STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medway Country Manor Skilled Nursing & Rehabilitat	115 Holliston Street Medway, MA 02053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183 Based on observations, records reviewed and interviews, for three of seven sampled residents (Resident #3, Resident #5, Resident #6), who required transmission based precautions to be utilized by nursing staff during the provision of care, the Facility failed to ensure, 1) that nursing staff were competent and had the necessary skill set to appropriately care for residents by donning the correct Personal Protective Equipment (PPE) when a resident was on Contact Precautions (CP) or Enhanced Barrier Precautions (EBP), when nursing staff members were observed not following precautions while caring for these residents and 2) that after a nursing staff member responsible for providing direct care to residents tested positive for Group A streptococcal Infection, (GAS, a bacterium that can cause many different infections, including strep throat and also cause severe, life-threatening invasive disease, and spread person to person through respiratory droplets or direct contact with an infected person's skin sores, nose, throat or wound secretions) that the staff member was removed from the schedule and not allowed to return to work until after being on an antibiotic for 24 hours, which increased the risk for the spread of an infectious disease to other residents in the facility. Findings include: Review of the Facility Policy, titled Isolation - Categories of Transmission-Based Precautions, dated as revised September 2022, indicated that transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection or has a laboratory confirmed infections and is at risk of transmitting the infection to other residents. The Policy indicated the following: -standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status; -transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected; -these measures are determined by the specific pathogen and how it is spread from person to person; -transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures; (continued on next page)

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

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

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-when a resident is placed on transmission based precautions, appropriate notification is placed on the room entrance door so that personnel and visitors are aware of the need and type of precaution; -the signage informs the staff of the type of CDC precaution, instructions for use of PPE, and/or instructions to see a nurse before entering the room; -Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment; -Contact Precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified; -Contact Precautions are used for residents infected or colonized with Multi Drug Resistant Organisms (MDRO) when a resident has wounds, secretions, or excretions that are unable to be covered or contained and on units where, despite attempts to control the spread of MDRO, ongoing transmission is occurring; -Enhanced Barrier Precautions (EBP) additional usage of PPE may be used for residents who do not meet criteria for contact precautions but are infected or colonized with MDRO's; -staff wear gloves, when entering the room, while caring for a resident, staff will change gloves after having contact with infective material, gloves are removed and hand hygiene performed before leaving room, staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed; -staff wear a disposable gown upon entering the room and remove gown before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed; Review of the CDC Recommendations for GAS, Transmission Based Precautions, dated 04/03/24 indicated to use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. During an in-person interview on 1/22/25 at 3:20 P.M. with Surveyor #1 and Surveyor #2 and subsequent telephone interview on 1/23/25 at 8:39 A.M. with Surveyor #1, the Director of Nurses (DON) said that the Facility does not have a separate policy for staff competencies. The DON said that each staff member has a Job Description which includes a competency evaluation column that is used for competencies. The DON said that the competencies are completed with each newly hired employee within 90 days of employment and then annually with their review. Review of the Facility's Nurse Supervisor Job Description, indicated it included but was not limited to the following: -ensure that personnel follow established procedures for the use and disposal of PPE; (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-participate in the development, implementation, and maintenance of the infection control program for monitoring communicable and/or infectious diseases among the residents and personnel; -ensure that nursing service personnel follow established infection control procedures when isolations precautions become necessary; Review of the Facility's Unit Manager (Registered Nurse) Job Descriptions, indicated it included but was not limited to the following: -is responsible for overseeing direct nursing care to assigned residents and assumes responsibility and accountability for the nursing care and services provided on the assigned unit; -is responsible for and adheres to the standards of care for assigned residents; -makes daily rounds on unit to ensure resident care needs and environmental standards are met; -makes frequent rounds to ensure nursing personnel are performing their work assignments in accordance with acceptable nursing standards; Review of the Unit Manager's personnel file, indicated that she had received and reviewed a copy of the Unit Manager Job Description which was a five page packet of information specific to the Unit Manager, and that she signed and dated the Job Descriptions on 12/11/24. Review of the Facility's Charge Nurse (Registered Nurse RN/Licensed Practical Nurse LPN) Job Description, indicated it included but was not limited to the following: -ensure that all nursing personnel assigned to you comply with the written policies and procedures established by this facility; -primary purpose of your job description is to provide direct nursing care to residents; -to supervise the day-to-day nursing activities performed by nursing assistants; -participate in the development, implementation, and maintenance of the infection control program for monitoring communicable and/or infectious diseases among the residents and personnel; -follow established infection control procedures when isolation precautions become necessary. Review of Nurse #1's personnel file, indicated he had received and reviewed a copy of the Charge Nurse RN/LPN Job Description which was a sixteen page packet of information specific to nurses, including a Competency Evaluation Section and that he signed and dated the Job Description on 12/26/24. Review of the Facility's Certified Nursing Assistant Job Description, indicated it included but was not limited to the following: -perform all assigned tasks in accordance with our established policies and procedures; -follow established isolation precautions and procedures; (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-wash hands before entering and after leaving an isolation room; -follow established procedures in the use and disposal of personal protective equipment; Review of Certified Nurse Aide (CNA) #2's and CNA #3's personnel files, indicated they had received and reviewed a copy of the Certified Nursing Assistant Job Description which was a nine page packet of information specific to certified nursing assistants, and included Competency Evaluation Sections and that CNA #2 signed and dated the Job Description on 12/27/24 as having been completed, and CNA #3 signed and dated the Job Description on 12/19/24 as having been completed. 1. On 1/22/25, Surveyor #1 observed an EBP sign posted on the door outside the room occupied by Resident #3 and Resident #7 and there was a bin with Personal Protective Equipment (PPE) outside the room by the door. The EBP sign indicated that Resident #3 was on EBP and everyone must clean their hands, including before entering and when leaving the room. The EBP sign indicated that staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of urinary catheter. Resident #3 was admitted to the Facility in November 2024, medical diagnoses included, urinary tract infection, sepsis, Chronic Obstructive Pulmonary Disease (COPD) , Extended Spectrum Beta Lactamase (ESBL) Resistance, bacteremia, and Diabetes Mellitus. Review of Resident #3's Physician Orders, dated 11/24/24, indicated he/she required Enhanced Barrier Precautions (EBP) related to an indwelling Foley catheter and wound care treatment. Review of the Residents on Precautions List, updated 01/17/25, indicated that Resident #3 was on EBP related to use of a Foley catheter. Review of Resident #3's most current Care Plan related to Enhanced Barrier Precautions for the care of Foley catheter, indicated to wear gloves and gown for the following high-contact resident care: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, for device care or use of urinary catheter and wound care, and any skin opening requiring a dressing. Resident #7 was admitted to the Facility in August 2024, medical diagnoses included chest pain, cirrhosis of liver, malignant neoplasm of prostate, dementia, traumatic brain injury and urinary tract infection. Review of Resident #7's Current Care Plans and Current Physician Orders indicated that he/she was not on any Infection Control Precautions. On 1/22/25 at 8:52 A.M., Surveyor #1 observed Certified Nurse Aide (CNA) #3 enter Resident #3's room wearing gloves, a mask, but not a gown. CNA #3 assisted Resident #3 with dressing, touched the bed linens and then set-up his/her meal tray. CNA #3 then removed her gloves, performed hand hygiene, donned on a new pair of gloves and proceeded to reposition Resident #7's upper body and legs in bed. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 1/22/25 at 9:00 A.M. with Surveyor #1, CNA #3 said that Resident #7 was on precautions and that she did not believe Resident #3 was on any precautions. CNA #3 said that she put on gloves and not a gown when she entered Resident #3 and Resident #7's room, because she was only delivering breakfast trays. CNA #3 said that she dressed Resident #3, touched his/her bed linens without wearing a gown and said she was unaware that she was supposed to wear a gown when performing those activities for residents on EBP. CNA #3 said that she had seen the EBP sign at the door and said that she believed that Resident #7 was the one on EBP. CNA #3 said that if she was unsure if a resident was on precautions, she would ask the nurse. On 1/22/25 at 9:00 A.M., Surveyor #1 observed CNA #2 enter Resident #7's room wearing gloves, a mask and set up his/her breakfast tray. CNA #2 then removed her gloves, performed hand hygiene and exited the room. During an interview on 1/22/25 at 9:05 A.M. with Surveyor #1, CNA #2 said that she had seen the EBP sign at the door (to Resident #3 and #7's room) but said she did not know which resident in the room was on EBP. CNA #2 said that sometimes the signs are not accurate as to which resident in the room is on precautions or if any of the residents in the room are on precautions at all. CNA #2 said that sometimes the precaution signs posted outside a residents door belonged to a previous resident who was discharged but the sign was not taken down. CNA #2 said that if she was unsure if a resident was on precautions, she would ask the nurse. Although CNA #2 and CNA #3 received education, training and were required to complete competencies in the areas of isolation precautions and the use of PPE, they were unable to apply their training into practice when they were both observed entering resident rooms without putting on gowns and then caring for a resident on EBP, which required the use of full PPE. CNA #3 was unaware of Resident #3's specific clinical condition which necessitated the need for EBP, and CNA #2 had no idea which resident (#3 or #7) required EBP, yet both proceeded into the room to provided care without checking with nursing. Resident #5 was admitted to the Facility in November 2024, diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, bipolar disorder, chronic myeloid leukemia in remission, malignant neoplasm of cervix, and type 2 diabetes mellitus. Review of Resident #5's Care Plan related to chemotherapy due to cancer, dated 11/15/24, indicated he/she required contact isolation precautions due to chemotherapy, to dedicate equipment to resident, no sharing, wear gown/gloves during care if risk of exposure to body fluids. Review of Resident #5's Physician Orders, dated 12/31/24, indicated he/she required Contact Precautions for chemotherapy drug treatments. Review of Resident #5's Treatment Administration Record (TAR), dated 01/01/25 through 1/22/25, indicated he/she required Contact Precautions due to Chemotherapy drug administration and to see directions posted outside of room. Review of the Residents on Precautions List, updated 01/17/25, indicated that Resident #5 was on Contact Precautions related to chemotherapy. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Contact Precaution sign posted outside Resident #5's room indicated staff to put on gloves before room entry and discard gloves before room exit, put on gown before room entry and discard gown before room exit, and there was a bin with Personal Protective Equipment (PPE) just outside the room by the door. On 1/22/25 at 8:40 A.M., Surveyor #2 observed Certified Nurse Aide (CNA) #2 enter Resident #5's room without putting on and using a gown or gloves and assist Resident #5 with the set-up of a meal tray. CNA #2 then exited the room and performed hand hygiene. On 1/22/25 at 8:42 A.M., Surveyor #2 observed Nurse #1 enter Resident #5's room without putting on a gown or gloves. Nurse #1 asked Resident #5 about his/her medications, performed hand hygiene and exited the room. During an interview on 1/22/25 at 8:43 A.M., with Surveyor #2, CNA #2 said that she delivered Resident #5's breakfast tray and did not wear any PPE as indicated on the Contact Precaution sign outside his/her room. CNA #2 said that she asked the nurse (exact name unknown) about the Contact Precautions for Resident #5 and was told by the nurse that Resident #5 was no longer on Contact Precautions. Although Nurse #1 and CNA #2 had received education, training and had been required to complete competencies related to isolation precautions and the use of PPE, they were unable to apply their training into practice when they were observed entering Resident #5's room, which had a Contact Precaution sign clearly posted outside of it with instructions for PPE, yet both of them were observed going into the room without putting on gowns or gloves. Resident #6 was admitted to the Facility in June 2020, diagnoses included vascular dementia with behavioral disturbance, dysphagia, aphasia, cerebral infarction, atrial flutter, cardiac pacemaker, benign prostatic hyperplasia and anxiety disorder. Review of Resident #6's Physician Orders, dated 12/26/24, indicated that he/she was on Contact Precautions for a rash. Review of Resident #6's Treatment Administration Record (TAR), dated 12/26/24 through 12/31/24 indicated that he/she was on Contact Precautions for a rash. Review of Resident #6's Weekly Skin Assessment, dated 12/26/24, indicated that he/she had a rash to his/her left front thigh. Review of December 2024 Infection Control Line Listing, indicated that on 12/27/24 Resident #6 developed itch and redness to his/her bilateral lower extremities, had a rash to his/her skin and was started on an antibiotic. Review of Resident #6's Care Plan related to suspected scabies, dated 12/26/24, indicated to educate caregivers that anyone in close contact with an infected person should seek medical treatment, that infestation may occur by direct skin to skin contact with an infected person and to wash all clothing, bedding and towels in hot water and dry in a hot dryer. The Care Plan indicated that Scabies is spread by sharing towels, clothing and bedding. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Residents on Precautions List, updated 01/17/25, indicated that Resident #6 was not on any Infection Control Precautions. During the Survey, the Surveyors observed that Resident #6 had a Contact Precaution sign posted outside his/her room. The Sign indicated staff to put on gloves before room entry and discard gloves before room exit, put on gown before room entry and discard gown before room exit. There was also a bin with Personal Protective Equipment (PPE) outside the room by the door. On 1/22/25 at 8:47 A.M., Surveyor #2 observed Certified Nurse Aide (CNA) #2 enter Resident #6's room without the use of a gown or gloves, assist Resident #6 with the set-up of a meal tray and placed a blanket on his/her shoulders. CNA #2 stood in the room chatting with Resident #6, then rubbed his/her (Resident #6's) arm prior to exiting the room and then then performed hand hygiene. During an interview on 1/22/25 at 8:55 A.M. with Surveyor #2, CNA #2 said that she did not know why Resident #6 was on Contact Precautions and said she would have to ask the nurse. CNA #2 said she was not wearing any PPE when she entered Resident #6's room as the sign indicated. On 1/22/25 at 9:12 A.M., Surveyor #2 observed Nurse #1 enter Resident #6's room without the use of a gown or gloves. Nurse #1 repositioned Resident #6 from a sitting position on the side of the bed to a lying position. Nurse #1 was observed adjusting Resident #6's blankets, handing Resident #6 the call light and then performed hand hygiene and exited the room. During an interview on 1/22/25 at 9:15 A.M. with Surveyor #2, Nurse #1 said that Resident #6 was previously on Contact Precautions because he/she had a urinary catheter and said he did not believe Resident #6 was still on Contact Precautions. Nurse #1 said that he would have to ask the Unit Manager about the status of Resident #6's precautions and said he could not explain why Resident #6 had a Contact Precaution sign posted outside the door of his/her room. During an interview on 01/22/25 at 9:24 A.M. with Surveyor #2, the Unit Manager said that after reviewing Resident #6's Medical Record, that he/she was no longer on Contact Precautions. The Unit Manager said that Resident #6's urinary catheter was removed and he/she was on comfort measures only. The Unit Manager said that she would speak with the Infection Preventionist (IP) to confirm Resident #6's status related to need for precautions. Although Nurse #1 and CNA #2 received education, training and were required to complete competencies in the areas of isolation precautions and the use of PPE, they were unable to apply their training into practice when they were observed entering Resident #6's room, that had a Contact Precaution sign posted outside of it, which clearly indicated what PPE staff were to use, yet both of them went into the room without using any PPE. As Resident #6's nurse, Nurse #1 was unsure and unaware if the resident was on precautions and CNA #2 did not check with nursing to see if Precautions were necessary. The Unit Manager was unable to demonstrate that she was competent in identifying residents on her assigned unit who required EBP or Contact Precautions and when the surveyors pointed the residents/rooms out to her, the Unit Manager was unable to identify why those residents' required precautions. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 01/22/25 at 11:15 A.M. and throughout the survey with Surveyor #1 and Surveyor #2, the Infection Preventionist (IP) said staff were trained and required to complete competencies on EBP and Contact Precautions and were aware that there were signs posted outside room doors indicating which resident(s) was on precautions. The IP said that the signs clearly indicate what type of PPE to wear when performing resident care activities. The IP said that staff are supposed to wear gloves and a gown when performing dressing activities, repositioning residents, and touching linens. The IP said it was her expectation that staff follow the directives that are posted on the precaution signs. The IP said she did not know the status of Resident #6's infection control needs and said she would have to look into it. During an in-person interview on 01/22/25 at 3:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 01/23/25 at 8:39 A.M. with Surveyor #1, the Director of Nurses (DON) said that staff were required to complete competencies, have been trained on EBP and Contact Precautions, and were aware that there are signs posted outside the resident room door indicating which resident or residents was on precautions. The DON said that it was her expectation that staff follow the directives that are posted on the precaution signs and wear the appropriate PPE when providing resident care according to the directives on the signs. The DON said that it was her expectation that nursing staff are aware of the residents who are on precautions and why they are on precautions. The DON said that as the DON, she was ultimately responsible for the Facility's Infection Control Program and ensuring that all of the policies and procedures were followed. 2. Review of the Facility Policy, titled Staff Compliance During Group A Streptococcus (GAS) Outbreaks, dated 06/21/2024, indicated that during an outbreak of GAS in the nursing home, staff are encouraged to undergo testing for GAS. The Policy indicated that staff who test positive must follow medical advice for treatment and may not return to work until cleared by a healthcare professional. The Policy further indicated that CDC recommendations are used as a reference. Review of CDC Recommendations for GAS, dated 03/25/2024 indicated that for healthcare personnel with known or suspected Group A Streptococcus infection, obtain a sample from the infected site, and exclude from work until 24 hours after the start of effective antimicrobial therapy. The DON said on 1/18/25, CNA #1 tested positive for GAS. The DON said that the Laboratory reported CNA #1's positive test results for GAS to the facility on [DATE]. The DON said that on 1/18/25, someone from the facility notified her that CNA #1 was positive for GAS and that she called CNA #1 to tell her that her results were positive for GAS, and to go see a doctor to get treatment for herself and her family. The DON said on 1/18/25 when she called and notified CNA #1 that her test results were positive, she assumed that CNA #1 was home and not at work. The DON said that she did not tell CNA #1 to go home because she was not aware that CNA #1 was working at the facility that day. Review of the Daily Schedules, dated 1/18/25 and 1/19/25, indicated that CNA #1 worked on the [NAME] Unit starting at 7:00 A.M. and worked through to 11:00 P.M. (working a double, day and evening shifts). Review of the Daily Schedule, dated 1/20/25, indicated that CNA #1 worked on the Second Unit from 7:00 A. M. through 3:00 P.M. shift and on the [NAME] Unit from 3:00 P.M. through 11:00 P.M. shift. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of CNA #1's Timecards, indicated that she worked the following: -on 1/18/25 from 7:07 A.M. to 10:53 P.M.; -on 1/19/25 from 7:06 A.M. to 10:53 P.M.; -on 1/20/25 from 7:09 A.M. to 10:53 P.M. West Unit had a total number of 31 residents residing on it. Second Unit had a total number of 35 residents residing on it. Therefore all residents residing on the [NAME] and Second units, as well as other staff member, were put at risk for contracting and spreading GAS. During an in-person interview on 1/22/25 at 2:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 1/23/25 at 8:52 A.M. with Surveyor #1, CNA #1 said that on 1/18/25 the DON called her, (exact time unknown) and informed her that she was positive for GAS. CNA #1 said the DON told her that she needed to go home and see a doctor. CNA #1 said that she was at work when the DON called her and said sometime after supper (exact time unknown) she went home. CNA #1 said that on 1/19/25, she went to see her doctor (exact time unknown) and she was prescribed antibiotics. CNA #1 said that her doctor did not discuss anything with her regarding when she could return to work. CNA #1 said that she took her first dose of antibiotics at 3:00 P.M. on 1/19/25 and said she came into work the 3:00 P.M. through 11:00 P.M. shift that night on the [NAME] Unit. CNA #1 said that on 1/20/25, she worked from 7:00 A.M. through 3:00 P.M. shift on the Second Floor and from 3:00 P.M. through 11:00 P.M. shift on the [NAME] Unit. CNA #1 said that sometime during the day on 1/20/25, (exact time unknown) she went to the DON's office, gave the DON her doctor's note and told the DON she was on antibiotics. CNA #1 said that the DON never asked her if she was working and never told her that she could not work until after she was on antibiotics for 24 hours. CNA #1 said after speaking with the DON on 1/20/25 she went back to work her scheduled shift. The DON said that on 1/20/25 she noticed that the schedule for 1/19/25 indicated that CNA #1 worked the 3:00 P.M. to 11:00 P.M. shift. The DON said that she had not previously informed CNA #1 or the Scheduler that CNA #1 could not return to work prior to being on antibiotics for 24 hours. The DON said she was unsure if CNA #1 had worked on 1/19/25 and was unaware if CNA #1 had worked on 1/20/25. The DON said that on 1/20/25 (exact time unknown) CNA #1 gave her a doctor's note and told her that she took her first dose of antibiotics on the evening of 1/19/25 and took the next dose of antibiotics in the morning of 1/20/25. The DON said that after reviewing the schedules and timecards, that CNA #1 had returned to work prior to being on antibiotics for 24 hours. The DON said facility policy indicates that staff who are positive for GAS cannot return to work prior to being on antibiotics for 24 hours and said her expectation was that they all follow facility policy. The DON said it was her responsibility to let CNA #1 and the Scheduler know that CNA #1 could not return to work prior to being on antibiotics for 24 hours and said it was a miscommunication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medway Country Manor Skilled Nursing & Rehabilitat	115 Holliston Street Medway, MA 02053

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183 Based on records reviewed and interviews for one of seven sampled residents (Resident #1), who per Laboratory test results reported to the facility on [DATE] indicated he/she tested positive for Group A Streptococcal (GAS, a bacterium that can cause many different infections, including strep throat and also cause severe, life-threatening invasive disease, spread person to person through respiratory droplets or direct contact with an infected person's skin sores, nose, throat or wound secretions), the Facility failed to ensure Nursing promptly notified the physician of the results, who was not informed until four days later (1/22/25), as a result Contact Precautions were not initiated timely, therefore placing other residents and staff at risk for potentially contracting and spreading the infectious disease. Findings include: Review of the Facility Policy, titled Lab and Diagnostic Test Results - Clinical Protocol, dated as revised November 2018, indicated the following: -the physician will identify and order diagnostic and lab testing on the resident's diagnostic and monitoring needs; -staff will process test requisitions and arrange for test; -the lab will report test results to the facility; -a nurse will identify the urgency of communicating with the physician the seriousness of any abnormality and the individuals current condition; -nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab result: -whether the result should be conveyed to the physician regardless of other circumstances that is, the abnormal result is problematic regardless of other factors; -direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the current treatment needs review or clarification; -staff should document information about when, how, and to whom the information was provided and the response in the progress notes; -a physician will respond with an appropriate time frame based on the clinical significance of the information; -a physician should respond within one hour regarding a lab test result requiring immediate notification; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Medway Country Manor Skilled Nursing & Rehabilitat		STREET ADDRESS, CITY, STATE, ZIP CODE: 115 Holliston Street Medway, MA 02053	

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-when responding to notification of test results, the physician and staff will discuss the implications of the test results for the resident, as well as subsequent actions; for example, new or modified medication orders, additional monitoring, etc. Review of the CDC Recommendations for GAS, Transmission Based Precautions, dated 04/03/24 indicated to use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Resident #1 was admitted to the Facility in September 2023, medical diagnoses included stage 4 pressure ulcer (full thickness skin and tissue loss) of sacral region, unspecified dementia with agitation, local infection of the skin and subcutaneous tissue, hyperlipidemia and hypertension. Review of the Laboratory Results Report, sent to the facility on [DATE], indicated that Resident #1 tested positive for GAS isolated in his/her left shoulder. Review of Resident #1's Medical Record indicated there was no documentation to support that after the facility was made aware he/she tested positive for GAS in his/her left shoulder on 1/19/25, that Contact Precautions were initiated per CDC recommendations. Review of Resident #1's Medical Record indicated there was no documentation to support that the physician was notified that he/she had a positive GAS culture of his/her left shoulder until 01/22/25, four days after the positive result had been reported to the facility. Review of Resident #1's Physician Orders, dated 01/22/25, indicated administer Penicillin V(antibiotic) Oral Tablet 500 milligrams (mg) by mouth twice daily for ten days for GAS in wound. Review of Resident #1's Care Plan related to GAS in the wound, dated 01/22/25, indicated to administer antibiotics per Physician orders and Resident to be placed on Enhanced Barrier Precautions (EBP) due to wound infection. During an interview on 01/22/25 at 11:15 A.M. and throughout the survey with Surveyor #1 and Surveyor #2, the Infection Preventionist (IP) said that Resident #1 was tested for GAS on 1/17/25 and said that on 01/19/25, the lab sent Resident #1's result to the facility which indicated he/she tested positive for GAS. The IP said that typically the nurses on the Units get the results of the labs, then notify the provider and nursing management of any positive GAS results. The IP said that she was not notified that Resident #1 tested positive for GAS until 1/22/25 (the date of the survey) when the DON notified her that Resident #1 had tested positive for GAS (on 1/19/25). The IP said she could not explain why the nurses had not notified the provider and nursing management of Resident #1's positive GAS result on 01/19/25. The IP said that it was her expectation that nurses notify the provider and nursing management of any positive GAS results so that appropriate precautions and treatments can be implemented. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an in-person interview on 01/22/25 at 3:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 01/23/25 at 8:39 A.M. with Surveyor #1, the Director of Nurses (DON) said that she found out the morning of the survey (01/22/25) that Resident #1 tested positive for GAS (on 1/19/25) in his/her wound, and said the physician was also notified that morning and he/she was started on antibiotics. The DON said she could not explain why the physician was not notified of Resident #1's positive GAS results on 01/19/25 and said it was her expectation that staff notify the physician, IP, and her of any positive GAS results immediately so that appropriate precautions and treatments can be implemented. During a telephone interview on 1/23/25 at 2:23 P.M., the Medical Director said he became the Medical Director for the Facility in December 2024. The Medical Director said that he was aware that the Facility had several cases of GAS and said he has spoken to an Epidemiologist with the DPH regarding the cases. The Medical Director said that he was aware that Resident #1 tested positive for GAS, but could not recall exactly when he was notified. The Medical Director said that he was not aware that the Facility waited four days before reporting Resident #1's positive GAS results and said it was his expectation that the staff immediately report any positive GAS results to the physician so that treatment can be implemented.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183 Based on records reviewed and interviews, for two of three nursing units (West and Second) after a staff member Certified Nurse Aide (CNA) #1 tested positive for Group A Streptococcal (GAS, a bacterium that can cause many different infections, including strep throat and also cause severe, life-threatening invasive disease, spread person to person through respiratory droplets or direct contact with an infected person's skin sores, nose, throat or wound secretions) on 1/18/25, facility administration failed to ensure it provided appropriate administrative oversight of Infection Control Practices when CNA #1 was not removed from the schedule until being on antibiotic therapy for 24 hours. Facility Administration was aware there were issues with GAS infections and transmission within the facility, however CNA #1 was scheduled and worked on two different resident care units between 1/19/25 and 1/20/25, placing the residents and staff at risk for contracting and/or spreading the infectious disease that could cause adverse harm up to and including death. Findings include: Review of the Facility Policy, titled Staff Compliance During Group A Streptococcus (GAS) Outbreaks, dated 06/21/2024, indicated that during an outbreak of GAS in the nursing home, staff are encouraged to undergo testing for GAS. The Policy indicated that staff who test positive must follow medical advice for treatment and may not return to work until cleared by a healthcare professional. The Policy further indicated that CDC recommendations are used as a reference. Review of CDC Recommendations for GAS, dated 03/25/2024 indicated that for healthcare personnel with known or suspected group A Streptococcus infection, obtain a sample from the infected site, and exclude from work until 24 hours after the start of effective antimicrobial therapy. During the Entrance Conference on 1/22/25 at 10:40 A.M., with Surveyor #1 and Surveyor #2, the Administrator acknowledged that the Facility has had outbreaks of GAS infections amongst residents and staff. The Administrator said that when an outbreak was identified on a particular unit, the residents on the unit and staff who worked on that unit were tested for GAS. The Administrator said that for residents who test positive, isolation precautions were instituted. During an interview on 01/22/25 at 11:15 A.M. and throughout the survey with Surveyor #1 and Surveyor #2, the Infection Preventionist (IP) said that she was new to the Infection Preventionist role and has only been in the role for three months. The IP said that she was the one responsible for the Facility's Infection Control Program, which included tracking, monitoring and surveillance of all infections for the Facility. The IP said that on 01/15/25 an Epidemiologist from the Department of Public Health (DPH) recommended that the Facility test the residents and staff that work on the [NAME] Unit for GAS because one of their residents' that had passed away was positive for GAS. The IP said that on 01/16/25, residents and staff on the [NAME] Unit were tested for GAS and the samples were picked up by the laboratory on 01/17/25. The IP said that on 01/18/25, the lab reported CNA #1's positive GAS result to the Facility. The IP said that she was not notified of CNA #1's positive GAS result and said the Director of Nurses (DON) was the person that had been notified. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The IP said that although she was aware that the residents and staff on the [NAME] Unit were tested for GAS on 01/16/25, said that she had not followed up with the results of those tests when she returned to work on 01/20/25, 01/21/25, or 01/22/25, but said she should have followed up. The IP said that the DON was the one who followed up with the staff member (CNA #1) who tested positive for GAS. The IP said that the Facility Policy for a staff member with a positive GAS result was that they needed to be on antibiotics for 24 hours before returning to work. The IP said that she thought that CNA #1 had not returned to work until she had been on antibiotics for 24 hours, but would have to check with the DON. During an in-person interview on 01/22/25 at 3:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 01/23/24 at 8:39 A.M. with Surveyor #1, the Director of Nurses (DON) said that she, as the DON, was the one ultimately responsible for the Facility's Infection Control Program and ensuring that all of the policies and procedures were followed. The DON said on 1/18/25, CNA #1 tested positive for GAS. The DON said that the Laboratory reported CNA #1's positive test results for GAS to the facility on [DATE]. The DON said that on 1/18/25, someone from the facility notified her that CNA #1 was positive for GAS, that she called CNA #1 to tell her her results, told her to go see a doctor to get treatment for herself and her family. The DON said that she was not aware that CNA #1 was working at the facility when she notified her of the test results and that she assumed when she called CNA #1, she was home. The DON said that she had not informed CNA #1 or the Scheduler that CNA #1 could not return to work prior to being on antibiotics for 24 hours, but said she should have told them. Review of the Daily Schedule, dated 1/18/25 and 1/19/25, indicated that CNA #1 worked on the [NAME] Unit starting at 7:00 A.M. through to 11:00 P. M. (double shift). Review of the Daily Schedule, dated 1/20/25, indicated that CNA #1 worked on the Second Unit from 7:00 A. M. through 3:00 P.M. shift and on the [NAME] Unit from 3:00 P.M. through 11:00 P.M. shift. Review of CNA #1's Timecards, indicated that she worked the following: -on 1/18/25 from 7:07 A.M. to 10:53 P.M.; -on 1/19/25 from 7:06 A.M. to 10:53 P.M.; -on 1/20/25 from 7:09 A.M. to 10:53 P.M. West Unit had a total number of 31 residents residing on it. Second Unit had a total number of 35 residents residing on it. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an in-person interview on 1/22/25 at 2:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 1/23/25 at 8:52 A.M. with Surveyor #1, CNA #1 said that on 1/18/25 the DON called her (exact time unknown) and informed her that she was positive for GAS. CNA #1 said that the DON told her she needed to go home and see a doctor. CNA #1 said that she was at work when the DON called and said sometime after supper (exact time unknown) she went home. CNA #1 said that on 1/19/25, she went to see her doctor (exact time unknown) and she was prescribed antibiotics. CNA #1 said the DON never told her she could not work until after being on antibiotics for 24 hours and that her doctor did not discuss anything with her about work. CNA #1 said that she took her first dose of antibiotics at 3:00 P.M. on 1/19/25 and said she came to work that night at the facility for the 3:00 P.M. through 11:00 P.M. shift on the [NAME] Unit. CNA #1 said that on 1/20/25, she worked the 7:00 A.M. through 3:00 P.M. shift on the Second Floor and the 3:00 P.M. through 11:00 P.M. shift on the [NAME] Unit. The DON said that on 1/20/25, CNA #1 gave her a doctor's note and told her that she took her first dose of antibiotics on the evening of 1/19/25 and took another dose of antibiotics in the morning of 1/20/25. The DON said that CNA #1 had returned to work prior to being on antibiotics for 24 hours, which was not consistent with facility policy. During a telephone interview on 1/23/25 at 2:23 P.M., the Medical Director said he became the Medical Director for the Facility in December 2024. The Medical Director said that he was aware that the Facility had several cases of GAS and said he had spoken to one of the DPH Epidemiologists regarding the cases. The Medical Director said that he was going to have a meeting with the Facility on 1/24/25 to discuss the GAS cases, review Infection Control Policies and Procedures for GAS to mitigate the spread of GAS amongst residents and staff. The Medical Director said that it was his expectation that the staff follow the Facility's policies and procedures for Infection Control.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37183 Based on observations, records reviewed and interviews for five of seven sampled residents (Resident #1, Resident #2, Resident #3, Resident #5 and Resident #6), all of which required the need for staff to use Personal Protective Equipment (PPE) during the provision of care due to an active infection, the Facility failed to ensure they implemented and maintained an infection control program that helped prevent the development and spread of infections, including Group A Streptococcal (GAS, a bacterium that can cause many different infections, including strep throat and also cause severe, life-threatening invasive disease, spread person to person through respiratory droplets or direct contact with an infected person's skin sores, nose, throat or wound secretions), that required treatment with antibiotics, when 1) 1/19/25 laboratory results for a resident who tested positive for GAS was not reported to the physician until 1/22/25, resulting in a delay in the implementation of appropriate precautions, 2) Nursing staff were observed going in/out of resident rooms with precaution signs posted outside of them, but were not compliant with the use of PPE, and/or were unaware of why or which residents required precautions, and 3) and a staff member who tested positive for GAS was not removed from the schedule and worked on two different units, all of which increased the potential for additional residents and staff to be exposed and at risk for developing GAS. Findings include: Review of the Facility Policy, titled Isolation - Categories of Transmission-Based Precautions, dated as revised September 2022, indicated that transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection or has a laboratory confirmed infections and is at risk of transmitting the infection to other residents. The Policy indicated the following: -standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status; -transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected; -these measures are determined by the specific pathogen and how it is spread from person to person; -the CDC maintains a list of diseases, modes of transmission and recommended precautions; -transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures; -when a resident is placed on transmission based precautions, appropriate notification is placed on the room entrance door so that personnel and visitors are aware of the need and type of precaution; -the signage informs the staff of the type of CDC precaution, instructions for use of PPE, and/or instructions to see a nurse before entering the room; (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment; -Contact Precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified; -Contact Precautions are used for residents infected or colonized with Multi Drug Resistant Organisms (MDRO) when a resident has wounds, secretions, or excretions that are unable to be covered or contained and on units where, despite attempts to control the spread of MDRO, ongoing transmission is occurring; -Enhanced Barrier Precautions (EBP) additional usage of PPE may be used for residents who do not meet criteria for contact precautions but are infected or colonized with MDRO's; -the decision on whether contact precautions are necessary are evaluated on a case by case basis; -staff wear gloves, when entering the room, while caring for a resident, staff will change gloves after having contact with infective material, gloves are removed and hand hygiene performed before leaving room, staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed; -staff wear a disposable gown upon entering the room and remove gown before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed; Review of the CDC Recommendations for GAS, Transmission Based Precautions, dated 04/03/24 indicated to use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Review of the Facility Policy, titled Enhanced Barrier Precautions (EBP), dated as revised August 2022, indicated the following: -EBP are used as an infection prevention and control intervention to reduce the spread of Multi Drug Resistant Organisms (MDRO's) to residents; -EBP employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply; -gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room); -PPE is changed before caring for another resident; -Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (urinary catheter, feeding tube); (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-EBP are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with Extended Spectrum Beta Lactamase (ESBL); -EBP are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization; -EBP remain in place for the duration of the resident's stay or until the resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk; -staff are trained prior to caring for residents on EBP's; -signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required; -PPE is available outside of the resident rooms. Review of the Facility Policy, titled Lab and Diagnostic Test Results - Clinical Protocol, dated as revised November 2018, indicated the following: -the physician will identify and order diagnostic and lab testing on the resident's diagnostic and monitoring needs; -staff will process test requisitions and arrange for test; -the lab will report test results to the facility; -a nurse will identify the urgency of communicating with the physician the seriousness of any abnormality and the individuals current condition; -nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab result: whether the result should be conveyed to the physician regardless of other circumstances that is, the abnormal result is problematic regardless of other factors; -direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the current treatment needs review or clarification; -a physician will respond with an appropriate time frame based on the clinical significance of the information; -a physician should respond within one hour regarding a lab test result requiring immediate notification; 1. Resident #1 was admitted to the Facility in September 2023, diagnoses included stage 4 pressure ulcer (full thickness skin and tissue loss) of sacral region, unspecified dementia with agitation, local infection of the skin and subcutaneous tissue, hyperlipidemia and hypertension. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Residents on Precautions List, updated 01/17/25, indicated that Resident #1 was on EBP for wound care. Review of Resident #1's Laboratory Results Report, reported to facility on 01/19/25, indicated that he/she had GAS infection isolated in his/her left shoulder. Review of Resident #1's Medical Record indicated there was no documentation to support that the physician was notified that he/she had a positive GAS culture of his/her left shoulder or that Contact Precautions were initiated per facility policy and CDC recommendations until 01/22/25, four days after the positive result were reported to the facility. Review of Resident #1's Physician Orders, dated 01/22/25, indicated administer Penicillin V (antibiotic) Oral Tablet 500 milligrams (mg) by mouth twice daily for ten days for GAS in wound. Review of Resident #1's Care Plan related to GAS in the wound, dated 01/22/25, indicated to administer antibiotics per Physician orders and he/she required EBP due to wound infection. During an interview on 01/22/25 at 11:15 A.M. and throughout the survey with Surveyor #1 and Surveyor #2, the Infection Preventionist (IP) said that she was the one responsible for the Facility's Infection Control Program, which included tracking, monitoring and surveillance of all infections for the Facility. The IP said that on 01/15/25 an Epidemiologist from the Department of Public Health (DPH) recommended that the Facility test the residents and staff that work on the [NAME] Unit for GAS because one of their previous residents had passed away and was positive for GAS. The IP said that on 01/16/25, residents and staff on the [NAME] Unit were tested for GAS and the samples were picked up by the laboratory on 01/17/25. The IP said that on 01/19/25, the lab reported Resident #1's positive GAS results to the facility. The IP said that typically the nurses get the results of the labs, then notify the provider and nursing management of any positive GAS results. The IP said she could not explain why the nurses did not notify the provider and nursing management of Resident #1's positive GAS result on 01/19/25, but said they should have so that appropriate precautions could have been implemented. The IP said although she was aware that the residents and staff on the [NAME] Unit were tested for GAS on 01/16/25, said that she had not followed up on the results of those tests when she returned to work on 01/20/25, 01/21/25 or 01/22/25, but said she should have. The IP said that on 01/22/25 (during the survey), the Director of Nurses (DON) notified her that Resident #1 had tested positive for GAS. The IP said that Resident #1 was already on EBP and should be placed on Contact Precautions due to positive GAS in his/her wound. The IP said she was responsible for initiating precautions and ensuring all of the precaution signs were accurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Medway Country Manor Skilled Nursing & Rehabilitat		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Holliston Street Medway, MA 02053	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an in-person interview on 01/22/25 at 3:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 01/23/25 at 8:39 A.M. with Surveyor #1, the Director of Nurses (DON) said that on 01/16/25, the [NAME] Unit Residents and Staff were tested for GAS. The DON said that the lab picked up the specimens on 01/17/25 and the lab reported the results to the facility on [DATE] and 01/19/25. The DON said that she found out the day of the survey (1/22/25) that Resident #1 tested positive for GAS in his/her wound. The DON said the physician should have been notified of Resident #1's positive GAS results on 01/19/25 and said it was her expectation that staff notify the physician, IP, and her of any positive GAS results immediately. The DON said that Resident #1 was already on precautions, that she was not sure what level of precautions Resident #1 was on, but said that Resident #1 should be on Contact Precautions. 2. Resident #2 was admitted to the Facility in December 2023, medical diagnoses included, urinary tract infection, severe sepsis, cirrhosis, dementia, and rheumatoid arthritis. Review of Resident #2's Hospital Discharge Summary, dated 12/18/24, indicated that he/she had sepsis secondary to UTI with toxic metabolic encephalopathy (condition where brain function is impaired due to accumulation of toxins), had a positive blood culture, and left lower extremity cellulitis. The Summary indicated that on 12/17/24, Resident #2 was on precautions, had GAS bacteremia (presence of bacteria in the bloodstream) and the Massachusetts Department of Public Health (MDPH) was notified. Review of Resident #2's Physician Orders, dated 12/19/24, indicated he/she required Enhanced Barrier Precautions (EBP) for an infection. Review of the December 2024 Infection Control Line Listing, indicated that on 12/18/24, Resident #2 was on Augmentin (antibiotic) for sepsis, however the line listing was incomplete and did not include site of infection, signs, symptoms or culture site. The Line Listing indicated that on 12/19/24, Resident #2 presented with confusion and behaviors, was identified as having a urinary tract infection (UTI) and Levofloxacin (antibiotic) was started. Review of Resident #2's Physician Orders, dated 12/19/24, indicated administer Levofloxacin (antibiotic) oral tablet 500 mg. by mouth once daily for 14 days for sepsis UTI. Review of Resident #2's Care Plan related to Infection Cellulitis/Strep, dated 12/19/24, indicated to administer antibiotics per Physician orders, follow facility policy and procedures for line listing, summarizing and reporting infections and maintain universal precautions (avoiding contact with patients bodily fluids by means of wearing of nonporous articles such as gloves, goggles and face shields) when providing resident care. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of a Nurse Practitioner (NP) Progress Note, dated 12/21/24, indicated that Resident #2 was admitted to the hospital on 12/15/24 and was found to have bacteremia and cellulitis leading to sepsis and UTI. The Note indicated that Resident #2's lab results came back today (12/19/24) and urine was positive for GAS, E-Coli (type of urinary tract bacterial infection) and Group B strep (GBS - an infection cause by bacteria streptococcus agalactiae which can cause serious illness and death in the elderly) and blood culture was also positive for GAS. The Note indicated that Resident #2 was discharged to the facility on Augmentin however both organisms are resistant to Augmentin. The Note indicated that Augmentin will be discontinued and Levofloxacin will be started as it is susceptible to both organisms. Review of the Residents on Precautions List, updated 01/17/25, indicated that Resident #2 was on EBP for a wound infection Resident #2 had an EBP sign outside his/her room on the day of the survey. During an interview on 01/22/25 at 11:15 A.M. and throughout the survey with Surveyor #1 and Surveyor #2, the Infection Preventionist (IP) said that Resident #2 returned from the hospital on 12/18/24 with sepsis, was on antibiotics and was on EBP. The IP said that she could not find any information in Resident #2's Hospital paperwork about what microorganism caused the sepsis. The IP said she was the person responsible for the Infection Control Line Listing and said she could not explain why the December 2024 documentation related to Resident #2's infection was incomplete. The IP said she was unaware that Resident #2 returned from the hospital with GAS in his/her urine and blood. The IP said that if a resident is positive for GAS in the urine and blood they should be on Contact Precautions. The IP said she was responsible for initiating precautions and ensuring all of the precaution signs posted outside the resident rooms were accurate. During an in-person interview on 01/22/25 at 3:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 01/23/25 at 8:39 A.M. with Surveyor #1, the Director of Nurses (DON) said that Resident #2 was on EBP for wounds. The DON said that when a resident returns from the hospital, the medical record is reviewed, the IP adds all the pertinent infection information into the Infection Control Line Listing, obtains orders for necessary precautions and puts signage at the entrance to the resident's room. The DON said she could not explain why the December 2024 Infection Control Line Listing was incomplete for Resident #2 and said that the hospital does not always send the facility all of the information that they need. The DON said that it was her expectation that when a resident returns from the hospital with GAS in their urine and blood, that Contact Precautions be initiated and that the Infection Control Line Listing include all of the information related to the infection. Resident #3 was admitted to the Facility in November 2024, diagnoses included, urinary tract infection, sepsis, Chronic Obstructive Pulmonary Disease, Extended Spectrum Beta Lactamase (ESBL) Resistance, bacteremia, and Diabetes Mellitus. Review of Resident #3's Physician Orders, dated 11/24/24, indicated he/she required Enhanced Barrier Precautions (EBP) related to Foley Catheter and wound infection. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Residents on Precautions List, updated 01/17/25, indicated that Resident #3 was on EBP for Foley catheter only. Review of Resident #3's current Care Plan related to Enhanced Barrier Precautions for the care of Foley catheter, indicated nursing staff to wear gloves and gown for the following high-contact resident care, dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, for device care or use of urinary catheter and wound care, and any skin opening requiring a dressing. Resident #7 (who shared a room with Resident #3) was admitted to the Facility in August 2024, diagnoses included chest pain, cirrhosis of liver, malignant neoplasm of prostate, dementia, traumatic brain injury and urinary tract infection. Review of Resident #7's Current Care Plans and Current Physician Orders indicated that he/she was not on any Infection Control Precautions. On 1/22/25, Surveyor #1 observed an EBP sign posted on the outside of Resident #3 and Resident #7's door and a bin with Personal Protective Equipment (PPE) just outside the door. The sign indicated that Resident #3 was on EBP and everyone must clean their hands, including before entering and when leaving the room. The EBP sign indicated that staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of urinary catheter. On 1/22/25 at 8:52 A.M., Surveyor #1 observed Certified Nurse Aide (CNA) #3 enter Resident #3's room wearing gloves, without putting on a gown, she assisted Resident #3 with dressing, touched the bed linens and set-up of his/her meal tray. CNA #3 then removed her gloves, performed hand hygiene, donned on a new pair of gloves and proceeded to reposition Resident #7's upper body and legs in bed. During an interview on 1/22/25 at 9:00 A.M. with Surveyor #1, CNA #3 said that Resident #7 was on EBP precautions and said that she did not believe Resident #3 was on any precautions. CNA #3 said that she just put on gloves when she entered Resident #3 and Resident #7's room, because she was only delivering breakfast trays. CNA #3 said that she dressed Resident #3, touched his/her bed linens without wearing a gown and said she was unaware that she was supposed to wear a gown when performing those activities for residents on EBP. CNA #3 said that she did see the EBP sign at the door. CNA #3 said that if she was unsure if a resident was on precautions, she would ask the nurse. On 1/22/25 at 9:00 A.M., Surveyor #1 observed CNA #2 enter Resident #7's room wearing gloves and set up his/her breakfast tray. CNA #2 then removed her gloves, performed hand hygiene and exited the room. During an interview on 1/22/25 at 9:05 A.M. with Surveyor #1, CNA #2 said that she did see the EBP sign at the door, but did not know which resident (#3 or #7) in the room was on EBP. CNA #2 said that sometimes the signs are not accurate as to which resident in the room is on precautions or if any of the residents in the room are on precautions at all. CNA #2 said that if she was unsure if a resident was on precautions, she would ask the nurse. (continued on next page)

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F 0880

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

Resident #5 was admitted to the Facility in November 2024, diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, bipolar disorder, chronic myeloid leukemia in remission, malignant neoplasm of cervix, and type 2 diabetes mellitus.

Review of Resident #5's Care Plan related to chemotherapy due to cancer of the cervix, dated 11/15/24, indicated he/she required contact precautions due to chemotherapy, dedicate equipment to resident, no sharing, wear gown/gloves during care if risk of exposure to body fluids.

Review of Resident #5's Physician Orders, dated 12/31/24, indicated he/she required Contact Precautions due to chemotherapy drug treatment.

Review of Resident #5's Treatment Administration Record (TAR), dated 01/01/25 through 1/22/25, indicated he/she required Contact Precautions for Chemotherapy drug, and to see directions posted outside of room.

Review of the Residents on Precautions List, updated 01/17/25, indicated that Resident #5 was on Contact Precautions for chemotherapy.

On 1/22/25, Surveyor #2 observed a Contact Precautions sign posted on the outside of Resident #5's door and a bin with Personal Protective Equipment (PPE) just outside the room by the door. The Sign indicated staff to put on gloves before room entry and discard gloves before room exit, put on gown before room entry and discard gown before room exit.

On 1/22/25 at 8:40 A.M., Surveyor #2 observed Certified Nurse Aide (CNA) #2 enter Resident #5's room without the use of a gown or gloves and assist Resident #5 with the set-up of a meal tray. CNA #2 then exited the room and performed hand hygiene.

On 1/22/25 at 8:42 A.M., Surveyor #2 observed Nurse #1 enter Resident #5's room without the use of a gown or gloves. Nurse #1 asked Resident #5 about his/her medications, performed hand hygiene and exited the room.

During an interview on 1/22/25 at 8:43 A.M., with Surveyor #2, CNA #2 said that she delivered Resident #5 his/her breakfast tray but did not wear any PPE as indicated on the Contact Precaution sign. CNA #2 said that she had asked the nurse (exact name unknown) this morning about the Contact Precautions for Resident #5 and said she was told by the nurse that Resident #5 was no longer on Contact Precautions.

Resident #6 was admitted to the Facility in June 2020, diagnoses included vascular dementia with behavioral disturbance, dysphagia, aphasia, cerebral infarction, atrial flutter, cardiac pacemaker, benign prostatic hyperplasia and anxiety disorder.

Review of Resident #6's Physician Orders, dated 12/26/24, indicated that he/she was on Contact Precautions for a rash.

Review of Resident #6's Weekly Skin Assessment, dated 12/26/24, indicated that he/she had a rash to his/her left front thigh.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #6's Treatment Administration Record (TAR), dated 12/26/24 through 12/31/24 indicated that he/she was on Contact Precautions for a rash. Review of December 2024 Infection Control Line Listing, indicated that on 12/27/24, Resident #6 developed itch and redness to his/her bilateral lower extremities, had a rash to his/her skin and was started on an antibiotic. Review of Resident #6's Care Plan related to suspected scabies, dated 12/26/24, indicated to educate caregivers that anyone in close contact with an infected person should seek medical treatment, that infestation may occur by direct skin to skin contact with an infected person and to wash all clothing, bedding and towels in hot water and dry in a hot dryer. The Care Plan indicated Scabies is spread by sharing towels, clothing and bedding. On 1/22/25, Surveyor #2 observed a Contact Precautions sign posted on the outside of Resident #6's door and a bin with Personal Protective Equipment (PPE) just outside the room by the door. The Sign indicated staff to put on gloves before room entry and discard gloves before room exit, put on gown before room entry and discard gown before room exit. Review of the Residents on Precautions List, updated 01/17/25, indicated that Resident #6 was not listed as being on any Infection Control Precautions. On 1/22/25 at 8:47 A.M., Surveyor #2 observed Certified Nurse Aide (CNA) #2 enter Resident #6's room without the use of a gown or gloves and assist Resident #6 with the set-up of a meal tray and place a blanket on the shoulders of the resident. CNA #2 stood in the room chatting with Resident #6 and then rubbed his/her (Resident #6's) arm prior to exiting the room. During an interview on 1/22/25 at 8:55 A.M. with Surveyor #2, CNA #2 said that she did not know why Resident #6 was on Contact Precautions and said she would have to ask the nurse. CNA #2 said she was not wearing any PPE when she entered Resident #6's room, as the sign indicated. On 1/22/25 at 9:12 A.M., Surveyor #2 observed Nurse #1 enter Resident #6's room without the use of a gown or gloves. Nurse #1 repositioned Resident #6 from a sitting position on the side of the bed to a lying position. Nurse #1 was observed adjusting Resident #6's blankets, and handing Resident #6 the call light. During an interview on 1/22/25 at 9:15 A.M. with Surveyor #2, Nurse #1 said that Resident #6 was previously on Contact Precautions because he/she had a urinary catheter and said he did not believe Resident #6 was still on Contact Precautions. Nurse #1 said that he would have to ask the Unit Manager about the status of Resident #6's precautions and said he could not explain why Resident #6 still had a Contact Precaution sign posted outside the door of his/her room. During an interview on 01/22/25 at 9:24 A.M. with Surveyor #2, the Unit Manager said that after reviewing Resident #6's Medical Record, that he/she was no longer on Contact Precautions. The Unit Manager said that Resident #6's urinary catheter had been removed. The Unit Manager said that she would speak with the IP to confirm Resident #6's status related to the need for precautions. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 01/22/25 at 11:15 A.M. and throughout the survey with Surveyor #1 and Surveyor #2, the Infection Preventionist (IP) said staff are trained on EBP and Contact Precautions and are aware that there are signs posted outside the door indicating which resident or residents in the room are on precautions. The IP said that the signs clearly indicate what type of PPE to wear when performing resident care activities. The IP said that staff are supposed to wear a gown when performing dressing activities, repositioning residents, and touching linens. The IP said it is her expectation that staff follow the directives that are posted on the precaution signs. The IP said she did not know Resident #6's infection control status and said she would look into it. During an in-person interview on 01/22/25 at 3:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 01/23/25 at 8:39 A.M. with Surveyor #1, the Director of Nurses (DON) said that staff have been trained on EBP and Contact Precautions and are aware that there are signs posted outside the resident rooms door indicating which resident or residents are on precautions. The DON said that it is her expectation that staff follow the directives that are posted on the precaution signs and wear the appropriate PPE when providing resident care according to the directives on the signs. The DON said that it was her expectation that staff are aware of the residents who are on precautions and why they are on precautions. 3. Review of the Facility Policy, titled Staff Compliance During Group A Streptococcus (GAS) Outbreaks, dated 06/21/2024, indicated that during an outbreak of GAS in the nursing home, staff are encouraged to undergo testing for GAS. The Policy indicated that staff who test positive must follow medical advice for treatment and may not return to work until cleared by a healthcare professional. The Policy further indicated that CDC recommendations are used as a reference. Review of CDC Recommendations for GAS, dated 03/25/2024 indicated that for healthcare personnel with known or suspected group A Streptococcus infection, obtain a sample from the infected site, and exclude from work until 24 hours after the start of effective antimicrobial therapy. During an in-person interview on 01/22/25 at 3:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 01/23/24 at 8:39 A.M. with Surveyor #1, the Director of Nurses (DON) said that the residents and staff on the [NAME] Unit were tested for GAS on 1/17/25. The DON said that the Laboratory reported CNA #1's positive test results for GAS to the facility on [DATE]. The DON said that on 1/18/25 someone from the facility notified her that CNA #1 was positive for GAS and said she called CNA #1 to tell her results, that she needed to go see a doctor and get treatment for herself and her family. The DON said that she was not aware that CNA #1 was working at the facility at the time she was notified that her test results were positive and assumed that when she called CNA #1 that she was home. The DON said that on 1/18/25 she had not informed CNA #1 or the Scheduler that CNA #1 could not return to work prior to being on antibiotics for 24 hours. The DON said that on 1/20/25, (exact time unknown), CNA #1 gave her the doctor's note and told her that she took her first dose of antibiotics on the evening of 1/19/25 and took another dose of antibiotics in the morning of 1/20/25. The DON said that CNA #1 returned to work prior to being on antibiotics for 24 hours. The DON said facility policy indicates that staff who are positive for GAS cannot return to work prior to being on antibiotics for 24 hours and said her expectation is that they follow the facility policy. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Daily Schedule, dated 1/18/25 and 1/19/25, indicated that CNA #1 worked on the [NAME] Unit starting at 7:00 A.M. through to 11:00 P. M. (double shift). Review of the Daily Schedule, dated 1/20/25, indicated that CNA #1 worked on the Second Unit from 7:00 A. M. through 3:00 P.M. shift and on the [NAME] Unit from 3:00 P.M. through 11:00 P.M. shift. Review of CNA #1's Timecards, indicated that she worked the following: -on 1/18/25 from 7:07 A.M. to 10:53 P.M.; -on 1/19/25 from 7:06 A.M. to 10:53 P.M.; -on 1/20/25 from 7:09 A.M. to 10:53 P.M. West Unit had a total number of 31 residents residing on it. Second Unit had a total number of 35 residents residing on it. During an in-person interview on 1/22/25 at 2:20 P.M. with Surveyor #1 and Surveyor #2 and a subsequent telephone interview on 1/23/25 at 8:52 A.M. with Surveyor #1, CNA #1 said that on 1/18/25 the DON called her (exact time unknown) and informed her that she was positive for GAS, told her that she needed to go home and see a doctor. CNA #1 said that she was at work when the DON called and said sometime after supper (exact time unknown), she went home. CNA #1 said that she took her first dose of antibiotics at 3:00 P.M. on 1/19/25 and said she came into work that night for the 3:00 P.M. through 11:00 P.M. shift on the [NAME] Unit. CNA #1 said that on 1/20/25, she worked from 7:00 A.M. through 3:00 P.M. shift on the Second Floor Unit and from 3:00 P.M. through 11:00 P.M. shift on the [NAME] Unit. CNA #1 said that sometime during the day, (on 1/20/25, exact time unknown), she went to the DON's office, gave the DON her doctor's note and told the DON she was on antibiotics. CNA #1 said that the DON never asked her if she was working and never told her that she could not work until after she was on antibiotics for 24 hours, CNA #1 said she went back and work her scheduled shifts. During a telephone interview on 1/23/25 at 2:23 P.M., the Medical Director said he became the Medical Director for the Facility in December 2024. The Medical Director said that he was aware that the Fac[TRUNCATED]