation, Major Depressive Disorder, Psychotic Disorder with Delusions, Anxiety Disorder, Bipolar disorder and Schizophrenia.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/15/24, indicated that Resident #72 has a diagnosis of suicidal ideations. The MDS further indicated that Resident #72 scored a 6 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment and had expressed feelings of sadness/depression more than half of the time in the past week.<br><br>Review of Resident #72's medical record failed to indicate a care plan for suicidal ideation had been developed.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the hospital discharge summary dated 12/12/24 indicated that Resident #72 was admitted to the hospital on 11/1/24 with suicidal ideations and discharged 6 weeks later to the facility on [DATE]. Further review indicated that Resident #72 had multiple previous hospitalization s for a similar presentation.<br><br>Review of the facility documents titled Nursing Documentation Note, dated 12/13/24, 12/14/24, 12/16/24, and 12/17/24, indicated the following: mental health/behavior reviewed; Pt. (patient) is experiencing agitation/restlessness, suicidal ideations, and excessive crying.<br><br>Review of Resident #72's Behavioral Health Service notes indicate the following:<br><br>-An initial psychological evaluation, dated 12/20/24, conducted by a psychological (Psych) therapist. Psych Therapist #1, indicated Resident #72 has a life long history do (sic) Schizophrenia and multiple suicide attempts and multiple psych hospitalization s. Psych Therapist #1 indicated Resident #72 reported I am so upset with how I feel right now. I need my medication to kick in so I can feel good again. Psych Therapist #1 indicated that Resident #72 is currently back to his/her emotional baseline in the mornings but shows great improvement after 10:00 A.M.<br><br>-A psych therapy note, dated 12/23/24. Psych Therapist #2 documented that tearfulness and anxiety is prominent in the mornings but subsides after morning medications are given.<br><br>-A psych therapy note, dated 1/13/25. Psych Therapist #2 indicated that Resident #72 is usually tearful and anxious in the morning before medication administration, and improved mood after.<br><br>-A psych therapy note, dated 1/24/25, Psych Therapist #2 indicated Resident #72 said that I know I feel better now but I feel so terrible in the morning.<br><br>Review of the record failed to indicate the time of Resident #72's morning medications had been assessed or that the Physician had been notified of Resident #72's mood state until medications were administered.<br><br>On 1/28/25, at 8:07 A.M., the surveyor observed Resident #72 crying in bed, yelling out to call an ambulance because he/she was having extreme suicidal thoughts and was afraid he/she was going to snap. There were a long call light cords and a bed adjustment cord hanging from the wall next to Resident #72's bed.<br><br>The surveyor observed several staff members in the hallway and 2 nurses sitting at the nurse's station not responding to the distress calls from Resident #72. The surveyor informed Nurse #10 of Resident #72's verbalizations. Nurse #10 said this is Resident #72's normal behavior and brought Resident #72 to the dining room to eat.<br><br>On 1/28/25, at 3:45 P.M., the surveyor observed Resident #72 alone in his/her room. The long call light cords and a bed adjustment cord were hanging from the wall next to Resident #72's bed.<br><br>On 1/29/25 at 8:00 A.M. the surveyor observed Resident #72 standing in his/her room doorway crying out I don't feel good inside, I want to kill myself. Resident #72 was observed to be agitated and shaking, in acute psychosocial distress. There were several staff members in the hallway however none responded to Resident #72.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 1/29/25 at 8:12 A.M. Nurse #11 said that he worked the 11 P.M.-7 A.M. shift last night. Nurse #11 said that it had not been reported to him that Resident #72 had verbalized SI the previous day and had requested a ambulance be called. Nurse #11 said that the physician should be notified if a resident verbalizes SI, and that a progress note should be in the clinical record indicating the physician's instructions.<br><br>Review of the clinical record failed to indicate that the physician had been notified of Resident #72's verbalization of SI on 1/28/25 or that Psych Services had been notified or assessed the Resident's mood state to determine a plan to keep the Resident safe.<br><br>During an interview on 1/29/25 at 8:02 A.M., with Resident #72's Certified Nursing Assistant (CNA) #7 said that Resident #72 wakes up around 6:00 A.M. and often says he/she doesn't feel good inside, but she has never heard Resident #72 claim to want to commit suicide. CNA #7 said that Resident #72 usually feels better by lunch.<br><br>During an interview on 1/29/25 at 8:14 A.M., Nurse #4 said that Resident #72 just told her that he/she wanted to commit suicide. Nurse #4 then said that she would expect that a resident with active suicidal ideations to have an active care plan in place.<br><br>During an interview on 1/29/25 at 8:22 A.M., the Director of Nursing (DON) said that the physician and psych services should be notified immediately if a resident verbalizes SI, exhibits psychosocial distress and is requesting an ambulance be called. The DON also said that she would expect that a progress note would have been entered into the medical record. The DON said that said nursing should document in the clinical record the plan to keep the resident safe. The DON said all residents with a history of SI should have a care plan, with resident specific triggers and interventions, to address the SI.<br><br>On 1/30/25 the surveyor observed the following:<br><br>At 7:58 A.M. Resident #72 yelled out I am going to kill myself (three times), I feel like I am suicidal, I don't feel good, I am going to do it. Nurse #12 was in the hallway however walked away and did not acknowledge the Resident's verbalizations of SI. Housekeeping was in the room at the time and also, did not intervene.<br><br>At 8:01 A.M. Resident #72 yelled out I need help, I'm suicidal. I'm going to kill myself. Resident #72 was observed to be crying, and pleading with Nurse #12, who had briefly entered the room, not to leave him/her. Nurse #12 did not acknowledge the Resident's request and exited the room to resume working at his medication cart.<br><br>At 8:05 A.M. Resident #72 said I feel suicidal, I need help. Nurse #12 went into Resident #72's room and said give me 5 min. Resident #72 responded I don't feel good inside, I am going to kill myself. Nurse #12 ignored Resident #72.<br><br>At 8:07 A.M. Resident #72 was observed tearful and crying as he/she said I am suicidal I want to kill myself. Nurse #12 entered Resident #12's room with a breakfast tray, then walked out closing the door shut to 3-4 inches behind him and exited. Resident #72 was left alone in the room crying.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Between 8:08 and 8:41 A.M., the surveyor observed Resident #72 alone in his/her room, crying out feelings of SI and no staff intervened or checked on him/her. observed in bed moving, weeping, saying I am going to kill myself, I am suicidal please help me please. No staff responded<br><br>During an interview on 1/30/25 at 8:38 A.M., Resident #72 told the surveyor 'I'm having anxiety attacks, I put the call light on because mornings are difficult, I want to kill myself, I need help.<br><br>During an interview on 1/30/25 at 8:41 A.M., Nurse #12 said Resident #72 says I don't feel good inside all the time and explained it's a behavior thing, eventually he/she stops saying he/she wants to kill him/herself.<br><br>During an interview on 1/30/25 at 8:46 A.M., the Administrator was updated on the observations of Resident #72 since 1/28/25. The Administrator said Resident #72 should not be left alone after making threats to harm him/herself and a plan should have been established immediately to ensure his/her safety.<br><br>During an interview on 1/30/25, at 10:20 A.M., the Medical Director said that she was. not notified of Resident #72's verbalizations of SI on 1/28/25 and his/her request for an ambulance to be called. The Medical Director said that it is her expectation that she be notified whenever a resident verbalizes SI so that she can make a determination of a treatment plan. In this case, the Medical Director said that the facility notified her of a verbalization of SI on 1/29/25, but that if she had been made aware that the verbalizations began on 1/28/25 and continued on 1/29/25 she would have ordered Resident #72 be sent to the hospital for evaluation and treatment.<br><br>During an interview on 1/30/25 at 11:10 A.M. the Director of Nursing said that no plan had been put in place since she was notified of the Resident's suicidal ideation's yesterday. She said that she thought that the Resident was put on 1:1 supervision but couldn't be sure. The DON said that a plan should have been implemented immediately when the Resident made the acute statements of suicidal ideation.<br><br>During an interview on 1/30/25, at 11:18 A.M. Social Worker (SW) #1 said she was Informed on 1/29/25 that Resident #72 had verbalized SI and that she never heard him/her say this before. SW #1 said #72 should have immediately been offered behavioral health services.<br><br>During an interview on 1/30/25 at 12:04 P.M., CNA #6, said she is Resident #72's regular CNA and that she was his/her CNA last night, (1/29/25 11 P.M.-7 A.M.) and that therefore no plan had been put in place to ensure safety. CNA #6 said that she did not get a report that Resident #72 was having suicidal ideations. CNA #6 said that Resident #72 always says he/she doesn't feel good inside and was very anxious last night and this morning. CNA #6 said that Resident #72 was more anxious last night and again this morning and just kept saying he/she doesn't feel good inside and needs his mother. he was not on 1:1 and was left alone in his room during the night. CNA #6 said she was upset that she was not told and said that that is not good if he/she was saying he/she was going to kill him/herself.<br><br>(continued on next page) |

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

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| F 0740<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 1/31/25 at 7:27 A.M. Psych Therapist #1 said that Resident #72 is upset and says that all the time (that he/she is going to kill him/herself and that he/she is suicidal). Psych Therapist #1 said If you go back at 11 A.M. he/she will be much better. Psych Therapist #1 said that it was not possible to change Resident #72's medication to earlier in the morning because this is a nursing home you know.<br><br>Review of Psych Therapist #2's note dated 2/3/25, indicated to change morning medication administration timing to 6:00 A.M.<br><br>Review of the physician orders dated February 2025 indicated that all morning medications, including antipsychotic and antianxiety medication administration times were changed from 8:00 A.M. to 6:00 A.M.<br><br>On 1/4/25, at 7:05 A.M. the surveyor observed Resident #72 resting quietly in bed without observed psychosocial distress.<br><br>During an interview on 1/4/25, at 9:00 A.M., Nurse #10 said that Resident #72 is usually highly agitated in the mornings until around 10:00 A.M. (4 hours since waking up) and today he/she is calm, not verbalizing anxiety or SI. Nurse #10 then said that he believes that changing the Resident's medication time to 6 A.M. has helped Resident #72 a lot.<br><br>48671<br><br>2. Resident #80 was admitted to the facility in January 2024 with diagnoses including major depressive disorder, mood affective disorder, anxiety disorder, insomnia and dementia.<br><br>Review of Resident #80's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she scored 13 out of a possible 15 on the Brief Interview for Mental Status Exam indicating intact cognition. Further review of the MDS indicated Resident # 80 has a psychiatric/mood disorder including anxiety and depression.<br><br>Review of the Resident's hospital discharge paperwork, dated January 2024, indicated that Resident #80 was admitted to the facility after history of suicide attempt, chronic mental illness, and recent discharge from inpatient psychiatric unit for severe major depression disease and received 12 rounds of ECT (Electro-Conclusive Therapy (electrical impulses used to treat depression and other mental health conditions). History of trauma, abuse and discharged with protective factors.<br><br>Safety Assessment included strong social support, engagement with treatment, Risk factors including hopelessness, personal loss, limited coping skills.<br><br>Review of the hospital discharge Safety Plan included:<br><br>-Warning signs (thoughts, image, mood, situation, behavior) that a crisis may be developing:<br><br>1. Feeling aggravated.<br><br>2. Thoughts of leaving the situation/environment.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Internal coping strategies- Things I can do to take mind off my problem without contacting another person (relaxation technique, physical activity).<br><br>1. Focus on something else that is more positive.<br><br>2. Self-reflect on what is bothering you.<br><br>3. Focus on the fact that things get better<br><br>-People whom I can ask for help: family.<br><br>Review of Resident #80's care plans on 1/28/25 failed to indicate any behavioral health care plan or interventions were implemented identifying Resident #80's history of attempted suicide or suicidal ideations.<br><br>Review of the Nurse Practitioner note dated 2/2/24, indicated: Patient presented to Hospital on 11/22/2023 due to depressive symptoms. The patient was transferred from Psychiatric Hospital where he was admitted for 22 days due to depression. Upon evaluation the patient was impacted by significant grief, loss of independence, loss of companionship and isolation contributing to a loss of identity and motivation to live when his wife passed away. The patient received 12 ECT treatments and his mood and energy significantly improved. Assessment and Plan: ADL (activities of daily living) and mobility dysfunction secondary to major depressive disorder. Will continue discussion with the therapy team, family, and social worker.<br><br>Review of the Social Services progress note dated 11/4/24, indicated: This Social Worker met with (Resident) today related to the resident to resident altercation he/she was involved in last week. He/she recalled the incident and reported that he has no psychosocial issues at this time. Social Services will continue to follow and support.<br><br>Review of the Physician Progress noted dated 11/6/24, indicated: Follow-up depression, generalized weakness chronic pain occasional psychotic features. Psychiatric: Not agitated. Depressed mood. Follow-up generalized weakness, chronic pain anxiety depression involved in recent altercation with another resident, psych evaluating follow-up with dementia management of other medical problems and rehabilitation.<br><br>Review of the Behavioral Health Services Nurse Practitioner note dated, 11/11/24, indicated:<br><br>-Reports depression is fairly stable though tearful when discussing wife, denies SI. Recently was victim of resident altercation, reports he feels safe and is doing fine now but has some back pain from incident of being pushed.<br><br>-Pertinent Current Medications: None<br><br>-History of Trauma: No-denies.<br><br>-Affect: Tearful, appropriate.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Diagnostic Assessment: Resident with hx (history) of MDD (major depressive disorder), severe without psychosis, anxiety and dementia. AO (alert and oriented) x2-3 with some forgetfulness. S/p (status post) 12 rounds of ECT in January of this year. Managed on Zoloft (antidepressant) and Remeron (antidepressant). Mood and behavior stable, no SI/HI (suicidal ideation/homicidal ideation)<br><br>-Non-pharmacological recommendations include:<br><br>-Provide reassurance and redirection as able.<br><br>-Continue with behavioral recommendations that facility currently has in place.<br><br>-Continue to document changes in mood or behavior<br><br>-Continue to engage resident in facility activities.<br><br>-Encourage good sleep hygiene habits - lights on in room, time during day spent out of bed, engage in activities, limit caffeine intake especially in the afternoons, avoid late afternoon naps.<br><br>-GDR (gradual dose reduction) Rational: GDR not indicated at present time due to patient being recently referred; GDR will be evaluated once care is established.<br><br>Review of Resident #80's active physician orders indicated the following:<br><br>-Zoloft Oral Tablet 100 MG (milligrams) (Sertraline HCl) Give 2 tablet by mouth one time a day for Depression Total Dose 200 mg. Start Date 2/1/24.<br><br>-Mirtazapine Oral Tablet Give 15 mg by mouth at bedtime for appetite stimulant, depression. Start Date 2/13/24.<br><br>Review of the Behavioral Health Services Psychologist note dated 11/22/24 indicated:<br><br>-Patient engaged in this initial evaluation while in his room. Reports challenges with depression and anxiety related to the death of his wife and health challenges. History of significant depression and mild anxiety. Reports use of medication to help manage his/her emotions but is also requesting emotional support while in the facility.<br><br>-Progress towards goals: N/A (not applicable)- First visit<br><br>-Recommendations: Patient would benefit from continued Cognitive Behavioral Therapy interventions, positive action planning, continued medication, management, encourage social engagements, grounding when needed, encourage time with family and/or friends, encourage attending activities, encourage time outside when weather allows.<br><br>Review of the medical record failed to indicate a care plan was implemented for history of suicide attempts or suicidal ideations upon admission or after Resident #80 returned from the hospital on 10/31/24. Further, the medical record failed to indicate a referral was made, or that Resident #80 was assessed by the behavioral health team for psychotherapy to address his/her history of suicide attempts or suicidal ideations upon admission.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 1/30/25 at 11:18 P.M. Nurse #1 said Resident #80 had a history of SI and should have been evaluated by behavioral health on admission and said the Resident should have a behavior care plan in place.<br><br>During an interview on 1/30/25 at 11:39 A.M., the Director of Nursing said when a resident is admitted with a history of suicidal ideation, and attempted suicide they should be assessed upon admission by psych services for both medication management and psychotherapy and a care plan must be in place. The DON said the Resident must be monitored appropriately and staff should know the history of the Resident.<br><br>During an interview on 1/31/25 at 12:55 A.M., the Administrator said Behavioral Health Services must be implemented and in place and said Resident #80 should have been care planned on admission due to his/her history of suicide attempt and suicidal ideations. |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797<br><br>Based on record review and interview, the facility failed to provide the appropriate treatment and services for one Resident (#72), with a known history of mental disorders, suicidal ideation, and adjustment difficulty. Specifically, the facility failed to develop, implement, and update the plan of care, resulting in the Resident experiencing on going psychosocial distress and requesting hospitalization for suicidal ideation's after 2 days of repeated vocalizations of suicidal ideation without intervention from the facility.<br><br>Findings include:<br><br>Review of the facility policy titled Behavioral Assessment, Intervention and Monitoring, dated revised March 2019 indicated that the facility will provide and the residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment. Further review indicated that the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately is necessary to protect the resident from harm.<br><br>Resident #72 was admitted to the facility in October 2023 and had diagnoses that include Suicidal Ideation, Major Depressive Disorder, Psychotic Disorder with Delusions, Anxiety Disorder, Bipolar disorder and Schizophrenia<br><br>Review of the Minimum Data Set, dated dated dated [DATE], indicated that resident #72 has a diagnosis of suicidal ideation's. Further review indicated that Resident #72 scored a 6 out of 15 on the Brief Interview for Mental Status exam indicating severe cognitive impairment. Further review indicated that Resident #72 did express feelings of sadness/depression more than half of the time.<br><br>On 1/28/25, at 8:07 A.M., the surveyor observed Resident #72 crying in bed, yelling out to call an ambulance because he/she was having extreme suicidal thoughts. The nurse observed several staff members in the hallway and 2 nurses sitting at the nurse's station not responding to the distress calls from Resident #72. The surveyor also observed long call light cords and a bed adjustment cord hanging from the wall next to Resident #72's bed. The surveyor then informed Nurse #10 of Resident #72's suicidal ideation's. Nurse #10 then went into the Resident's room and said this is his/her normal behavior. Nurse #10 then brought Resident #72 to the dining room to eat.<br><br>On 1/28/25, at 3:45 P.M., the surveyor observed Resident #72 in his/her room without staff present and the long call light cords and a bed adjustment cord hanging from the wall next to Resident #72's bed.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/29/25 at 8:00 A.M. the surveyor observed Resident #72 standing in his/her room doorway crying out I don't feel good inside, I want to kill myself. The surveyor also observed the long call light cords and a bed adjustment cord hanging from the wall next to Resident #72's bed. The surveyor also observed several staff members in the hallway not responding to the Resident. The surveyor then observed a Certified Nurse's Aide (CNA) guide the Resident into his/her enter the room to provide morning care.<br><br>During an interview on 1/29/25 at 8:12 A.M. the surveyor informed Nurse #11 of the statements made by Resident #72. Nurse #11 said that he worked the 11 P.M.-7 A.M. shift last night and no one had reported to him that Resident #72 had made statements regarding having suicidal ideation's. Nurse #11 then said that he would expect that the physician would be notified if a resident were to exhibit behaviors indicating a desire to commit suicide. Nurse #11 then said that he would expect that the Resident's plan of care for mood/behavior would be reviewed and revised as the current plan was not effective if the Resident was having active suicidal ideation's. Nurse #11 also said that he would expect that a progress note would have been entered into the medical record and that he would have been informed at the beginning of his shift. Nurse #11 also said that Resident #72 slept alone in his/her room all night.<br><br>Review of the current care plan failed to indicate a care plan for suicidal ideation's.<br><br>Review of the progress notes failed to indicate that Resident #72 was expressing suicidal ideation's or that a progress note was written on 1/28/25 describing this new behavior.<br><br>Review of the psychiatrist note dated 12/20/24 indicated the following: has a life long history do (sic) Schizophrenia and multiple suicide attempts and multiple psych hospitalization s.<br><br>During an interview on 1/29/25 at 8:02 A.M., Certified nurse's Aide (CNA) #7 said that Resident #72 often says he/she doesn't feel good inside, but she has never heard Resident #72 claim to want to commit suicide.<br><br>During an interview on 1/29/25 at 8:14 A.M., Nurse #4 said that Resident #72 just told her that he/she wanted to commit suicide. Nurse #4 then said that she would expect that a resident with active suicidal ideation's to have an active care plan in place.<br><br>During an interview on 1/29/25 at 8:22 A.M., the Director of Nursing (DON) said that she would expect that the physician would be notified immediately if a resident were to exhibit behaviors indicating a desire to commit suicide. The DON also said that she would expect that a progress note would have been entered into the medical record. The DON then said that a care plan specific to suicidal ideation's should have been developed for Resident #72.<br><br>On 1/30/25, 8:38 A.M., the surveyor observed Resident #72 in his/her room with the door slightly ajar and without staff in the room. The surveyor also observed long call light cords and a long electric bed adjustment cord hanging next to Resident #72's bed.<br><br>During an interview on 1/30/25, at 10:20 A.M., the Medical Director said that she would have expected that the facility would have implemented an immediate plan to keep Resident #72 safe, including removing any and all potential hazards the Resident would have access to and notifying her of the situation on 1/28/25.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/30/25 at 11:10 A.M., the Director of Nursing said that any resident with a history of SI should have a care plan in place to address resident specific triggers and interventions to keep the resident safe, including non-pharmalogical interventions. In Resident #72's case she said there was not a care plan in place to address his/her SI. She also said that no plan had been put in place since she was notified of the Resident's suicidal ideation's on 1/29/25 to ensure the Resident's safety.<br><br>During an interview on 1/30/25, at 11:18 AM Social Worker #1 said all residents with a history of SI should have a care plan in place with resident specific interventions and triggers. In Resident #72's case no care plan was in place but should have been.<br><br>During an interview on 1/31/25 at 7:27 A.M. Psych Therapist #1 said that the behavioral health care plan had been deleted when Resident #72 was sent to the hospital and when he/she was readmitted the care plans were not reinstated and should have been. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>36797<br><br>Based on record review and interview, the facility failed to ensure recommendations from the Monthly Medication Reviews (MMR) conducted by the consultant pharmacist were addressed by the facility in a timely manner for five Residents (#51, #52, #72, #7, and #86) out of a total sample of 26 Residents.<br><br>Findings include:<br><br>Review of the facility policy titled Pharmacy Consultant, dated as revised 2022, indicted that the facility works with the consultant pharmacist to establish a system whereby the consultant pharmacist observations and recommendations regarding resident's medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion. Further review indicated that all recommendations received from the pharmacy consultant should be addressed prior to the next medication regimen review.<br><br>1. Resident #51 was admitted to the facility in July 2021 with diagnoses including dementia, schizophrenia and diabetes.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/14/24, indicated that Resident #51 was unable to complete the Brief interview for Mental Status exam and was assessed by staff to have moderately impaired cognition.<br><br>Review of the pharmacy recommendation dated 11/20/24, indicated the following:<br><br>-Please order daily blood sugars/Lantus (insulin)<br><br>-Amantadine can make tremors worse . can get prior authorization for Vmat2 (from insurance).<br><br>Review of the pharmacy recommendation dated 12/20/24, indicated the following:<br><br>-Please order daily blood sugars/Lantus (insulin)<br><br>-Amantadine can make tremors worse . can get prior authorization for Vmat2 (from insurance).<br><br>Review of the medical record failed to indicate that the physician reviewed the 11/20/24 or 12/20/24 pharmacy recommendations.<br><br>Review of the physician orders dated January 2025 failed to indicate an order for daily blood sugars or changes to the Amantadine order.<br><br>2. Resident #52 was admitted to the facility in April 2022 with diagnoses including Alzheimer's dementia, cancer and kidney disease.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the most recent Minimum Data Set (MDS) assessment, dated 9/13/24, indicated that Resident #52 scored a 3 out of 15 on the Brief interview for Mental Status exam, indicating severe cognitive impairment.<br><br>Review of the pharmacy recommendation dated 12/20/24 indicated the following:<br><br>-Consider disc (discontinuing) multivitamin, Omeprazole, Pravastatin and aspirin/hospice.<br><br>Review of the physician orders dated January 2025 indicated the following orders:<br><br>-Aspirin EC low dose oral tablet delayed release 81 MG (milligrams) give 1 tablet by mouth one time a day.<br><br>-Multivitamin-minerals tablet give 1 tablet by mouth one time a day.<br><br>-Omeprazole Magnesium delayed release 20 MG give 20 mg by mouth one time a day.<br><br>Review of the medical record failed to indicate that the physician reviewed the 12/20/24 pharmacy recommendations.<br><br>3. Resident #72 was admitted to the facility in October 2023 and had diagnoses that include Suicidal Ideation, Major Depressive Disorder, Psychotic Disorder with Delusions, Anxiety Disorder, Bipolar disorder and Schizophrenia.<br><br>Review of the most recent Minimum Data Set assessment, dated 12/15/24, indicated that Resident #72 scored a 6 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment.<br><br>Review of the pharmacy recommendation dated 12/20/24 indicated the following:<br><br>-Consider initiate a VMAT 2 inhibitor.<br><br>Review of the January 2025 physician's orders for Resident #72 failed to indicate an order for a VMAT 2 inhibitor.<br><br>Review of the medical record failed to indicate that the physician reviewed the 12/20/24 pharmacy recommendations.<br><br>During an interview on 1/29/25 at 11:32 A.M., the Director of Nursing (DON) said that the month of November 2024 pharmacy recommendations were delayed. The DON then said that she could not remember why.<br><br>41105<br><br>4. Resident #7 was admitted to the facility in March 2014 and has diagnoses that include Hypothyroidism (is a condition where the thyroid gland does not produce enough hormones), Type II Diabetes (a condition results from insufficient production of insulin, causing high blood sugar) and obesity.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the most recent Minimum Data Set (MDS) assessment, dated 12/31/24, indicated that on the Brief Interview for Mental Status exam Resident # 7 scored a 10 out of a possible 15, indicating moderately impaired cognition.<br><br>Review of the January 2025 Physician orders for Resident # 7 included the following orders:<br><br>1. Lansoprazole 30 milligrams (mg) once a day at 6:00 A.M., Give 30 mg by mouth one time a day for Acid reflux Before breakfast. Dissolve on tongue before swallowing particles; do not chew, cut, break, or swallow whole. Start date 7/4/24<br><br>2. Levothyroxine tablet 50 mcg (micrograms) once a day at 6:00 A.M., Give 50 mcg by mouth one time a day for hypothyroidism. Start date 10/2/23.<br><br>Review of the January 2025 Medication Administration Record (MAR) indicates that Resident # 7 was administered Lansoprazole and Levothyroxine daily at 6:00 A.M.<br><br>Review of the monthly Pharmacist recommendations indicate the following:<br><br>-11/22/24: Nurse rec: please separate the dose of Lansoprazole and Levothyroxine, currently both at 0600<br><br>-12/23/24: Nurse rec: please separate the dose of Lansoprazole and Levothyroxine, currently both at 0600<br><br>-1/27/25: Nurse rec: please separate the dose of Lansoprazole and Levothyroxine, currently both at 0600<br><br>Review of the clinical record failed to indicate the Physician or Nurse Practitioner were notified of the pharmacists recommendations.<br><br>During an interview on 1/29/25 at 11:04 A.M., with the Unit Manager (#1) she said that she had not yet received the 1/27/25 pharmacy recommendations from the Director of Nursing (DON). Unit Manager #1 said that the expected process after the pharmacy conducts their monthly visit is that they provide their recommendations to the Director of Nursing (DON) who distributes them to each unit to get the recommendation reviewed by the Physician/Nurse Practitioner (MD/NP). She said that the MD/NP sign the recommendation and indicate if they agree or disagree with it. Unit Manager #1 searched Resident #7's record but was unable to locate the 12/23/24 and 11/22/24 recommendations.<br><br>During an interview on 1/29/25 at 1:09 P.M., with the Director of Nursing she said that she is unable to find any of the recommendations for November 2024 and December 2024 and there is no indication that the recommendations were addressed.<br><br>44095<br><br>5. Resident #86 was admitted to the facility in August 2024 with diagnoses including morbid obesity, alcohol abuse, and infection of the joint prosthesis.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225400 | A. Building<br>B. Wing | 02/04/2025 |

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

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the most recent Minimum Data Set (MDS) assessment, dated 11/20/24, indicated that Resident #86 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of a possible 15.<br><br>Review of Resident #86's pharmacy noted, dated 11/20/24 and again on 1/27/25, indicated:<br><br>- Nursing Recommendation: currently on Omeprazole at 8:00 A.M., and 5:00 P.M., changing administration times, should be given on empty stomach.<br><br>- Physician Recommendation: evaluate concomitant use qvar and mometasone duplication of therapy.<br><br>Review of Resident #86's medical record failed to indicate the Physician or Nurse Practitioner were notified of the pharmacist's recommendations as evidenced by the following orders:<br><br>Review of Resident #86's physician's order, dated 8/20/24, indicated:<br><br>- Omeprazole Oral Capsule Delayed Release 40 milligrams (Omeprazole), give 1 capsule by mouth two times a day for heartburn. Scheduled twice daily at 8:00 A.M. and 5:00 P.M.<br><br>Review of Resident #86's physician's order, dated 9/20/24, indicated:<br><br>- Mometasone Furoate Inhalation Aerosol Powder Breath Activated 220 micrograms, 1 puff inhale orally one time a day for asthma. Rinse mouth after use.<br><br>Review of Resident #86's physician's order, dated 10/21/24, indicated:<br><br>- Qvar RediHaler Inhalation Aerosol Breath Activated 80 micrograms, 1 puff inhale orally one time a day for asthma, rinse mouth after use with water.<br><br>During an interview on 1/29/25 at 12:24 P.M., the Director of Nursing (DON) said she did not have access to pharmacy records for November 2024 and December 2024 and she said that pharmacy recommendations should be addressed monthly but were not. Further the DON said she had received the records for November 2024 and December 2024 a week or so ago and she sorted out the recommendations for the units and she said she had no idea where they went. |

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

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>44095<br><br>Based on interview and record review, the facility failed to ensure that one Resident (#45) out of a total sample of 26 residents was free from significant medication errors.<br><br>Specifically, the facility failed to ensure nursing held midodrine (medication used to raise blood pressure) in accordance with the physician's orders.<br><br>Findings include:<br><br>Review of the facility policy titled Administering Medications, dated as revised April 2022, indicated that medications are administered in a safe and timely manner, and as prescribed.<br><br>4. Medications are administered in accordance with prescriber orders, including any required time frame.<br><br>12. The following information is checked/verified for each resident prior to administering medications:<br><br>b. Vital signs, if necessary.<br><br>Resident #45 was admitted to the facility in January 2025 with diagnoses including hypertension, orthostatic hypotension, syncope and collapse.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/17/25, indicated that Resident #45 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 14 out of 15.<br><br>Review of Resident #45's physician's order, dated 1/12/25, indicated:<br><br>-Midodrine HCl oral tablet 10 milligrams (mg) (Midodrine HCl), give one tablet by mouth with meals for blood pressure. Hold if systolic blood pressure (SBP) is greater than 120.<br><br>Review of Resident #45's Medication Administration Record (MAR), dated January 16, 2025, through January 27, 2025, indicated nursing administered Resident #45's midodrine on the following dates and times despite the physician's order to hold for a systolic blood pressure greater than 120:<br><br>- 1/16/25 at 5:00 P.M., blood pressure 112/63.<br><br>- 1/20/25 at 5:00 P.M., blood pressure 130/70.<br><br>- 1/22/25 at 5:00 P.M., blood pressure 124/72.<br><br>- 1/23/25 at 8:00 A.M., blood pressure 127/75.<br><br>- 1/23/25 at 12:00 P.M., blood pressure 127/75.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - 1/25/25 at 5:00 P.M., blood pressure 126/72.<br><br>- 1/26/25 at 12:00 P.M., blood pressure 123/68.<br><br>- 1/27/25 at 8:00 A.M., blood pressure 131/72.<br><br>- 1/27/25 at 12:00 P.M., blood pressure 127/74.<br><br>- 1/27/25 at 5:00 P.M., blood pressure 124/70<br><br>During an interview on 1/29/25 at 11:05 A.M., Nurse #5 said that Resident #45 receives midodrine. Nurse #5 said that midodrine is used to help raise his/her blood pressure. Nurse #5 said Resident #45's order has parameters and that the nurses should check his/her blood pressure prior to administrating the midodrine. Nurse #5 said if the blood pressure is greater than 120 the medication should be held.<br><br>During an interview on 1/29/25 at 3:07 P.M., the Director of Nursing (DON) said nursing should implement the physician's order and hold the midodrine for a systolic blood pressure greater than 120. The DON reviewed the MAR with the surveyor and said the medication should have been held for a systolic blood pressure greater than 120 but the medication was not held. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105<br><br>Based on observations and interviews the facility failed to ensure drugs and biologicals were stored in accordance with acceptable professional standards of practice. Specifically, nursing failed to secure the medication and treatments carts on 1 of 3 units.<br><br>Findings include:<br><br>The facility policy titled Medication Labeling and Storage, undated, indicated the following:<br><br>-The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.<br><br>-Compartments (including, but nit limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications and biologicals are locked when not in us, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.<br><br>On 1/28/25 at 7:00 A.M., the surveyor observed an unlocked and unattended medication cart on the [NAME] Unit. Nurse #8 and a staff person were observed at the desk talking however they were unaware that the surveyor was able to open and access the cart.<br><br>On 1/28/25 at 7:03 A.M., the surveyor observed a treatment cart on the [NAME] Unit with keys in the cart. Several Nurses and CNAs in the area but none appeared to be aware that there were keys in the cart<br><br>During an interview on 1/28/25 at 7:04 A.M., with Nurse #8 the surveyor shared the observation of the unlocked medication cart that was able to be accessed and together the surveyor and Nurse #8 observed the treatment cart with the keys in it. Nurse #8 removed the keys and said that it is the expectation that the medication and treatment carts be locked when unattended and that the keys should not be left with the cart.<br><br>On 1/29/25 at 2:19 P.M., the surveyor observed an unlocked and unattended treatment cart on the [NAME] Unit and was able to open the cart.<br><br>During an interview on 1/29/25 at 2:20 P.M., with Nurse #3, he observed the surveyor with the open medication cart and said that the cart is always supposed to be locked when unattended.<br><br>During an interview on 1/30/25 at 2:39 P.M., the Director of Nursing (DON) said that it is her expectation that medication and treatment carts be locked when unattended. The DON said that the risk of it not being locked is that a resident could access the medications. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095<br><br>Based on observation, record review, and interview, the facility failed to ensure accurate documentation in the medical record for one Resident (#66) out of a total sample of 26 residents. Specifically for Resident #66 the facility failed to ensure that the physician's order for the wander guard was accurate.<br><br>Findings include:<br><br>Review of the facility policy titled Charting and Documenting, dated as revised [DATE], indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.<br><br>1. Documentation in the medical record may be electronic, manual or a combination.<br><br>2. The following information is to be documented in the resident medical record:<br><br>a. Objective observations;<br><br>b. Medications administered;<br><br>c. Treatments or services performed;<br><br>d. Changes in the resident's condition;<br><br>e. Events, incidents or accidents involving the resident; and<br><br>f. Progress toward or changes in the care plan goals and objectives.<br><br>Review of the facility policy titled Wandering and Elopements, dated as revised [DATE], indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.<br><br>1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.<br><br>Resident #66 was admitted to the facility in [DATE] with diagnoses including dementia, diabetes, hemiplegia and hemiparesis following a cerebral infraction.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated that Resident #66 had a memory problem. This MDS further indicated Resident #66 wandered 1 to 3 days in the past week.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #66's plan of care related to elopement behaviors, dated [DATE], indicated:<br><br>-Ensure that all ancillary staff is aware of elopement potential.<br><br>Review of Resident #66's nursing progress note, dated [DATE], indicated:<br><br>-Resident attempted to self propel towards the front desk multiple times, wandering in hallway and into other resident's rooms multiple times, requiring frequent redirection and monitoring.<br><br>Review of Resident #66's physician's order, dated [DATE], indicated:<br><br>-Wander Guard/Wander Elopement Device to Left Ankle due to poor safety awareness expiration date: , d+[DATE], every shift for Elopement every night shift, check function and document in supplemental documentation and every night shift for Elopement every night shift, check function and document in supplemental documentation. Expiration date: [DATE] (update the order with the new date when the bracelet is changed).<br><br>Further review of this order included two different expiration dates for [DATE] and [DATE].<br><br>Review of Resident #66's Treatment Administration Record (TAR), dated [DATE], indicated that nursing reviewed the function on the wander guard device every night shift and checked the placement of the wander guard device each shift.<br><br>On [DATE] at 6:48 A.M., the surveyor and Nurse #7 observed Residents #66's wander guard on his/her left ankle. The wander guard had an expiration dated [DATE]. This expiration date did not match the current physician's order which indicated the wander guard expired in [DATE] and the wander guard would expire in [DATE]. Nurse #7 said that he was supposed to check this and verify the correct expiration, but he did not.<br><br>During an interview on [DATE] at 3:19 P.M., the Director of Nursing (DON) said that nursing should be reviewing the order for the wander guard and nursing should be ensuring the accuracy of the order such as correcting incorrect dates. The DON said that the nurses who are implementing the order should verify the expiration date when the order documented as complete on the TAR. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>36797<br><br>Based on observation, review of the Quality Assurance Performance Improvement (QAPI) plan, and interview, the facility failed to ensure that the Quality Assurance Committee developed and implemented an appropriate corrective action plan with effective monitoring for non-functioning call bell systems and Infection Control program related to COVID-19 vaccinations.<br><br>Findings Include:<br><br>During the survey period, multiple residents were identified as having signed consent to receive the COVID-19 vaccine however the facility failed to order the vaccine from the pharmacy or provide any monitoring of the vaccination status of Residents.<br><br>During the survey period, two out of three nursing units were identified as having non-functioning call bell systems in place.<br><br>Review of the QAPI program for the year 2024, failed to indicate that a QAPI was established and implemented for the ongoing non-functioning of the call bell system on two out of three units.<br><br>Review of the QAPI program for the year 2024, failed to indicate that a QAPI was established and implemented for Infection Control program related to COVID-19 vaccinations.<br><br>During an interview on 1/31/25, at 12:55 P.M., the Administrator said that he became aware of the issue with the call light system when he was hired a year ago. The Administrator then said that he should have completed a QAPI regarding the non-functioning of the call bells. The Administrator said he should have implemented a QAPI to track the progress of the vaccination status and monitoring of the infection control program to ensure the program is being followed. |

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095

Based on observation and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically,

1. The facility failed to ensure that nursing performed hand hygiene and changed a wound dressing in accordance of professional standards to prevent infection.

2. The facility failed to sanitize shared resident equipment between resident uses.

Findings include:

1. Review of the facility policy titled Handwashing/ Hand Hygiene, dated as revised October 2023, indicated this facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections.

1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.

2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.

3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol - based hand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility.

4. Personnel are educated regarding ways to prevent contact dermatitis and other skin irritation, and provided with supplies that support healthy hand skin.

a. Facility-supplied lotions are compatible with antiseptics and gloves.

b. ABHRs, soaps and lotions are free of allergenic surfactants, preservatives, fragrances and [NAME].

c. Triclosan-containing soaps are not recommended for use or supplied by the facility.

Indications for Hand Hygiene

1. Hand hygiene is indicated:

a. immediately before touching a resident;

b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device);

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. after contact with blood, body fluids, or contaminated surfaces;<br><br>d. after touching a resident;<br><br>e. after touching the resident's environment;<br><br>f. before moving from work on a soiled body site to a clean body site on the same resident; and<br><br>g. immediately after glove removal.<br><br>5. The use of gloves does not replace hand washing/hand hygiene.<br><br>Review of the facility policy titled Dressing, Dry/Clean, dated as revised September 2013, indicated the purpose of this procedure is to provide guidelines for the application of dry, clean dressings.<br><br>Steps in the Procedure<br><br>1. Clean bedside stand. Establish a clean field.<br><br>2. Place the clean equipment on the clean field. Arrange the supplies so they can be easily reached.<br><br>3. Tape a biohazard or plastic bag on the bedside stand or use a waste basket below clean field.<br><br>4. Position resident and adjust clothing to provide access to affected area.<br><br>5. Wash and dry your hands thoroughly.<br><br>6. Put on clean gloves. Loosen tape and remove soiled dressing.<br><br>7. Pull glove over dressing and discard into plastic or biohazard bag.<br><br>8. Wash and dry your hands thoroughly.<br><br>9. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface.<br><br>10. Label tape or dressing with date, time and initials. Place on clean field.<br><br>11. Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze).<br><br>12. Wash and dry your hands thoroughly.<br><br>13. Put on clean gloves.<br><br>14. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 15. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward).<br><br>16. Use dry gauze to pat the wound dry.<br><br>17. Apply the ordered dressing and secure with tape or bordered dressing per order. (Note: Use non-allergenic tape as indicated.) Label with date and initials to top of dressing.<br><br>18. Discard disposable items into the designated container.<br><br>19. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly.<br><br>20. Reposition the bed covers. Make the resident comfortable.<br><br>21. Place the call light within easy reach of the resident.<br><br>22. Clean the bedside stand.<br><br>23. Wash and dry your hands thoroughly.<br><br>24. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.<br><br>On 1/29/25 at 11:20 A.M., the surveyor observed Nurse #3 perform Resident #86's wound care. The following observations were made:<br><br>At 11:21 A.M., Nurse #3 applied gloves and entered the room (touching the door knob with the gloves, potentially contaminating the gloves), Nurse #3 placed wound care supplies directly onto an unclean bedside table.<br><br>At 11:22 A.M., Nurse #3, wearing the same gloves, removed the dressing from the front of Resident #86's left thigh. Nurse #3 removed his gloves, he did not perform hand hygiene and he applied new gloves.<br><br>At 11:23 A.M., Nurse #3 cleaned the right thigh wound with wound cleanser. Nurse #3 removed his gloves; he did not perform hand hygiene, and he applied new gloves.<br><br>At 11:24 A.M., Nurse #3 used scissors that were not cleaned prior to use and he cut directly through a xeroform (sterile dressing) package, potentially contaminating the dressing supply.<br><br>At 11:25 A.M., Nurse #3 applied the xeroform directly to the wound bed with his gloved hands and he covered the wound with a dressing. Nurse #3 removed his gloves; he did not perform hand hygiene.<br><br>At 11:27 A.M., Nurse #3 applied new gloves and removed the dressing from Resident #86's posterior right thigh wound. There was a large amount of drainage to this wound.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At 11:28 A.M., Nurse #3 removed his gloves, he did not perform hand hygiene, and he applied new gloves.<br><br>At 11:29 A.M., Nurse #3 cleansed the wound, patted the wound dry, and he removed the gloves without performing hand hygiene.<br><br>At 11:30 A.M., Nurse #3 applied new gloves, he touched xeroform directly with his hands and applied the xeroform directly to the posterior right thigh wound and covered the wound with a dressing.<br><br>At 11:31 A.M., Nurse #3 removed his gloves, he did not perform hand hygiene, and he applied new gloves.<br><br>At 11:34 A.M., Nurse #3 rolled Resident #86 over and applied barrier cream to his/her buttocks. Nurse #3 removed his gloves and he did not perform hand hygiene, and he gathered the supplies from the bedside table and placed them directly into the trash.<br><br>During an interview on 1/29/25 at 4:04 P.M., Nurse #3 said he should have performed hand hygiene after glove removal, but he did not.<br><br>During an interview on 1/29/25 at 3:13 P.M., the Director of Nursing said nursing should perform hand hygiene between changing gloves and complete dressing changes according to facility policy.<br><br>48671<br><br>2. Review of the CDC (Centers for Disease Control and Prevention) Recommendations for Disinfection and Sterilization in Healthcare Facilities indicated the following:<br><br>4. Selection and Use of Low-Level Disinfectants for Noncritical Patient-Care Devices<br><br>4.a. Process noncritical patient-care devices using a disinfectant and the concentration of germicide listed in Table 1.<br><br>4.b. Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA-registered hospital disinfectant using the label's safety precautions and use directions.<br><br>4.c. Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly).<br><br>Review of the Micro-Kill Two manufacturer's instructions indicated: Contact time: Allow surface to remain visibly wet two minutes, let air dry.<br><br>a. On 1/29/25 at 7:46 A.M., the surveyor made the following observations: Nurse #3 exited a resident room carrying a glucometer with his bare hand and placed the glucometer directly on top of the medication cart, potentially contaminating the top of the medication cart. Nurse #3 then cleaned the top of the glucometer with a Micro-kill two (germicidal wipe) and placed the glucometer directly back on top of the medication cart. The nurse did not allow the glucometer to air dry. Nurse #3 closed the lid to the germicidal wipe, picked up the glucometer with his bare hand, and placed the glucometer into the medication cart, potentially contaminating the contents of the drawer.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/29/25 at 7:48 A.M. Nurse #3 said he thinks the glucometer needs to be cleaned with germicidal wipes and left to dry for one minute.<br><br>b. On 1/30/25 at 7:26 A.M., the surveyor made the following observations: Nurse #13 exited a resident room carrying a glucometer with his gloved hand and placed the glucometer directly on top of the medication cart, potentially contaminating the top of the medication cart. Nurse #13 then cleaned the glucometer with a Micro-kill two (germicidal wipe) and with his gloved hand, placed the glucometer into the medication cart, potentially contaminating the contents of the drawer. The nurse did not allow the glucometer to air dry.<br><br>During an interview on 1/30/25 at 7:29 A.M., Unit Manager #1 said the glucometer needs to be cleaned before and after use for 10 seconds and said the directions on the container should be followed.<br><br>During an interview on 1/30/25 at 11:49 A.M., Director of Nursing said the glucometer must be cleaned with alcohol for ten seconds before and after use and said if staff use a germicidal wipe, she expects staff to read the instructions first. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Implement a program that monitors antibiotic use.<br><br>48671<br><br>Based on record review and interview, the facility failed to implement an antibiotic stewardship program to promote and monitor the appropriate use of antibiotics.<br><br>Findings include:<br><br>Review of the Centers for Disease Control and Prevention (CDC) guidance titled The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following:<br><br>-The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance.<br><br>-Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.<br><br>-The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use.<br><br>-Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting.<br><br>Review of the facility policy titled Antibiotic Stewardship, dated as revised December 2016, indicated antibiotic usage and outcome data will be collected and documented using a facility approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. As part of the facility antibiotic stewardship program. All clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee. The Infection Preventionist or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. All resident antibiotic regimens will be documented on the facility approved antibiotic surveillance tracking form.<br><br>Review of the facility's antibiotic stewardship program failed to indicate a monitoring system was in place and failed to indicate that antibiotics prescribed to the residents in the facility had an antibiotic time out to reassess the need for the antibiotic therapy.<br><br>During an interview on 1/29/25 at 9:30 A.M., Unit Manager #1 said she is not aware of the antibiotic stewardship program and said the Director of Nurses manages infections with the Infection Preventionist. Unit Manager #1 said she does not keep line listings or track of antibiotics.<br><br>During an interview on 1/30/25 at 1:48 P.M., the Infection Preventionist (IP) said the facility has not conducted any antibiotic stewardship meetings and said she has not received any pharmacy reports regarding the use of antibiotic therapy because they have a new pharmacy. The IP said staff tell her when a resident is prescribed an antibiotic, but they do not contact the provider or review the need for antibiotic therapy. The IP said each month she reports infection to the Director of Nurses and Administrator but not information related to antibiotic stewardship.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 1/31/25 at 9:33 A.M., the Director of Nurses said there have been no meetings regarding the antibiotic stewardship program since she started in the facility in November 2024 and said the facility is lacking management right now. The DON said she is not aware of the antibiotic usage or infection control rates in the facility but would expect the Infection Preventionist to report and follow the antibiotic stewardship program.<br><br>During an interview on 1/31/25 at 12:38 P.M., the Administrator said an antibiotic stewardship program is needed to monitor the usage and need for therapy and said staff should be aware of what the program is and how to initiate the program when a resident starts an antibiotic. The Administrator said he expects the Infection Preventionist and Director of Nurses to be implementing the Antibiotic program and tracking the usage monthly with the pharmacy and reporting data monthly. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671<br><br>Based on record review, and interview, the facility failed to offer COVID-19 vaccines, in accordance with national standards of practice to 8 of 8 resident records reviewed, out of a total sample of 26 residents.<br><br>Specifically, the facility failed to offer COVID-19 vaccines to the eligible residents when:<br><br>-The Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommended an additional dose of updated (2024-2025 formula) of COVID-19 vaccine be administered for older adults, aged [AGE] years and older.<br><br>-The COVID-19 vaccine was not medically contraindicated and had not already been immunized with the recommended additional COVID-19 vaccine dose.<br><br>Findings include:<br><br>Review of the facility's policy titled Vaccination of Residents, dated as revised October 2019, indicated:<br><br>-All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated.<br><br>-Prior to receiving vaccinations the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations<br><br>-All new residents shall be assessed for current vaccination status upon admission.<br><br>During an interview on 1/30/25 at 1:50 P.M., the Infection Preventionist (IP) said the facility has not given the COVID-19 vaccine since 2023 when the new company took over and said Residents have consented to the vaccine in 2024, but the facility has not placed an order with the pharmacy. The IP said that she was aware of the CDC recommendation from 4/25/24 for individuals [AGE] years of age and older to receive a second dose of the updated 2023/2024 COVID-19 vaccine. The IP said she notified corporate on 1/27/25 that she had eligible residents to receive the COVID-19 vaccine and inquired about ordering the vaccine. The IP said she does not have access to the Massachusetts Immunization Information System Report (MIIS-system used to track vaccinations) and is unable to check or confirm vaccination status. The IP said she does not have an accurate count of vaccination status within the facility because she is unable to confirm vaccination data.<br><br>Review of 8 out of 8 Resident medical records had documented consent on file to receive the COVID-19 vaccine.<br><br>-No evidence that the COVID-19 vaccine was medically contraindicated.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -No evidence the Residents had been offered an updated dose of the 2024/2025 COVID-19 vaccine.<br><br>-On resident failed to have any documented COVID-19 vaccines.<br><br>During an interview on 1/31/25 at 9:37 A.M., the Director of Nurses said she was not aware that the COVID-19 vaccine was not given and said Residents who consent to the vaccine should be offered the vaccine and said the facility should have place and order with the pharmacy and documented the status of the vaccines for residents and staff. The DON said she does not have access to the Massachusetts Immunization Information System Report (MIIS-system used to track vaccinations) and said she expects the IP to know the status of residents and staff for her required reporting.<br><br>During an interview on 1/31/25 at 12:40 P.M., the Administrator said he expects the Infection Preventionists and Director of Nurses to be monitoring and reporting accurate vaccination status for residents and employees and said he does not have access to the Massachusetts Immunization Information System Report (MIIS-system used to track vaccinations) but can call a sister facility to check a status if necessary. The Administrator said staff and residents should be informed of the latest guidance and offered the vaccine. The Administrator said a new pharmacy was implemented over a year ago and said the COVID-19 vaccine should have been ordered and administered. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671<br><br>Based on observation and interviews, the facility failed to ensure it provided a means for residents to communicate to staff on two out of three nursing units.<br><br>Findings included:<br><br>On 1/30/25 at approximately 11:27 A.M., the surveyor observed that the call bell system was not functioning on the Solana Unit. The surveyor sampled the call bell system from several bedrooms and noted that the call bell did not sound, either in the hallway of the nursing station, and the call bell board at the nursing station continued to beep and displayed a list of room numbers but did not identify which bedroom requested help. The surveyor observed that in some of the sampled bedrooms the call light button illuminated the light outside the bedroom doorway. The surveyor observed that the call lights in the hallway located on each wing of the Solana unit, and the end of the hallway, were not visible from the nursing station.<br><br>During an interview on 1/30/25 at 11:34 P.M., Nurse #1 said the call lights have been an ongoing issue on the Solana and [NAME] Units because the panel behind the nurse's station will continuously beep and show an error message. Nurse #1 said the panel is not reliable because the lights, bells and panel are not always accurate. Nurse #1 said she has notified management and said staff use an online reporting system called TELS (system used to track environmental issues), to report environmental issues like broken call bells to the maintenance department.<br><br>On 1/30/25 at approximately 2:50 P.M., the surveyor along with the Director of Housekeeping tested the call bell system function in each of the following rooms by pressing the call bell button, observing the call light outside of the room, and checking the call bell panel at the nurse's station:<br><br>room [ROOM NUMBER]-A Call bell system not working. No hand bell in the room.<br><br>room [ROOM NUMBER]-A Call bell system not working. No hand bell in the room.<br><br>room [ROOM NUMBER]-A Call bell system not working. No hand bell in the room.<br><br>room [ROOM NUMBER]-B Call bell system not working. No hand bell in the room. The call bell cord was located behind the Residents bed and beyond the reach of the Resident.<br><br>room [ROOM NUMBER]-A Call bell system not working. No hand bell in the room.<br><br>room [ROOM NUMBER]-B Call bell system not working. No hand bell in the room.<br><br>room [ROOM NUMBER]-A Call bell system not working. No hand bell in the room.<br><br>room [ROOM NUMBER]-B Call bell system not working. No hand bell in the room.<br><br>room [ROOM NUMBER]-C Call bell system not working. No hand bell in the room<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the call bell panel located behind the nurse's station displayed the following data:<br><br>203W: TROUBLE<br><br>205W: TROUBLE<br><br>213W: TROUBLE<br><br>215W: TROUBLE<br><br>The call bell panel was beeping throughout the observations. The surveyor and the Director of Housekeeping observed rooms 202, and 208 had call lights on in the hallways that did not display on the call bell panel.<br><br>During an interview on 1/30/25 at 3:10 P.M., the Director of Housekeeping said when he presses the call bell the light outside of the Residents room should flash and the alarm should sound at the nurse's station indicating a call light is on. The Director of Housekeeping said the call bells are not working and not indicating that a resident needs help.<br><br>On 1/31/25 at approximately 7:34 A.M., the surveyor observed that the call bell system was not functioning on the [NAME] Unit. The surveyor sampled the call bell system from several bedrooms and noted that the call bell did not sound, either in the hallway of the nursing station, and the call bell board at the nursing station did not illuminate to identify which bedroom requested help. The surveyor observed that in some of the sampled bedrooms the call light button illuminated the light outside the bedroom doorway. The surveyor observed that the call lights in the hallway located on each wing of the [NAME] unit, and the end of the hallway, were not visible from the nursing station.<br><br>During an interview on 1/31/25 at 8:50 A.M., Certified Nursing Assistant (CNA) #8 said if residents need help the light might not go on outside the door or beep at the nurses station. CNA #8 said staff would notify maintenance if there are issues and said she would tell them verbally.<br><br>On 1/31/25 at approximately 9:25 A.M., the surveyor along with the Director of Housekeeping tested the call bell system function in each of the following rooms by pressing the call bell button, observing the call light outside of the room, and checking the call bell panel at the nurses station:<br><br>-room [ROOM NUMBER]E Call bell system not working. No hand bell in the room. The Director of Maintenance removed the call bell box from the wall and showed the surveyor wires that were not attached inside the wall. The Director of Maintenance said the cords need to be swapped out and said the call bell panel will say trouble when call bells do not work.<br><br>Review of the call bell panel located behind the nurse's station displayed the following data:<br><br>room [ROOM NUMBER]W TROUBLE<br><br>room [ROOM NUMBER]W TROUBLE<br><br>room [ROOM NUMBER]W TROUBLE<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | room [ROOM NUMBER]E TROUBLE<br><br>room [ROOM NUMBER]E TROUBLE<br><br>The call bell panel was beeping throughout the observations. The surveyor observed call lights on in the hallways that did not display on the call bell panel.<br><br>During an interview on 1/31/25 at 9:31 P.M., the Director of Maintenance said the facility had issues with the call bell system and said the facility has been replacing the broken units one by one and said he notified corporate that they need more supplies to change out the system. The Director of Maintenance said staff must enter maintenance issues in the online TELS system to be fixed and said the system does not indicate when a call light is pressed or if a light is on and not sounding at the display panel.<br><br>Review of the open TELS Work Orders report dated 1/31/25, failed to indicate any notification of call bells not working.<br><br>During an interview on 1/31/25 at 9:55 A.M., the Director of Nurses (DON) said if a call bell is not working, she would expect the staff to notify maintenance right away and give the resident a new room with a functioning call bell or a hand bell to ring for help. The DON said she was not aware of any call bell issues in the facility.<br><br>During an interview on 1/23/25 at 12:51 P.M., the Administrator said he was aware of the technical issues with the call bell system when he started working in the facility and said the purchasing department sends units to the facility in regular intervals to replace broken call bells. The Administrator said he was not aware of how many units were not working in the facility and said Residents must have a way to call for help. The Administrator said the facility should have put a system in place to track the broken call bells and address the concerns during their QAPI (Quality Assurance Performance Improvement) program. |

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| F 0949<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide behavior health training consistent with the requirements and as determined by a facility assessment.<br><br>36797<br><br>Based on employee training records reviewed and interview the facility failed to implement, and maintain an effective training program for staff, which includes, at a minimum, training on behavioral health care and services (consistent with S483.40) that is appropriate and effective, as determined by staff need and the facility assessment for 24 out of 24 direct care staff training records reviewed.<br><br>Findings include:<br><br>Review of the document titled Facility Assessment, dated 8/1/2024, indicated that on a daily average 40 plus residents with behavioral symptoms reside in the facility. Further review indicated that the facility provides behavioral health services for residents with mental health and behavioral health needs that require intervention. Further review indicated that all personnel are required to be trained in behavioral health including but not limited a review of the behavioral health program's written policies, review of competencies and skills necessary to provide person-centered care and services that promote mental and psychosocial well-being.<br><br>Review of licensed staff training records, working in the facility on 1/28/25, 1/29/25 and 1/30/25, failed to indicate behavioral/mental health training was completed in 24 out of 24 employee training records reviewed.<br><br>During an interview on 1/31/25 at 8:32 A.M., the Director of Nursing (DON) said that the facility had been without a Staff Development Coordinator (SDC) since September 2024. The DON said that it was the SDC that provided the staff with training on behavioral health. The DON said that without a SDC the training did not get completed.<br><br>During an interview on 1/31/25 at 12:41 P.M., the Administrator said that all of the training records for the licensed staff working on 1/28/25, 1/29/25 and 1/30/25, were provided to the surveyors. The Administrator then said if the behavioral training is not in the employee training records provided to the surveyors then the training did not occur. |