STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225402	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Rehabilitation Nursing Center	500 Wilbur Avenue Somerset, MA 02725

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 43935 Based on documentation review and interview, the facility failed to act promptly and demonstrate their response to concerns brought forth by the Resident Council. Findings include: Review of the facility's policy titled Resident Council Meetings, undated, indicated but was not limited to the following: - the facility shall act upon concerns of the council, make attempts to accommodate recommendations and communicate its decision to the council. Review of the Resident Council Minutes from November 2023 to March 2024 indicated but were not limited to the following: November 28, 2023: -Several residents had concerns with not getting selected menu items as ordered for their meals -Voiced concerns of cold food and not wanting to ask nursing staff to reheat it, because they are too busy The Activity Director (AD) informed the residents he would forward their concerns to the Food Service Director (FSD) December 27, 2023 -Voiced concerns about cold food -Voiced concerns about not receiving menu items as preferred and ordered in their selected menus The residents requested the FSD attend the next meeting and the AD informed them he would make the FSD aware of their request and concerns. January 23, 2024: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Voiced concerns about not receiving menu items as ordered -Voiced concerns about cold food The FSD was present for the meeting and informed the residents that the nursing staff can always heat up the food on the units. February 28, 2024: -Many residents voiced concerns about receiving cold food and not getting what they ordered The FSD was present at the meeting and reminded the residents to ask the nursing staff to reheat the food. March 26, 2024: -Residents voiced concerns about receiving cold meals The Dietitian was present at the meeting and the meeting minutes indicated that the residents' concern would be investigated. From November 2023 to March 2024 there was no documentation or evidence that a resolution to the continued concerns of cold food and not receiving requested select menu items had been resolved. During an interview on 4/8/24 at 3:39 P.M., the FSD said the diet tech or concierge ensure the residents' select meal menus are completed weekly. He said the expectation is that residents are receiving the preferred meal items that they are requesting on their weekly menus. He said he has attended Resident Council and that the food issues are usually about cold food or not getting their preferred meal items. He said he tells them in the meeting to have nursing heat up their food if it is cold. He said he does not complete any audits or investigations on the issues and he has not completed a documented response to Resident Council concerns. During an interview on 4/8/24 at 4:18 P.M., the Dietitian said she attended the March Resident Council Meeting and was informed of the concerns of cold food. She said she was not aware that she was supposed to investigate the issue and did not complete an investigation, but did inform the FSD of the residents' concerns. During an interview on 4/9/24 at 4:08 P.M., the AD said that there have been similar food related concerns coming up month to month at Resident Council. He said there is no process in which they provide a response at the next Resident Council Meeting and no documentation of a response being supplied to the residents for their ongoing food concerns. He said the concerns about the residents receiving cold food and not receiving their preferred selected menu items are unresolved at this time. During an interview on 4/10/24 at 9:04 A.M., Resident #36, who attends Resident Council each month, said the concerns brought forth in the meeting from month to month about receiving cold food and not receiving their preferred selected menu items are ongoing and remain unresolved at this time.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 36542 Based on interviews, review of grievance documentation, and policy review, the facility failed to formulate grievances and failed to ensure the prompt resolution of grievances for the following: 1. Concerns brought forward by Resident #121 and their Family Member regarding long call light wait times and response from staff; and 2. Concerns brought forward by Resident #86 and their Family Member regarding missing items. Findings include: Review of the facility's policy titled Resident and Family Grievances, undated, indicated the following: -Prompt efforts to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance. -A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (long term care) stay. -Grievances may be voiced in the following forums: verbal complaint to a staff member or Grievance Official. -A staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family to complete the form. -The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. 1. Resident #121 was admitted to the facility in November 2023 for short-term rehabilitation. During an interview on 4/9/24 at 3:04 P.M., the Family Member of Resident #121 said that at the care plan meeting the Resident had voiced concerns about the call light wait time and the Unit Manager had said she would take care of it. She said the concerns with long call light wait times continued after the care plan meeting. The Family Member said when Resident #121 went out to the hospital in January 2024 she had come in to pick up the Resident's belongings and voiced concerns to the Unit Manager about the call light wait times and staff response to Resident #121. She said the Unit Manager asked the Family Member to meet with the Director of Nurses to discuss concerns. She said the Director of Nurses met with her and made her feel as though she did not care about my complaints and was not going to do anything about it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated Resident #121 had a care plan meeting on 12/5/23 with their Family Member in attendance. The Social Service progress note did not indicate any concerns voiced by the Resident or the family during the care plan meeting. Review of the Grievance Binder failed to include any Grievance Forms for the months of November 2023 and December 2023. Further review indicated there was one Grievance Form for January 2024, which was not for Resident #121. During an interview on 4/9/24 at 2:05 P.M., Unit Manager #3 said she could recall that there were some concerns voiced regarding call light wait times during Resident #121's stay. She said she could not recall any additional concerns voiced by the Resident or the family. She said she recalled the Resident having concerns that were voiced at the care plan meeting but had not initiated a Grievance form because she had just addressed the problem right away with the staff. She said if families or residents have concerns, they can fill out the Grievance Forms. She said she recalled the Family Member of Resident #121 having concerns when the Resident was hospitalized and had referred the Family Member to the Director of Nurses. During an interview on 4/9/24 at 2:47 P.M., Social Worker #2 said she did not recall getting any complaints from the Resident or the Family Member during the care plan meeting and had not formulated a Grievance Form for the Resident or Family Member. During an interview on 4/10/24 at 9:00 A.M., the Director of Nurses said if residents or families have concerns, such as call lights, the Unit Managers will address the issues immediately and do not always initiate a Grievance Form. She said she was unable to recall any concerns from Resident #121 or their Family Member and could not recall speaking with the Family Member following the Resident's hospitalization and would speak with Unit Manager #3 to discuss the concerns the family brought forward. During an interview on 4/10/24 at 11:00 A.M., the Director of Nurses said she could recall Resident #121 after discussing it with Unit Manager #3. The Director of Nurses said Unit Manager #3 informed her the Family Member had concerns and had asked the Director of Nurses to meet with the family when the Resident was hospitalized in January 2024. She said she was unable to recall meeting with the Family Member and what their concerns were and she had not initiated a grievance on the concerns voiced by the family. 2. Resident #86 was admitted to the facility in October 2021. Review of the Minimum Data Set (MDS) assessment, dated 3/13/24, indicated Resident #86 scored a 12 out of 15 on the Brief Interview for Mental Status which indicated the Resident had moderate cognitive impairment. During an interview on 4/7/24 at 11:15 A.M., Resident #86 said he/she has had items go missing. During an interview on 4/7/24 at 11:15 A.M., the Family Member of Resident #86 said there had been a lot of things that had gone missing, including money. He said they had talked about this at the care plan meeting the previous week and the staff said they would follow up. He said he hoped things did not continue to go missing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Grievance Binder failed to include any Grievance Forms for Resident #86. Review of the medical record indicated Resident #86 had a care plan meeting on 3/28/24 with the family. The Social Service progress note did not indicate any concerns voiced by the Resident or the family during the care plan meeting regarding missing items. During an interview on 4/8/24 at 2:06 P.M., Social Worker #1 said Resident #86 and their Family Member had reported missing money at the care plan meeting and mentioned that it had happened once before but had not been specific about what the prior missing item was. She said the process was for the Unit Manager to complete a Missing Item Report, which would be kept in the nursing office. During an interview on 4/8/24 at 2:10 P.M., Unit Manager #2 said the Family Member of Resident #86 had voiced concerns regarding $3.00 that was missing. She said she had not completed a Missing Item Report because it was only $3.00. She said the process for missing items was for the staff member to complete a Missing Item Form, which was kept separate from the Grievance Forms. Review of a blank Missing Item Report indicated: This form should be used to document property loss reported by a resident or their representative and to record follow-up action taken and outcome. This report must be completed immediately and submitted to on-duty supervisor. During an interview on 4/10/24 at 9:08 A.M., the Director of Nurses said Unit Manager #2 should have completed the Missing Item Report so that the facility could follow up with the Resident and family on the missing items. She said there was a process in place for missing items and the process was not followed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43935 Based on record review, interview, observation, and policy review, the facility failed for four Residents (#78, #29, #74, and #1), out of 26 sampled residents, to develop and implement individualized resident-centered care plans to meet the residents' needs. Specifically, the facility failed: 1. For Resident #78, to ensure a care plan was developed for the Resident's treatment of insomnia using an as needed (PRN) psychotropic medication; 2. For Resident #29, to implement fall care plan interventions, specifically to ensure the call light was wrapped with bright colored tape for better visibility and to ensure the anti-slip material to prevent the Resident from sliding off the wheelchair was in place; 3. For Resident #74, to implement fall care plan interventions, specifically to ensure the anti-slip material to prevent the Resident from sliding off the chair was in place; and 4. For Resident #1, to develop and implement a care plan for the use of a compression sleeve and glove to treat their lymphedema (tissue swelling caused by an accumulation of fluid that's usually drained through the body's lymphatic system). Findings include: Review of the facility's policy titled Comprehensive Care Plans, undated, indicated but was not limited to the following: - comprehensive care plans will be developed within seven days after the completion of the comprehensive minimum data set (MDS) - factors identified by the interdisciplinary team (IDT) or in accordance with the resident's preferences will be addressed in the care plan - the comprehensive care plan will describe at a minimum: services to be furnished to maintain or attain a resident's highest practicable physical, mental and psychosocial well-being, goals desired outcomes and preferences, resident specific interventions that reflect a resident's needs and preferences, and will include measurable objectives - qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out interventions 1. Resident #78 was admitted to the facility in November of 2023 with the following diagnoses: mood disorder, depression, delusional disorder, and hallucinations. Review of the most recent Minimum Data Set (MDS) assessment for Resident #78, dated 2/15/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the Resident was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current Physician's Orders for Resident #78, dated 4/8/24, indicated but were not limited to the following: - Trazodone (an antidepressant) 50 milligram (mg) tablet, give 25 mg by mouth PRN for sleep (3/21/24) - Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift for monitoring Review of the discontinued orders for Resident #78 indicated the Resident had a PRN Trazodone orders in place for the treatment of insomnia with re-evaluation dates since 11/8/23. During an interview on 4/8/24 at 9:33 A.M., Resident #78 said he/she did have trouble sleeping a while back but does not have this issue any longer. Review of the medication administration record (MAR) for Resident #78 indicated the Resident received the PRN Trazodone three times out of seven opportunities in the month of April 2024 as of 4/8/24. Review of the current care plans for Resident #78 as of 4/8/24, indicated but were not limited to the following: Focus: Resident #78 uses antidepressant medications related to depression and mood disorder and is at risk for side effects associated with medication use (revised: 4/7/24) Goal: Resident will be free from discomfort of adverse reactions related to antidepressant therapy (initiated: 11/16/23) Interventions: Administer antidepressant medications as ordered and document/monitor side effects and effectiveness; monitor and report adverse reactions PRN (initiated: 11/16/23) Sertraline (Zoloft - an antidepressant) as ordered; social worker visits PRN (initiated: 1/12/24) The care plan for antidepressant medication use failed to indicate the Resident was using antidepressant medications for insomnia or that he/she suffered from insomnia. Focus: Resident uses psychotropic medications related to hallucinations (initiated: 4/7/24) The psychotropic medications care plan failed to indicate in the focus, goal, or interventions the Resident used psychotropic medications for insomnia or suffered from insomnia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: Resident has an alteration in mood due to depression (initiated: 11/9/23) The alterations in mood care plan failed to indicate in the focus, goal, or interventions the Resident used psychotropic medications for insomnia or suffered from insomnia. Review of the medical record failed to indicate a care plan for insomnia and PRN Trazodone for the treatment of insomnia had been developed for Resident #78. During an interview on 4/8/24 at 11:09 A.M., Unit Manager #1 said Resident #78 has had orders for PRN Trazodone since November of 2023 for the treatment of insomnia. She said the care plans for the Resident did not indicate the Resident suffered from insomnia or was receiving medications for the treatment of insomnia. During an interview on 4/8/24 at 5:17 P.M., the Director of Nurses (DON) said Resident #78 should have a care plan in place to address his/her insomnia and use of medications to manage insomnia and did not. 48084 2. Resident #29 was admitted to the facility in June 2019 with diagnoses which included age-related cataracts (clouding of the eye lens), glaucoma (slow vision loss), cerebral infarction (stroke) with hemiplegia and hemiparesis (weakness) affecting left side, and Parkinson's disease. Review of the MDS assessment, dated 1/18/24, indicated Resident #29 scored a 15 out of 15 on the BIMS, indicating he/she was cognitively intact. Review of the medical record, including progress notes and evaluations, indicated Resident #29 had a history of falls, and had scored a 14 on the fall risk evaluation, dated 1/26/24, indicating he/she was at high risk for falls. Review of the Care Plan indicated but was not limited to the following: -Anti-slip added to wheelchair (6/12/23). -Brightly colored tape to call button for better visibility (10/28/23). The surveyor made the following observations: -4/7/24 at 9:30 A.M., no bright colored tape on call light and no anti-slip material on wheelchair. -4/8/24 at 8:33 A.M., no bright colored tape on call light and no anti-slip material on wheelchair. -4/8/24 at 1:30 P.M., no bright colored tape on call light and no anti-slip material on wheelchair. -4/9/24 at 9:37 A.M., no bright colored tape on call light and no anti-slip material on wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/10/24 at 10:16 A.M., no bright colored tape on call light; Resident was not in the room to inspect the wheelchair. -4/10/24 at 12:58 P.M., no bright colored tape on call light. During an interview on 4/9/24 at 9:38 A.M., Resident #29 said there used to be bright colored tape on the call light, but it has not been there for a while. He/she said it was sticky and they took it off but never replaced it. He/she was unsure about the anti-slip material that should be on the wheelchair. During an interview on 4/9/24 at 2:35 P.M., Unit Manager #2 said the bright colored call bell probably did not follow the Resident over to this unit when they moved. She said it should be in place and it is not. Additionally, she said the anti-slip material should have been on the wheelchair all along too, and it was not until today. During an interview on 4/10/24 at 11:39 P.M., the DON said they were not following the care plan as the bright colored tape on the call bell still is not in place and the anti-slip material was not on the wheelchair until she had them check it yesterday. 3. Resident #74 was admitted to the facility in March 2023 with diagnoses including disc degeneration of the lumbar region, repeated falls, skin cancer, and arthritis. Review of the MDS assessment, dated 1/17/24, indicated Resident #74 scored 14 out of 15 on the BIMS, indicating he/she was cognitively intact. Additionally, he/she had a history of recent falls. Review of the medical record, including progress notes and evaluations, indicated Resident #74 had a history of falls, and had scored a 19 on the fall risk evaluation, dated 4/2/24, indicating he/she was at high risk for falls. Review of the Care Plan indicated but was not limited to the following: -Anti-slip added to chair (9/19/23) -Has Dycem (a brand of anti-slip) on chair (12/7/23) Review of the Fall Incident Report, dated 9/19/23, indicated he/she had multiple items in the chair with him/her and slid off the chair onto the floor. The rehab screen (attached) indicated non-slip material was added to the seating surface. The surveyor made the following observations: -4/7/24 at 12:55 P.M., no anti-slip material or Dycem on chair cushion. -4/8/24 at 8:33 A.M., no anti-slip material or Dycem on chair cushion. -4/9/24 at 8:50 A.M., no anti-slip material or Dycem on chair cushion. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/24 at 2:35 P.M., Unit Manager #2 said the anti-slip material should have been on the chair and it was not until today. During an interview on 4/10/24 at 11:39 A.M., the DON said they were not following the care plan as the anti-slip material was not on the chair cushion until she had them check it yesterday. She said it was under the cushion keeping the cushion from sliding off the chair, but not on top of the cushion to prevent the Resident from sliding off the cushion. 36542 4. Resident #1 was admitted to the facility in May 2020 with a diagnosis of lymphedema. Review of the MDS assessment, dated 2/5/24, indicated Resident #1 scored a 15 out of 15 on the BIMS, indicating the Resident was cognitively intact. Review of the medical record indicated Resident #1 had lymphedema to the left arm and had attended a Lymphedema Clinic on 9/29/23 with a recommendation to continue daily use of compression sleeve and compression glove and to obtain new garments in the new year. During an interview on 4/7/24 at 8:25 A.M., Resident #1 said he/she had lymphedema on their left arm and was supposed to wear a compression sleeve and glove on the left arm every day at 9:00 A.M. and the Certified Nursing Assistants (CNAs) tell him/her that the Nurse has to put on the compression sleeve and glove. Review of the care plans indicated a focus of acute pain, chronic arthritis, degenerative joint disorder and chronic lymphedema in the left arm with potential for discomfort, with a goal of satisfactory pain control and interventions to encourage use of prescribed assistive devices and may consult lymphologist as needed. Review of the medical record including the MAR, Treatment Administration Record, and care plans failed to include information on the procedure of when to use the compression sleeve and glove. During an interview on 4/8/24 at 4:04 P.M., CNA #2 said Resident #1 had a compression sleeve and a compression glove and the Nurses were supposed to be putting these on daily. She said the Resident will ask the CNAs to put the sleeve and glove on because the Resident did not like waiting for the Nurse. During an interview with observation on 4/9/24 at 10:53 A.M., the surveyor observed Hospice Aide #1 putting the compression sleeve and glove on Resident #1. Hospice Aide #1 said when she provides care for the Resident, three times per week, she puts the compression sleeve and the glove on for the Resident. During an interview on 4/9/24 at 11:10 A.M., Nurse #5 said Resident #1 has compression sleeves that were put on every morning after morning care and get removed every night when the Resident goes to bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/24 at 1:30 P.M., Unit Manager said Resident #1 was admitted to the hospital in January 2024 and when he/she returned the compression sleeve and glove were not re-ordered due to a change in condition of the Resident. She said she was unaware the Resident had started using the compression sleeve and glove again and the plan of care should have been updated to reflect the use of both.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48362 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services for three Residents (#4, #221, #32), out of a total sample of 26 residents. Specifically, the facility failed: 1. For Resident #4, to ensure oxygen tubing was changed and stored in a plastic bag when not in use per facility policy; 2. For Resident #221, to store the Resident's Bilevel positive airway pressure (BiPAP) respiratory tubing and nasal pillow in a sanitary way when not in use by the Resident to prevent potential contamination by germs and environmental debris; and 3. For Resident #32, to ensure oxygen tubing was changed and stored in a plastic bag when not in use per facility policy. Findings include: Review of the facility's policy titled Oxygen Administration, undated, indicated but was not limited to: - Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. - Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. - Keep delivery devices covered in plastic bag when not in use. - Type of delivery systems include: Nasal Cannula, Simple Mask, Non-Rebreather Mask, Continuous Positive Airway Pressure (CPAP) Mask, Bi-level Positive Airway Pressure (BiPAP) Mask, Venturi Mask, and Aerosol Generating Device. 1. Resident #4 was admitted to the facility in October 2023 with diagnoses including chronic obstructive pulmonary disease (COPD- a disease making it difficult to breathe), dependence on supplemental Oxygen, atrial fibrillation, and hypertension. Review of the Minimum Data Set (MDS) assessment, dated 1/31/24, indicated a score of 10 out of 15 on the Brief Interview for Mental Status (BIMS), representing moderate cognitive impairment. Further review of the MDS indicated Resident #4 required oxygen therapy and extensive assistance for activities of daily living. Review of Resident #4's active Physician's Orders indicated but were not limited to: - 1/26/24: Oxygen (O2) at 4 liters via nasal cannula, monitor oxygen saturation related to COPD; and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Rehabilitation Nursing Center	500 Wilbur Avenue Somerset, MA 02725

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/29/23: Change O2 tubing one time per week (every day shift every Sunday), please date tubing. On 4/7/24 at 10:04 A.M., the surveyor observed Resident #4 in his/her room resting in bed utilizing 4 liters of Oxygen via nasal cannula (dated 4/7/24) from a concentrator. Resident #4 had a portable oxygen tank attached to his/her wheelchair. The portable oxygen tank had an undated nasal cannula tubing attached to the tank. The nasal cannula tubing attached to the portable tank was lying across the back of the wheelchair with clothing laying on top of it. There was no bag attached to the wheelchair for storage of the nasal cannula tubing. On 4/8/24 at 9:52 A.M., the surveyor observed Resident #4 in his/her room resting in bed utilizing 4 liters of Oxygen via nasal cannula (dated 4/7/24) from a concentrator. Resident #4 had a portable oxygen tank attached to his/her wheelchair. The portable oxygen tank had an undated nasal cannula tubing attached to the tank. The nasal cannula tubing attached to the portable tank was lying across the back of the wheelchair with clothing laying on top of it. There was no bag attached to the wheelchair for storage of the nasal cannula tubing. On 4/9/24 at 1:37 P.M., the surveyor observed Resident #4 in his/her room resting in bed utilizing 4 liters of oxygen via nasal cannula (dated 4/7/24) from a concentrator. Resident #4 had a portable oxygen tank attached to his/her wheelchair. The portable oxygen tank had a nasal cannula tubing attached to the tank. The nasal cannula tubing attached to the portable tank was lying across the back of the wheelchair. There was no bag attached to the wheelchair for storage of the nasal cannula tubing. Review of Resident #4's Treatment Administration Record (TAR) for April 2024 indicated his/her oxygen tubing was changed on 4/7/24. During an interview on 4/9/24 at 1:38 P.M., Nurse #4 said nasal cannula tubing is changed weekly on Sundays for all residents in the facility utilizing Oxygen. Nurse #4 said tubing is changed for oxygen concentrators as well as portable tanks and nebulizers. Nurse #4 said when oxygen tubing is changed, bags are provided to residents for storage of tubing when it is not in use. During an interview on 4/9/24 at 1:42 P.M., Unit Manager (UM) #3 said nasal cannula tubing is changed weekly on Sundays for residents utilizing Oxygen. UM #3 said her expectation was for staff to provide a bag for oxygen tubing when it is not in use. UM #3 and the surveyor reviewed the observations of Resident #4's oxygen tubing attached to his/her portable oxygen tank. UM #3 said there should be a bag in place for the oxygen tubing attached to the portable tank on the wheelchair. UM #3 said all oxygen tubing should be dated when it is changed. During an interview on 4/9/24 at 1:59 P.M., the Director of Nursing (DON) said oxygen tubing is changed for the entire facility every Sunday. The DON said when tubing is not in use, staff are to place it in a bag. The DON said the bag should be dated when it was provided. The DON said typically oxygen tubing is moved from the resident's concentrator to the portable oxygen tank when the resident is mobile. The DON and the surveyor reviewed the observations of Resident #4's portable oxygen tank tubing. The DON said the tubing should be placed in a bag when not in use and properly dated. 43935 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #221 was admitted to the facility in March 2024 with diagnoses including: chronic obstructive pulmonary disease and obstructive sleep apnea (an illness that causes intermittent pauses in breathing while sleeping). Review of the BIMS for Resident #221, dated 4/2/24, indicated the Resident was cognitively intact with a score of 15 out of 15. Review of the current Physician's Orders for Resident #221, dated 4/10/24, indicated but were not limited to the following: - BiPAP per home settings every evening shift, assist as needed for obstructive sleep apnea (3/29/24) During an observation with interview on 4/7/24 at 8:37 A.M., the surveyor observed a BiPAP machine on the Resident's bedside table and the attached tubing and nasal pillow mask were hanging over the siderail of the Resident's bed, not in use by the Resident, and not stored in a plastic respiratory bag to protect it from potential contamination by germs and environmental debris. There was no respiratory storage bag observed in the Resident's room. Resident #221 said the staff wipe down the machine and clean the water chamber and tubing, but there is no storage bag, he/she hasn't been offered one and the tubing and nasal pillow are left hanging on his/her siderail daily. Throughout the survey, the surveyor made the following observations: - 4/7/24 at 4:08 P.M., BiPAP nasal pillow and tubing hanging over the siderail of the Resident's bed, not stored in a respiratory bag to protect it from germs or environmental debris - 4/8/24 at 11:22 A.M., BiPAP nasal pillow and tubing hanging in between the bars of the Resident's siderail, not in use by the Resident and not stored in a sanitary manner to protect it from potential contamination of germs and environmental debris - 4/8/24 at 3:17 P.M., BiPAP nasal pillow and tubing hanging in between the bars of the Resident's siderail, not in use by the Resident, touching bed linens and not stored in a respiratory equipment bag to prevent potential contamination of the tubing and nasal pillow During an interview on 4/9/24 at 7:48 A.M., Unit Manager #1 said it is protocol in the facility for BiPAP tubing and mask or nasal pillows to be stored in a respiratory bag at all times when not in use by the Resident to protect it from germs. She said she does not know why the Resident was not provided a storage bag. During an interview on 4/9/24 at 2:32 P.M., the DON said the expectation is for BiPAP tubing and nasal pillows or masks to be stored in a respiratory bag at all times when not in use by the resident. She said this standard was not met based on the surveyor's observations of Resident #221's equipment. 48084 3. Resident #32 was admitted to the facility in July 2021 with diagnoses which included heart disease, anxiety, and Parkinson's disease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment, dated 3/13/24, indicated Resident #32 scored 14 out of 15 on the BIMS, indicating he/she was cognitively intact, and he/she was administered Oxygen. Review of the Physician's Orders indicated but were not limited to the following: -Oxygen at 2 Liters per minute (LPM) via nasal canula as needed to maintain saturation above 91% as needed for shortness of breath (2/8/24). -Change tubing every night shift every Sunday (2/8/24). Review of the March and April 2024 TAR indicated Resident #32 had used the Oxygen 3/5/24, 3/7/24, 3/30/24, and 4/2/24. The surveyor made the following observations: -4/7/24 at 8:30 A.M., Oxygen machine was running, the nasal cannula/tubing was on top of the oxygen machine (not in the bag), dated 3/11/24, and the storage bag was attached to the machine dated 3/10/24. -4/8/24 at 8:35 A.M., Oxygen machine was off, tubing and bag were dated 4/7/24. During an interview on 4/7/24 at 1:36 P.M., Resident #32 said he/she uses Oxygen mostly at night. During an interview on 4/9/24 at 2:35 P.M., Unit Manager #2 said the tubing should be changed weekly even if the oxygen is only used as needed because it is too hard to track. During an interview on 4/10/24 at 11:39 A.M., the DON said the tubing should be changed weekly. Additionally, she said if the oxygen is not in use, they should either have nothing attached or a new one set up and put in the bag for when the Resident needs it. She said the tubing should be changed and dated weekly for infection control purposes.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 43935 Based on record review, interview, and policy review, the facility failed to ensure one Resident (#78), out of 26 sampled residents, had a documented rationale and appropriate monitoring in place for the ongoing, as needed (PRN) use of a psychotropic medication. Findings include: Review of the facility's policy titled Use of Psychotropic Medications, undated, indicated but was not limited to the following: - residents are not given psychotropic medications unless the medication is necessary to treat a specific condition, as diagnosed and documented in the medical record - PRN orders for psychotropic medications shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration - if the attending physician/practitioner believes it is appropriate to extend the PRN order beyond 14 days, he/she will document their rationale in the resident's medical record and indicate a duration for the PRN order Resident #78 was admitted to the facility in November 2023 with the following diagnoses: mood disorder, depression, delusional disorder, and hallucinations. Review of the most recent Minimum Data Set (MDS) assessment for Resident #78, dated 2/15/24, indicated Resident #78 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 4/8/24 at 9:33 A.M., Resident #78 said he/she did have trouble sleeping a while back but does not have this issue any longer. Review of the discontinued medication orders for Resident #78 from November 2023 through April 2024 indicated the Resident had a PRN Trazodone order in place for the treatment of insomnia since 11/8/23 which was routinely re-evaluated and extended. Review of the current Physician's Orders for Resident #78, dated 4/8/24, indicated but were not limited to the following: - Trazodone (an antidepressant) 50 milligram (mg) tablet, give 25 mg by mouth PRN for sleep (3/21/24) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift for monitoring. The medical record failed to indicate the physician had diagnosed the Resident with insomnia. The physician's orders failed to indicate the Resident was being monitored for sleeplessness or insomnia. Review of the psychoactive PRN medication evaluation forms in Resident #78's medical record indicated the following: - 11/22/23 Pertinent diagnosis: Insomnia; current medication: Trazodone 25 mg daily; medication benefits: decrease insomnia; has been used 5 times in the last 14 days; non-pharmacological interventions: change position; specific behavior being treated: insomnia; new order: continue Trazodone 25mg for 30 days. - 12/22/23 Pertinent diagnosis: Insomnia; current medication: Trazodone 25 mg daily; medication benefits: better sleep; has been used 6 times in the last 14 days; non-pharmacological interventions: none were documented; specific behavior being treated: insomnia; new order: continue Trazodone 25 mg for 30 days - 1/22/24 Pertinent diagnosis: anxiety; current medication: Trazodone 25 mg daily; medication benefits: decrease anxiety; there was no documentation to the number of times the Resident used the medication; non-pharmacological interventions: one to one; specific behavior being treated: picks; new order: continue Trazodone 25mg for 60 days - 3/2/24 Pertinent diagnosis: anxiety; current medication: Trazodone 25 mg daily; medication benefits: decrease anxiety; medication was used 5 times in the last 14 days; non-pharmacological interventions: change position and encourage rest; specific behavior being treated: anxious; new order: continue Trazodone 25mg for 60 days The forms failed to indicate a rationale for the continued use of the PRN medication or how the benefits to the Resident outweighed the risks. Further, the forms changed the purpose of the medication from insomnia to anxiety without any explanation for the change in use. Review of the medication administration record (MAR) for Resident #78 from February 2024 through April 8, 2024 indicated, but was not limited to the following: - February 2024 the Resident used the PRN Trazodone only 3 times out of 29 opportunities throughout the month - March 2024 the Resident used the PRN Trazodone only 5 times out of 31 opportunities throughout the month - April 2024 the Resident used the PRN Trazodone only 3 times out of 7 opportunities from April 1st through April 8th (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current care plans for Resident #78 as of 4/8/24, indicated but were not limited to the following: -Focus: Resident #78 uses antidepressant medications related to depression and mood disorder and is at risk for side effects associated with medication use (revised: 4/7/24) -Focus: Resident uses psychotropic medications related to hallucinations (initiated: 4/7/24) -Focus: Resident has an alteration in mood due to depression (initiated: 11/9/23) The care plans for antidepressant medication use, psychotropic medication use, and alterations in mood failed to indicate the Resident used psychotropic medications for insomnia or suffered from insomnia. Review of the medical record failed to indicate a care plan for insomnia and PRN Trazodone for the treatment of insomnia had been developed for Resident #78 or that any non-pharmacological interventions had been attempted to assist the Resident in getting a restful night's sleep without the use of medication. During an interview on 4/8/24 at 11:09 A.M., Unit Manager #1 said the process for the reevaluation of psychotropic PRN medications is for the nursing staff to complete the psychoactive PRN medication evaluation forms and then review the forms with the physician or clinician for a signature to extend the orders. She reviewed the forms in the medical record for Resident #78 and said there was no rationale documented by the physician for the continued use of the PRN medication. She said there was no indication as to why the purpose of the PRN medication changed from insomnia to anxiety and it was likely documented that way in error. She reviewed the MAR for Resident #78 and said the Resident rarely uses the medication and it is not likely necessary and would need to be reviewed by the clinician again. During an interview on 4/8/24 at 5:17 P.M., the Director of Nurses (DON) reviewed the above information with the surveyor and said the forms did not provide a clinical rationale for the continued use of the PRN Trazodone and there was no indication as to why the purpose for the medication had changed. On review of the frequency of which the Resident was receiving the medication over the last few months the DON said the medication was likely no longer necessary for the Resident and there was no documentation by the physician to indicate the benefit to the Resident would outweigh the risks of the medication use. Review of the progress notes and physician notes from 2/1/24 through 4/8/24 failed to indicate any evidence that the Resident had a documented diagnosis of insomnia or clinical rationale for ongoing PRN Trazodone use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48084 Based on observation, interview, and policy review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed: 1. For Resident #8, to ensure the morning medications were administered under direct supervision and not left at the bedside; 2. For Resident #106, to ensure Saline 0.65% Nasal Spray (for dryness) was stored in the medication cart and not left at the bedside; and 3. For Resident #112, to ensure Fluticasone Propionate Nasal Spray (for allergies) was stored in the mediation cart and not left at the bedside. Findings include: Review of the facility's policy titled Medication Administration, undated, indicated but was not limited to the following: -Medications are administered by licensed nurses in accordance with professional standards of practice. -Observe resident consumption of medication. Review of the facility's policy titled Resident Self-Administration of Medication, undated, indicated but was not limited to the following: -A resident may only self-administer medications after the facility's interdisciplinary team (IDT) has determined which medications may be self-administered safely. -Each resident is offered the opportunity to self-administer mediations during routine assessment. -Resident preference will be placed in the medical record. -The following conditions are met for bedside storage: The manner of storage prevents access by other residents. -The care plan must reflect resident self-administration and storage arrangements for such medications. Review of the facility's policy titled Medication Storage, undated, indicated but was not limited to the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All drugs and biologicals will be stored in locked compartments. -During a medication pass, medications must be under direct observation of the person administering the medications or locked in the medication storage area/cart. 1. Resident #8 was admitted to the facility in October 2015. Review of the Minimum Data Set (MDS) assessment, dated 3/20/24, indicated Resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. On 4/7/24 at 8:30 A.M., the surveyor observed Resident #8 sitting in a chair eating breakfast; a clear medicine cup full of pills was on the overbed table next to the breakfast tray. During an interview on 4/7/24 at 8:30 A.M., Resident #8 said, Those are my morning pills and I will take them after breakfast. Review of the New Admission Self-Administration of Medications form, dated 10/27/15, signed by the Resident indicated he/she wanted Medication Administration done by the Nursing Staff. Review of the Care Plan failed to indicate the Resident self-administered medications. Review of the Physician's Orders failed to indicate an order to self-administer medications. Review of the April 2024 Medication Administration Record (MAR) indicated the following medications were scheduled for 9:00 A.M. and signed off as administered by the nurse: -Eliquis 2.5 milligrams (mg) (blood thinner) -Metoprolol 25 mg (blood pressure) -Amlodipine 5 mg (blood pressure) -Docusate Sodium 100 mg (stool softener) -Farxiga 5 mg (heart failure) -Ferrous Sulfate 325 mg (iron supplement) -Aspirin 325 mg (heart) -Oxybutynin Extended Release 10 mg (overactive bladder) -Tradjenta 5 mg (diabetes) -Gabapentin 200 mg (neuropathy/pain) During an interview on 4/9/24 at 2:35 P.M., Unit Manager #2 said Resident #8 cannot self-administer medications and they should not be left at the bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #106 was admitted to the facility in February 2024. Review of the MDS assessment, dated 3/7/24, indicated Resident scored 13 out of 15 on the BIMS, indicating he/she was cognitively intact. On 4/9/24 at 3:15 P.M., the surveyor observed the following during a medication pass: -Nurse #6 poured the medications for Resident #106 and said he/she always keeps the Nasal Spray at the bedside. -Resident was sitting in a chair in the room with Saline 0.65% Nasal Spray on their overbed table. -Nurse #6 assisted with administration of the Nasal Spray and then returned the Nasal Spray to the overbed table before exiting the room. During an interview on 4/9/24 at 3:15 P.M., Nurse #6 said Resident #106 always keeps the Nasal Spray at their bedside and he/she did not have a self-administration consent or evaluation, and probably self-administers when he/she feels dry. On 4/10/24 at 7:40 A.M., the surveyor observed Saline 0.65% Nasal Spray on Resident #106's overbed table. Review of the New Admission Self-Administration of Medications form dated 2/17/24, signed by the Resident indicated he/she wanted Medication Administration done by the Nursing Staff and he/she did not have any medication in their possession that they wished to keep in their possession. Review of the Care Plan failed to indicate the Resident self-administered medications. Review of the physician's orders failed to indicate an order to self-administer medications. Further review of the Physician orders indicated but was not limited to the following: -Saline Nasal Spray Nasal Solution 0.65% spray in nostril four times a day for dry nostrils (2/17/24). Review of the April 2024 MAR indicated the Saline Nasal Spray was administered at 8:00 A.M, 12:00 P.M., 4:00 P.M., and 8:00 P.M. daily as ordered. During an interview on 4/9/24 at 4:05 P.M., Nurse #6 said Resident #106 does not have an assessment or order to self-administer but he/she is very particular and likes to keep it at the bedside. 3. Resident #112 was admitted to the facility in March 2024. Review of the MDS assessment, dated 3/12/24, indicated Resident scored 14 out of 15 on the BIMS, indicating he/she was cognitively intact. On 4/10/24 at 7:47 A.M., the surveyor observed Allergy Nasal Spray in an opened box on Resident #112's nightstand. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the New Admission Self-Administration of Medications form, dated 3/9/24, signed by the Resident indicated he/she wanted Medication Administration done by the Nursing Staff and he/she did not have any medication in their possession that they wished to keep in their possession. Review of the Care Plan failed to indicate the Resident self-administered medications. Review of the physician's orders failed to indicate an order to self-administer medications. Further review of the Physician's Orders indicated but was not limited to the following: -Fluticasone Propionate Nasal Spray 50 micrograms (mcg)/actuation (ACT) two sprays in both nostrils daily for allergy relief (3/9/24). Review of the April 2024 MAR indicated the Fluticasone Propionate Nasal Spray was administered daily at 9:00 A.M., as ordered. During an interview on 4/10/24 at 10:05 A.M., Unit Manager #3 said neither Resident #106 nor #112 should have a nasal spray at their bedside and they do not self-administer medications. During an interview on 4/10/24 at 11:39 A.M., the Director of Nurses (DON) said medications should not be left at the bedside and the nurse should observe the residents take all medications. Additionally, she said to self-administer medication the resident would express desire to do so, the team would assess and review, then obtain a physician's order to self-administer and the medication would need to be locked at bedside. She said none of these residents self-administer medications and the medications should not be left at the bedside for consumption or storage.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Rehabilitation Nursing Center	500 Wilbur Avenue Somerset, MA 02725

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48362 Based on resident and staff interviews, observation, and meal test tray results on two of three units, the facility failed to prepare and serve meals in a manner that conserved flavor, were palatable, and served at safe and appetizing temperatures. Findings include: During initial resident screening on 4/7/24, the survey team identified the following concerns expressed by residents about food palatability: - Resident #83 said the food is cold all the time and coffee and or tea is always cold. - Resident #107 said the food is okay, but it is frequently cold. - Resident #9 said the food is always cold. - Resident #321 said the food has a weird consistency and strange flavors. Resident #321 said the food is often cold and he/she does not always like the way the food tastes. - Resident #1 said the food lacks flavor. - Resident #56 said the food was okay, but drinks like coffee and tea are often not hot. Resident #56 said soups are often cold. - Resident #86 said breakfast food is not good and eggs are cold. Review of Resident Council Meeting Minutes, dated 12/27/23, indicated several resident concerns about receiving cold food. Review of Resident Council Meeting Minutes, dated 1/23/24, indicated residents expressed concerns about food being too salty or peppery. Residents also voiced concerns about food being cold, potatoes being lumpy and lettuce in salad being withered. Resident Council Meeting Minutes indicated the Food Service Director (FSD) was in attendance. Review of the Resident Council Meeting Minutes, dated 2/28/24, indicated many residents voiced concerns about receiving cold food. Review of the Resident Council Meeting Minutes, dated 3/26/24, indicated several residents voiced concerns about the soup being too salty. Residents also expressed concerns about bagels and grilled cheese sandwiches being too hard to bite into during meal times. Residents also voiced concerns about receiving cold meals at breakfast. On 4/8/24 at 11:20 A.M., the surveyor requested a lunch test tray to the [NAME] One Unit. The food truck left the kitchen at 12:40 P.M., and arrived on the unit at 12:42 P.M. The test tray was conducted with the FSD obtaining temperatures at 1:00 P.M. with the following results: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Herbed Chicken: 135.9 Fahrenheit (F), moist, cool temperature - Wax [NAME] Beans: 116.5 F, cold and watery to taste, no flavor - Carton Whole Milk: 52.3 F, warm to taste - Coffee: 136.1 F During an interview on 4/8/24 at 1:10 P.M., the FSD said the temperature of the milk was too warm. The FSD said the wax beans should be warmer and flavorful. The FSD said he does attend Resident Council Meetings when invited and was aware of concerns related to meal temperatures and taste. The FSD said he does try to complete one test tray per month to assess food concerns. On 4/9/24 at 7:15 A.M., the surveyor requested a breakfast test tray to the East Two Unit. The food truck left the kitchen at 7:35 A.M. and was delivered to the unit at 7:37 A.M. The FSD remained in the kitchen during the breakfast test tray. The test tray was conducted at 7:55 A.M., with the following results: - French Toast: 119.5 F, cool temperature to taste - Maple Oatmeal: 146.6 F, bland and flavorless, minimal maple flavor - Scrambled Eggs: 120.9 F, bland flavor and cool temperature - Cranberry Juice: 62.1 F, warm to taste - Carton Whole Milk: 51.7 F, warm to taste During an interview on 4/9/24 at 9:55 A.M., the FSD and the surveyor reviewed the findings of the breakfast test tray. The FSD said the drink temperatures should not be that warm when delivered to residents. The FSD said meals should be warm and flavorful when given to residents. During an interview on 4/9/24 at 10:04 A.M., the Administrator and the surveyor reviewed the findings of the two test trays completed during the survey. The Administrator said items should be held to appropriate temperatures and flavorful when delivered to residents.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observation, policy review, and interview, the facility failed to follow their policy and professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to properly label and date food products, and maintain safe and clean equipment in three of three nourishment kitchenettes. Findings include: Review of the facility's policy titled Use and Storage of Food Brought in by Family or Visitors, undated, indicated but was not limited to: - It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. - Family members or other visitors may bring the resident food of their choosing. - The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. - The prepared food must be consumed by the resident within three days. - If not consumed within three days, food will be thrown away by facility staff. On [DATE] at 9:56 A.M., the surveyor made the following observations on the [NAME] Two Unit resident refrigerator and nourishment kitchenette: - The resident refrigerator contained a tuna sandwich in saran wrap, dated [DATE]; - The resident refrigerator had a Tupperware container containing leftover food items, undated; - The resident refrigerator had a Chobani Coconut Yogurt with use by date of [DATE], undated, and no resident identification; - The resident refrigerator had a package of Greek Vanilla Light and Fit Yogurt with use by date of [DATE], with packaging dated [DATE] by facility; - The inside of the microwave had food particle splatter/stains. The glass dish on the inside of the microwave contained food particle splatter/stains; and - The nourishment freezer had a frozen [NAME] Cheese Pizza with a use by date of [DATE], undated and no resident identification On [DATE] at 10:24 A.M., the surveyor made the following observations on the East Two Unit resident refrigerator and nourishment kitchenette: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident refrigerator had an undated individual salad container with brown lettuce and visible water moisture on the container; - The resident refrigerator had an opened 20 fluid ounce Pepsi bottle, undated, and no resident identification; - The resident refrigerator had an 18.5 fluid ounce Pure Leaf Iced Tea bottle, undated, and no resident identification; - The resident refrigerator had two single mini-Diet Pepsi cans, undated, and no resident identification; and - The inside of the microwave had food particle splatter and stains. On [DATE] at 2:11 P.M., the surveyor made the following observations on the [NAME] One Unit resident refrigerator and nourishment kitchenette: - The resident refrigerator contained a white bag of takeout food, undated; - The resident refrigerator contained a plastic container of soup, dated [DATE]; - The resident refrigerator contained a brown paper bag of desserts, undated; - The resident refrigerator contained a plastic bag with pizza slices, undated; - The resident refrigerator contained a plastic container of rice pudding, undated, and no resident identification; - The inside of the microwave had food particle splatter and stains; and - The nourishment freezer contained a plastic Tupperware container filled with ice cream. The Tupperware container was undated and had no resident identification. The ice cream had freezer burn covering the top of the ice cream. On [DATE] at 8:07 A.M., the surveyor made the following observations on the [NAME] Two Unit resident refrigerator and nourishment kitchenette: - The resident refrigerator had a Chobani Coconut Yogurt with use by date of [DATE], undated, and no resident identification; - The resident refrigerator had a package of Greek Vanilla Light and Fit Yogurt with use by date of [DATE], with packaging dated [DATE] by facility; - The inside of the microwave had food particle splatter/stains. The glass dish on the inside of the microwave contained food particle splatter/stains; and - The nourishment freezer had a frozen [NAME] Cheese Pizza with a use by date of [DATE], undated and no resident identification. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:12 A.M., the surveyor made the following observations on the East Two Unit resident refrigerator and nourishment kitchenette: - The resident refrigerator had an opened 20 fluid ounce Pepsi bottle, undated, and no resident identification; - The resident refrigerator had two single mini-Diet Pepsi cans, undated, and no resident identification; and - The inside of the microwave had food particle splatter and stains. On [DATE] at 8:36 A.M., the surveyor made the following observations on the [NAME] One Unit resident refrigerator and nourishment kitchenette: - The resident refrigerator contained a plastic container of soup, dated [DATE]; - The resident refrigerator contained a plastic bag with pizza slices, undated; - The inside of the microwave had food particle splatter and stains; and - The nourishment freezer contained a plastic Tupperware container filled with ice cream. The Tupperware container was undated and had no resident identification. The ice cream had freezer burn covering the top of the ice cream. During an interview on [DATE] at 12:55 P.M., the Food Service Director (FSD) said nourishment kitchenettes and the resident refrigerator on the units are stocked and cleaned by the kitchen's nourishment aide three times a day. The FSD said the nourishment aide is to check temperatures of the freezer and refrigerators, stock food items, and throw away any expired food products. During an interview on [DATE] at 8:46 A.M., Certified Nurse Assistant (CNA) #6 said when residents have food items brought to the facility they must be labeled and dated. CNA #6 said the resident name and the date the item was put in the refrigerator must be on all products. CNA #6 said the resident refrigerator and nourishment kitchenette are stocked and cleaned out by the kitchen staff. During an interview on [DATE] at 9:55 A.M., the FSD and the surveyor reviewed the findings of the unit resident refrigerators and nourishment kitchenettes. The FSD said food items brought in from the outside should be labeled with a resident name and date the item was brought to the facility. The FSD said items that are not properly labeled or expired should be removed. During an interview on [DATE] at 10:05 A.M., the Administrator and the surveyor reviewed the findings of the unit resident refrigerators and nourishment kitchenettes. The Administrator said all nourishment kitchenettes should always remain clean. The Administrator said food products brought into the facility by visitors should not be expired and should be properly labeled and dated.

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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. 48084 Based on observation, interview, record review, and policy review, the facility failed to follow infection control practices including: 1. Ensuring staff performed hand hygiene in between resident care and with glove changes during the medication pass; and 2. Ensuring staff disinfected blood glucose monitoring equipment per policy. Findings include: 1. Review of the facility's policy titled Hand Hygiene, undated, indicated but was not limited to the following: -All staff will perform proper hand hygiene procedures to prevent the spread of infection. -The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves. -Hand Hygiene Table attached to the policy indicated but was not limited to the following occurrences when staff should perform hand hygiene: a. Between resident contacts. b. After handling contaminated objects. c. Before performing invasive procedures. d. Before applying and after removing personal protective equipment (PPE), including gloves. e. Before preparing or handling medications. f. Before performing resident care procedures. g. After handling items potentially contaminated with blood, bodily fluids, secretions, or excretions. Review of the facility's policy Medication Administration, undated, indicated but was not limited to the following: GUIDELINES: -Wash hands prior to administering medication. -Administer medication as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wash hands per protocol. Review of the facility policy Medication Administration-Nasal Administration, dated 9/2010 indicated but was not limited to the following: PROCEDURE: -Perform hand hygiene -Administer medication to resident or help resident to do so. -Return medication container to med cart for storage. -Perform hand hygiene. Review of the facility policy Blood Glucose Monitoring, undated, indicated but was not limited to the following: PROCEDURE: -Perform hand hygiene. -Collect blood sample -Remove and discard gloves and perform hand hygiene. On 4/9/24, the surveyor made the following observations during the afternoon Medication Pass with Nurse #6: -3:15 P.M., Nurse #6 put on gloves, opened and poured a supplement drink, then labeled the open container with a permanent marker along with other drinks, entered resident room, assisted with nasal spray administration, removed gloves, and exited the room without performing hand hygiene. -3:19 P.M., without performing hand hygiene, Nurse #6 opened and poured a supplement drink, opened a plastic straw, touched the straw with her fingers and put it in the cup, assisted with administration of the drink and returned to the medication cart without performing hand hygiene. Nurse #6 then reviewed the Resident's orders in the computer (touching the keyboard), then opened the medication cart drawer and looked for a medication card for a different resident (touching multiple medication cards in the drawer), Nurse #6 then re-entered the Resident's room to inform the Resident they did not have an order for Tussin Syrup (cough medicine). Upon returning to the med cart this time hand hygiene was performed. -3:34 P.M., hand hygiene was performed, Nurse #6 put on gloves, obtained a blood sample for glucose test, removed gloves, did not perform hand hygiene, opened a container of Sani Wipes to clean the glucometer, cleaned the glucometer and placed it on top of the med cart, then without performing hand hygiene moved the med cart to another room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3:48 P.M., without performing hand hygiene Nurse #6 got a different glucometer and supplies, put gloves on, obtained a blood sample for glucose test, removed the gloves, at the med cart wrote on her report sheet, opened a container of Sani Wipes to clean the glucometer, cleaned the glucometer and placed it on top of med cart, then without performing hand hygiene moved the med cart to another room. -3:50 P.M., without performing hand hygiene opened and poured a supplement drink, entered resident room to administer the drink, and then exited the room without performing hand hygiene returning to the computer at the med cart. -3:52 P.M., without performing hand hygiene Nurse #6 poured medications for the next resident, entered the resident's room, administered the medications, and left the resident's room, then performed hand hygiene. During an interview on 4/9/24 at 4:05 P.M., Nurse #6 said hand hygiene should be done between every resident and with glove changes. During an interview on 4/10/24 at 10:05 A.M., Unit Manager #3 said hand hygiene should be done between every resident and before/after glove changes. During an interview on 4/10/24 at 11:39 A.M., the Director of Nurses (DON) said hand hygiene should be done between every resident and before/after changes. 2. Review of the facility's policy titled Blood Glucose Monitoring, undated, indicated but was not limited to the following: -The nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy. PROCEDURE: -Perform hand hygiene. -Collect blood sample. -Remove and discard gloves and perform hand hygiene. -Clean and disinfect the glucometer. -Perform hand hygiene. Review of the facility's policy titled Glucometer Disinfection, undated, indicated but was not limited to the following: -The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cleaning is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with detergents or enzymatic products. - Disinfection is a process that eliminates many or all pathogenic microorganisms, except bacterial spores on inanimate objects. -The facility will ensure blood glucometers will be cleaned and disinfected after each use. -The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant. PROCEDURE: -Retrieve two disinfectant wipes from container. -Using first wipe, clean first to remove heavy soil, blood, and/or other contaminants left on the surface of the glucometer. -After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe. Allow the glucometer to air dry. -Discard disinfectant wipe. -Perform hand hygiene. Review of the Super Sani-Cloth Germicidal Disposable Wipe General Guidelines for Use, dated 2021, indicated but were not limited to the following: -If present use a wipe to remove visible soil prior to disinfection. -Unfold the wipe and thoroughly wet surface. -Allow the thoroughly wet surface to remain wet for two minutes. Let air dry. On 4/9/24, the surveyor made the following observations during the afternoon Medication Pass with Nurse #6: -3:34 P.M., Nurse #6 put on gloves, obtained a blood sample for glucose test, removed gloves, did not perform hand hygiene, opened a container of Sani Wipes to clean the glucometer, cleaned the glucometer by wiping it down, wrapping the machine in the wet wipe and then placed it on top of med cart, without performing hand hygiene moved med cart to another room. -3:48 P.M., without performing hand hygiene Nurse #6 got a different glucometer and supplies, put gloves on, obtained a blood sample for glucose test, removed the gloves, at the med cart wrote on her report sheet, opened a container of Sani Wipes to clean the glucometer, cleaned the glucometer by wiping it down, wrapping the machine in the wet wipe and then placed it on top of med cart, she then dried off the glucometer that was wrapped in the wipe from the previous resident and put it back in the glucose testing supply bin, without performing hand hygiene moved med cart to another room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/24 at 4:05 P.M., Nurse #6 said she was told to wrap the machine in the Sani Wipe after wiping it off. She said she usually leaves it out for three minutes wrapped in the wipe then dries it off because it doesn't air dry wrapped in the wipe and then she would put it away. During an interview on 4/10/24 at 10:05 A.M., Unit Manager #3 said the nurses should be wiping the glucometer with a Sani Wipe, then wrapping it in the wipe, leave it sit for three minutes to sanitize it. During an interview on 4/10/24 at 10:48 A.M., Unit Manager #3 said she checked the Sani Wipes directions and it's only two minutes, so the nurse should wipe it down, then wrap it in the wipe and leave it for two minutes, then remove the wipe and let the glucometer air dry before putting it away. During an interview on 4/10/24 at 11:39 A.M., the DON said they only need to use one wipe. The procedure would be to wipe the machine down and then let it air dry for two minutes. She said the air drying is how it is sanitized and if they wipe it dry it defeats the purpose. Additionally, she said they should not be wrapping the machine in the wet wipe, letting it sit and then drying it off to put away and the nurse should be doing hand hygiene before and after cleaning the glucometer.