STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225401	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview House Skld Nrsg and Residential Care Fac	87 Shattuck Street Haverhill, MA 01830

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to ensure staff alerted the physician when one Resident (#18) had a change in condition, out of a total of eight sampled residents. Findings include: Resident #18 was admitted to the facility in February 2023 with diagnoses including dementia and hypertension. Review of Resident #18's Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she is severely cognitively impaired as evidenced by a score of 7 out of a possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated Resident #18 requires assistance with bathing, dressing and eating. Review of Resident #18's active physicians orders indicated: Eliquis (a blood thinner) 2.5 MG (milligrams), give 1 tablet by mouth twice daily, initiated 2/2/23. Aspirin (an over the counter medication which is used to reduce pain, fever, and/or inflammation, and as an antithrombotic), 81 MG give 1 tablet by mouth daily, initiated 2/2/23. Review of Resident #18's clinical record included discharge paperwork from the hospital dated 7/25/24: Pt (patient) via EMS with c/o (complaints of) hematuria (blood in the urine). Per EMS staff noted small amount of blood in urine last night (7/24/24) but when providing incontinence care around lunch time, noted large amount of [NAME] (visible) hematuria. Pt on Liquids. No hx (history) recent catheterizations. CT (computerized tomography) scan is consistent with cystitis (a bladder infection) as well as stones in the bladder. Review of Resident #18's nurse progress notes failed to indicate any entries for 7/24/24. Review of the nursing communication log indicated the following entries for the Resident: 7/24/24: 3:00 P.M. - 11:00 P.M. shift: Resident #18: dark blood on depend (incontinence brief). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/24/24: 11:00 P.M. - 7:00 A.M. shift: Resident #18: blood in urine. During an interview on 8/6/24 at 11:46 A.M., Nurse #1 said she worked the 3:00 P.M. - 11:00 P.M. shift on 7/24/24. Nurse #1 said that towards the end of her shift, a Certified Nursing Assistant (CNA) alerted her that Resident #18 had some blood in his/her brief. Nurse #1 said she met with Nurse #2 and they decided to keep an eye on the resident overnight as there was not a lot of blood on the brief. Nurse #1 said she did not contact Resident #18's physician. During an interview on 8/6/24 at 12:23 P.M., Nurse #2 said she worked the 11:00 P.M. - 7:00 A.M. shift on 7/24/24. Nurse #2 said that she and Nurse #1 discussed Resident #18's hematuria and decided to monitor Resident #18 throughout the shift as there was not a lot of blood in the brief as Nurse #2 said that Resident #18 had a history of hematuria and it is a common symptom of a urinary tract infection. Nurse #2 said she was aware that Resident #18 was not being treated at that time for a bladder infection. Nurse #2 said she did not notify the physician. During an interview on 8/6/24 at approximately 1:15 P.M., Nurse #3 said she worked the 7:00 A.M. - 3:00 P.M. on 7/25/24. Nurse #3 said she did not recall if Nurse #2 informed her at report that Resident #18 had hematuria at night and thought another nurse had obtained the order and sent Resident #18 to the hospital. During an interview on 8/7/24 at 9:00 A.M., the Director of Nursing said that Nurse #1 and Nurse #2 should have documented in a nurse progress note and contact the physician after Resident #18 had hematuria on 7/24/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to identify and assess the use of a geri-chair (a high back chair on wheels with the ability to recline) as a restraint for one Resident (#8) out of a total of eight sampled Residents. Findings include: Review of the facility's Use of Restraints policy, dated July 2024, failed to indicate the frequency of assessment for restraints, the frequency for releasing the restraint, or the need for consent and a physician's order for the restraint. Resident #8 was admitted to the facility in June 2024 with diagnoses including stroke, aphasia, and bipolar disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #8 is cognitively intact as evidenced by a score of 14 out possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated that Resident #8 requires assistance with bathing, dressing and toileting. The MDS did not indicate any restraints for Resident #8. Review of Resident #8's Monthly Nursing Summaries indicated: June 2024: Mobility; Ambulation; walks with assist of one short distance. Wheelchair: Wheelchair with assist longer distance. Behavior problems: Poor safety awareness. Tries to get up and ambulate several times a day. July 2024: Mobility: Walks with assist of one short distance. Wheelchair with assist longer distance. Also uses geri-chair. Behavior problems: Attempts to get out of chair. On 8/6/24 at 8:09 A.M. the surveyor observed Resident #8 seated in a geri-chair in the reclined position in the dining area. On 8/6/24 at approximately 10:30 A.M., and 1:02 P.M., the surveyor observed Resident #8 in his/her room seated in a geri-chair in the reclined position. During an interview on 8/6/24 at 1:38 P.M., Resident #8 was in his/her room seated in the geri-chair in the reclined position. When asked if he/she likes the geri-chair, Resident #8 said, No. I hate it. I want to use my own feet. Resident #8 said he/she could not get out of the chair. There was no walker or standard wheelchair observed in Resident #8's room. Review of Resident #18's active physicians orders indicated: May use geri-chair, PRN (as needed). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's behavioral care plan indicated: Problem start date: 6/24/24: Resident resists care and has poor safety awareness. He/she frequently attempts to transfer and ambulate without staff assistance. He/she is frequently reminded to ask for staff assistance to prevent falls as he/she has had a history of falls. Interventions: Assess resident's resistance to care. Re-educate the purpose and advantages of treatment for the resident. Maintain a calm environment and approach to the resident. Area will be barrier and clutter free to reduce the potential for falls. Additional review of Resident #18's care plans failed to indicate the use of the geri-chair. Review of Resident #28's rehab notes failed to indicate staff assessed for the use of a geri-chair. Review of the Adaptive Equipment/Restraint assessment dated [DATE] did not indicate the geri-chair was assessed, only for the use of a personal alarm. Review of Resident #18's Nurse progress notes indicated: 6/5/24: PA (personal alarm) alerted staff resident was getting out of bed. 6/12/24: Alarm sounded pt (patient) observed sitting on floor next to bed. 6/12/24: Resident tried to get out from the bed x 2. Removed PA. 6/13/24: Continues with poor safety awareness. 6/14/24: Resident ambulated X 1 without staff. 6/15/24: Continues with poor safety awareness and removing alarm. 6/16/24 This evening around 8:45 P.M., heard alarm sounding staff rushed to room, saw resident laying on floor. 6/17/24: Pt anxious/restless trying to get out of bed. 6/18/24: Pt tried to get up twice alone. Redirected. 6/27/24: Resident up in WC (wheelchair) in DR (dining room) PA in place. Resident observed standing up from WC himself/herself. This writer spoke with resident regarding safety. Resident just started laughing standing up from WC x 3. Redirected with little effect. 7/2/24: New Order, may use geri-chair PRN. 7/8/24: 7-3 shift: Attempting to get up despite education. 7/8/24 3-11-7 shift: Pt has continued to try and get up from geri-chair and bed. Did not listen to staff. Unaware of safety. Kept sliding himself/herself down the chair. Kept climbing out of bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/12/24: Increased agitation, increased anxiety. Resident cont (sic) to try to climb out of geri chair. 7/13/24: Cont (sic) with poor safety awareness. Cont (sic) to try to climb out of geri chair. 7/14/24: Resident cont (sic) with poor safety awareness. Cont (sic) to climb out of geri-chair. 7/15/24: Laughing at staff trying to get out of bed by himself/herself. 7/15/24: 7-3 shift: Up in chair today. Occas (sic) trying to push and climb out of chair. In bed in the afternoon. On 8/7/24 at 7:30 A.M. the surveyor observed Resident #8 seated in his/her geri-chair in the reclined position in the dining room. During an interview on 8/7/24 at 7:38 A.M., Certified Nursing Assistant (CNA) #1 said that Resident #8 used to have a standard wheelchair and would push himself/herself up to stand and try to walk. CNA #1 said that Resident #8 is a fall risk and is now in the geri-chair to prevent him/her from falling. CNA #1 said Resident #8 will still sometimes try to get out of the chair, but because his/her legs are elevated he/she can't really lift himself/herself up. During an interview on 8/7/24 at 8:40 A.M., Nurse #3 said that Resident #8 used to have a standard wheelchair but is now in a geri-chair for comfort. Nurse #3 said that Resident #8 would sometimes try to stand up and walk when he/she was in the standard wheelchair. Nurse #3 said that Resident #8 can stand up from the geri-chair when it is not in the reclined position. On 8/7/24 at 8:46 A.M. and 10:49 A.M., the surveyor observed Resident #8 in his/her room seated in his/her geri-chair in the reclined position. During an interview on 8/7/24 at 9:12 A.M., the Director of Nursing (DON) said that Resident #8 was not safe in his/her standard wheelchair and was switched to the geri-chair. The DON said that Resident #8 had not told her that he/she does not like his/her geri-chair. The DON said that she thought an assessment for the use of the geri-chair had been completed. The Assistant Director of Nursing (ADON) was present and said she thinks that Resident #8 wants to get back to walking.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, interview and record review, the facility failed to ensure that the correct diet texture was implemented for one Resident (#10) out of a total sample of eight residents. Specifically, the facility failed to ensure that Resident #10 received a ground textured diet as ordered by the physician. Findings include: Resident #10 was admitted to the facility in April 2022 with diagnoses including unspecified dementia, unspecified psychosis and Sjogren syndrome (An immune system illness that mainly causes dry eyes and dry mouth). Review of Resident #10's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status score of 8 out of a possible 15 indicating moderate cognitive impairment. Further review of the MDS indicated that the Resident is independent with eating and does not require staff supervision. The surveyor made the following observations: - On 8/6/24 at 8:06 A.M., Resident #10 received his/her breakfast tray while laying in his/her bed. The Certified Nursing Assistant (CNA) set up the tray and left the room. On Resident #10's breakfast tray was a meal card with a sticker that stated, Diabetic Ground. On the tray was a whole, uncut banana, and a bowl of cereal containing Cheerios and a cup of milk. The surveyor observed Resident #10 attempting to eat the banana but was having difficulty putting it in his/her mouth. The surveyor observed Resident #10 eating the dry Cheerios cereal with a spoon. The CNA did not pour the cup of milk into the cereal. - On 8/7/24 at 8:10 A.M., Resident #10 received his/her breakfast tray while laying in his/her bed. The Certified Nursing Assistant (CNA) set up the tray and left the room. On Resident #10's breakfast tray was a meal card with a sticker that stated, Diabetic Ground. On the meal tray were two pieces of uncut bread and along the edges and on the top of them were black marks indicating the bread had been toasted. The breakfast tray also contained a bowl containing Cheerios cereal and a cup of milk. The surveyor observed Resident #10 eating the toast and dry Cheerios with a spoon. The CNA did not pour the cup of milk into the cereal. Review of a document that hung at the nursing station indicated the diets that each resident is currently ordered. Review of this document indicated that Resident #10 is currently on a ground diet. Review of Resident #10's physician's orders dated August 1, 2024 - August 31, 2024, indicated the following order with a start date of 4/11/22: Diet - HCC, Ground. Review of Resident #10's document titled Resident's Census Sheet indicated that the Resident's current diet is a ground diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's nutrition care plan revised and edited 6/15/24 indicated that the Resident is currently on a ground diet. Review of Resident #10's most recent Nutrition assessment dated [DATE] indicated that the Resident's current diet order is for a ground diet. Review of Resident #10's Quarterly Nutrition Review documents dated 7/13/23, 1/11/24 and 7/10/24 indicated that the Resident's current diet order is for a ground diet. Review of the Facility's Diet Manual Binder located at the nursing station indicated the following under the Ground Texture section: - Breads and Cereals: Foods Allowed - plain soft bread, dry cereals that soften in milk. Foods to Avoid - All other breads with dry, hard crusts. - Fruits and Fruit Juices: Foods Allowed - Well mashed bananas. Review of the Facility's Diet Manual binder located in the kitchen indicated the following under the two most liberalized, textured diets: - Under the Level 6: Soft & Bite-Sized Food for Adults section: - Fruit: soft and chopped to pieces no bigger than 1.5 cm (centimeters) x 1.5 cm pieces - Examples of food to avoid: cereal with milk, dry bread, dry cereal - Under the Level 5: Minced and Moist for Adults section: - Fruit: serve finely mashed - Foods to avoid: cereal with milk, dry bread, dry cereal During a telephone interview on 8/7/24 at 9:55 A.M., the Registered Dietitian (RD) said Resident #10 is currently ordered a ground textured diet. The RD continued to say residents on a ground diet should not have toast and should only have dry cereal if it is mixed in milk and should only have bananas if cut up. During an interview on 8/7/24 at 9:37 A.M., the Food Service Director (FSD) said the kitchen knows each resident's diet because their meal tickets are written by the RD. The FSD said Resident #10 is on a ground diet and should only have dry cereal if it is mixed in with milk and should only have a banana if it is cut up. The FSD said the CNAs should mix the cereal in milk and cut up the banana. The surveyor and the FSD reviewed the diet manual and the FSD said Resident #10 should not have toast. During an interview on 8/7/24 at 10:05 A.M., Nurse #3 and the Assistant Director of Nursing (ADON) said the CNAs should have poured milk into Resident #10's cereal and cut up his/her banana. Nurse #3 and the ADON said Resident #10 should not receive toast while on a ground diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/24 at 11:01 A.M., the Director of Nursing said staff should have cut up Resident #10's banana and poured milk in his/her cereal. The DON continued to say that Resident #10 should not receive toast while on a ground diet.