

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Aspen Hill Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  190 North Avenue 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</b></p> <p>Based on record review and interview, the facility failed to keep one Resident (#1) free from abuse out of a total sample of 28 residents. Specifically, an allegation of abuse was made by Resident #95 and filed as a grievance, subsequently allowing the accused certified nursing aide to continue working, which led to the physical abuse of Resident #1.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse, Neglect, Exploitation and Missappropriation Prevention Program, undated, indicated the following:</p> <ul style="list-style-type: none"> <li>- Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.</li> <li>- Investigate and report any allegations within timeframes required by federal requirements.</li> <li>- Establish and implement a QAPI review and analysis of reports, allegations or findings of abuse, neglect mistreatment or misappropriation of property.</li> </ul> <p>Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised September 2022, indicates the following:</p> <ul style="list-style-type: none"> <li>-All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</li> <li>-All allegations are thoroughly investigated. The administrator initiates investigations.</li> <li>-The administrator is responsible for keeping the resident and his/her representative informed of the progress of the investigation.</li> <li>-Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</li> </ul> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The individual conducting the investigation as a minimum:</p> <ul style="list-style-type: none"> <li>* interviews the person(s) reporting the incident</li> <li>* interviews any witnesses to the incident</li> <li>* interviews the resident</li> <li>* interviews the resident's attending physician as needed to determine the resident's condition</li> <li>* interviews the resident's roommate</li> <li>* interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident</li> <li>* review all events leading up to the alleged incident</li> <li>* documents the investigation completely and thoroughly</li> </ul> <p>-The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.</p> <p>1. Resident #95 was admitted in November 2023 with diagnoses including hypertension and osteoporosis.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 10/31/24, indicated Resident #95 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated Resident #95 requires partial to moderate assistance with all activities of daily living.</p> <p>During review of a grievance filed on 11/27/24, written by the Administrator, it indicates Resident #95 reported to the Unit Manager that a C.N.A. (Certified Nursing Assistant #5) did not follow his/her preferences for transferring. The grievance also indicated Resident had reported that a CNA (CNA #5) pulled his/her arm too hard during a transfer. Resident said he/she felt safe and had no concerns and wants the Unit Manager to train her (CNA #5) on his/her (the Resident) preferences for transfer.</p> <p>During an interview on 1/15/25 at 11:48 A.M., Resident #95 told the surveyor that he/she clearly remembers the incident and told a staff member that CNA #5 was rough with him/her. Resident #95 said that CNA #5 was rough when transferring him/her to the toilet and Resident #95 said he/she requires an extra large brief, but CNA #5 only brought in a small one. Resident #95 said he/she told CNA #5 that he/she needs an extra large brief and CNA #5 said she was going to leave and started counting down 5, 4, 3, 2, 1 . to get Resident #95 to put on the small brief. Resident #95 said he/she forced the small brief on because he/she thought CNA #5 would leave him/her in the bathroom if he/she didn't put the brief on. Resident #95 said he/she felt like CNA #5 was purposeful in her actions. Resident #95 said he/she had never seen CNA #5 before and has not seen CNA #5 since the incident. Resident #95 said he/she does not remember if anyone came to check on him/her to see if he/she felt safe or follow up with him/her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 1/15/25 at 12:28 P.M., the Administrator said that Resident #95 reported to the Unit Manager that CNA #5 was kind of rushed and the Resident was upset with the transfer because the CNA was not taking her time. The Administrator said that from what she remembers, the CNA was very fast and quick and she does not remember the Resident mentioning anything about the briefs. The Administrator said that she asks residents verbatim if they feel like they have been abused. The Administrator said that from her recollection, she believes it was a customer service issue and that is why she filed it as a grievance. The Administrator said the Resident initially reported to her that it was rough handling, but she honed down the interview and the Resident wanted the CNA to go slower with his/her care.</p> <p>During an interview on 1/15/25 at 12:57 P.M., the Director of Nursing said she asked the Resident if he/she felt it was malicious and the Resident said no.</p> <p>Review of the medical record failed to indicate any information regarding the incident.</p> <p>Shortly after the interview, the facility Administrator provided two written statements and a skin check, dated 11/27/24. The written statements were from the Director of Nursing and the Unit Manager. The facility could not provide a written statement for the CNA involved.</p> <p>There was no action taken to prevent CNA #5 from working on the unit or at the facility.</p> <p>2. Resident #1 was admitted in September 2020 with diagnoses including depression and arthritis.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #1 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated Resident #1 requires substantial/maximal assistance with upper body dressing, is dependent on staff for lower body dressing and toileting.</p> <p>During an interview on 1/14/25 at 7:46 A.M., Resident #1 told the surveyor that on 12/9/24, a female CNA hurt his/her arm during an interaction. Resident #1 said that his/her arm still hurts from the incident.</p> <p>Review of a facility reported incident, dated 12/10/24, indicated Resident #1 reported to facility staff that CNA #5 was rough with him/her during care. Resident #1 told staff that, on 12/9/24, CNA #5 forcefully pulled the laptop case handle from my arm, causing him/her left upper arm pain, 8 out of 10 pain and that CNA #5 forcefully pulled a brief off of Resident #1. Resident #1 reported that he/she asked for a diet cola and CNA #5 brought the soda, but would not pour it for Resident #1 and told Resident #1 to open the bottle him/herself or he/she won't get any. Resident #1 also told staff that CNA #5 asked Resident #1 if he/she was full of urine or feces because she didn't have time to change Resident #1.</p> <p>Review of the Resident/Witness Statement, dated 12/10/24, indicated Resident #1 told the Social Worker that Resident #1 was not moving fast enough so CNA #5 grabbed the bag and pulled it off my arm fast and it hurt. The Social Worker documented Resident #1 reports his/her arm is still sore. There are no marks on the arm, but Resident #1 winced when it was lightly touched. He/she states that he/she feels safe with the other staff, but did not feel safe with CNA #5.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the medical record indicated that an x-ray was obtained on 12/10/24 in the facility of Resident #1's arm and showed a fracture of the left ulna (the long bone of the forearm) with indeterminate age (time of fracture could not be determined).</p> <p>Review of the Employee Performance Improvement Notification, dated 12/16/24, indicated CNA #5 was suspended from the facility, 6 days after the alleged incident occurred.</p> <p>Review of the Employee Performance Improvement Notification, dated 12/27/24, indicated CNA #5 was terminated due to performance.</p> <p>During an interview on 1/15/24 at 8:37 A.M., the Director of Nursing said Resident #1 reported the event the day after it occurred to the Unit Manager. The Director of Nursing said that Resident #1 felt like CNA #5 pulled his/her bag abruptly off when CNA #5 was changing him/her and felt the CNA was rude. The Director of Nursing said CNA #5 was suspended and then let go.</p> <p>See F609, F610, and F867.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>41019</p> <p>Based on record review and interview, the facility failed to implement their abuse policy by failing to investigate an allegation of abuse from one Resident (#95), which led to the abuse of another resident by the same certified nursing aide, out of a total sample of 28 residents. Specifically, Resident #95 alleged a certified nursing aide handled him/her roughly and refused to put the correct sized brief on Resident #95, which was filed as a grievance by the facility, ultimately leading to the same certified nursing aide physically abuse Resident #1.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised September 2022, indicates the following:</p> <p>-All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>-All allegations are thoroughly investigated. The administrator initiates investigations.</p> <p>-The administrator is responsible for keeping the resident and his/her representative informed of the progress of the investigation.</p> <p>-Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</p> <p>-The individual conducting the investigation as a minimum:</p> <ul style="list-style-type: none"> <li>* interviews the person(s) reporting the incident</li> <li>* interviews any witnesses to the incident</li> <li>* interviews the resident</li> <li>* interviews the resident's attending physician as needed to determine the resident's condition</li> <li>* interviews the resident's roommate</li> <li>* documents the investigation completely and thoroughly</li> </ul> <p>-The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 1/15/25 at 11:48 A.M., Resident #95 said that he/she clearly remembers the incident and told a staff member that a CNA was rough with him/her. Resident #95 said that the CNA was rough when transferring him/her to the toilet and Resident #95 said he/she requires and extra large brief, but the CNA only brought in a small one. Resident #95 said he/she told the CNA that he/she needs an extra large brief and the CNA said she was going to leave and started counting down 5, 4, 3, 2, 1 . to get Resident #95 to put on the small brief. Resident #95 said he/she forced the small brief on because he/she thought the CNA would leave him/her in the bathroom if he/she didn't put the brief on. Resident #95 said she felt like the CNA was purposeful in her actions. Resident #95 said he/she had never seen that CNA before and has not seen the CNA since the incident. Resident #95 said he/she does not remember if anyone came to check on him/her to see if he/she felt safe or follow up with him/her.</p> <p>During an interview on 1/15/25 at 12:28 P.M., the Administrator said that Resident #95 reported to the Unit Manager that a CNA was kind of rushed and the Resident was upset with the transfer and that the CNA was not taking her time. The Administrator said that from what she remembers, the CNA was very fast and quick and she does not remember the Resident mentioning anything about the briefs. The Administrator said that she asks residents verbatim if they feel like they have been abused. The Administrator said that from her recollection, she believes it was a customer service issue and that is why she filed it as a grievance. The Administrator said the Resident initially reported to her that it was rough handling, but she honed down the interview and the Resident wanted the CNA to go slower with his/her care.</p> <p>During an interview on 1/15/25 at 12:57 P.M., the Director of Nursing said she asked the Resident if he/she felt it was malicious and the Resident said no.</p> <p>Review of the medical record failed to indicate any information regarding the incident.</p> <p>Shortly after the interview, the facility Administrator provided two written statements and a skin check, dated 11/27/24. The written statements were from the Director of Nursing and the Unit Manager. The facility could not provide a written statement for the CNA involved.</p> <p>Review of the Healthcare Facility Reporting System failed to indicate the facility reported the incident to the state agency.</p> <p>Review of a facility reported incident, dated 12/10/24, indicated Resident #1 reported to facility staff that CNA #5 was rough with him/her during care. Resident #1 told staff that, on 12/9/24, CNA #5 forcefully pulled the laptop case handle from my arm, causing him/her left upper arm pain, 8 out of 10 pain and that CNA #5 forcefully pulled a brief off of Resident #1. Resident #1 reported that he/she asked for a diet cola and CNA #5 brought the soda, but would not pour it for Resident #1 and told Resident #1 to open the bottle him/herself or he/she won't get any. Resident #1 also told staff that CNA #5 asked Resident #1 if he/she was full of urine or feces because she didn't have time to change Resident #1.</p> <p>Review of the Resident/Witness Statement, dated 12/10/24, indicated Resident #1 told the Social Worker that Resident #1 was not moving fast enough so CNA #5 grabbed the bag and pulled it off my arm fast and it hurt. The Social Worker documented Resident #1 reports his/her arm is still sore. There are no marks on the arm, but Resident #1 winced when it was lightly touched . He/she states that he/she feels safe with the other staff, but did not feel safe with CNA #5.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the medical record indicated that an x-ray was obtained on 12/10/24 in the facility of Resident #1's arm and showed a fracture of the left ulner (the long bone of the forearm) with indeterminate age (time of fracture could not be determined).</p> <p>Review of the Employee Performance Improvement Notification, dated 12/16/24, indicated CNA #5 was suspended from the facility pending investigation of the incident that occurred with Resident #1.</p> <p>Review of the Employee Performance Improvement Notification, dated 12/27/24, indicated CNA #5 was terminated due to performance.</p> <p>During an interview on 1/15/25 at 11:36 A.M., the Administrator was asked why CNA #5 was terminated and what performance indicated. The Administrator said she terminated CNA #5 for customer service and insubordination because CNA #5 was mouthy with her. The Administrator cannot recall the exact phrases CNA #5 said to her, but remembers it was her body language and attitude. The Administrator did not specify if CNA #5 was terminated due to the investigated allegations.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41019</p> <p>Based on record review and interview, the facility failed to report an allegation of potential abuse for one Resident (#95) out of a total sample of 28 residents. Specifically, Resident #95 reported rough handling of a certified nursing aide to another staff member and the incident was not reported and filed as a grievance.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised September 2022, indicates the following: - All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>- If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be immediately reported to the administrator and to other officials according to the state law.</p> <p>- The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:</p> <ul style="list-style-type: none"> <li>* The state licensing/certification agency responsible for surveying/licensing the facility</li> </ul> <p>- Immediately is defined as:</p> <ul style="list-style-type: none"> <li>* Within two hours of an allegation involving abuse or result in serious bodily injury</li> </ul> <p>- Notices include, as appropriate:</p> <ul style="list-style-type: none"> <li>* The date and time the alleged incident occurred</li> <li>* The names of all persons involved in the alleged incident</li> <li>* What immediate action was taken by the facility</li> </ul> <p>Resident #95 was admitted in November 2023 with diagnoses including hypertension and osteoporosis. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #95 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the MDS indicated Resident #95 requires partial to moderate assistance with all activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During review of the a grievance filed on 11/27/24, written by the Administrator, indicates Resident #95 reported to the Unit Manager that a C.N.A. (certified nursing aide) did not follow her preferences for transferring. The grievance also indicated Resident had reported that a CNA pulled his/her arm too hard during a transfer. Resident said he/she felt safe and had no concerns and wants the Unit Manager to train her (staff member) on his/her (the Resident) preferences for transfer.</p> <p>During an interview on 1/15/25 at 11:48 A.M., Resident #95 said that he/she remembers the incident and told a staff member that a CNA was rough with him/her. Resident #95 said that the CNA was rough when transferring him/her to the toilet and Resident #95 said he/she requires and extra large brief, but the CNA only brought in a small. Resident #95 said he/she told the CNA that he/she needs an extra large brief and the CNA said she was going to leave and started counting down 5, 4, 3, 2, 1 . to get Resident #95 to put on the small brief. Resident #95 said he/she forced the small brief on because he/she thoguht the CNA would leave him/her in the bathroom if he/she didn't put the brief on. Resident #95 said she felt like the CNA was purposeful in her actions. Resident #95 said he/she had never seen that CNA before and has not seen the CNA since the incident. Resident #95 said he/she does not remember if anyone came to check on him/her to see if he/she felt safe or follow up with him/her.</p> <p>During an interview on 1/15/25 at 12:28 P.M., the Administrator said that Resident #95 reported to the Unit Manager that a CNA was kind of rushed and the Resident was upset with the transfer and that the CNA was not taking her time. The Administrator said that from what she remembers, the CNA was very fast and quick and she does not remember the Resident mentioning anything about the briefs. The Administrator said that she asks residents verbatim if they feel like they have been abused. The Administrator said that from her recollection, she believes it was a customer service issue and that is why she filed it as a grievance. The Administrator said the Resident initially reported it was rough handling, but she honed down the interview and the Resident wanted the CNA to go slower with his/her care.</p> <p>During an interview on 1/15/25 at 12:57 P.M., the Director of Nursing said she asked the Resident if he/she felt it was malicious and the Resident said no.</p> <p>Review of the medical record failed to indicate any information regarding the incident.</p> <p>Review of the Healthcare Facility Reporting System failed to indicate the incident was reported on or around 11/27/24.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Aspen Hill Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  190 North Avenue Haverhill, MA 01830	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41019</p> <p>Based on record review and interview, the facility failed to 1a. investigate an allegation of potential abuse for one Resident (#95), which 1b. failed to keep Resident (#1) free from abuse, out of a total sample of 28 residents. Specifically, Resident #95 reported to staff having been rough handled by a certified nursing aide. The report was not thoroughly investigated, which allowed the accused certified nursing aide to continue working, and eventually abuse Resident #1.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised September 2022, indicates the following:</p> <ul style="list-style-type: none"> <li>-All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</li> <li>-All allegations are thoroughly investigated. The administrator initiates investigations.</li> <li>-The administrator is responsible for keeping the resident and his/her representative informed of the progress of the investigation.</li> <li>-Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</li> <li>-The individual conducting the investigation as a minimum: <ul style="list-style-type: none"> <li>* interviews the person(s) reporting the incident</li> <li>* interviews any witnesses to the incident</li> <li>* interviews the resident</li> <li>* interviews the resident's attending physician as needed to determine the resident's condition</li> <li>* interviews the resident's roommate</li> <li>* documents the investigation completely and thoroughly</li> </ul> </li> <li>-The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.</li> </ul> <p>1a. Resident #95 was admitted in November 2023 with diagnoses including hypertension and osteoporosis.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Minimum Data Set (MDS) assessment, dated 10/31/24, indicated Resident #95 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of the MDS indicated Resident #95 requires partial to moderate assistance with all activities of daily living.</p> <p>Review of a grievance filed on 11/27/24, written by the Administrator, indicates Resident #95 reported to the Unit Manager that a C.N.A. (certified nursing aide #5) did not follow his/her preferences for transferring. The grievance also indicated Resident had reported that a CNA pulled his/her arm too hard during a transfer. Resident said he/she felt safe and had no concerns and wants the Unit Manager to train her (staff member) on his/her (the Resident) preferences for transfer.</p> <p>Review of the medical record failed to indicate any information regarding the incident.</p> <p>During an interview on 1/15/25 at 11:48 A.M., Resident #95 said that he/she clearly remembers the incident and told a staff member that a CNA (CNA #5) was rough with him/her. Resident #95 said that CNA #5 was rough when transferring him/her to the toilet and Resident #95 said he/she requires and extra large brief, but CNA #5 only brought in a small one. Resident #95 said he/she told the CNA that he/she needs an extra large brief and CNA #5 said she was going to leave and started counting down 5, 4, 3, 2, 1 . to get Resident #95 to put on the small brief. Resident #95 said he/she forced the small brief on because he/she thought CNA #5 would leave him/her in the bathroom if he/she didn't put the brief on. Resident #95 said she felt like CNA #5 was purposeful in her actions. Resident #95 said he/she had never seen CNA #5 before and has not seen CNA #5 since the incident. Resident #95 said he/she does not remember if anyone came to check on him/her to see if he/she felt safe or follow up with him/her.</p> <p>During an interview on 1/15/25 at 12:28 P.M., the Administrator said that Resident #95 reported to the Unit Manager that a CNA was kind of rushed and the Resident was upset with the transfer and that the CNA was not taking her time. The Administrator said that from what she remembers, the CNA was very fast and quick and she does not remember the Resident mentioning anything about the briefs. The Administrator said that she asks residents verbatim if they feel like they have been abused. The Administrator said that from her recollection, she believes it was a customer service issue and that is why she filed it as a grievance. The Administrator said the Resident initially reported to her that it was rough handling, but she honed down the interview and the Resident wanted the CNA to go slower with his/her care.</p> <p>During an interview on 1/15/25 at 12:57 P.M., the Director of Nursing said she asked the Resident if he/she felt it was malicious and the Resident said no.</p> <p>Shortly after the interview, the facility Administrator provided two written statements and a skin check, dated 11/27/24. The written statements were from the Director of Nursing and the Unit Manager. The facility could not provide a written statement from the CNA involved nor could she provide any written statements from other staff working on the unit that day.</p> <p>1b. Resident #1 was admitted in September 2020 with diagnoses including depression and arthritis.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #1 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated Resident #1 requires substantial/maximal assistance with upper body dressing, is dependent on staff for lower body dressing and toileting.</p> <p>On 12/10/24, an abuse incident report was filed through the healthcare facility reporting system detailing an incident that occurred with CNA #5 and Resident #1, who alleged that CNA #5 pulled a bag off of his/her shoulder roughly and hurt Resident #1's arm.</p> <p>Review of a facility reported incident, dated 12/10/24, indicated Resident #1 reported to facility staff that CNA #5 was rough with him/her during care. Resident #1 told staff that, on 12/9/24, CNA #5 forcefully pulled the laptop case handle from my arm, causing him/her left upper arm pain, 8 out of 10 pain and that CNA #5 forcefully pulled a brief off of Resident #1. Resident #1 reported that he/she asked for a diet cola and CNA #5 brought the soda, but would not pour it for Resident #1 and told Resident #1 to open the bottle him/herself or he/she won't get any. Resident #1 also told staff that CNA #5 asked Resident #1 if he/she was full of urine or feces because she didn't have time to change Resident #1.</p> <p>Review of the Resident/Witness Statement, dated 12/10/24, indicated Resident #1 told the Social Worker that Resident #1 was not moving fast enough so CNA #5 grabbed the bag and pulled it off my arm fast and it hurt. The Social Worker documented Resident #1 reports his/her arm is still sore. There are no marks on the arm, but Resident #1 winced when it was lightly touched . He/she states that he/she feels safe with the other staff, but did not feel safe with CNA #5.</p> <p>Review of the medical record indicated that an x-ray was obtained on 12/10/24 in the facility of Resident #1's arm and showed a fracture of the left ulner (the long bone of the forearm) with indeterminate age (time of fracture could not be determined).</p> <p>Review of the Employee Performance Improvement Notification, dated 12/16/24, 6 days after the alleged incident, indicated CNA #5 was suspended from the facility pending investigation of the incident that occurred with Resident #1.</p> <p>Review of the Employee Performance Improvement Notification, dated 12/27/24, indicated CNA #5 was terminated.</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>36797</p> <p>Based on record review and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for two Residents (#71 and #47) out of a total sample of 28 residents. Specifically;</p> <ol style="list-style-type: none"> <li>For resident #71 the facility inaccurately coded dental status on the MDS.</li> <li>For Resident #47 the facility failed to code a feeding tube on the MDS.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Resident #71 was admitted to the facility in May 2024 with diagnoses including Parkinson's, malnutrition and depression.</li> </ol> <p>Review of the Minimum Data Set (MDS) assessment, dated 5/22/24, indicated Resident #71 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam indicating intact cognition. The MDS further indicated Resident #71 did not have any obvious broken/carious teeth.</p> <p>During an interview on 1/15/25 at 2:05 P.M., Resident #71 said that he/she has not seen the dentist while a resident at the facility but that if it would help him/her to chew he/she would want to see the dentist. Resident #71 showed the surveyor his/her teeth. The surveyor observed multiple upper and lower teeth missing and obvious carious teeth that had dark discoloration on all remaining teeth.</p> <p>Review of the facility document titled Admission/Readmission Screener-V 10, dated 5/15/24, indicated that Resident #71 had missing teeth. Further review failed to indicate Resident #71 had carious teeth.</p> <p>During an interview on 1/15/25 at 3:11 P.M., the Director of Nursing said that the MDS should accurately reflect the condition of Resident #71's teeth.</p> <p>44095</p> <ol style="list-style-type: none"> <li>Resident #47 was admitted to the facility in May 2024 with diagnoses including chronic obstructive pulmonary disease, tracheostomy status, paranoid schizophrenia, anxiety, and dysphagia.</li> </ol> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 10/17/24, indicated that Resident #47 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of a possible 15. This MDS further indicated Resident #47 required set up assistance with eating. The MDS was coded the following:</p> <p>-Feeding tube (e.g., nasogastric or abdominal (PEG)), coded as no.</p> <p>.</p> <p>Review of Resident #47's plan of care related to enteral tube feeding, dated 5/2/24, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>-Administer Tube feeding as ordered.</p> <p>During an interview on 1/15/25 at 7:41 A.M., the MDS Nurse said the tube feeding should have been coded on Resident #47's MDS, but was not.</p> <p>During an interview on 1/15/25 at 3:32 P.M., the Director of Nursing said that the MDS should be coded based on the RAI (resident assessment instrument) manual.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>44095</p> <p>Based on observation, record review, and interview, the facility failed to ensure that an individualized, comprehensive care plan was implemented for one Resident (#106), out of a total sample of 28 residents. Specifically for Resident #106, the facility failed to implement fall mats.</p> <p>Findings include:</p> <p>Review of the facility policy titled Care Plans, Comprehensive Person-Center, dated as revised March 2022, indicated:</p> <p>-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>7. The comprehensive, person-centered care plan:</p> <p>a. includes measurable objectives and timeframes;</p> <p>b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including:</p> <p>(1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.</p> <p>Resident #106 was admitted to the facility in November 2024 with diagnoses including metabolic encephalopathy, falls, anxiety, and atrial fibrillation.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 11/29/24, indicated that Resident #106 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 11 out of a possible 15. This MDS further indicated Resident #106 required assistance with activities of daily living.</p> <p>Review of Resident #106's plan of care related to falls, dated 11/27/24, indicated:</p> <p>- Fall mat(s) to both side(s) of the bed at all times when the resident is in bed.</p> <p>Review of Resident #106's incident accident reports indicated Resident #106 had fallen on the following dates and times:</p> <p>- On 11/9/24 at 12:45 P.M., Resident #106 fell in his/her room while ambulating. There were not witnesses and the Resident was found on floor.</p> <p>- On 11/10/24 at 11:04 P.M., Resident #106 fell in his/her room and was found on the floor.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 11/27/24 at 8:45 P.M., Resident #106 fell in his/her room and was sitting and yelling for pain medications. Injuries included three skin tears. An intervention to include fall mats to the plan of care.</p> <p>- On 12/1/24 at 1:45 A.M., Resident #106 had a fall in his/her room on the floor.</p> <p>- On 12/10/24 at 12:15 A.M., Resident #106 had a fall in his/her room on the floor.</p> <p>- On 12/16/24 at 3:57 P.M., Resident #106 had a fall in his/her room on the floor.</p> <p>- On 12/17/24 at 5:30 A.M., Resident #106 had a fall in his/her room on the floor.</p> <p>Review of Resident #106's health status note, dated 1/12/25 at 2:33 A.M., indicated:</p> <p>-Note Text: At 1:00 A.M., the CNA (Certified Nursing Assistant) found the resident on the floor in a praying position. This writer responded immediately to the resident's room. Assessment performed; Resident was safely removed from the floor.</p> <p>On 1/14/25 at 8:03 A.M., 1:54 P.M., 3:13 P.M., and at 4:24 P.M., and on 1/15/25 at 6:48 A.M., and 7:27 A.M., the surveyor observed Resident #106 in his/her bed without bilateral fall mats on both sides of bed.</p> <p>During an interview on 1/15/25 at 7:30 A.M., CNA #3 said that Resident #106 does not utilize fall mats. CNA #3 and the surveyor searched the Resident's room and CNA #3 was unable to locate any fall mats.</p> <p>During an interview on 1/15/25 at 7:55 A.M., Nurse #5 said that Resident #106 had a fall on 1/12/25, and Nurse #5 is not aware of Resident #106 requiring fall mats. Nurse #5 said that Resident #106 is a high risk for falls.</p> <p>During an interview on 1/15/25 at 9:01 A.M., Unit Manager #3 said that Resident #106 is a high risk for falls. Unit Manager #3 reviewed Resident #106's care plan and Unit Manager #3 said that the intervention for fall mats should be implemented if it is on the plan of care.</p> <p>During an interview on 1/15/25 at 3:44 P.M., the Director of Nursing (DON) said Resident #106 has altered mental status and he/she is cognitively impaired. The DON said that Resident #106 has had multiple falls, and nursing should implement the care plan for bilateral fall mats.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>44095</p> <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observations, record review and interviews, the facility failed to meet professional standards of practice for four Residents (#111, #106, #71, and #112) out of a total of sample of 28 residents. Specifically;</p> <ol style="list-style-type: none"> <li>For Resident #111, the facility failed to ensure nursing implemented compression stockings as ordered by the physician.</li> <li>For Resident #106 the facility failed to ensure nursing clarified a physician's order for g-tube flushes (two different flush orders) and failed to ensure Resident #106's feeding tube pump was set to the correct flush settings.</li> <li>For Resident #71 the facility failed to ensure Resident #71's diet was least restrictive.</li> <li>For Resident #112 the facility failed to obtain weights as ordered by the physician.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility policy titled Apply Anti- Emboli Stockings (TED Hose), dated as revised October 2010, indicated the purpose of this procedure is to improve venous return to the heart, to improve arterial circulation to the feet, to minimize edema to the legs and feet, and to prevent complications associated with deep vein thrombosis and pulmonary embolism.</li> </ol> <p>- Preparation</p> <ol style="list-style-type: none"> <li>Verify that there is a physician's order for anti-emboli stockings. If there is no order for anti-emboli stockings, contact the Attending Physician to obtain orders. (Note: Document the receipt of telephone orders in the resident's medical record.)</li> </ol> <p>General Guidelines</p> <ol style="list-style-type: none"> <li>If possible, anti-emboli stockings should be applied in the morning, prior to the resident getting out of bed.</li> </ol> <p>Resident #111 was admitted to the facility in December 2024 with diagnoses including pneumonia, chronic diastolic heart failure, atrial fibrillation, and generalized edema.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/23/24, indicated that Resident #111 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 11 out of a possible 15. This MDS further indicated Resident #111 received a diuretic (a medication that increases urine production and help lower blood pressure and fluid retention), did not reject care, and was dependent on staff with putting on/taking off footwear which included the ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.</p> <p>Review of Resident #111's physician's order, dated 12/27/24, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Compression Stockings applied to bilateral lower extremity (BLE) in the morning for lower extremity (LE) edema. Apply compression stockings in the morning (scheduled daily at 8:00 A.M.) and at bedtime for LE edema Remove Compression stockings (scheduled daily at 9:00 P.M.).</p> <p>On 1/14/24 at 7:47 A.M., 8:07 A.M., 12:20 P.M., 3:42 P.M., 4:24 P.M., and on 1/15/25 at 7:42 A.M., 11:09 A.M., and 1:25 P.M., the surveyor observed Resident #111 dressed and out of bed and sitting. Resident #111's legs were swollen, and he/she was not wearing compression stockings.</p> <p>Review of the January 2025 Treatment Administration Record (TAR) on 1/15/24 at 3:15 P.M., indicated nursing had documented that they had applied Resident #111's compression stockings. The surveyor and Unit Manager #3 went into Resident #111's room. Resident #111 was not wearing his/her compression stockings. The compression stocking were in his/her dresser drawer. The TAR further indicated nursing applied Resident #111's compression stockings on 1/14/25 and 1/15/25. However, based on the surveyor's observations on 1/14/25 and 1/15/25, the compression stockings were not applied.</p> <p>During an interview on 1/15/25 at 3:22 P.M., Nurse #9 said she did not apply Resident #111's compression stockings on 1/15/25, but she signed off the order that they were applied.</p> <p>During an interview on 1/15/25 at 3:18 P.M., Unit Manager #3 said that nursing should apply compression stockings as ordered by the physician.</p> <p>During an interview on 1/15/25 at 3:38 P.M., the Director of Nursing said nursing should apply Resident #111's compression stockings as ordered by the physician.</p> <p>2.) Review of the facility policy titled Enteral Nutrition, dated November 2018, indicated that adequate nutritional support through enteral nutrition is provided to residents as ordered.</p> <p>3. The dietitian, with input from the provider and nurse:</p> <p>d. calculates fluids to be provided (beyond free fluids in formula).</p> <p>Resident #106 was admitted to the facility in November 2024 with diagnoses including metabolic encephalopathy, anxiety and atrial fibrillation.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/29/24, indicated that Resident #106 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 11 out of a possible 15. The MDS further indicated Resident #106 required assistance with activities of daily living and required a feeding tube for nutrition.</p> <p>On 1/14/25 at 7:32 A.M., the surveyor observed Resident #106 receiving tube feeding. The tube feeding machine was set for water flushes at 100 milliliters every 8 hours. The water flush bag was dated 1/13/25 and had approximately 800 mL in the bag.</p> <p>On 1/15/25 at 7:27 A.M., the survey observed Resident #106 receiving tube feeding. The tube feeding machine was set for water flushes at 100 milliliters every 8 hours. The water flush bag was dated 1/13/25 and had approximately 600 mL in the bag.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #106's plan of care related to enteral nutrition support, dated 1/7/25, indicated:</p> <ul style="list-style-type: none"> <li>- Registered Dietitian to evaluate nutritional status and make recommendations as applicable PRN (as needed).</li> </ul> <p>Review of Resident #106's Nutritional Risk Assessment - V 8, dated 1/3/25, indicated:</p> <ul style="list-style-type: none"> <li>-Recommend increasing free water flushes to 150 milliliters every six hours to meet daily fluid goal.</li> </ul> <p>Review of Resident #106's physician's order, dated 1/7/25, indicated:</p> <ul style="list-style-type: none"> <li>-Free water flushes of 150 ml every 6 hours, every 6 hours for patency and hydration. Scheduled every 6 hours at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M.</li> </ul> <p>Review of Resident #106's physician's order, dated 1/9/25, indicated:</p> <ul style="list-style-type: none"> <li>-Five times a day free water flush: 150 ml every 4 hours (total volume 750 ml). The order was scheduled five times daily at 4:00 A.M., 7:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M. Further review of this physician's order revealed the order was unclear to the reader (every 4 hours would indicate that nursing should administer the flushes six times daily), the order was not scheduled every four hours and the times that flushes were scheduled were not consistently spaced four hours apart.</li> </ul> <p>During an interview on 1/15/25 at 7:56 A.M., Nurse #5 said that Resident #106's flush orders are based on the physician's order. Nurse #5 said that the flushes on the pump are set to 100 ml every 8 hours. Nurse #5 said he verifies the physician's order and provides flushes according to the orders.</p> <p>During an interview on 1/15/25 at 8:22 A.M., the Registered Dietitian (RD) said she most recently estimated Resident #106's fluid needs and she reviewed Resident #106's labs on 1/9/25. The RD said that she calculated Resident #106's fluids need to be 150 ml every four hours during the 20-hour tube feeding run period. The RD said that providing too much water to Resident #106 could cause him/her hyponatremia.</p> <p>On 1/15/25 at 8:30 A.M., the surveyor and the RD observed Resident #106's flush bag dated 1/13/25 and the pump was set to 100 ml water flushes every 8 hours.</p> <p>During an interview on 1/15/25 at 8:50 A.M., Unit Manager #3 reviewed the physician's orders for Resident #106's water flushes. Unit Manager #3 said the flush orders are not scheduled every 4 hours and there are two different orders for flushes. Unit Manager #3 said that nursing should have clarified the flush orders.</p> <p>During an interview on 1/15/25 at 3:51 P.M., the Director of Nursing said nursing should set the pump to the correct settings and that nursing should read the flush orders correctly.</p> <p>36797</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of the facility policy titled Therapeutic Diets, dated 2001, indicated that the dietitian, nursing staff, and attending physician will regularly review the need for, and resident acceptance of prescribed therapeutic diets.</p> <p>Resident #71 was admitted to the facility in May 2024 with diagnoses including Parkinson's, malnutrition and depression.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 10/31/24, indicated Resident #71 scored a 11 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition.</p> <p>During an interview on 1/13/25, at approximately 8:00 A.M., Resident #71 said he/she wants a regular diet and explained I am on mechanical diet for the past six months. I want to eat regular food, a burger would be nice. I'm not sure why I need this diet.</p> <p>Review of the hospital discharge summary, dated 5/15/24, indicated Resident #71 was on a regular diet consistency.</p> <p>Review of the physician's order, dated 5/20/24, indicated an order for a Regular diet, Regular texture, Thin consistency.</p> <p>Review of the dietitian note titled Nutritional Risk Assessment - V 8, dated 5/22/24, indicated the following recommendation:</p> <p>-Continue Regular unrestricted, regular texture, thin liquid diet a/o.</p> <p>Review of the hospital discharge summary dated 8/12/24, indicated to continue an L 6 SBS (soft bite size) diet.</p> <p>Review of the physician's order, dated 8/19/24, indicated an order for a Regular diet, Mechanical Soft texture, Thin consistency.</p> <p>Review of the physician's order, dated 8/13/24, indicated an order for Consult Speech Therapy for evaluation and treatment as needed.</p> <p>Review of the dietitian note, dated 11/1/24, indicated:</p> <p>-Recommendations &amp; Plan: Continue Regular, Mechanical Soft texture, Thin liquid diet, w/ 2x portions; ? SLP (speech language pathology) re-eval (evaluation).</p> <p>Review of the physician's orders indicated an order, dated 1/15/25, for SLP Clarification Order: Oropharyngeal swallow grossly WFL (within functional limits) at bedside. Poor po (by mouth) intake suspected d/t on-going GI deficits (sic)/colostomy. Resident appropriate for upgrade but defer to provider re: upgrade in setting of GI deficits w/ hx (with history) of perforation and colostomy status. No acute ST (speech therapy) needs indicated. Please reconsult (sic) as needed.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/15/25 at 10:00 A.M., the Director of Rehabilitation said that Resident #71 had not been evaluated by speech therapy for a recommended diet consistency. The Director of Rehabilitation said that when the dietitian makes a recommendation for speech therapy, nursing generates a communication form in the electronic health record that triggers the therapy department to screen a resident for evaluation and treatment, but that in this case nursing did not generate a form to notify therapy of the recommendation. She added that the therapy department reviews admission records including any diet changes and Resident #71's hospital discharge records should have triggered the speech therapist to screen the Resident.</p> <p>49880</p> <p>4. Resident #112 was admitted to the facility in December 2024 with diagnoses that include anemia, muscle wasting and atrophy and dysphagia (difficulty chewing and swallowing).</p> <p>Review of the most recent Minimum Data Set (MDS) Assessment, dated 12/29/24, indicated a Brief Interview for Mental Status exam score of 15 out of a possible 15 indicating that Resident #112 is cognitively intact. The MDS further indicated that Resident #112 has coughing or choking during meals and complaints of difficulty or pain when swallowing. Further, the MDS indicates that the Resident has a feeding tube and did not indicate any behaviors for refusal of care.</p> <p>Review of Resident #112's active nutrition care plan, initiated on 1/12/25, indicated the following:</p> <ul style="list-style-type: none"> <li>-I have a nutritional problem or potential nutritional problem r/t (related to) reported weight loss, PMHx (past medical history) significant for malignant CA (cancer), malnutrition, dysphagia w/ PEG (percutaneous endoscopic gastrostomy), a feeding tube that goes directly into the stomach), anemia, depression, HLD (hyperlipidemia), GERD (Gastroesophageal reflux disease), and anxiety.</li> <li>-Interventions in Resident #112's care plan include to obtain weights at ordered intervals.</li> </ul> <p>Review of Resident #112's Nutritional Risk Assessment, dated 12/31/24, indicated the following:</p> <ul style="list-style-type: none"> <li>-Recommendations and Plan: Weekly weights x4 from admission.</li> </ul> <p>Review of Resident #112's physician's orders indicated the following:</p> <ul style="list-style-type: none"> <li>-Weight on admission then weekly every Friday, dated initially 12/30/24, then updated on 1/10/25.</li> </ul> <p>Review of Resident #112's documented weights in the Electronic Medical Record (EMR) indicated the following:</p> <ul style="list-style-type: none"> <li>-12/28/24: 149.2 pounds (lbs.)</li> <li>-12/30/24: 146.0 lbs.</li> <li>-1/15/25: 141.5 lbs.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the medical record failed to indicate that Resident #112 was weighed as ordered between 12/30/24 and 1/15/25. Further review of the medical record failed to indicate that Resident #112 refused to be weighed.</p> <p>During an interview on 1/15/25 at 12:02 P.M., Unit Manager #3 said that weights should be obtained on admission and weekly for four weeks, unless otherwise specified by a physician's order. She said that Resident #112 should have been weighed weekly and monitored per physician's orders. Unit Manager #3 said that given Resident #112's recent history he/she is at risk for weight loss and malnutrition. She said that someone should have noticed that the Resident was not weighed since 12/20/24 but they did not.</p> <p>During an interview on 1/15/25 at 2:01 P.M., the Director of Nurses said that it is the facility policy to weigh residents on admission and weekly for four weeks. She further said that she would expect that nurses are obtaining resident weights per physician orders.</p> <p>During an interview on 1/16/25 at 7:57 A.M., the Dietitian said that she would expect staff to obtain weights as ordered for appropriate weight management.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>44095</p> <p>Based on record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for one Resident (#111), out of a total sample of 28 residents. Specifically, the facility failed to follow physician orders to obtain daily weights for a resident with a diagnosis of congestive heart failure (condition when the heart muscle doesn't pump blood as well as it should causing a potential for fluid buildup/ weight gain), nursing did not obtain daily weights for 3 consecutive days and then Resident #111 was found to have a 5.2-pound weight gain.</p> <p>Findings Include:</p> <p>Review of the facility policy titled Heart Failure - Clinical Protocol, dated as revised November 2018, indicated:</p> <p>1. The physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights) to monitor, when to report findings to the physician, etc.</p> <p>Resident #111 was admitted to the facility in December 2024 with diagnoses including pneumonia, chronic diastolic heart failure (CHF), atrial fibrillation, and generalized edema.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/23/24, indicated that Resident #111 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15. This MDS further indicated Resident #111 received a diuretic (medicines that increase urine production and help lower blood pressure and fluid retention), did not reject care, and was dependent on staff with putting on/taking off footwear, which included the ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.</p> <p>Review of Resident #111's plan of care related to fluid deficit, dated 1/9/25, indicated:</p> <p>-Obtain weights at ordered intervals. Notify physician and registered dietitian of significant changes.</p> <p>Review of Resident #111's physician's order, dated 12/18/24, indicated:</p> <p>- Weights Daily at 6:00 A.M., in the morning Notify physician if weight is greater than or equal to 3 pound increase.</p> <p>Review of Resident #111's Medication Administration Record (MAR), dated January 2025, indicated nursing did not obtain the daily weights on 1/10/25, 1/11/25, 1/12/25, and 1/13/25.</p> <p>Review of Resident #111's eMar - Medication Administration note, dated 1/12/25 and 1/13/25, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Weights Daily at 6:00 A.M., in the morning Notify physician if weight is greater than or equal to 3 pound increase. Scale Broken</p> <p>Review of Resident #111's weights and vital signs summary, dated 12/19/24 to 1/14/24 indicated the following weights:</p> <p>-1/8/25 179.7 pounds (lbs),</p> <p>-1/9/25 181.4 lbs,</p> <p>-1/13/25 186.6 lbs, a weight gain on 5.2 lbs in 3 days. (there were no weights obtained or documented in the clinical record on 1/10/25, 1/11/25, or 1/12/25)</p> <p>Review of Resident #111's nursing progress note, dated 1/13/25, indicated:</p> <p>-Resident up 5.2 lbs since 1/9.</p> <p>Review of Resident #111's physician's order, dated 1/14/25, indicated: 2 view chest x-ray (CXR) and a kidneys ureters and bladder (KUB) - diagnosis: lower extremity edema and abdominal distention.</p> <p>Review of Resident #111's nursing progress note, dated 1/15/24, indicated:</p> <p>-Resident with weight fluctuations, trending up since 1/9/25 in setting of CHF.</p> <p>During an interview on 1/16/25 at 8:34 A.M., Nurse #10 said that Resident #111 has congestive heart failure and requires daily weights. Nurse #10 said she couldn't remember why she documented the weight as refused on Friday 1/10/25 on the MAR, but the daily weight should have been obtained.</p> <p>During an interview on 1/16/25 at 8:39 A.M., Nurse #11 said that Resident #111 has congestive heart failure and required daily weights for monitoring. Nurse #11 said the scale was broken and she was unable to obtain Resident #111's weight on Saturday 1/11/25.</p> <p>During an interview on 1/15/25 at 1:28 P.M., Nurse #7 said he worked the overnight shift over the weekend and he said the scale was not consistently working over the weekend. Nurse #7 said the scale had last been serviced in 2023. Nurse #7 said he was unable to obtain Resident #111's weight for 2 days (1/12/25 and 1/13/25) and Nurse #7 said he was not sure if there was another scale in the facility to use.</p> <p>During an interview on 1/15/25 at 3:22 P.M., Nurse #8 said the scale on the unit was not working correctly and there have been issues with the scale over the last few months. Nurse #8 said that a few residents, including Resident # 111, have congestive heart failure and their weights needs to be monitored closely.</p> <p>During an interview on 1/15/25 at 12:08 P.M., Unit Manager #3 said she was not aware nursing was not obtaining Resident #111's weights because the scale was broken. Unit Manager #3 said that Resident #111 has congestive heart failure and is receiving a diuretic. Unit Manager #3 said that staff should have used a scale from a different unit to obtain Resident #111's weight.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 3:39 P.M., the Director of Nursing (DON) said she was not aware the scale was broken until she read the nursing progress notes. The DON said Resident #111 has congestive heart failure and has orders for daily weights and should have obtained the weights using a different scale.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>49880</p> <p>Based on observations, interviews and record review, the facility failed to provide care, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for one Resident (#473) out of a total sample of 28 residents. Specifically for Resident #473, the facility failed to obtain a physician's order with appropriate settings for an air mattress that was in use.</p> <p>Findings include:</p> <p>Resident #473 was admitted to the facility in December 2024 with diagnoses that include heart failure and hypotension</p> <p>Review of Resident #473's most recent Minimum Data Set (MDS) Assessment, dated 1/2/25, indicated a Brief Interview for Mental Status exam score of 12 out of 15, indicating moderate cognitive impairment.</p> <p>On 1/14/25 at 7:57 A.M. and 1:36 P.M., the surveyor observed Resident #473 in bed on an air mattress. The air mattress was set at 175 pounds (lbs.).</p> <p>On 1/15/25 at 7:34 A.M., 8:08 A.M., and 9:31 A.M., the surveyor observed Resident #473 laying in bed on an air mattress. The air mattress was set at 175 lbs.</p> <p>Review of Resident #473's active physician's orders failed to indicate an order for an air mattress with settings.</p> <p>Review of progress notes indicated a note, dated 1/14/25 that indicated, Rt (Resident) has DTI (Deep Tissue Injury) to coccyx, and DTI to right heel.</p> <p>Review of Resident #473's active skin breakdown care plan, initiated 1/1/25, indicated that the Resident has a pressure ulcer, or has potential for pressure ulcer development, related to immobility. DTI to right heel and coccyx present on admission.</p> <p>Review of the care plan indicated the use of a low air loss mattress, but failed to indicate appropriate settings.</p> <p>Review of Resident #473's most recently documented weight in the Electronic Medical Record (EMR) indicated Resident #473 weighed 148.7 lbs. on 1/14/25.</p> <p>During an interview on 1/15/25 at 9:34 A.M., Nurse #5 said that air mattresses are set according to the Resident's weight. He said there should be a physician's order indicating the settings so that nursing can assess the settings and ensure they are correct. Nurse #5 said that if the settings are too high or too low, according to the Resident's weight, then the air mattress does not serve its purpose for preventing skin breakdown. He further said that when air mattresses are applied, maintenance applies them, and asks the nurse for the resident's weight so that the settings are set appropriately.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 11:50 A.M., Unit Manager #3 said that Resident #473 has two unstageable DTI pressure wounds, one to the heel and one to the coccyx. She said that air mattresses can be set to weight or comfort, but when being used by a resident with skin breakdown, it should be set by weight. Unit Manager #3 said there should be a physician's order with the settings in it so staff can monitor and ensure the correct settings every shift, but that Resident #473 does not have one.</p> <p>During an interview on 1/15/25 at 2:02 P.M., the Director of Nurses (DON) said that the general rule with air mattresses is to be set by weight or comfort, but that their should be a physician's order with settings and nurses should be following that order and checking the settings on the air mattress.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>44095</p> <p>Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC: a flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV] ), consistent with professional standards of practice for one Resident (#106), out of a total sample of 28 residents. Specifically, for Resident #106, the facility failed to change the PICC line dressing as ordered by the physician and the facility failed to obtain weekly measurements for the external length of Resident #106's PICC line to ensure the PICC line had not migrated (moved from the heart to another area, which could have a significant impact on treatment, or cause serious harm).</p> <p>Findings include:</p> <p>Review of the Lippincott Manual of Nursing Practice, 11th Edition, dated 2021, included the following for documentation related to PICC line migration and dressing changes: Use a sterile measuring tape or incremental markings on the catheter to measure the external length of the catheter from hub to skin entry to make sure that the catheter hasn't migrated.</p> <p>Review of the facility policy titled Central Venous Catheter Care and Dressing Changes, dated as revised March 2022, indicated that the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings.</p> <ol style="list-style-type: none"> <li>1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled).</li> <li>2. Maintain sterile dressing (transparent semi-permeable membrane [TSM] dressing or sterile gauze) for all central vascular access devices. The type of dressing is based on the condition of the resident and his or her preference.</li> <li>3. Change the dressing if it becomes damp, loosened or visibly soiled and:             <ol style="list-style-type: none"> <li>a. at least every 7 days for TSM dressing.</li> </ol> </li> <li>6. Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion.</li> <li>8. For PICCs, measure arm circumference and compare to baseline when clinically indicated to assess for edema and possible deep-vein thrombosis.</li> </ol> <p>Documentation</p> <ol style="list-style-type: none"> <li>1. The following information should be recorded in the resident's medical record:             <ol style="list-style-type: none"> <li>a. Date and time dressing was changed.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Aspen Hill Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  190 North Avenue Haverhill, MA 01830	
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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Location and objective description of insertion site.</p> <p>c. Any complications, interventions that were done.</p> <p>f. Signature and title of the person recording the data.</p> <p>Resident #106 was admitted to the facility in November 2024 with diagnoses including metabolic encephalopathy, falls, pain, benign prostatic hyperplasia, anxiety and atrial fibrillation.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 11/29/24, indicated that Resident #106 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 11 out of a possible 15. The MDS further indicated Resident #106 required assistance with activities of daily living.</p> <p>On 1/14/25 at 8:03 A.M., the surveyor observed Resident #106's PICC line dressing dated 1/2/25.</p> <p>Review of Resident #106's plan of care related to intravenous (IV) therapy, dated 1/3/25, indicated:</p> <ul style="list-style-type: none"> <li>- Monitor dressing at IV insertion site daily and change as ordered and as needed.</li> </ul> <p>Review of Resident #106's physician's order, dated 1/3/25, indicated:</p> <ul style="list-style-type: none"> <li>-Daptomycin Intravenous Solution Reconstituted 500 milligrams (mg) (Daptomycin), Use 400 mg intravenously one time a day for bacteremia (infection in the blood) until 1/18/25.</li> </ul> <p>Review of Resident #106's physician's order, dated 1/3/25, indicated:</p> <ul style="list-style-type: none"> <li>- IV:(Midlines and PICCs) Document baseline mid-upper arm circumference, check arm circumference as needed, one time only for admission process until 1/3/2025.</li> <li>- IV: (Midlines and PICCs) Document baseline external length of IV catheter, check external length with each dressing change and as needed one time a day every 7 day(s) document external length and as needed.</li> <li>- IV: (Midline, PICC, CVAD) Change Transparent Dressing on Admission and then every 7 days; Caps to be changed during dressing change. one time only for best practices on Admission and one time a day every 7 day(s) for best practices.</li> </ul> <p>Review of Resident #106's January 2025 Medication Administration Record (MAR) indicated on 1/10/25, Nurse #3 changed the transparent dressing as ordered by the physician. However, based on the surveyor's observation on 1/14/25 at 8:03 A.M., the dressing was last changed on 1/2/25.</p> <p>During an interview on 1/15/25 at 8:15 A.M., Nurse #3 said that she has never changed a PICC line dressing, and she does not know how to change them. Nurse #3 said she thinks only Registered Nurses can change PICC line dressings and she is a Licensed Practical Nurse. Nurse #3 said that when orders are signed off on the Treatment Administration Record (TAR) they should be completed.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 8:55 A.M., Unit Manager #3 said she observed the PICC line on 1/14/25 and the PICC line was dated 1/2/25. The Unit Manager #3 said that the dressing should have been changed every 7 days, and measurements should have been obtained but they were not.</p> <p>During an interview on 1/15/25 at 3:47 P.M., the Director of Nursing said PICC lines dressings need to be changed every 7 days, and she said the nurse's completing the dressing changes should obtain PICC line measurements.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>41105</p> <p>Based on observations and interviews, the facility failed to provide respiratory care service in accordance with professional standards of practice for one Resident (#88) out of a total sample of 28 residents. Specifically, the facility failed to maintain Resident #88 on the Oxygen (O2) level ordered by the physician, failed to change the O2 tubing as ordered by the physician, and failed to implement foam ear protectors on the nasal cannula.</p> <p>Findings include:</p> <p>The facility policy titled Oxygen Administration, dated as revised October 2010, indicated the following:</p> <ul style="list-style-type: none"> <li>-Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter).</li> <li>-Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.</li> </ul> <p>Resident #88 was admitted to the facility in September 2024 and has diagnoses that include Acute Respiratory Failure with Hypoxia and shortness of breath.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/7/24, indicated that on the Brief Interview for Mental Status exam Resident #88 scored a 7 out of a possible 15, indicating severely impaired cognition. The MDS further indicated that Resident #88 was dependent on staff for upper and lower body care.</p> <p>Review of the current physician's orders indicated the following orders:</p> <ul style="list-style-type: none"> <li>-Oxygen at 2L/ Minute via Nasal Cannula to O2 sat greater than 90%, start date 12/2/24;</li> <li>-Change Oxygen Tubing, Humidifier, and clean filter weekly on Sunday 11 to 7 and as needed for soiling or damage, start date 12/2/24; and</li> <li>-Apply foam ear protectors to oxygen nasal cannula tubing. check for placement every shift, start date 12/2/24.</li> </ul> <p>Review of Resident #88's current care plans indicating the following:</p> <ol style="list-style-type: none"> <li>1. FOCUS: I have altered respiratory status r/t (related to) Hypoxia, Shortness of Breath, Hypoxemia, initiated 12/19/24.</li> </ol> <p>Interventions include:</p> <ul style="list-style-type: none"> <li>-Administer oxygen as ordered.</li> </ul> <ol style="list-style-type: none"> <li>2. FOCUS: I require supplemental oxygen r/t decrease O2 sats (saturations), initiated 12/2/24.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions include:</p> <ul style="list-style-type: none"> <li>-Change tubing as per facility protocol.</li> <li>-Monitor skin on ears and nose for breakdown from oxygen tubing. Pad tubing as needed.</li> </ul> <p>3. FOCUS: I have an ADL Self Care Performance Deficit r/t Dementia, weakness, dated as revised 9/12/24.</p> <p>Interventions include:</p> <ul style="list-style-type: none"> <li>-Turn &amp; Position- Dependent</li> </ul> <p>The care plan failed to indicate Resident #88 has any behaviors of removing the foam ear protectors or of changing his/her O2 level.</p> <p>Review of the January 2025 Treatment Administration Record indicated the following was documented by nursing, contrary to observations:</p> <ul style="list-style-type: none"> <li>-On 1/14/25 the O2 was running at 2L all three shifts;</li> <li>-The O2 tubing was changed by nursing on 1/5/25 and 1/12/25; and</li> <li>-The foam ear protectors were in place all three shifts on 1/14/25.</li> </ul> <p>On 1/14/25 at 7:45 A.M., Resident #88 was observed in bed asleep wearing O2 that was running at 3L. The O2 tubing was dated 12/31/24 and there were no foam ear protectors in place.</p> <p>On 1/14/25 at 11:39 A.M., Resident #88 was observed in bed asleep wearing O2 that was running at 3L. The O2 tubing was now dated 1/10/25 and there were no foam ear protectors in place.</p> <p>On 1/15/25 at 7:15 AM Resident #88 was observed in bed asleep wearing O2 that was running at 3L. The O2 tubing was dated 1/10/25 and there were no foam ear protectors in place.</p> <p>During an observation and interview on 1/15/25 at 7:25 A.M., Certified Nursing Assistant (CNA) #1 said that Resident #88 requires max assist with bed mobility and has no behavior of changing the O2 setting. The surveyor and CNA #1 observed Resident #88 in bed with the O2 running at 3L and no foam ear protectors in place. CNA #1 said that nursing is responsible to set the O2 to the accurate setting and that the foam ear protectors come with each tubing kit and should be in place.</p> <p>During an observation and interview on 1/15/25 at 7:29 A.M., with Unit Manager #1, Resident #88 was observed in bed with the O2 running at 3L and no foam ear protectors in place. Unit Manager #1 set the O2 to 2L. She said that Resident #88 should be on the oxygen level ordered by the Physician and that Resident #88 should have foam ear protectors in place. Unit Manager #1 said that on 1/10/24 Resident #88 was at rehabilitation using his/her portable oxygen and the 12/31/24 tubing. She said that she left the 1/10/24 tubing in the room but never circled back when the resident returned from rehabilitation to remove the 12/31/24 tubing and connect the resident to the new tubing.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 8:46 A.M., with the Director of Nursing said that she would expect that the O2 be running at the correct setting, that the O2 tubing be changed as ordered and Resident #88 have the foam ear protectors in place, as ordered by the physician.</p> <p>See F842</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>36797</p> <p>Based on record review and interview the facility failed to ensure a care plan was developed for Trauma Informed Care, or Post Traumatic Stress Disorder (PTSD) with resident specific triggers and interventions, for two Residents (#7 and #85) out of a total sample of 28 residents.</p> <p>Findings include:</p> <p>By the end of the survey the facility failed to produce a policy for trauma informed care or PTSD.</p> <p>1. Resident #7 was admitted to the facility in May 2023 with diagnoses including PTSD, depression and anxiety.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/5/24, indicated Resident #7 scored a 15 out of 15, indicating intact cognition.</p> <p>Review of the active diagnoses list indicated Resident #7 has a diagnosis of PTSD.</p> <p>Review of the facility document titled Social Services Assessment - V 4, dated 5/12/23, indicated that Resident #7 did not experience a past trauma.</p> <p>Review of the current active care plan indicated a focus for PTSD related to family discord/abuse. Further review indicated the following interventions:</p> <p>-Accept my current level of function. Be consistent, positive, honest and nonjudgmental while working with me.</p> <p>-Assist me with identifying coping/calming mechanisms to manage anxiety or correct misunderstandings conditioned at the time of trauma/stress, such as relaxation techniques, deep breathing, visualization, removing myself from the situation.</p> <p>-My strengths are: enjoys playing guitar and is very good at it.</p> <p>-Provide spiritual/religious support as needed.</p> <p>Further review failed to indicate triggers or interventions specific to Resident #7.</p> <p>2. Resident #85 was admitted to the facility in February 2024 with diagnoses including PTSD, dementia and depression.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/23/24, indicated Resident #85 has a diagnosis of PTSD. The MDS indicated Resident #85 scored a 6 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment.</p> <p>Review of the current active care plan indicated a focus for PTSD related to (blank).</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review indicated the following interventions:</p> <ul style="list-style-type: none"> <li>-Accept my current level of function. Be consistent, positive, honest and nonjudgmental while working with me.</li> <li>-Avoid situations that may cause flashbacks. Ask me about my triggers and incorporate them into my plan of care.</li> <li>-Monitor and document resident's feelings, such as insecurity, anxiety, anger, mistrust, emotional detachment, unwanted/intrusive thoughts, insomnia, etc. Report observations to physician, or designee, as clinically indicated.</li> </ul> <p>Further review failed to indicate triggers or interventions specific to Resident #85.</p> <p>During an interview on 1/15/25 at 9:23 A.M., Social Worker (SW) #1 said that the documents titled Social Services Assessment - V 10, dated 3/11/24, are not accurate and should reflect that Resident #7 has PTSD. SW #1 then said that a care plan should either reflect resident specific triggers and interventions or should reflect that the resident/responsible party was unable to respond.</p> <p>During an interview on 1/15/25, at 8:44 A.M. the Director of Nursing said that it is her expectation that the care plans are resident specific. She said that she would expect that the trauma informed care plans would contain specific triggers and interventions to relieve a triggered episode.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>36797</p> <p>Based on record review and interview the facility failed to ensure sufficient staffing to assure residents attain or maintain the highest practicable physical, mental, and psychosocial well being. Specifically, the facility failed to have sufficient staffing on the weekends as indicated on the payroll-based journal report submitted to The Centers of Medicare and Medicaid (CMS) for FY (Fiscal Year) Quarter 4, 2024.</p> <p>Findings include:</p> <p>Review of the PBJ Staffing Data Report CASPER Report 1705D</p> <p>FY Quarter 4 2024 (July 1 - September 30) indicated the following:</p> <ul style="list-style-type: none"> <li>-This Staffing Data Report identifies areas of concern that will be triggered (e.g., requires follow-up during the survey).</li> <li>-Excessively Low Weekend Staffing Triggered = Submitted Weekend Staffing data is excessively low</li> </ul> <p>Review of the facility's 'Facility Assessment Tool, not dated, indicated at the staffing plan the following: Total Number Needed or Average or Range of Staff:</p> <ul style="list-style-type: none"> <li>-Licensed nurses providing direct care = 15.</li> <li>-Nurse Aides = 30.</li> <li>-Hours Per Patient Day (HPPD) = 3.20 total direct care staff.</li> </ul> <p>Review of the facility staffing records indicated that only one out of 12 weeks, during the FY Quarter 4 2024, did the facility meet the 3.20 HPPD required to adequately care for the residents in the facility.</p> <p>During an interview on 1/16/25, at approximately 9:00 A.M., the Administrator said that the facility had difficulty recruiting last year, but has since been able to staff appropriately using on call nursing management when needed.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>48671</p> <p>Based on observations, and interviews, the facility failed to ensure 1.) medications were labeled, and dated once opened, according to manufacturer's guidelines in two out of three medication carts sampled, and 2.) ensure medications were stored in locked compartments on one nursing unit.</p> <p>Findings include:</p> <p>Review of facility policy titled Medication Labeling Storage undated, indicated the following:</p> <ul style="list-style-type: none"> <li>-The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</li> <li>-Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biological's are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.</li> <li>-If the facility has discounted, outdated or deteriorated medications or biological's, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.</li> <li>-Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly.</li> <li>-Multi-dose vials that have been opened or accessed (e.g., needle punctured are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</li> <li>-If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.</li> </ul> <p>1. The facility failed to ensure medications were labeled, and dated once opened, according to manufacturer's guidelines.</p> <p>During an observation on 1/14/25 at 12:22 P.M., the following medications were observed of the B-Unit medication Cart 1:</p> <ul style="list-style-type: none"> <li>- One bottle of saline nasal spray, opened and undated, therefore unable to determine an expiration date. Manufacturer instruction indicates to discard the bottle after 30 days of opening.</li> <li>-One bottle of Risperidone Oral Solution, USP. Open and undated, therefore unable to determine an expiration date. Manufacture instructions to discard after 90 days of opening.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Two Fluticasone-salmeterol (an inhaled medication to treat breathing conditions) 250mcg/ 50 mcg (micrograms), open and undated. Manufacturer's instructions to discard 30 days after the foil pouch is opened.</p> <p>-One bottle of fluticasone nasal spray (nasal spray contains steroid used to treat allergies) 50 mcg (micrograms) open and undated, therefore unable to determine the expiration date. Manufacture instructions to discard after using 120 sprays.</p> <p>During an interview on 1/14/25 at 12:22 P.M., Nurse #6 said medications must be dated when opened and discarded according to the manufacturer's directions.</p> <p>During an interview on 1/14/25 at 12:25 P.M., Unit Manager #3 said medications should not be stored undated or expired and must be removed from the medication cart.</p> <p>During an interview on 1/15/25 at 12:30 P.M., the Director of Nursing (DON) said medications must be dated and labeled appropriately when opened according to the manufacturer's instructions and said expired medications must be removed.</p> <p>During an observation on 1/14/25 at 12:51 P.M., the following medications were observed on the A-Unit medication Cart 2:</p> <p>-One 887mL (milliliter) Bottle of Liquid Protein opened and undated, therefore unable to determine an expiration date. Manufacturer instruction indicates to discard the bottle after 90 days of opening.</p> <p>-One bottle of fluticasone nasal spray (nasal spray contain steroid used to treat allergies) 50 mcg (micrograms) open and undated, therefore unable to determine the expiration date. Manufacture instructions to discard after using 120 sprays.</p> <p>-4 packages of ipratropium Bromide and albuterol sulfate (an inhaled medication to treat breathing conditions) 0.5 mg/ 3mg ml (milligrams/milliliter) open and undated, therefore unable to determine an expiration date. Manufacturer instructions indicate once removed from foil pouch individual vials should be used within one week.</p> <p>-One Bottle Tuberculin Purified Protein Derivative (Mantoux) Tubersol. Multi-dose vial (50 Tests) 5 Tuberculin units per test. Open and dated 12/19/24, unrefrigerated. Manufacturer instructions indicate to store refrigerated after opening.</p> <p>During an interview on 1/14/25 at 1:05 P.M., Nurse # 5 said medications should have been dated when opened and said the Tuberculin solution needs to be refrigerated after opening.</p> <p>During an interview on 1/14/25 at 1:07 P.M., Unit Manager #3 said medications should not be stored undated or expired and must be removed from the medication cart. Unit Manager #3 said Tuberculin solution should be dated when opened and stored in the medication room in the refrigerator.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Aspen Hill Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  190 North Avenue Haverhill, MA 01830	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/15/25 at 12:35 P.M., the Director of Nursing (DON) said medications must be dated and labeled appropriately when opened according to the manufacturer's instructions and said expired medications must be removed. The DON said she would expect staff to know that Tuberculin must be stored in the refrigerator.</p> <p>41105</p> <p>2. On 1/15/25 at 8:14 A.M., the surveyor observed a medication cart unlocked on the Dementia Unit and was able to open and access it. There were no staff present.</p> <p>On 1/15/25 at 8:17 A.M., Nurse #1 walked down the hallway and returned to the medication cart. Nurse #1 said that the cart was supposed to be locked when unattended.</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>36797</p> <p>Based on observation, record review and interview for one Resident (#71) out of a total sample of 28, the facility failed to provide dental care.</p> <p>Findings include:</p> <p>Review of the facility policy titled Availability of Services, Dental, dated as revised August 2007 indicated that dental services are available to all residents requiring routine and emergency dental care.</p> <p>Resident #71 was admitted to the facility in May 2024 with diagnoses including Parkinson's Disease, malnutrition and depression.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 10/31/24, indicated Resident #71 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam indicating intact cognition. The MDS further indicated Resident #71 did not have any obvious broken/carious teeth.</p> <p>During an interview on 1/15/25, at 2:05 P.M., Resident #71 said that he/she has not seen the dentist while a resident at the facility but that if it would help him/her to chew he/she would want to see the dentist. Resident #71 also said that he/she had not been asked if he/she wanted to see a dentist. Resident #71 showed the surveyor his/her teeth. The surveyor observed multiple upper and lower teeth missing and obvious carious teeth that had dark discoloration on all remaining teeth.</p> <p>Review of the facility document titled Admission/Readmission Screener-V 10 dated 5/15/24, indicated that Resident #71 had missing teeth. Further review failed to indicate Resident #71 had carious teeth.</p> <p>Review of the current active care plan indicated a focus for I have oral/dental health problems R/t (related to ) poor dental hygiene with interventions including coordinate arrangements for dental care, transportation as needed/as ordered.</p> <p>Review of the medical record failed to indicate that Resident #71 had been seen by a dentist. Further review failed to indicate that Resident #71 had been asked if he/she wanted to a dentist.</p> <p>During an interview on 1/15/25 at 3:11 P.M., the Director of Nursing said that Resident #71 should have had a dental consult.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671</b></p> <p>Based on observation, record review and interview, the facility failed to have one Resident (#93), out of a total sample of 28 residents seen by the oral surgeon after the consulting dentist made the recommendation for tooth extractions and new dentures in May 2024.</p> <p>Findings include:</p> <p>Review of the facility policy titled Medication and Treatment Orders, Dental Services, dated February 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>-Orders for the treatment of the resident's dental problems must be signed by the attending dentist.</li> <li>-All orders for the treatment of the resident's dental problems must be in writing and signed and dated by the dentist providing the service.</li> <li>-Medication orders and treatment will be administered by nursing service personnel as soon as the order has been received.</li> <li>-The residents attending physician must be informed of the treatment and medications ordered by the dentist.</li> <li>- Any conflict in treatment or medication must be brought to the attention of the dentist, attending physician, and director of nursing services prior to the performance or administration of such treatment or medication.</li> </ul> <p>Resident #93 was admitted to the facility in June 2024 with diagnoses including gastro-esophageal reflux disease, delusional disorders, depression, and anxiety disorder.</p> <p>Review of Resident #93's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status exam score of 9 out of a possible 15, indicating he/she has moderate cognitive impairment. The MDS further indicated Resident #93 did not have any broken, loose or missing teeth or dentures and was left blank under the oral/dental section.</p> <p>Review of Resident #93's oral/dental care plan dated 7/10/24 indicated the following:</p> <ul style="list-style-type: none"> <li>-Coordinate arrangements for dental care, transportation as needed/as ordered.</li> <li>-Monitor/document/report to physician PRN (as needed) s/sx (signs and symptoms) of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions.</li> <li>-Provide mouth care (i.e. (for example) brush teeth, denture care, gum care) as per ADL (activities of daily living) personal hygiene.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/14/25 at 7:50 A.M., Resident #93 said he/she has missing teeth and saw a dentist about dentures in the spring but has not received them. Resident #93 said he/she was unaware if there was any follow-up that needed to occur after that dental appointment and proceeded to show the surveyor his/her missing teeth, exposing the upper and lower gums. Resident #93 said it's been months, and nothing was done and said he/she has no choice but to not have them and chew the best he/she can. Resident #93 said he/she has asked staff about the dentures but no one knows anything, about the dentures.</p> <p>Review of Resident #93's medical record indicated he/she was seen by the dentist on 5/7/24 with the following assessment and recommendations:</p> <p>Patient presents for periodic exam. Patient complains that bottom teeth hurt occasionally, comes and goes for the last two months. Doesn't specifically say which area Recommend ext. (extract) non-restorable teeth prior to fabrication of dentures: #23, 24, 25, 26, 31. Patient states he/she is afraid of needles and would like extractions done under sedation. Refer to OS (oral surgeon) for extraction of teeth. Recommend follow up after referral to OS. Recommend FMX (dental x-ray) for insurance approval of partial denture - will ask for X-rays to be sent from OS. Discussed healing time prior to fabrication of dentures.</p> <p>Review of the medical record failed to indicate any nursing notes or follow up information related to the recommendations made by the dentist on 5/7/24.</p> <p>Further review of Resident #93's medical record failed to indicate consent forms were signed for tooth extraction or any other follow-up to schedule the extractions of teeth.</p> <p>Review of the nursing oral assessment, dated 7/22/24, indicated that Resident #93 did not have dentures present, has fractured/missing teeth and soft plaque build-up. No nursing interventions needed at present.</p> <p>During an interview on 1/15/25 at 10:18 A.M., Nurse #2 said Resident #93 does not have dentures and was unaware he/she needed teeth extractions or needed dentures.</p> <p>During an interview on 1/15/25 at 10:35 A.M., Unit Manager #2 reviewed Resident #93's medical chart with the surveyor and said Resident #93 should have been seen by the oral surgeon and dental recommendations were not followed up on from the 5/7/24 dental visit. Unit Manager #2 said she was unaware that Resident #93 needed teeth extractions or needed dentures and said the process should have been documented in the medical record and communicated with the clinical team. Unit Manager #2 said there is no documentation in the nursing progress notes regarding the dental visit and said Resident #93 has not been seen by an oral surgeon as of 1/15/25.</p> <p>During an interview on 1/15/25 at 11:32 A.M., the Director of Nursing said she and the medical records department will manage the follow up process for dentures and a health drive status update report is submitted. The Director of Nursing reviewed the report and said she has no documentation that the recommendations were communicated or that the process was implemented for Resident #93 after the 5/7/24 dental visit, and said the facility is responsible for ensuring all recommendations are reviewed and followed up on.</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>49880</p> <p>Based on record review and interviews, the facility failed to ensure that recommended specialist appointments were scheduled for three Residents (#32, #28, and #93), who had recommendations for an evaluation for cataract surgery from the consulting eye doctor, out of a total sample of 28 residents.</p> <p>Findings include:</p> <p>Review of facility policy titled Consultants, dated as revised December 2009, indicated the following:</p> <p>-Our facility may use as needed outside resources to furnish specific services to residents and to the facility.</p> <p>During the Resident Group meeting on 1/15/25 at 11:06 A.M., three residents indicated that they were recommended to have follow up appointments for the evaluation of cataracts, but no appointments have been communicated with them.</p> <p>1a. Resident #32 was admitted to the facility in December 2021 with diagnoses that include vertigo and hyperlipidemia.</p> <p>Review of Resident #32's most recent Minimum Data Set (MDS) Assessment, dated 10/17/24, indicated a Brief Interview for Mental Status exam score of 8 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated the use of corrective lenses for vision.</p> <p>Review of Resident #32's medical record failed to indicate a plan of care for vision impairment.</p> <p>Review of Resident #32's eye doctor consult, dated 4/23/24, indicated the following:</p> <p>-Plan: cataract surgery recommended.</p> <p>-Referral: cataract ophthalmology; note to nurses please call [outpatient eye doctor's office] and schedule initial cataract evaluation and removal to improve vision.</p> <p>Review of the medical record failed to indicate that facility staff scheduled the recommended follow up for evaluation for cataract surgery.</p> <p>During an interview on 1/16/25 at 7:39 A.M., Resident #32 said that he/she is not aware of any follow ups scheduled for cataract evaluation. Resident #32 said that he/she would like to pursue options because he/she has trouble seeing the television and is unable to read anymore due to worsening vision which is very frustrating. Resident #32 said that no one from the facility has followed up about an appointment.</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 1/16/25 at 8:11 A.M., an employee at the outpatient eye doctor's office [which was specifically recommended from the consulting eye doctor in the facility] said that the office has not received any referrals or inquiries to schedule evaluations for cataract surgery for Resident #32.</p> <p>During a phone interview on 1/16/25 at 8:20 A.M., Resident #32's activated Health Care Proxy (HCP) said that he/she was not aware of the need for a consult regarding cataract surgery. The HCP said that Resident #32 does express frustration about his/her vision but that the facility had not indicated that there were follow up recommendations that needed to be scheduled. He/she said they are open to exploring Resident #32's options regarding improvement of vision.</p> <p>During an interview on 1/16/25 at 9:11 A.M., the Director of Nurses said that her expectation is that recommendations from consulting providers are followed up on within a week, and the recommendations for Resident #32 were not.</p> <p>1b. Resident #28 was admitted to the facility in February 2023 with diagnoses that include chronic obstructive pulmonary disease, depression and anxiety.</p> <p>Review of the most recent Minimum Data Set (MDS) Assessment, dated 11/23/24, indicated a Brief Interview for Mental Status exam score of 15 out of a possible 15, indicating that the Resident is cognitively intact.</p> <p>Review of Resident #28's medical record failed to indicate a plan of care for vision impairment.</p> <p>Review of Resident #28's eye doctor consult, dated 12/5/24, indicated the following:</p> <p>-Cataract surgery recommended; ophthalmology consult</p> <p>-Note to nurses: Please call [outpatient eye doctor's office] and schedule initial cataract evaluation ASAP (as soon as possible) and schedule initial cataract evaluation and removal.</p> <p>Review of the medical record failed to indicate that facility staff scheduled the recommended follow up for evaluation for cataract surgery.</p> <p>Review of Resident #28's medical record failed to indicate that the Resident has an activated health care proxy. The record indicates that Resident #28 makes his/her own healthcare decisions.</p> <p>During an interview on 1/16/25 at 7:44 A.M., Resident #28 said that the eye doctor told him/her that a follow up is needed at an outpatient setting regarding cataracts and his/her vision. Resident #28 said he/she gets frustrated because he/she loves watching television but is also hard of hearing so uses closed captioning to read the words. He/she said this has become increasingly difficult to do as he/she cannot always see the closed captioning. Resident #28 also said that he/she loves to read and has not been able to read because he/she cannot read the pages anymore. Resident #28 said that he/she would like to pursue their options regarding cataract surgery but that no one at the facility has followed up with him/her regarding the recommendations from the eye doctor over a month ago.</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 1/16/25 at 8:11 A.M., an employee at the outpatient eye doctor's office [which was specifically recommended from the consulting eye doctor in the facility] said that the office has not received any referrals or inquiries to schedule evaluations for cataract surgery for Resident #28.</p> <p>During an interview on 1/16/25 at 9:11 A.M., the Director of Nurses said that her expectation is that recommendations from consulting providers are followed up on within a week, and the recommendations for Resident #28 were not.</p> <p>1c. Resident #93 was admitted to the facility in June 2024 with diagnoses that include chronic obstructive pulmonary disease, hypertension and depression.</p> <p>Review of Resident #93's most recent Minimum Data Set (MDS) Assessment, dated 12/5/24, indicated a Brief Interview for Mental Status exam score of 9 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated that Resident #93 has no vision impairment and utilizes corrective lenses.</p> <p>Review of Resident #93's active care plan failed to indicate a plan of care for vision impairment.</p> <p>Review of Resident #93's eye doctor consult dated 12/5/24 indicated the following:</p> <p>-plan: Cataract surgery recommended</p> <p>-Referral: cataract ophthalmology; note to nurses please call [outpatient eye doctor's office] and schedule initial cataract evaluation and removal.</p> <p>Review of the medical record failed to indicate that facility staff scheduled the recommended follow up for evaluation for cataract surgery.</p> <p>During an interview on 1/16/25 at 7:47 A.M., Unit Manager #2 said that when consultant recommendations are made, it is reviewed with the resident's health care proxy and the attending provider and then orders are put into place. She said a hard copy of the consult is provided to the Unit Managers to review with providers.</p> <p>During a phone interview on 1/16/25 at 8:11 A.M., an employee at the outpatient eye doctor's office [which was specifically recommended from the consulting eye doctor in the facility] said that the office has not received any referrals or inquiries to schedule evaluations for cataract surgery for Resident #93.</p> <p>During a follow up interview on 1/16/25 at 8:26 A.M., Unit Manager #2 said she was not aware of the recommendations for evaluation for cataract surgery needed for Residents #32, #28 or #93. She reviewed the eye doctor consults and said referrals should have been made.</p> <p>During an interview on 1/16/25 at 9:11 A.M., the Director of Nurses said that her expectation is that recommendations from consulting providers are followed up on within a week, and the recommendations for Resident #93 were not.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>41105</p> <p>Based on record review and interview the facility failed to ensure accurate documentation in the medical record for four Residents (#88, #47, #418, #89) out of a total sample of 28 residents. Specifically:</p> <ol style="list-style-type: none"> <li>1. For Resident #88 nursing documented in the Treatment Administration Record (TAR) that a. oxygen (O2) was running at the correct setting, when it was not, b. that the O2 tubing was changed as ordered and c. that foam ear protectors were in place as ordered.</li> <li>2. For Resident #47 the facility failed to ensure his/her risperidone (antipsychotic medication) order included an associated diagnosis as part of the physician's order.</li> <li>3. For Resident #418 the facility failed to document accurately in the Medication Administration Record (MAR) when the nurse documented adminstraion of Insulin was given when it was not.</li> <li>4. For Resident #89 the facility failed to document the appropriate vitals location for blood pressure.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The facility policy titled Oxygen Administration, dated as revised October 2010, indicated the following: <ul style="list-style-type: none"> <li>-Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter).</li> <li>-Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.</li> </ul> </li> </ol> <p>Resident #88 was admitted to the facility in September 2024 and has diagnoses that include Acute Respiratory Failure with Hypoxia and shortness of breath.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 12/7/24, indicated that on the Brief Interview for Mental Status exam Resident #88 scored a 7 out of a possible 15, indicating severely impaired cognition. The MDS further indicated that Resident #88 was dependent on staff for upper and lower body care.</p> <p>Review of the current physician's orders indicated the following orders:</p> <ol style="list-style-type: none"> <li>a. Oxygen at 2L (2 liters)/ Minute via Nasal Cannula to O2 sat greater than 90%, start date 12/2/24;</li> <li>b. Change Oxygen Tubing, Humidifier, and clean filter weekly on Sunday 11 to 7 and as needed for soiling or damage, start date 12/2/24; and</li> </ol> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Apply foam ear protectors to oxygen nasal cannula tubing. check for placement every shift, start date 12/2/24.</p> <p>Review of Resident #88's current care plans indicating the following:</p> <p>1. FOCUS: I have altered respiratory status r/t (related to) Hypoxia, Shortness of Breath, Hypoxemia, initiated 12/19/24.</p> <p>Interventions include:</p> <p>-Administer oxygen as ordered.</p> <p>2. FOCUS: I require supplemental oxygen r/t decrease O2 sats (saturation), initiated 12/2/24.</p> <p>Interventions include:</p> <p>-Change tubing as per facility protocol.</p> <p>-Monitor skin on ears and nose for breakdown from oxygen tubing. Pad tubing as needed.</p> <p>3. FOCUS: I have an ADL Self Care Performance Deficit r/t Dementia, weakness, dated as revised 9/12/24.</p> <p>Interventions include:</p> <p>-Turn &amp; Position Dependent</p> <p>The care plan failed to indicate Resident #88 has any behaviors of removing the foam ear protectors or of changing his/her O2 level.</p> <p>Review of the January 2025 Treatment Administration Record (TAR) indicated the following was documented by nursing, contrary to observations:</p> <p>a. On 1/14/25 the O2 was running at 2L all three shifts;</p> <p>b. The O2 tubing was changed by nursing on 1/5/25 and 1/12/25; and</p> <p>c. The foam ear protectors were in place all three shifts on 1/14/25.</p> <p>On 1/14/25 at 7:45 A.M., Resident #88 was observed in bed asleep wearing O2 that was running at 3L. The O2 tubing was dated 12/31/24 and there were no foam ear protectors in place.</p> <p>On 1/14/25 at 11:39 A.M., Resident #88 was observed in bed asleep wearing O2 that was running at 3L. The O2 tubing was now dated 1/10/25 and there were no foam ear protectors in place.</p> <p>On 1/15/25 at 7:15 AM Resident #88 was observed in bed asleep wearing O2 that was running at 3L. The O2 tubing was dated 1/10/25 and there were no foam ear protectors in place.</p> <p>(continued on next page)</p>

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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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 1/15/25 at 7:25 A.M., Certified Nursing Assistant (CNA) #1 said that Resident #88 requires max assist with bed mobility and has no known behavior of changing the O2 setting. The surveyor and CNA #1 observed Resident #88 in bed with the O2 running at 3L and no foam ear protectors in place. CNA #1 said that nursing is responsible to set the O2 to the accurate setting and that the foam ear protectors come with each tubing kit and should be in place.</p> <p>During an interview on 1/15/25 at 7:29 A.M., with Unit Manager #1, she said that when nurses are signing off on the TAR it should be accurate. Unit Manager #1 said that on 1/10/24 Resident #88 was at rehabilitation using his/her portable oxygen and the 12/31/24 tubing. She said that she left the 1/10/24 tubing in the room but never circled back when the resident returned from rehabilitation to remove the 12/31/24 tubing and connect the resident to the new tubing. She could not explain why it was documented in the TAR that the tubing was changed on 1/4/25 and 1/12/24, when the tubing was still dated 12/31/24.</p> <p>During an interview on 1/15/25 at 8:46 A.M., with the Director of Nursing (DON) she said that she would expect that the documentation in the TAR be accurate.</p> <p>44095</p> <p>2. Review of the facility policy, Psychotropic Medication Use, dated July 2022, indicated that residents will not receive medications that are not clinically indicated to treat a specific condition.</p> <p>2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications:</p> <p>a. Anti-psychotics.</p> <p>3. Residents, families and/or the representative are involved in the medication management process.</p> <p>Psychotropic medication management includes:</p> <p>a. indications for use.</p> <p>Resident #47 was admitted to the facility in May 2024 with diagnoses including chronic obstructive pulmonary disease, tracheostomy status, paranoid schizophrenia, anxiety, and dysphagia.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 10/17/24, indicated that Resident #47 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. The MDS was coded as the following:</p> <p>-Antipsychotic coded as yes, indication coded as yes.</p> <p>Review of Resident #47's physician's order, dated 5/4/24, indicated:</p> <p>-Risperidone oral tablet 4 milligrams (mg) (Risperidone), give 1 tablet via PEG-Tube at bedtime for antipsychotic (class of medication and not a diagnosis). Further review of the physician's order failed to include a medical diagnosis related to the administration of risperidone.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/14/25 at 3:01 P.M., Unit Manager #3 said that Resident #47's Risperidone order should have an associated medical diagnosis as part of the physician's order.</p> <p>During an interview on 1/15/25 at 3:35 P.M., the Director of Nursing said that Resident #47's Risperidone order should have an associated diagnosis as part of the physician's order.</p> <p>48671</p> <p>3. Review of the facility policy titled Administering Medications, Dated as revised April 2019, indicated the following:</p> <p>-Policy Statement: Medications are administered in a safe and timely manner, and as prescribed.</p> <p>4. Medications are administered in accordance with prescriber orders, including any required time frame.</p> <p>5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:</p> <p>a. enhancing optimal therapeutic effect of the medication.</p> <p>b. preventing potential medication or food interactions; and</p> <p>c. honoring resident choices and preferences, consistent with his or her care plan.</p> <p>7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p> <p>21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR (medication administration record) space provided for that drug and dose.</p> <p>Resident #418 was admitted to the facility in January 2025 with diagnoses including type two diabetes mellitus and acute kidney failure.</p> <p>Review of Resident #418's most recent Minimum Data Set Assessment (MDS) assessment, dated 1/8/25, indicated the Resident had a Brief Interview for Mental Status exam score of 11 out of a possible 15, indicating he/she has moderate cognitive impairment. Further review of the MDS indicated that Resident #418 had received insulin injections seven days leading up to the assessment.</p> <p>Review of Resident #418's active physician orders dated 10/15/24 indicated:</p> <p>-Insulin Aspart Prot &amp; Aspart Subcutaneous Suspension (70-30) 100 UNIT/ML (units per milliliter) (Insulin Aspart Protamine &amp; Aspart (Human) (Rapid acting insulin used to treat diabetes). Inject 25 units subcutaneously two times a day for DM (diabetes mellitus). Start Date: 1/02/25.</p> <p>Review of Resident #418's Medication Administration Record indicated that Nurse #3 administered 25 units of Insulin Aspart Protamine &amp; Aspart Subcutaneous Suspension on 1/25/25 at 7:52 A.M.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/15/25 at 7:56 A.M., the surveyor observed Nurse #3 prepare and administer oral medications to Resident #418. Resident #418 said You didn't give me my insulin yet. Nurse #3 told Resident #418 she was working on it and would be back to administer the morning insulin. Nurse #3 told the surveyor she checked Resident #418's blood sugar earlier in the morning and said she would be back to administer the insulin. The surveyor continued to observed Nurse #3 as she completed her medication pass with Resident #418 and exited the room. Nurse #3 did not administer insulin during the medication pass observation.</p> <p>On 1/15/25 at 8:06 A.M., the surveyor observed a staff member deliver a breakfast tray to Resident #418. The surveyor observed Resident #418 eating breakfast in bed at 8:09 A.M. The surveyor continued to make observations of Nurse #3 in the hall and she did not re-enter Resident #418's room throughout the observation period.</p> <p>During an interview on 1/15/25 at 8:13 A.M., the surveyor asked Resident #418 if he/she had received the morning insulin yet and the Resident sad no I am supposed to have it before breakfast, but she didn't give it to me.</p> <p>During an interview on 1/15/25 at 8:18 A.M., Nurse #3 said she has not administered the insulin to Resident #418 and said she is working on getting it together now. The surveyor observed Nurse #3 continue with her medication pass with other Residents and did not return to Resident #418's room.</p> <p>During an interview on 1/15/25 at 9:28 A.M., the surveyor asked Resident #418 if he/she received the insulin and Resident #418 said, Yes, I got it late, it was after breakfast and usually its before, but I didn't get it until now.</p> <p>During an interview on 1/15/25 at 8:45 A.M., Unit Manager #3 said blood sugar checks are done early in the morning and said Residents requiring morning insulin must be administered as ordered and before meals.</p> <p>During an interview with Nurse #3 on 1/15/25 at 9:54 A.M., Nurse #3 said she should not have documented the insulin as given when she did not administer it and said she is new and thought she gave i,t but did not. Nurse #3 said she administered the insulin after breakfast around 9:30 A.M.</p> <p>During an interview on 1/15/25 at 12:38 P.M., the Director of Nursing (DON) said Nurse #3 should not have documented the insulin as given when it was not administered to the Resident and said insulin must be given when ordered and before breakfast. The DON said the Nurse should have notified the doctor if the insulin was given late and said the Nurse corrected the administration time in the medical record.</p> <p>Review of Resident #418's Medication Administration Record on 1/15/25 indicated that Nurse #3 documented the insulin was administered at 8:26 A.M., despite previous documentation of administration at 7:20 A.M., and actually administering the medication to Resident #418 at 9:30 A.M.</p> <p>41019</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. The facility failed to document the appropriate vitals location for blood pressure for 1 Resident (#89) out of a total sample of 28 residents. Specifically, documentation shows the nurse obtained a blood pressure on the Resident's right arm when blood pressure vitals are to be obtained on the left arm per physician orders.</p> <p>Resident #89 was admitted in July 2024 with diagnoses including end stage renal disease. Review of the Minimum Data Set (MDS) assessment, dated 12/19/24, indicated Resident #89 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated Resident #89 attends dialysis.</p> <p>Review of the medical record for Resident #89 indicated that he/she should not have blood pressure vitals, intravenous fluids, or blood drawn from his/her right arm due to having a dialysis shunt (an access point for when a patient receives dialysis).</p> <p>Review of the blood pressure vitals measurements for the month of December 2024 indicated the nurse obtained a blood pressure measurement from Resident #89's right arm on 5 occasions.</p> <p>During an interview on 1/16/25 at 8:09 A.M., the Director of Nursing said that she is willing to bet that the nurse who obtained the blood pressure reading is documenting the wrong arm in the computer because Resident #89 is cognitively intact and would advocate for him/herself. The Director of Nursing said that she would expect nurses to document the appropriate arm that the vitals were taken from.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>41019</p> <p>Based on record review and interview, the facility failed to develop a Quality Assurance Performance Improvement (QAPI) after two allegations of abuse for one certified nursing aide. Specifically, two Residents alleged abuse against the same certified nursing aide, and the facility failed to develop and implement a QAPI plan to prevent quality of care issues and ensure safety of residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) Program, undated, indicated the following:</p> <ul style="list-style-type: none"> <li>-The objectives of the QAPI program are to</li> </ul> <ol style="list-style-type: none"> <li>1. provide a means to measure current and potential indicators for outcomes of care and quality of life.</li> <li>2. provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators.</li> <li>4. establish systems through which to monitor and evaluate corrective actions.</li> </ol> <ul style="list-style-type: none"> <li>-The Administrator is responsible for assuring that this facility's QAPI program complies with federal, state, and local regulatory agency requirements.</li> <li>-The QAPI committee reports directly to the administrator.</li> </ul> <p>Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, undated, indicated the following:</p> <ul style="list-style-type: none"> <li>-Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.</li> <li>-Investigate and report any allegations within timeframes required by federal requirements.</li> <li>-Establish and implement a QAPI review and analysis of reports, allegations or findings of abuse, neglect mistreatment or misappropriation of property.</li> </ul> <p>Review of the grievance log indicated a grievance was filed on 11/27/24 from a Resident alleging rough handling from CNA #5.</p> <p>Review of the facility reported incident report, dated 12/10/24, indicated that another Resident of the facility alleged abuse against CNA #5.</p> <p>CNA #5 was terminated following the abuse allegation on 12/10/24.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 11:36 A.M., the Administrator was asked why CNA #5 was terminated and what performance meant, which was what the termination paperwork indicated. The Administrator said she terminated CNA #5 for customer service and insubordination because CNA #5 was mouthy with her. The Administrator cannot recall the exact phrases CNA #5 said to her, but remembers it was her body language and attitude. The Administrator said that she spends a lot of time on the interview process to determine if there was abuse or neglect that occurred, but if the Resident had said they were being harmed or mentally harmed, then she would consider it to be abuse or neglect. The Administrator said that she had developed a QAPI plan after the alleged abuse incident and provided the surveyor with a binder.</p> <p>Review of the QAPI plan indicated that education was completed, but not further audits or plan to keep resident's safe was implemented. Two surveyors reviewed the QAPI plan, which was blank and incomplete. The Administrator said she may have resident safety interviews, but could not produce them during survey.</p> <p>The Administrator produced a QAPI plan after the survey was conducted with a target date of 11/5/24, 3 weeks prior to the initial incident.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48671</p> <p>Based on observations, interviews and record review for two Residents (Resident #111 and #2i) out of a total sample of 30 residents, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. Specifically,</p> <p>1a. For Resident #111, the facility failed to implement contact precautions, for a Resident who was diagnosed with Clostridium difficile (C. difficile- an inflammation of the colon).</p> <p>1b. For Resident #2i, the facility failed to implement contact precautions, for a Resident who was diagnosed with Methicillin-Resistant Staphylococcus Aureus (MRSA- a bacteria that is resistant to several antibiotics).</p> <p>Findings include:</p> <p>Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions, dated September 2022 indicated the following:</p> <p>- Transmission based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents.</p> <p>5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the cart so that personnel and visitors are aware of the need for and type of precaution.</p> <p>a. The signage informs the staff of the type of CDC (Center for Disease Control) precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room.</p> <p>b. Signs and notifications comply with the resident's right to confidentiality or privacy.</p> <p>Review of the facility policy titled Clostridium Difficile, dated October 2018 indicated the following:-Measures are taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. Precautions are taken while caring for residents with C. difficile to prevent transmission to other residents.</p> <p>3. The primary reservoirs for C. difficile are infected people and surfaces. Spores can persist on resident -care items and surfaces for several months and are resistant to some common cleaning and disinfection methods.</p> <p>5d. Frequent hand washing with soap and water by staff and residents.</p> <p>9. Residents with diarrhea associated with C. difficile (i.e., residents who are colonized and symptomatic) are placed on contact precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>14. When caring for residents with CDI, staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior to alcohol-based hand rub (ABHR) for the mechanical removal of C. difficile spores from hands.</p> <p>1a. Resident #111 was admitted to the facility in December 2024 with diagnoses including pneumonia, chronic kidney disease, ileus (lack of movement in the intestines), and chronic kidney disease.</p> <p>Review of Resident #111's most recent Minimum Data Set (MDS) assessment, dated 12/23/24, indicated that Resident #111 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. The MDS also indicated Resident #111 was dependent on staff for toileting.</p> <p>Review of Resident #111's medical record indicated the following:</p> <p>Laboratory report dated 2/20/25: Clostridioides difficile (C. difficile) result is positive.</p> <p>Review of the nursing progress note dated 2/20/25, indicated that Resident #111 tested positive for C. difficile and a physician order for antibiotic therapy was initiated.</p> <p>On 2/21/25 at approximately 9:09 A.M., the surveyor observed a sign posted at Resident #111's doorway titled Contact Precautions. The Contact Precaution sign indicated for anyone who enters this Residents room must: Clean their hands with soap and water, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person.</p> <p>On 2/21/25 at approximately 9:10 A.M., the surveyor observed a staff member enter into Resident #111's room. The staff member was not wearing Personal Protective Equipment (PPE). The surveyor observed from the hall as the staff member exited the Residents room and walked directly across the hall and into another Residents room. The surveyor observed a sign posted at his/her doorway titled Contact Precautions. The staff member was not wearing any PPE and did not perform hand hygiene upon entering or exiting any of the Resident rooms.</p> <p>On 2/21/25 at approximately 9:20 A.M., the surveyor observed a staff member enter into Resident #111's room. The surveyor observed a sign posted at his/her doorway titled Contact Precautions. The staff member was not wearing any Personal Protective Equipment (PPE). The surveyor observed from the hall as the staff member was touching items on the Residents overbed table. During the observation the Director of Nursing walked by Resident #111's room and could be heard saying to the staff member inside the room That's a contact room you need to wear PPE. The staff member then exited the room without washing her hands and used her contaminated hands to open the drawers to the PPE cart located in the hall.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/25 at 9:24 A.M., the surveyor observed a staff member picking up Resident #111's breakfast tray that was located on the over bed table and then passed the breakfast tray with her gloved hands to a second staff member who was standing in the doorway to the Residents' room. The staff member in the doorway was not wearing gloves and took the tray with her bare hands and walked down the hall and then passed the breakfast tray to another staff member who then placed the tray into the breakfast cart. The staff members did not perform hand hygiene during any of the observations and continued to collect breakfast trays from many other resident rooms.</p> <p>On 2/21/25 at 9:29 A.M., the surveyor observed the staff member removing her PPE, exiting Resident #111's room and immediately entered a different Resident's room across the hall without performing hand hygiene. The surveyor observed a contact precaution sign on the door, and the door was open. The Nurse then entered the residents room without wearing any PPE. The Nurse then was observed to exit the Residents room, used hand sanitizer and touched items on top of her medication cart</p> <p>During an interview on 2/21/25 at 9:39 A.M., Unit Manager #1 said Resident #111 is positive for C. difficile and staff must wear PPE when entering the Residents room. Unit Manager #1 said staff must perform hand washing with soap and water after any encounter with that Resident.</p> <p>During an interview on 2/21/25 at 9:42 A.M., the Infection Preventionist said staff must wear PPE when entering a contact precaution room and said staff must wash their hands with soap and water because the Resident is positive for C. difficile.</p> <p>On 2/21/25 at 9:56 AM., the surveyor observed a housekeeping staff member exit Resident #111's room wearing PPE and removed her gown and mask at the doorway. The housekeeping staff member used her contaminated gloves to place a mop on to the cleaning cart outside the Resident's door. Using her contaminated gloved hand, the housekeeping staff member pushed the cart down the hall, and was observed removing her contaminated gloves, and continued to push the cart touching the contaminated cart handle with her bare hand. She then used hand sanitizer and removed the mop from the cart and entered another Residents room.</p> <p>During an interview on 2/21/25 at 10:22 A.M., with the Director of Nursing (DON) and the Administrator, the DON said staff must follow infection control guidelines and said contact precautions should have been implemented for Resident #111 who is positive for C. difficile. The DON said staff must perform hand hygiene with soap and water after removing PPE and before entering another Residents room. The DON said staff must not touch items with contaminated gloves and expect staff to properly remove and discard them. The Administrator said she expects staff to implement infection control protocols and expects the staff to follow infection control guidelines when providing care.</p> <p>1b. Resident #2i was admitted to the facility in January 2025 with diagnoses including phantom limb syndrome with pain, pain in left leg, and morbid obesity.</p> <p>Review of Resident #2i's most recent Minimum Data Set (MDS) assessment, dated 2/4/25, indicated that Resident #2i had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS also indicated Resident #2i required partial to moderate assistance with most activities of daily living tasks.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/25 at 9:32 A.M., the surveyor observed Resident #2i sitting in a wheelchair in the doorway of his/her room. The Resident told the surveyor that he/she had MRSA in his/her elbow. The surveyor did not observe signage for contact precautions on Resident #2i's doorway and there was no PPE cart observed outside the door.</p> <p>Review of Resident #2i's nursing progress note dated 2/20/25, indicated a culture report was sent by Rheumatology and the Resident is positive for MRSA. Left elbow dressing intact/patent. MRSA precautions maintained.</p> <p>Review of Resident #2i's care plan related to infections, dated 2/19/25, indicated the following:</p> <ul style="list-style-type: none"> <li>- I require Enhanced Barrier Precautions related to Wound(s).</li> <li>- Enhanced Barrier Precautions sign posted on room door or in room.</li> </ul> <p>During an interview on 2/21/25 at 9:40 A.M., Unit Manager #1 said the Resident is positive for MRSA and should be on contact precautions. Unit Manager #1 said contact precautions should have been implemented and said a sign should be on the Residents door but is not.</p> <p>During an interview on 2/21/25 at 9:46 A.M., the Infection Preventionist said she was not aware that Resident #2i had MRSA and said contact precautions should have been implemented.</p> <p>During an interview on 2/21/25 at 10:24 A.M., with the Director of Nursing (DON) and the Administrator, the DON said staff must follow infection control guidelines and she expects contact precautions to be initiated and followed. The DON said Resident #2i should have been placed on contact precautions for MRSA and said a sign and a PPE cart should have been in place. The Administrator said she expects staff to implement infection control protocols and expects the staff to follow infection control guidelines when providing care.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Aspen Hill Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  190 North Avenue 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)
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>43807</p> <p>Based on record review and interviews, the facility failed to offer the COVID 19 (Coronavirus disease) vaccine to two out of a sample of six employees. Specifically, the facility failed to offer COVID 19 vaccinations during new hire orientation.</p> <p>Findings include:</p> <p>A review of the facility policy titled, Employee Infection and Vaccination Status, dated as revised January 2024, indicated the following:</p> <ul style="list-style-type: none"> <li>-Prior to or upon an employee's duty assignment, the facility will assess the status of an employee's vaccination against infectious conditions. Vaccinations are documented in the employee health record.</li> <li>-Employees will be current with mandated vaccinations prior to performing direct resident care.</li> <li>-Employees are offered or provided with vaccinations per state or local agency policies/regulations.</li> <li>-Employees are provided with education materials to make informed decisions for non-mandated vaccinations. If declined, a declination form is completed and placed in the employee's health record.</li> </ul> <p>A review of 6 employee health records indicated 2 out of the 6 employees had not been vaccinated for COVID 19.</p> <p>A review of the informed consent forms provided by the Director of Nurses for Nurse #3 and Activities Assistant #1 indicated the following:</p> <ul style="list-style-type: none"> <li>-Nurse #3 was provided the informed consent and educated on the COVID 19 vaccination side effects. Nurse #3 refused to accept the vaccination; Nurse #3 signed the form but did not date it.</li> <li>-Activities Assistant #1 was provided the informed consent and educated on the COVID 19 vaccination side effects. Activities Assistant #1 refused to accept the vaccination. Activities Assistant #1 signed and dated the form on 1/15/25.</li> </ul> <p>During an interview and record review on 1/16/25 at 8:15 A.M., the Director of Nurses reviewed Nurse #3's and Activities Assistant #1's informed consent forms. She said Nurse #3 signed the consent form on 1/15/25 but did not date it. She said the Activities Assistant #1 signed the consent form on 1/15/25. The Director of Nurses said both employees should have been offered the COVID 19 vaccination during their new hire orientation but were not.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review on 1/16/25 at 8:30 A.M., the Human Resources Manager said Nurse #3 attended new hire orientation on 11/26/24 and the Activities Assistant #1 attended new hire orientation on 10/1/24 and 10/2/24.</p> <p>During a telephone interview on 1/21/25 at 11:04 A.M., the Administrator said both Nurse #3 and Activities Assistant #1 have worked in the facility since they attended new hire orientation.</p>