STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225420	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Extended Care at Amherst	150 University Drive Amherst, MA 01002

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation, interview, and policy review the facility failed to ensure a dignified existence for the facility residents in one dining room ([NAME]) out of three dining rooms observed on the Dharma Unit (Dementia Special Care Unit - DSCU). Specifically, the facility failed to ensure that: 1. the staff spoke respectfully of residents. 2. staff were seated while assisting residents with their meals. Findings include: Review of the facility policy titled Dignity, revised February 2021, indicated the following: -Residents are treated with dignity and respect at all times. -Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice, and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. Review of the facility policy titled Assistance with Meals, revised March 2022, indicated the following: -Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting them with meals b. keeping interactions with other staff to a minimum while assisting residents with meals c. avoiding the use of labels when referring to residents (e.g. feeders) During the initial dining observation on 4/7/24 from 9:55 A.M. to 10:15 A.M., in the [NAME] dining room the surveyor observed the following: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A staff member asked loudly enough for all in the dining room to hear, Are there anymore feeders? -A staff member responded loudly enough for all in the dining room to hear He/she is also a feed, you can do him/her when you are done. During a dining observation at the breakfast meal on 4/8/24 from 9:06 A.M. to 9:25 A.M., in the [NAME] dining room the surveyor observed the following: -A staff member standing at the side of a resident assisting him/her with his/her meal. -The surveyor further observed that there were multiple empty chairs available for the standing staff member to sit while assisting the resident with his/her meal. During a dining observation at the lunch meal on 4/8/24 from 12:47 P.M. to 1:27 P.M., in the [NAME] dining room the surveyor observed the following: -Certified Nurses Aides (CNA) #1 and CNA #2 were seated at a dining room table with multiple residents present, and having a personal conversation in a language that was not fluent for all the residents seated at the table. During an interview on 4/8/24 at 12:49 P.M., Unit Manager (UM) #2 said not all residents who were seated at the table where CNA #1 and CNA #2 were seated, spoke the language the CNA's were speaking. UM #2 said the CNAs should not be having a personal conversation in the dining room while seated at a table with residents. During a dining observation at the breakfast meal on 4/9/24 from 8:53 A.M. to 9:31 A.M., in the [NAME] dining room the surveyor observed the following: -The Dharma Unit Activities Director said loudly enough for all in the dining room to hear He/she (referring to a resident still in the dining room) is a feed. -The Staff Development Coordinator (SDC) was standing while assisting a resident with his/her meal from 9:05 A.M. to 9:10 A.M. -The surveyor further observed that there were multiple empty chairs available for the SDC to sit in while assisting the resident. During an interview on 4/9/24 at 9:10 A.M., the SDC said she should not have been standing over the resident to assist him/her with his/her meal, that she should have been seated next to the resident. During an interview on 4/9/24 at 9:31 A.M., UM #2 said when staff members are assisting residents with their meals, the staff members should be seated at the residents' level. During an interview on 4/9/24 at 1:45 P.M., the Dharma Unit Activities Director said the residents should not be referred to as feeds and wording such as he/she needs assistance should be used instead. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/24 at 1:48 P.M., UM #2 said staff should not refer to residents by their level of care needs such as feeders, that staff should utilize the resident's name which is more dignified.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on interview and record review, the facility failed to notify the Physician/Non-Physician Practitioner (NPP/ Nurse Practitioner) of a significant change in condition for two Residents (#54 and #74) out of a total sample of 25 residents. Specifically, the facility staff failed to notify the Physician/NPP: 1. To determine the need to alter medication treatment when Resident #54 had recurrent seizure activities. 2. When Resident #74 experienced an unplanned, significant weight loss in one month. Findings include: 1. Resident #54 was admitted to the facility in November 2017 with diagnoses including: Idiopathic Epilepsy (a type of epilepsy with a strong genetic basis that affects people of all races and sexes), Epileptic Syndromes (a group of signs and symptoms that tend to occur together in seizure activity) with Seizures (a burst of uncontrolled electrical activity in the brain that cause temporary changes in muscle tone, behaviors, sensations or awareness) of localized onset and Conversion Disorder (functional neurologic system disorder that causes physical and sensory problems that are not caused by the person faking them). Review of Resident #54's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact, as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of total possible 15, and that the Resident was independent with activities of daily living (ADLs). During an interview on 4/10/24 at 8:47 A.M., Resident #54 said that he/she had chronic pain related to his/her uncontrolled seizures. The Resident said that most of the time the seizure activity resulted in a fall or hitting part of his/her body on objects in his/her room. Review of the April 2024 Physician's orders for Resident #54 indicated: -Lamotrigine (medication used to treat seizures) 400 milligram (mg) tablet every morning and at bedtime for Epilepticus (medical emergency of seizures), initiated 1/3/2022. Review of the Nursing Progress Notes indicated the following: -On 5/19/23, Resident #54 had a seizure while ambulating in the hallway and was lowered to the floor. The Nursing Progress Note further indicated that Resident #54's seizure lasted approximately 30 seconds and he/she was assisted back into a wheelchair, then into his/her bed. -On 10/15/23, Resident #54 had a seizure that lasted approximately 10 seconds and that the Resident was assisted into his/her bed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/12/23, Resident #54 had a seizure that lasted 10 to 15 seconds. -On 12/9/23, Resident #54 mentioned to the Nurse that he/she did not feel right, and the Nurse observed that the Resident had a seizure that lasted for 10 seconds. -On 1/7/24, Resident #54 wheeled him/herself in the hallway, had a seizure and was lowered to the floor. The Nursing Progress Note further indicated that the Resident's seizure lasted approximately 15 seconds and he/she was assisted back to bed. -On 3/3/24, Resident #54 had a seizure that lasted approximately 20 seconds and the Resident was assisted back to his/her bed. Further review of Resident #54's Medical Record failed to indicate that the Physician/NPP was notified of Resident #54's seizure activity on: 5/19/23, 10/15/23, 11/12/23, 12/9/23, 1/7/24, and 3/3/24. During an interview on 4/10/24 at 10:47 A.M., Nurse #4 said if a Resident had a seizure, he would perform vital signs and notify the Physician/NPP for further orders. Nurse #4 further said he had not had Resident #54 on his assignment. During an interview on 4/10/24 at 11:00 A.M., Nurse #1 said she had only worked in the facility for a few months, but if she had a resident with seizures, she would perform a physical assessment and notify the Physician/NPP. During an interview on 4/10/24 at 11:15 A.M., the NPP said the facility staff had never informed her that Resident #54 ever had any seizure activity. The NPP said she should have been notified each time Resident #54 had seizure activity and was not notified. The NPP further said there had been concerns about Physicians/NPP not receiving notification from the facility staff about resident change in condition and this was a task being worked on with the facility. During an interview on 4/10/24 at 12:18 P.M., the Director of Nurses (DON) said the facility had no policy on Physician/NPP notification. When the surveyor asked the DON about the Physician/NPP notification process for Resident #54, the DON said the Resident's seizures were not true and if the staff believed they were true seizures the staff would have notified the Physician. 45429 2. Resident #74 was admitted to the facility in February 2024, with diagnoses including urinary tract infection (UTI: bacterial infection of the urinary tract) and fracture of the upper end of the left humerus (the bone of the upper arm, forming joints at the shoulder and the elbow). During an interview on 4/7/24 at 10:25 A.M., Resident #74 said that he/she had lost weight since their admission to the facility. The Resident also said that he/she had discussed the weight loss concerns with staff. Review of Resident #74's weights documented in the electronic medical record (EMR) indicated: -On 2/19/24, the Resident weighed 111.5 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 3/13/24, the Resident weighed 104.5 pounds (a 6.28 % significant weight loss in one month). Review of Resident #74's Minimum Data Set (MDS) Assessment, dated 2/24/24, indicated the following: -The Resident was cognitively intact as exhibited by a Brief Interview for Mental Status (BIMS) score of 15 out of a total 15 points. -The Resident was not on a Physician prescribed weight loss regimen. Review of Resident #74's care plan for Nutrition Risk, initiated 3/6/24, indicated the following interventions: -to report to Physician significant weight loss: 3 pounds in 1 week, greater than 5% in one month, greater than 7.5% in three months, greater than 10% in six months. -monitor weights and notify the Physician of any significant change. Review of the facility's Risk Meeting Notes indicated that the facility was aware that Resident #74 had triggered for weight loss on 3/7/24. Review of Resident #74's medical record did not indicate that the Physician/NPP had been notified of the significant weight loss. During an interview on 4/9/24 at 12:55 P.M., the Director of Nurses (DON) said when a resident experiences a significant weight loss, the Physician should be notified immediately. During an interview on 4/9/24 at 2:13 P.M., the Doctor of Nursing Practice (DNP) said that she had not been made aware of Resident #74's weight loss and that she should have been notified by the facility staff.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation and record review the facility failed to ensure that a homelike environment was maintained for residents in one dining area ([NAME]) out of three dining areas observed on the Dharma Unit (Dementia Special Care Unit). Specifically, the facility and staff failed to ensure that the dining experience for residents was a homelike environment by adding tablecloths to the dining room tables and removing meals from the meal trays prior to serving the residents. Findings include: On the following days and times: -4/7/24 at 10:15 A.M., -4/8/24 at 9:06 A.M., -4/8/24 at 12:47 A.M., -4/9/24 at 9:00 A.M., the surveyor observed in the [NAME] dining area, multiple residents seated at tables with no tablecloths covering the tables and all resident meals were being served on the delivery trays, that no meals had been removed from the delivery trays before being placed in front of the residents. During an interview on 4/9/24 at 9:31 A.M., Unit Manager (UM) #2 said the dining in the [NAME] dining area would be more homelike if tablecloths were added to the tables. UM #2 further said she was unsure why tablecloths were not utilized in the [NAME] dining area as tablecloths were used on the tables in the other two dining areas on the Dharma Unit. UM #2 also said that staff used to take all items off the delivery trays and set them up in front of the residents, but that had not been done in some time. UM #2 said removing the meal items from the delivery trays would make the dining experience more homelike for the residents.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 45429 Based on observation, record review, and interview, the facility failed to complete an accurate comprehensive assessment, according to the required Resident Assessment Instrument (RAI) process, for one Resident (#77) out of a total sample of 25 residents. Specifically, the facility staff failed to assess Resident #77's cognitive status through the resident interview process and instead proceeded to the staff interview process on three consecutive Minimum Data Set (MDS) Assessments. Findings include: Resident #77 was admitted to the facility in February 2023 with diagnoses including Psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and Post Traumatic Stress Disorder (PTSD- a mental and behavioral disorder that developed from having experienced a traumatic event, causing flashbacks, nightmares and severe anxiety). Review of Resident #77's comprehensive Minimum Data Set (MDS) Assessments dated 8/10/23, 11/7/23, and 1/23/24, indicated the following: -The Resident had adequate hearing. -The Resident had clear speech. -The Resident could make him/herself understood. -The Resident understood others. -The Brief Interview for Mental Status (BIMS) should be attempted with all residents. -The BIMS was not conducted with the Resident and the responses were left blank. -The Staff Assessment for Mental Status had been completed. On 4/7/24 at 9:47 A.M., the surveyor observed Resident #77 lying on his/her bed. The surveyor was able to communicate clearly with the Resident, who understood the surveyor's questions that were asked in English during the screening process. During an interview on 4/8/24 at 8:08 A.M., the MDS Nurse said that the staff assessment (to attempt the resident interview) should have been completed as required for the 1/23/24 BIMS, but had not been completed as required. (continued on next page)

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 4/8/24 at 8:43 A.M., the Director of Nurses (DON and the facility's former MDS Nurse) said that the staff assessments (to attempt the resident interview) should have been completed for all of the BIMS assessments and they had not been.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on interview and record review the facility failed to ensure that Minimum Data Set (MDS) Assessments were accurately coded for two Residents (#101 and #122), out of a total sample of 25 residents. Specifically, the facility failed to ensure the MDS Assessment: 1. For Resident #101, was accurately coded relative to receiving hospice services. 2. For Resident #122, was accurately coded relative to the use of antibiotic medications. Findings include: 1. Resident #101 was admitted to the facility in November 2023 with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, identified with symptoms of trouble breathing and fatigue), Heart Failure (HF: when the heart is unable to pump blood as it should, resulting in fluid buildup in the feet, arms, lungs and other organs) and Multiple Sclerosis (MS: a chronic autoimmune disorder affecting movement, sensation, and bodily functions). Review of Resident #101's care plan, last revised 4/8/24, indicated that the Resident was receiving Hospice (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) services starting on 3/4/24. Review of Resident #101's Significant Change MDS assessment dated [DATE], indicated that the Resident was not receiving Hospice services. Review of April 2024 Physician's orders for Resident #101 indicated the following: -Admit to Hospice, start date 3/4/24 -Continue with Hospice services, start date 3/4/24 -Notify Hospice of any clinically significant changes, start date 3/15/24 During an interview on 4/8/24 at 10:44 A.M., the Director of Nurses (DON) said that the MDS was inaccurately coded and that Resident #101's MDS should have been coded as receiving Hospice services. 44222 2. Resident #122 was admitted to the facility in March 2024 with diagnoses of Retention of Urine (difficulty urinating and completely emptying the bladder), Bacteremia (bacteria in the blood), other specified sepsis (a body's response to infection damaging tissues) and Urinary Tract Infection (UTI: bacterial infection of the urinary tract). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2024 Physician's orders for Resident #122 included: -Ampicillin Sodium (an antibiotic medication) Intravenous (IV: administered into a vein) Solution Reconstituted 2 GM (gram), order date 3/1/24. -Ampicillin Sodium, Use 2 gram intravenously every 6 hours for infection until 3/10/2024 [at] 23:59, start date 3/2/24, completed 3/10/24. Review of the Resident's March 2024 Medication Administration Record (MAR) indicated that the Resident received the intravenous Ampicillin Sodium every 6 hours as ordered, from 3/2/24 until 3/10/24. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident had diagnoses of septicemia (bacteria that poisons the blood) and a UTI. The MDS did not indicate that the Resident was receiving antibiotic medication (Ampicillin Sodium). During an interview on 4/10/24 at 9:51 A.M., the MDS Nurse reviewed the Resident's clinical record and said that the MDS dated [DATE] should have indicated that the Resident was receiving antibiotic medication during the MDS look back period but it did not. The MDS Nurse further said that this was a coding error.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on observation, record review, and interview, the facility failed to provide care and services to achieve or maintain bladder function for one Resident (#122) out of three applicable residents, out of a total sample of 25 residents. Specifically, for Resident #122, the facility staff failed to obtain Physician's orders for the care and services of an indwelling urinary catheter (a flexible tube inserted into the bladder to allow for urine flow) to prevent complications and urinary tract infections. Findings include: Review of the Facility's Physician's Order Set for the care of Indwelling Urinary Catheters, undated, included: -Foley Catheter (brand name of an indwelling urinary catheter) Care every shift. -Foley Catheter ___F (F/Fr: French - unit of measurement for the size of the diameter of the tubing), ___cc (cubic centimeters a unit of measurement: indicating the capacity of the catheter's balloon/bulb) bulb (Insertion and PRN (as needed) change) Diagnosis: _____ as needed for Occlusion (blockage), Leakage AND one time only for initial insertion or re-insertion for 1 Day. -Flush Foley Catheter with 60 cc (cubic centimeters: indicating the amount of fluid) Normal Saline as needed for Obstruction. -Foley Catheter Privacy Bag every shift. -Change Foley Bag every day shift every 7 day(s). Resident #122 was admitted to the facility in March 2024 with diagnoses of Retention of Urine (difficulty urinating and completely emptying the bladder), Chronic Kidney Disease Stage 2 (CKD - when the kidneys are damaged and cannot filter blood the way that it should) and Urinary Tract Infection (UTI: bacterial infection of the urinary tract). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #122: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 13 out of 15. -had an indwelling urinary catheter. -required staff assistance with toileting tasks. Review of the April 2024 Physician's orders for Resident #122 included: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure catheter privacy leg bag placed higher to avoid pulling. Every day and evening shift for irritation. -Foley Catheter; 18 Fr, 10 ml (balloon/bulb) -Urine output Q (every) shift -every shift for catheter insitu (in the appropriate place) [catheter placement] Further review of the April 2024 Physician's orders did not indicate: -orders for catheter care every shift. -Instructions for irrigation/flushing of the catheter. -Instructions for replacing the catheter. -Instructions for replacing the bedside drainage bag. -Instructions for the application of an anchoring device. During an observation and interview on 4/10/24 at 10:30 A.M., Nurse #3 confirmed that the Resident's indwelling urinary catheter was size 18 Fr 10 ml, that there was an anchoring device in place on the Resident's right thigh, and that the bedside drainage bag was covered with a privacy bag and had been changed on 4/5/24. Nurse #3 reviewed the Resident's current Physician's orders and said that she thought there should be more orders in place for the care of an indwelling urinary catheter. Nurse #3 said she could not find any current Physician's orders for catheter care every shift, replacement of the catheter, or flushing of the catheter. Nurse #3 said there was usually a set of orders that was put in place for any resident with an indwelling urinary catheter, but she could not find any evidence that this had been done for Resident #122. During an interview on 4/10/24 at 12:00 P.M., the Director of Nurses (DON) said that the orders for the care and services of the Resident's indwelling urinary catheter should have been put in place but they were not. The DON said that there was no specific facility policy for the care and services of an indwelling urinary catheter and that the staff just put the Physician's order set in place for residents that have an indwelling urinary catheter. The DON said the Physician's order set was not put in place for Resident #122. The DON said that orders for catheter care each shift, placing a securing device weekly, flushing of the catheter for blockage, and replacment of the drainage bag and catheter were not in place but should have been.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42741 Based on interview and record review, the facility failed to accurately implement a psychotropic medication (medication that affects brain activity) gradual dose reduction (GDR) as recommended by the Psychiatric Certified Nurse Practitioner (CNP) for one Resident (#94) out of a total sample of 25 residents. Specifically, the facility staff failed to: -For Resident #94, ensure that the recommendation made by the Psychiatric CNP for a GDR of Zyprexa (an antipsychotic medication) morning dose from 5 milligrams (mg) to 2.5 mg was accurately implemented, when the morning dose of Zyprexa was increased back to 5 mg without any further recommendations, thereby cancelling the GDR process. Findings include: Review of the facility policy titled, Psychotropic Medication Use, revised July 2022, indicated the following: -Residents on psychotropic medications receive gradual dose reductions . Resident #94 was admitted to the facility in March 2022, and had diagnoses including anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), Alzheimer's Dementia (a progressive disease beginning with mild memory loss and leading to the loss of the ability to carry on a conversation and respond to the environment, that is severe enough to interfere with daily life), and a history of psychosis (when someone loses contact with reality). Review of the Psychiatric CNP note dated 1/9/24, indicated the following recommendation: -Patient with a decrease in cognition, suggest trial GDR. -Suggest discontinue (d/c) Zyprexa 5 milligram (mg) daily at 9:00 A.M. -Suggest Zyprexa 2.5 mg daily at 9 A.M. and Zyprexa 5 mg daily at 5:00 P.M. Review of the March 2024 Physician's Order Summary indicated the GDR recommended for the A.M. dose of Zyprexa by the Psychiatric CNP was implemented as ordered: -Zyprexa 2.5 mg, give 2.5 mg by mouth in the morning with a start date of 1/17/24. Further review of the Physician's Order Summary indicated the Resident continued to receive the evening dose of Zyprexa as evidence by the following order: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Zyprexa 2.5 mg, give 5 mg by mouth in the evening .with a start date of 1/17/24. Review of the January 2024, February 2024, and March 2024 Medication Administration Records (MARs) indicated: -from 1/17/24 through 3/9/24: the Resident received the 2.5 mg prescribed dose of Zyprexa in the morning. -from 1/17/24 through 3/10/24: the Resident received the 5 mg prescribed dose of Zyprexa in the evening. Review of the Psychiatric CNP note dated 3/5/24 indicated the following recommendation: -Suggest reducing HS (hour of sleep or bedtime) Zyprexa dose from 5 mg to 2.5 mg due to Resident decline. Review of the March 2024 Physician's Orders indicated the following orders: -Zyprexa Oral Tablet 2.5 mg, give 5 mg by mouth in the morning .with a start date of 3/9/24 and a discontinued date of 3/11/24. -Zyprexa Oral Tablet 2.5 mg, give 5 mg by mouth in the morning .with a start date of 3/11/24. -Zyprexa Oral Tablet 2.5 mg by mouth in the evening .with a start date of 3/11/24 Review of the March 2024 and April 2024 MARs indicated: -from 3/9/24 through 4/8/24: the Resident received the prescribed 5 mg dose of Zyprexa in the morning and the 2.5 mg dose of Zyprexa in the evening. Further review of the Resident's medical record indicated no documentation that any of the Resident's medical providers had made the recommendation for the Resident's morning dose of Zyprexa to be increased back to 5 mg. During an interview on 4/8/24 at 10:40 A.M., the Psychiatric CNP said she was unsure why the Resident's prescribed morning dose of Zyprexa was increased back to 5 mg. The CNP further said that her recommendation was for the Resident to have 2.5 mg Zyprexa in the morning and to have the evening dose of Zyprexa also reduced to 2.5 mg, and this was not done as recommended. During an interview on 4/8/24 at 4:41 A.M., Unit Manager (UM) #2 said she was unsure why Resident #94's morning dose of Zyprexa was increased back to 5 mg. UM #2 further said the morning dose of Zyprexa should have remained at 2.5 mg and the Psychiatric CNP had recently decreased the Resident's evening dose of Zyprexa down to 2.5 mg and it looked like the doses got swapped and the Resident never had the full GDR completed as recommended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, interview, and record review, the facility failed to maintained a clean and sanitary facility kitchen in accordance with professional standards for food service safety. Specifically, the facility failed to: -ensure that a rinse temperature issue with the facility dish machine was addressed according to professional standards when the minimum temperature and sanitation requirements were not being met as required. -ensure the use of a commercial grade chlorine-based sanitizer and not household bleach was used in the dish machine to sanitize the facility dish ware. Findings include: Review of the facility policies indicated no policy for management of dishware in the event the facility dish machine became compromised. On 4/9/24 at 12:10 P.M., the surveyor observed Dietary Staff #1 loading soiled dishes onto a rack and through the running dish machine. The surveyor observed the temperature gauges on the dish machine with the following readings: -Wash Temperature: 170 degrees -Rinse Temperature: 170 degrees -Final Rinse Temperature: 170 degrees The surveyor further observed signage affixed to the dish machine that read: >Dish Machine Temperature: -Wash Temperature: 160 degrees -Rinse Temperature: 180 degrees - If rinse temperature goes below 180 degrees you must let the Food Service Director (FSD) or the cook supervisor know immediately During an interview at the time of the observation with the FSD, the FSD said that the required rinse temperature for sanitation of the dishes was 180 degrees. The FSD said that the rinse temperature on the dish machine was 170 degrees because the machine had to run for a few cycles before the rinse temperature would reach 180 degrees and staff would re-wash the same dishes repeatedly until the rinse temperature reached 180 degrees. The FSD also said that the dish machine was a high temperature dish machine and that the facility had ordered a booster device to aid the dish machine in reaching the required 180 degrees rinse temperature more easily. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/24 at 2:07 P.M., the surveyor observed Dietary Staff #1 and Dietary Staff #2 operating the dish machine. The surveyor observed that the temperature gauges on the dish machine reflected a wash temperature of 170 degrees and a rinse temperature of 162 degrees. The surveyor further observed Dietary Staff #2 spray food and debris from soiled dish ware, then placed the dishes onto racks and slide the rack into the dish machine. Dietary Staff #1 then took the rack of dishes from the opposite end of the dish machine, placed the dishes on different racks and removed them from the dish room. When the surveyor asked, Dietary Staff #1 said he took the dishes and put them away for future use. The surveyor asked Dietary Staff #1 to provide the temperature readings on the temperature gauges of the dish machine and Dietary Staff #1 verified that the rinse temperature reading was 162 degrees and not the required 180 degrees. Dietary Staff #1 said the dish machine water temperature had been an issue for the last two months. Dietary Staff #2 then said that the dish machine had been broken for a long time and the facility management had been made aware of the issue. During an interview on 4/9/24 at 2:16 P.M., the FSD said that they were waiting for a booster device to be delivered for the dish machine. The FSD said that the dishes were cleaned and sanitized even though the dish machine was not rinsing at the required temperature of 180 degrees. The FSD further said that dietary staff were using bleach in the dish machine to sanitize the dish ware. During a follow-up observation with the FSD at the time in the dish room, the surveyor noted a strong odor of bleach and observed a gallon bottle of household bleach sitting on the top of the dish machine with a clear plastic hose coming out of the open spout at the top of the bottle. The FSD said that the bottle contained bleach and that the bleach was getting funneled through the wash cycle into the dish machine to sanitize the dish ware. The FSD said that he did not know who recommended the bleach sanitizer. Dietary Staff #1 then said that a dish machine representative had recommended the use of the bleach. During an interview on 4/9/24 at 2:46 P.M., with the Administrator and Consulting Staff #1, the Administrator said that he was unaware that dietary staff were using household bleach in the dish machine to sanitize the dishes and did not know how long the dietary staff had been using the household bleach as a sanitizer. Consulting staff #1 said that the bottle on top of the dish machine was household bleach and that staff should not have been using household bleach to sanitize dish ware. Consulting Staff #1 said that staff were supposed to be using a commercial grade chlorine based sanitizer in the dish machine. Consulting Staff #1 also said that the dish machine vendor was on his way to the facility to install the proper sanitizer solution. Review of an email communication provided by the facility to the Administrator dated 1/23/24, indicated the following: -Vendor representative came and serviced the dish machine and dropped off more test strips. -Staff instructed to use bleach until order arrives. -DO NOT dilute the bleach, use it directly out of the bottle for accurate readings of parts per million (PPM). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 4/10/24 at 8:42 A.M., Additional Staff #1 said that he worked as a vendor and had been to the facility on the evening of 4/9/24 to install a commercial grade chlorine-based sanitizer to the facility dish machine. Additional Staff #1 said he had been made aware during the visit that the facility staff had been using a gallon bottle of household bleach to sanitize dish ware in the dish machine. Additional Staff #1 also said that he came to the facility on [DATE], to drop off test strips to be used to test the chemical balance in the dish machine water while the dietary staff were using the commercial grade chlorine based sanitizer in the dish machine. Additional Staff #1 said he told the dietary staff to order additional commercial grade chlorine-based sanitizer because they were running low, but he did not tell staff to use household bleach to sanitize the dish ware in the dish machine. Additional Staff #1 said that he would never advise the facility to use household bleach to sanitize dish ware in the dish machine because there was no way of accurately measuring the sanitization level of the dish ware or the safest level of bleach for safe human consumption. Additional Staff #1 also said that the commercial grade chlorine-based sanitizer and household bleach are two different chemicals and that the commercial grade sanitizer contains no household bleach. During an interview on 4/10/24 at 11:30 A.M., the Administrator said that the commercial grade chlorine-based sanitizer had been installed in the dish machine on 4/9/24 by the vendor. The Administrator said that the dietary staff would use the commercial chlorine based sanitizer until the dish machine booster arrived and the machine was able to maintain the proper temperatures for sanitization. The Administrator said that the Maintenance Director had tested the chemical balance of the dish machine water this morning and had found the commercial chlorine-based sanitizer level readings to be within range. The Administrator said that dietary staff should not have been using household bleach to sanitize dish ware in the dish machine.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 42741 Based on interview and record review, the facility failed to re-evaluate a performance improvement plan (PIP) when the identified interventions were no longer making progress toward the identified goal for improving lunch meal tray arrival times for one unit (Dharma Unit) out of three units observed. Specifically, the facility failed to ensure that an effective system was maintained for implementing changes, monitoring performance, and obtaining feedback from residents and family representatives, related to consistently late lunch time meals. Findings include: Review of the facility Quality Assurance Performance Improvement Plan signed 1/17/24, indicated the following: -Areas of the plan are measures by clinical outcomes, aspects of performance, and resident satisfaction with the goal . -Information gathered is analyzed and compared to set benchmarks. Benchmarks may be adjusted based on the data outcomes. -Current performance improvement projects include Tray arrival time. Review of the PIP titled Dietary Department Improvements dated 1/2/24, indicated the following problem had been identified: Complaints from residents, Ombudsman, and families about food deliveries being late. During an interview on 4/7/24 at 11:44 A.M., Family Member #2 whose family resided on the Dharma Unit said he/she was always at the facility to assist his/her loved one with lunch and the lunch meal is late sometimes, even coming to the unit 30 minutes or more later than the scheduled time on some days. During an interview on 4/9/24 at 1:01 P.M., Family Member #1 whose family resided on the Dharma Unit said he/she was always at the facility to visit with his/her loved one during the lunch meal and that the lunch meal truck is often late and his/her family was always very hungry by the time the meal truck arrived to the unit. During an interview on 4/9/24 at 2:27 P.M., the Food Service Director (FSD) said he was aware of the current problems with the meal trucks getting to the units after the scheduled times. The FSD said the meal trucks should arrive on the unit within 5 minutes of the scheduled meal time. The FSD said the facility was currently completing a PIP for late meal trucks and he felt that the kitchen was short staffed. The FSD further said for the kitchen to run properly and for meals to be delivered on time there needed to be four staff members working in the kitchen. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the PIP Plan dated 1/2/24, indicated the following interventions: -Daily recordings of when trays come up and findings brought to QAPI monthly meeting until system improved and tray delivery time gets better. Further review of the PIP Plan dated 1/2/24, indicated no specific parameters for measuring what late meant or that a measurable goal had been set to detemine if interventions were working. Review of the last 14 days of Food Truck Delivery Daily Tracking Log from 3/27/24 through 4/8/24, indicated that on 10 of 15 days the lunch meal was not delivered on the unit per the FSD targeted time frame of five minutes from the scheduled meal time for the Dharma Unit. Further review of the Food Truck Delivery Daily Tracking Log indicated on 3/7/24, 4/3/24, 4/4/24, 4/5/24, 4/6/24, and 4/7/24, the lunch meal was delivered 20 minutes or more late to the Dharma Unit. Review of the Dietary Department QAPI sheet dated 2/1/24, indicated the following: Food Truck Delivery on Units Late: Lunch trays were late two times Review of the Dietary Department QAPI sheet dated 3/13/24, indicated the following: Food Truck Delivery on Units Late: Lunch trays were late six times Further review of the Dietary Department QAPI sheets from February 2024 and March 2024, indicated no documentation: -pertaining to which units the meal trucks were delivered late to. -on which days the meal trucks were late. -as to why the meal trucks were late on those days. -that new interventions were discussed and planned to improve meal truck delivery to the units. During an interview on 4/10/24 at 9:17 A.M., the Administrator said he was unsure why meal trucks continued to be late for the lunch meal on the Dharma Unit. The Administrator further said interventions should have been adjusted when the meal trucks continued to be late to the units over a period of two months and interventions had not been re-assessed at this time. The Administrator said the current intervention was to hire more staff but when he looked at the staffing schedule he was unable to show that there was not enough staff for the kitchen (3/27/24 through 4/8/24 indicated four or more staff members working) to run effectively except for 4/7/24 when there was only three staff members in the kitchen. During a follow-up interview on 4/10/24 at 10:55 A.M., the Administrator said he had no current process implemented to obtain feedback from the Residents and/or Resident Family Members from the Dharma unit to see if meal truck delivery time had improved. The Administrator said the current feedback was obtained only from the facility's other two units (not from the affected Dharma Unit)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47901 Based on record review, policy review and interview, the facility failed to ensure that the required members were included in the Quality Assurance and Performance Improvement (QAPI) committee meetings. Specifically, the facility failed to provide evidence: -that the Infection Preventionist (IP) was a required member of the QAPI committee and the IP attended two out of the four quarterly meetings. -that the Medical Doctor (MD) attended one out of the four quarterly meetings. Findings include: Review of the facility policy titled Quality Assurance Performance Improvement (QAPI), dated 1/17/24, indicated members of the committee may include but is not limited to: -Administrator -Director of Nursing (DON) -Medical Director Further review of the facility policy failed to indicate that the Infection Preventionist (IP) was a designated member of the QAPI Committee. During a meeting on 4/10/24 at 1:12 P.M., the surveyor reviewed the quarterly QAPI Committee sign-in sheets provided by the facility with the Director of Nurses (DON) and the Administrator. The quarterly QAPI Committee sign-in sheets did not indicate any evidence that the IP had attended the quarterly meetings in April 2023 and October 2023, as required. Further review of the quarterly QAPI Committee sign-in sheet did not indicate any evidence that the MD had attended the quarterly meeting held in July 2023, as required. During an interview on 4/10/24 at 1:19 P.M., the DON said that the IP and the MD were required members of the QAPI Committee. The DON further said that the IP and the MD should have attended all of the four quarterly QAPI meetings as required, but they did not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, interview and record review, the facility failed to implement infection control practices to prevent contamination and the spread of infection facility wide, and for one Resident (#24) and on one unit (Dharma Unit). Specifically, the facility failed to: 1. perform annual water testing for Legionella according to the facility water management plan. 2. clean and disinfect a vital signs monitoring machine between resident use on the Dharma Unit. 3. change gloves and perform hand hygiene while performing wound care for Resident #24. Findings include: 1. Review of the facility water management plan, last revised 1/23/23, indicated the following: -Legionella Testing: >The facility has a program to annually test the facility water for Legionella growth. >The facility tests the water using OnSite Legionella Testing. >One of the following locations to be selected at random to be tested : Ice Machines, Kitchen Hot Water Holding Tank, Kitchenette Cold Water faucet on [NAME] One Unit, Boiler Hot Water Tank, Resident Sink [NAME] two Unit . During an interview on 4/8/24 at 12:56 P.M., the Maintenance Director said that he performs water temperature checks on Tuesdays in random areas of the building and performs Legionella water testing annually, using an in-house water sampling kit that then gets sent to a lab. During a follow-up interview on 4/8/24 at 1:38 P.M., the Maintenance Director said that he could not provide any evidence that the facility had performed any annual Legionella water testing. The Maintenance Director said he has not performed any water testing for the past two years. The Maintenance Director further said he should have performed the Legionella water testing according to the facility water management plan. 42741 2. Review of the facility policy titled Cleaning and Disinfection of Resident - Care Items and Equipment, revised September 2022, indicated the following: -Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment [DME]). (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Many	On 4/8/24 at 8:23 A.M., the surveyor observed Nurse #3 using the portable vital signs machine to obtain measurements from a resident. The surveyor observed Nurse #3 apply the blood pressure cuff to the resident's upper arm and the pulse oximeter (device that measures a person's blood oxygen saturation [the amount of oxygen that is in the blood]) to the resident's finger. Nurse #3 proceeded to obtain the resident's vital signs from the machine. The surveyor observed Nurse #3 take the equipment off the resident and return it to her medication cart without cleaning and/or disinfecting the portable vital sign equipment. On 4/8/24 at 9:50 A.M., the surveyor observed Nurse #3 using the portable vital signs machine to obtain vital signs on a second resident. Nurse #3 applied the blood pressure cuff to the resident's upper arm and pulse oximeter to the resident's finger and proceeded to obtain the resident's vital signs. The surveyor observed Nurse #3 take the equipment off the resident after obtaining the vital signs and return the equipment to her medication. The surveyor did not observe Nurse#3 cleaning and/or disinfecting the portable vital signs machine after use on a second resident. On 4/8/24 at 10:09 A.M., the surveyor observed Nurse #3 using the portable vital signs machine to obtain vital signs on a third resident. Nurse #3 applied the blood pressure cuff to a resident's upper arm and pulse oximeter to the resident's finger and proceeded to obtain the resident's vital signs. The surveyor observed Nurse #3 remove the equipment from the resident's body and return the equipment to her medication cart. The surveyor did not observe Nurse #3 cleaning and/or disinfecting the portable vital signs machine after use on a third resident. During an interview on 4/8/24 at 10:13 A.M., Nurse #3 said the portable vital signs machine should be cleaned and disinfected between each resident use. Nurse #3 further said she had not cleaned and/or disinfected the portable vital signs machine between resident use as required. 47901 3. Review of facility policy titled Handwashing/Hand Hygiene revised August 2019, indicated: -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. -Hand washing to be performed before handling clean or soiled dressings, gauze pads, etc. -Handwashing to be performed after handling used dressings, contaminated equipment, etc. -Handwashing is the final step after removing and disposing of personal protective equipment. Resident #24 was admitted to the facility in September 2023 with diagnoses including Unspecified Intellectual Disabilities, Overweight, Cerebral Palsy (a congenital disorder of movement, muscle tone, or posture), Stage 4 Pressure Ulcer of the sacral area (large wound in which the skin is significantly damaged on the buttocks) and Abnormal Posture. Review of Resident #24's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was severely cognitively impaired, as evidenced by a Brief Interview for Mental Status (BIMS) score of two out of 15, and that the Resident was at risk of developing pressure ulcers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225420	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Extended Care at Amherst	150 University Drive Amherst, MA 01002

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Physician's orders dated 3/27/24 indicated: -Pressure injury Stage 4 wound to coccyx - cleanse wound with normal saline (solution of salt and water) -protect peri (area around the wound) wound with skin prep -lightly pack wound with Calcium Alginate (a pad containing calcium used to aid in wound healing) moistened with normal saline -cover with bordered foam dressing every day shift During an observation on 4/8/24 at 11:51 A.M., for a wound dressing change, the surveyor observed the following: -Nurse #1 accompanied by Unit Manager (UM) #1 entered Resident #24's room with gauze, normal saline, Calcium Alginate pad, a pack of cotton swabs and boarded foam pad. -Nurse #1 went to the bathroom, washed hands, and donned (put on) gloves and a gown. -Nurse #1 assisted UM #1 and repositioned Resident #24 to his/her side allowing access to the sacral wound. -Nurse #1 sprayed saline on the wound bed, wiped area off with gauze, and wearing the same gloves, took the scissors, and cut the Calcium Alginate pad to fit the wound bed while being directed by UM #1. -Nurse #1 moistened the Calcium Alginate pad and applied the pad to Resident #24's wound bed. -Nurse #1 applied the protective foam dressing to the wound, then dated the dressing. -Wearing the same gloves that was worn from Nurse #1's entry to the Resident's room, Nurse #1 picked up the remaining clean unused gauze and the pack of opened cotton swabs, exited the room, and placed the items on top of the treatment cart. -Nurse #1 then returned to the room, doffed (removed) the gloves, and washed her hands. During an interview on 4/8/24 at 12:15 P.M., the surveyor asked Nurse #1 if there was any breach (failure to follow established infection control procedures that prevent the transmission of infectious organisms) in infection control during the wound dressing change and Nurse #1 said that she did not have any breach. UM #1 explained to Nurse #1 that she should have removed her gloves after washing the wound bed, and worn new gloves before she applied clean dressings to the wound. UM #1 further explained that after applying the dressing, Nurse #1 should have removed her gloves and washed her hands, but she did not complete handwashing. UM #1 said that Nurse #1 touched the clean gauze and the opened cotton swabs with the same dirty gloves thereby contaminating the clean items.