STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225425	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watertown Rehabilitation and Nursing Center	59 Coolidge Hill Road Watertown, MA 02472

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40702 Based on observations, records reviewed, and interviews, for three of seven sampled residents (Resident #4, Resident #6 and Resident #7) and three non-sampled residents (NS RT #A, #B and #C), the facility failed to ensure the call bell system button was accessible and within reach for residents to call for assistance, per facility policy. Findings include: The Facility Policy, titled Call Bell, undated, indicated the following: -providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes --consistent with the goal of improving resident clinical outcomes this process monitors and periodically evaluates the response time by clinical nursing staff of residents requesting assistance -be sure that the call light is plugged in at all times -when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident During a tour of the facility on 08/27/24, Surveyor #1 and Surveyor #2 observed the following: -8:55 A.M., room [ROOM NUMBER]-A, Resident #7 was in bed, the call bell was hanging on the wall, out of his/her reach -9:03 A.M., room [ROOM NUMBER]-A, NS RT #A was in bed, the call bell was on the floor, out of his/her reach -11:52 A.M., room [ROOM NUMBER]-B, Resident #4 was in bed, the call bell was wedged behind the bed, out of his/her reach -12:54 P.M., room [ROOM NUMBER]-B, Resident #6 was in bed, the call bell was hanging behind the bed, out of his/her reach (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1:35 P.M., room [ROOM NUMBER]-A and B, NS RT #B and NS RT #C, there were no call bell cords plugged into the wall outlets above the beds or handheld call bells at their bedside, -1:42 P.M., room [ROOM NUMBER]-A, NS RT #A was in bed, the call bell was on the floor, out of his/her reach Resident #7 was admitted to the Facility in January 2024, diagnoses included rheumatoid arthritis, low back pain, muscle weakness, abnormal posture, and type 2 diabetes. During an interview on 08/27/24 at 8:55 A.M., Resident #7 (who resided in room [ROOM NUMBER]-A) said he/she could not reach the call bell all the time and said that he/she would yell loud for help. Resident #7 said sometimes it takes up to two hours for staff to show up. Resident #4 was admitted to the Facility in April 2024, diagnoses included asthma, obstructive sleep apnea, morbid obesity, and shortness of breath. During an interview on 08/27/24 at 11:52 A.M., Resident #4 (who resided in room [ROOM NUMBER]-B) said he/she could not reach his/her call bell and said that he/she has to get up out of bed to tell staff when he/she needs care. During an interview on 08/27/24 at 1:50 P.M., CNA #2 said she was assigned to care for the resident in room [ROOM NUMBER]-A and said all call bells are supposed to be right next to the resident so they can reach it to call staff if they need help. CNA #2 said call bells should not be behind the beds or on the floor. During an interview on 08/28/24 at 11:45 A.M., CNA #4 said call bells should be next to the resident. During an interview on 08/28/24 at 3:57 P.M., the Director of Nurses (DON) said all call bells should be left at the resident's bedside and within their reach.

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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. 43963 Based on records reviewed and interviews for one of seven sampled residents (Resident #3), who had an activated Health Care Proxy (HCP) and had experienced a significant decline in medical status, the Facility failed to ensure Resident #3's Health Care Agent (HCA) had been notified of the change in condition which included the development of an unstageable pressure (unable to stage due to necrosis) injury to his/her sacrum. Findings include: Review of the Facility Policy titled, Change in a Resident's Condition or Status, dated as last revised 12/2023, indicated that the staff will promptly notify the resident's attending physician, and representative of changes in the resident's medical/mental condition and or status. The Policy further indicated the nurse will notify the resident's physician when there has been an accident or injury, discovery of injuries of an unknown cause, significant change in resident's physical condition, and the need to alter his/her plan of care. Resident #3 was admitted to the Facility in July 2024, diagnoses included, metabolic encephalopathy (a problem in the brain caused by a chemical condition), urinary tract infection, dementia with agitation, peripheral vascular disease, and hypertension. Review of Resident #3's Admission Skin Assessment, dated 07/26/24, indicated that the nurse documented that his/her sacrum was pink and blanchable. Review of Resident #3's Physician Orders, dated 07/31/24, indicated his/her HCA was responsible for his/her medical care needs. Review of Resident #3's Weekly Skin Assessment, dated 08/02/24, completed by Nurse #4, indicated he/she had impaired skin integrity with an un-measurable area [of skin breakdown] on his/her buttock area. Review of Resident #3's Admission Minimum Date Set (MDS) Assessment, dated 08/02/24, indicated he/she was severely cognitively impaired and was dependent on staff to meet his/her care needs. Review of Resident #3's Weekly Skin Assessment, dated 08/09/24, completed by Nurse #4, indicated that he/she had impaired skin integrity with an un-measurable open area on his/her buttocks area. Review of Resident #3's Wound Evaluation and Management Progress Note, dated 08/09/24 (written by the Wound Physician), indicated he/she had a full thickness wound to his/her sacrum measuring 1.3 centimeters (cm) by 1.4 cm by 0.05 cm. and recommended treatment with Hydrogel dressing covered with a gauze sponge completed once daily for 30 days. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Wound Evaluation and Management Progress Note, dated 08/12/24 (written by the Wound Physician), indicated he/she had an unstageable area of breakdown due to necrosis full thickness wound to his/her sacrum measuring 2.0 cm x 2.1 cm by 0.1 cm. and recommended the continuation of the treatment with Hydrogel dressing covered with a gauze sponge completed once daily for 27 days. During a telephone interview on 08/26/24 at 10:36 A.M., Family Member #2 said that her biggest concern regarding Resident #3 was his/her risk for skin breakdown. Family Member #3 said she received a phone call from Resident #3's physician on 08/12/24, notifying her that he/she had an unstageable pressure injury on his/her buttocks and that the area had been identified by the nursing staff earlier that week. Review of Resident #3's Medical Record, indicated there was no documentation to support Nursing staff informed his/her HCA of the new unstageable pressure injury to his/her sacrum. During a telephone interview on 08/29/24 at 12:38 P.M., Nurse #4 said when he completed Resident #3's weekly skin assessment, dated 08/02/24 (signed as completed 08/04/24), which identified a stage two (partial loss of dermis) pressure injury, said he could not recall notifying Resident #3's HCA of his/her impaired skin but said he followed Facility Protocol. During an interview on 08/28/24 at 11:55 A.M., Nurse #1 said that if a nurse observes an alteration in skin while performing a skin assessment, the nurse must initiate an incident report. Nurse #1 said the nurse that identifies the area should notify the resident's responsible party, refer the resident to the Wound Physician, write a note, and add the resident to risk rounds. During an interview on 08/28/24 at 3:57 P.M., the Director of Nurses (DON) that it is the Facility's expectation that when a pressure injury is identified, the nurse is to initiate a Risk Assessment, begin an investigation and notify the HCA if activated.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 43963 Based on records reviewed, interviews and observations for three of seven sampled residents (Resident #4, #5, and #7), the Facility failed to ensure they provided the residents with a safe, clean, comfortable, and homelike environment. When during the survey, there were bugs noted in the resident rooms, insect spray on a resident's side table, old water pitchers, and an open perishable food package stored in a nightstand drawer. Finding include: Based on the Facility Policy titled, Homelike Environment, dated as last revised February 2021, indicated that residents are provided with a safe, clean, comfortable and homelike environment and to use their personal belongings to the extent possible. The Policy indicated the Facility will provide a clean, sanitary and orderly environment. 1) Resident #4 was admitted to the Facility in April 2024, diagnosis included asthma, major depression, obstructive sleep apnea (intermittent airflow blockage during sleep), and morbid obesity. During an observation on 08/27/24 at 11:50 A.M., Surveyor #1 observed numerous fruit flies hovering over Resident #4's headboard and tray table, piles of dirty clothing on his/her floor and chair, a toaster sitting on top of his/her walker, and multiple old water pitchers on the floor next to his/her bed with trash in them. During an interview on 08/27/24 at 11:52 A.M., Resident #4 said that there have been a lot of fruit flies around here. Resident #4 said he/she never sees the laundry person to give them his/her laundry and said he/she doesn't know when they pick up the residents' personal laundry. Resident #4 said that his/her sister brought in a toaster because the breakfast toast is never hot. During an interview on 08/27/24 at 12:30 P.M., Nurse #7 said that that the Facility has been working on pest control for some time and no resident should have a toaster in their room. During an interview on 08/27/24 at 2:14 P.M., the Director of Maintenance said that no one had informed him that Resident #4 had a toaster in his/her room. 2) Resident #5 was admitted to the Facility in November 2023, diagnoses included congestive heart failure, diabetes mellitus, anemia, and post-traumatic stress disorder. During an observation on 08/27/24 at 12:37 P.M., Surveyor #1 observed a clear plastic water pitcher on Resident #5's tray table and the label on the pitcher was dated 07/19/24. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/27/24, Resident #5 said that he/she loves ice and that the staff bring him/her ice in that water pitcher daily. During an interview on 08/27/24 at 12:38 P.M., Nurse #6 said that Resident #5 likes the staff to fill up the pitcher with ice everyday. When asked about the date on the water pitcher, Nurse #6 confirmed it was dated 07/19/24, and immediately removed it from Resident #5's room. Nurse #6 said a new pitcher should be provided daily and nursing should be putting a new dated sticker on the pitcher before giving it to him/her. During an observation on 08/28/24 at 2:50 P.M., Surveyor #1 observed a plastic package of open salami (deli meat) in Resident #5's bedside table drawer. The deli meat was observed to be dark brown in color with a layer of slime covering each piece and had a strong odor. During an interview on 08/28/24 at 2:52 P.M., Resident #5 said that his/her family bring food into him/her all the time. During an interview on 08/28/24 at 2:54 P.M., Nurse # 7 said that Resident #5 always has open food in his/her room. During an interview on 08/27/24 at 3:32 P.M., the Director of Social Services said she was unaware of the condition of Resident #5's room and said she does not know how to handle rooms like his/her while maintaining their resident rights. During an interview on 08/28/24 at 3:26 P.M., the Maintenance Director said that there are multiple rooms that are overly cluttered with food, trash, clothes and said some rooms are dangerous. 3) Resident #7 was admitted to the Facility in January 2024, diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease, obstructive sleep apnea (intermittent airflow blockage during sleep), and anxiety. During an observation on 08/27/24 at 8:55 A.M., Surveyor #1 observed a bottle of Raid Bug Spray on Resident #7's bedside table. During an interview on 08/27/24 at 08/27/24 at 8:55 P.M., Resident #7 said that he/she keeps the bug spray for the fruit flies and bugs that are around in his/her room. During an interview on 08/27/24 at 9:25 A.M., Nurse # 10 said that no residents should have any pesticides by their bedside. During an interview on 08/28/24 at 3:26 P.M., the Maintenance Director said that there are multiple rooms that are overly cluttered with food, trash, clothes and said some rooms can be dangerous for the residents. The Maintenance Director said he brings these rooms to the Administrator's attention during his safety rounds but says he has not seen a difference. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/27/24 at 3:03 P.M., the Administrator said it is very difficult to manage cluttered rooms and it may contribute to the pest issues.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 43963 Based on records reviewed and interviews for one of seven sampled residents, (Resident #3), the facility failed to ensure that upon admission, nursing developed and implemented baseline care plans with interventions, treatments, goals, and outcomes that addressed the residents overall immediate care needs. Findings include: Review of the Facility Policy titled, Care Plans-Baseline, dated as last revised 03/2022, indicated that a baseline plan of care to meet the resident's immediate health and safety needs will be developed for each resident within forty-eight hours of admission. The Policy indicated the following; -The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan (no later than 21 days after admission); -The Comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48-hours of the resident's admission and meets the requirements of the comprehensive assessment; -The resident and/or representative are provided a written summary of the baseline care plan that includes stated goals and objectives of the resident, a summary of resident's medications or dietary instructions, any services and treatments to be administered by the facility; and -Provision of the summary to the resident and/or representative is documented in the medical record. Resident #3 was admitted to the Facility in July 2024, diagnoses included, metabolic encephalopathy (problem in the brain caused by a chemical reaction), urinary tract infection, dementia with agitation, peripheral vascular disease, and hypertension. Review of Resident #3's Admission Nursing Evaluation, dated 07/26/24, indicated his/her immediate care needs were identified as follows; -impaired cognition with agitation; -risk for an alteration in skin integrity; -new antidepressant medication; and -occupational/physical therapy. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #'3's Medical Record indicated there was no documentation to support that Baseline Care Plans were developed and implemented, or that Comprehensive Care Plans that addressed these areas of concern, were in place within 48 hours of his/her admission. During a telephone interview on 09/06/24 at 2:38 P.M., the Director of Social Services said she was not certain how the resident's baseline care plans were done and said she enters the residents social service care plans when needed. The Director of Social Services said that the Interdisciplinary Team (IDT, nursing, social services, and therapy) does not go over or discuss any actual care plans at the initial meeting [typically held within 72-hours after admission]. During a telephone interview on 09/06/24 at 3:48 P.M., the Director of Nurses said that Resident #3's care plans were initiated on 07/31/24 and said they were not completed within the 48-hour period. The DON said that is the Facility's expectation that the nurse completing the admission of a resident must initiate the baseline care plans and said it is a check off system within the nursing admission paperwork in the Point Click Care (PCC, facility's electronic) system.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 43963 Based on records reviewed and interviews for one of seven sampled residents (Resident #3), who had a planned discharge and required services be in place upon discharge home, the Facility failed to ensure their discharge process included that services required upon discharge were confirmed and had accepted the resident on their service, when Visiting Nurse Association (VNA) services were not in place and he/she did not receive VNA services for approximately one week after his/her discharge. Findings include: Review of the Facility Policy titled, Discharge Summary and Plan, dated as last revised December 2016, indicated that when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The Policy indicated that the discharge summary will include a replication of the resident's stay and to include the following; -Course of illness, treatment and/or therapy since entering the Facility; and -Special treatments or procedures (that are not part of the basic services provided). The Policy indicated the post-discharge plan will include the following; -To be developed by the Interdisciplinary Team (IDT) with the assistance of the resident and his/her family; -Arrangements that have been made for follow-up care and services; -A description of the resident's stated discharge goals; -The degree of caregiver/support person availability, capacity, and capability to perform required care; and -A copy of the evaluation of the resident's discharge needs, post-discharge plan, and the discharge summary should be provided to the resident and or representative and a copy is to be maintained in the resident's medical record. Resident #3 was admitted to the Facility in July 2024, diagnoses included, metabolic encephalopathy (problem in the brain caused by a chemical reaction), urinary tract infection, dementia with agitation, peripheral vascular disease, and hypertension. Review of Resident #3's Physician Orders, dated 07/31/24, indicated his/her HCA had been responsible for his/her medical care needed. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Care Plan titled, Discharge Planning, dated 07/30/24, indicated he/she had been expected to discharge to his/her Assisted Living Facility (ALF) after his/her completion of care. The Care Plan indicated that Resident #3's goal was to be discharged safely to his/her ALF by assisting to explore resources in the community, request home therapies as needed, and to review with family and resident all discharge plans that were arranged for him/her. Review of Resident #3's Physician's Order, dated 08/14/24, indicated to discharge him/her with services. Review of Resident #3's Discharge Summary, dated as completed 08/14/24, indicated that a referral was needed for Home Health, physical, occupational therapy and VNA services. Review of Resident #3's medical record, including but not limited to social services notes and nurse progress notes, indicated there was no documentation to support that the facility staff confirmed that VNA services had been set-up and that nursing services would begin after Resident #3's discharge. During a telephone interview on 09/06/24, the Resident Care Director (RCD) at Resident #3's ALF said that on 08/12/24 she had gone to the Facility to assess Resident #3 and that the nursing staff had not reported to her that he/she had any skin impairment. The RCD said that she had informed the Facility that Resident #3 would not have been able to return because the ALF could not accept a resident with an open wound. The RCD said the ALF did not receive any discharge paperwork for Resident #3 until Friday 08/16/24 (two days after he/she returned to the ALF). Review of the Facility Fax Cover Sheet to the VNA, dated 08/15/24, indicated that Resident #3's discharge paperwork had been sent on 08/15/24 at 7:37 A.M., the day after Resident #3 had been discharged back to his/her ALF. During a telephone interview on 08/26/24 at 10:36 A.M., Family Member #2 said that on 08/15/24, she called who she had thought was Resident #3's VNA, that had been set up by the discharging facility. Family Member #2 said that the VNA denied having Resident #3 as a client and said that she was told by the service that they had informed the facility they were unable to accommodate him/her at the time due to the level of care he/she required. Family Member #2 said it was six days before the newly set-up VNA service, came which had been facilitated by the ALF, was able to come out and assist with Resident #3's wound care needs. During an interview on 08/29/24 at 2:47 P.M., the Regional Director of Operations (RDO) for the VNA (that the facility contracted with) said that they use an electronic portal system to communicate with the Facility. The RDO said that they had received a fax from the Facility on 08/15/24 and that at 8:19 A.M., she had personally made the facility aware that they had to Deny Acceptance of Resident #3 due to having no staff available to meet the level of care required by Resident #3. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/29/24 at 11:53 A.M., the Facility's Case Manager (CM) said that she called the VNA (however does not recall which one) and said that the VNA already had Resident #3 as an active client. The CM said that she had not documented the acceptance or denial by the VNA regarding their determination of Resident #3 as a client and said she just assumed they had accepted him/her. During an interview on 08/28/24 at 11:14 A.M., the Director of Social Services said that Family Member #2 had been concerned about Resident #3's wound and setting up the VNA services upon discharge. The Director of Social Services said that she should have documented what VNA she had set-up upon discharge for Resident #3 and that they were accepting the resident. During a telephone interview on 09/04/24 at 2:11 P.M., the Director of Nurses (DON) said that she was unaware that Resident #3's VNA services had not been set-up until approximately one week after his/her discharge from the facility and said Social Service should have documented in their progress note who the VNA was and that Resident #3 had been accepted as a client. The DON said it is the Facility's expectation to ensure that VNA services are confirmed and documented on prior to the resident being discharge by the Facility.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43963 Based on records reviewed and interviews for one of seven sampled residents (Resident #3), who upon admission was assessed as being at high risk for skin breakdown and was documented by nursing to have intact skin, the Facility failed to ensure Resident #3 received adequate care and services related to the prevention of the development and/or worsening of a pressure injury. On 8/02/24, Resident #3's weekly skin assessment indicated he/she had an area of impaired skin integrity on his/her buttocks that was un-measurable, however physician's orders for treatment were not obtained until 8/14/24, almost two weeks later. Upon his/her discharge from the facility, Resident #3's pressure injury was documented as having worsened into an unstageable pressure injury due to necrosis. Finding include: Review of the Facility Policy titled, Pressure Ulcer/Skin Breakdown-Clinical Protocol, dated as last revised 12/2023, indicated the nursing staff will assess and document an individual's significant risk factors for developing pressure ulcers. The Policy also indicated that the nurse shall describe and document the following, a full assessment of the pressure injury, including location, stage, length, width, and depth, presence of exudates or necrotic tissue and current treatments. During an interview on 08/28/24 at 3:57 P.M., the Director of Nurses (DON) said the Facility's expectation is that when a pressure injury is identified by a nurse, that the nurse begin an investigation, notify the physician, obtain physician orders for treatments and make recommendations to be seen by Wound Physician (MD), who does weekly rounds in the facility. The DON said that the Day Supervisor accompanies the Wound MD on weekly rounds, that the Day Supervisor follows-up on and communicates any recommendations given by the Wound MD to the residents physician, but said that the Day Supervisor was on vacation when Resident #3's pressure areas were observed, and was not aware he/she needed to be seen by the Wound MD. Resident #3 was admitted to the Facility in July 2024, diagnoses included, metabolic encephalopathy (problem in the brain caused by a chemical imbalance), urinary tract infection, dementia with agitation, peripheral vascular disease, and hypertension. Review of Resident #3's physician's orders, dated 07/31/24, indicated his/her Health Care Agent (HCA) was responsible for his/her medical care needs. During a telephone interview on 08/26/24 at 10:36 A.M., Family Member #2 said that her biggest concern regarding Resident #3 was his/her risk for skin breakdown. Review of Resident #3's Admission Skin Assessment, dated 07/26/24, indicated that the nurse documented that his/her sacrum was pink and blanchable. Review of Resident #3's Admission Nursing Evaluation, dated 07/26/24, indicated he/she had an immediate care need related to risk for an alteration in skin integrity. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #'3's Medical Record indicated there was no documentation to support that a Baseline Care Plan and/or a Comprehensive Care Plan had been developed and implemented related to skin breakdown. Review of Resident #3's Norton Scale for Predicting Risk of Pressure Injury, dated 08/02/24, indicated he/she had a score of 9, placing him/her at high risk for developing pressure injuries (Low risk 16-20, Moderate Risk 11-15, and High Risk 0-10). Review of Resident #3's Weekly Skin Assessment, dated 08/02/24, completed by Nurse #4, indicated the nurse identified an area of altered skin integrity, that Resident #3 had an un-measurable area of skin breakdown on his/her buttock area. Review of Resident #3's physicians orders and Treatment Administration Records (TAR), dated 8/02/24, indicated there was no documentation to support physician's orders were obtained for treatment. Review of Resident #3's Weekly Skin Assessment, dated 08/09/24, completed by Nurse #4, indicated Resident #3 had altered skin integrity, and the nurse identified an impaired un-measurable open area (pressure injury) on his/her buttock area. Review of Resident #3's Initial Wound Evaluation and Management Progress Note, dated 08/09/24 (written by the Wound Physician), indicated he/she had a full thickness wound to his/her sacrum measuring 1.3 centimeters (cm) by 1.4 cm by 0.05 cm. and recommended treatment with a Hydrogel dressing covered with a gauze sponge, to be completed once daily for 30 days. Review of Resident #3's Physicians Orders and Treatment Administration Records (TAR), dated 8/09/24, indicated there was no documentation to support physician's orders were obtained by nursing for treatment. Review of Resident #3's Wound Evaluation and Management Progress Note, dated 08/12/24 (written by the Wound Physician), indicated he/she had an unstageable full thickness wound, due to necrosis, to his/her sacrum measuring 2.0 cm x 2.1 cm by 0.1 cm. and recommended the continuation of treatment with a Hydrogel dressing covered with a gauze sponge, to be completed once daily for 27 days. Review of Resident #3's Physician and/or Nurse Practitioner progress notes, indicated there was no documentation to support they were made aware of his/her skin breakdown, until physician's orders for treatment were obtained on 8/14/24, almost two weeks after his/her skin breakdown was first documented by nursing. Review of Resident #3's Medical Record, Nurse Progress Notes, Physician's Orders, Medication Administration Records (MAR) and his/her Treatment Administration Record (TAR), indicated there was no documentation to support nursing staff notified the physician and obtained orders for treatments for his/her facility acquired pressure injury until 08/14/24, which was also the day Resident #3 was discharged home from the facility. During a telephone interview on 08/29/24 at 12:38 P.M., Nurse #4 said when he had completed Resident #3's weekly skin assessments, on 08/02/24 and 08/09/24, that he had identified stage two (partial loss of dermis) pressure injuries and said he thought Resident #3 had already been referred to the Wound Physician (who visits weekly). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nurse #4 said he could not recall if he contacted Resident #3's physician for treatment orders, and said he does not know why physician's order had not been obtained for treatments or dressing changes for his/her buttocks. During an interview on 08/28/24 at 11:55 A.M., Nurse #1 said that if a nurse observes an alteration in skin integrity while performing a resident skin assessment, that nurse should call the physician and obtain an order for treatment to the area, notify the resident's responsible party, refer the resident to the Wound Physician, write a progress note, and add the resident to skin risk rounds. During an interview on 08/28/24 at 3:57 P.M., the Director of Nurses (DON) said that she had been unaware of Resident #3's pressure injury. The DON said that it is the Facility's expectation that when a pressure injury is identified by a nurse, that the nurse begin an investigation, notify the physician and HCA as applicable, obtain physician orders for treatments, make recommendation for evaluation by Wound Physician and document accordingly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43963 Based on records reviewed, interviews and observations for three of seven sampled residents (Resident #2, #6 and #7), who had physician's orders for the continuous administration of oxygen, the facility failed to ensure that 1) Resident #2's oxygen equipment was continuously plugged in and/or functioning properly, and 2) Resident #6 and #7's oxygen therapy liter flow rates were administered per physician's orders. Findings include: Review of the Facility Policy titled, Oxygen Administration, dated as last revised October 2010, indicated to verify a physician's order of facility protocol for oxygen administration. The Facility further indicated while the resident is receiving oxygen therapy, asses for the following; -Signs and symptoms of cyanosis (i.e., blue tone to skin and mucus membranes); -Signs and symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); -Vital signs; -Lung sounds; and -Oxygen saturation levels. 1) Resident #2 was admitted to the Facility in May 2024, diagnoses included, Chronic Obstructive Pulmonary Disease (COPD), hypoxemia (low oxygen in blood), Obstructive Sleep Apnea (intermittent airflow blockage during sleep), morbid obesity and anxiety. Review of Resident #2's Physician's Orders dated, 05/31/24, indicated to administer oxygen (O2) via a nasal cannula continuously at 3 liters (L). Review of Resident #2's Care Plan titled Alteration in Respiratory Status, dated 06/01/24, indicated to monitor for signs and symptoms of respiratory distress and report to the physician and to provide oxygen as ordered by the physician. During a telephone interview on 08/26/24 at 9:55 A.M., Family Member #1 said that on more than on occasion Resident #2's oxygen concentrator had either been turned off, unplugged, or lost power causing him/her to be transported to the Hospital Emergency Department for signs of respiratory distress. During a telephone interview on 08/29/24 at 3:00 P.M., Family Member #3 said that on 07/22/24 while she was visiting Resident #2, he/she began having trouble breathing, his/her face was turning red and then his/her lips started to turn blue. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family Member #3 said she went out to the nurse's station and asked for a nurse to go and check on Resident #3 that staff ignored her, that the staff told her that there were only 2 staff members working and they could not help her at that time. Family Member #3 said no nurse, or any staff member went into Resident #2's room until after EMS arrived and no nurse on the unit assessed him/her. Review of Resident #2's Nurse Progress Note, (written by Nurse #9), indicated that his/her daughter called 911, the oxygen tank was on and the residents' oxygen saturation level went down, resident was taken to the Hospital Emergency Department (ED) for evaluation. Review of Resident #2's Medical Record, including but not limited to vital sign report, Medication Administration Record (MAR), Treatment Administration Records (TAR), and Nurse Progress notes, indicated that on 7/22/24, his/her oxygen saturation level obtained from Facility staff was 93 percent (%) on 2 L (at 8:50 P.M.) however, this level was noted after EMS had already applied supplemental oxygen. Further review of Resident #2's Medical Record, indicated that on 7/22/24, there was no documentation to support Nurse #9 assessed him/her prior to EMS arriving and transporting Resident #3 to the ED. Review of Resident #2's Fire Department Incident Report, dated 07/29/24, indicated on 07/22/24, a call was placed, (later identified as being placed by Family Member #3) related to Resident #2 had been complaining about being short of breath and complaining of nausea. The Report indicated that the oxygen concentrator had been turned off for a minimum of one hour (Resident #2 diagnosis include COPD, he/she required oxygen at 2 liters (L), his/her O2 sat was 60% upon arrival (8:37 P.M.), he/she had been tachypneic, and the nasal cannula had been unplugged from the concentrator for an uncertain amount of time. During an interview on 09/03/24 at 9:21 A.M., Nurse #9 said that Family Member #3 had been in visiting and reported that Resident #2 was having difficulty breathing and said by the time he got to his/her room Emergency Medical Services (EMS) had already arrived. Nurse #9 said that he had not noticed if Resident #2's oxygen concentrator had been unplugged and said EMS staff were the ones who noticed that Resident #3's oxygen concentrator had been unplugged. During an interview on 09/04/24 at 2:11 P.M., the Director of Nurses (DON) said that Nurse #9 told her that a Family Member had unplugged Resident #3's oxygen while charging a cellular phone and that the Family Member called 911 when they noticed he/she was having difficulty breathing. The DON said that it is the Facility's expectation for nursing to monitor emergency equipment, that nursing should monitor residents on oxygen for signs and symptoms of respiratory distress and report findings to the physician. 2) Resident #6 was admitted to the Facility in May 2024, diagnoses included COPD, chronic respiratory failure, congestive heart failure and anxiety. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident # 6's Physician's Order, dated 05/21/24, indicated to administer oxygen continuously via a nasal cannula at 2 liters (L) continuously. During an observation of Resident #6 at 12:54 P.M. Surveyor #1 observed his/her oxygen was continuously administered via a nasal cannula with a flow rate of 5 L, which was not consistent with his/her physician's orders. During an interview on 08/27/24 at 12:38 P.M., Nurse #6 said that when she checked Resident #6's oxygen it had been on 4 L and said she decreased it to 2 L, per his/her physician's order. Resident #7 was admitted to the Facility in January 2024, diagnoses included chronic respiratory failure, COPD, congestive heart failure, and anxiety. Review of Resident # 7's Physician's Order, dated as of 08/27/24, indicated to administer oxygen continuously via a nasal cannula at 2 L continuously. During an observation of Resident #7 at 9:08 A.M., surveyor #1 observed his/her oxygen was continuously being administered via a nasal cannula with a flow rate of 0.5 L, which was not consistent with his/her physician's orders. During an interview on 08/27/24 at 9:25 A.M., Nurse #10 said that Resident #7's oxygen was set low (0.5 L) and said that she adjusted it to 2 L according to his/her physician's orders. During an interview on 08/28/24 at 3:57 P.M., the Director of Nurses (DON) said that it is the Facility's expectation to follow Physician's Orders at all times. Resident's requiring oxygen should be maintained at the flow rate according to the resident's physician's order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43963 Based on records reviewed, interview, and observations for one of seven sampled residents (Resident #7) and one of four resident care units (Unit #4), the Facility failed to ensure nursing staff properly secured prescription medications, when 1) on 08/27/24 a prescription topical powder medication had been found at the bedside of Resident #7 and 2) on 08/27/24 and 08/28/24, Unit #4's medication room door was observed to be unlocked, and therefore medications were not secured. Findings include: Review of the Facility Policy titled, Storage of Medication, dated as last revised April 2019, indicated that all drugs and biologics will be stored in a safe, secure, and orderly manner. The Policy indicated the following; -Drugs and biologics used in the facility are stored in locked compartments, containers, or other dispensing systems under proper temperature, light, and humidity controls; -The nursing staff is responsible for maintaining medication storage and preparation areas; and -Compartments, including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes, containing drugs and biologics are locked when not in use. 1) Resident #7 was admitted to the Facility in January 2024, diagnoses included diabetes mellitus, respiratory failure requiring continuous oxygen, bilateral below the knee amputations, and depression. During an observation on 8/27/24 at 9:07 A.M., the surveyor observed a bottle of Nystatin (antifungal) Powder on the tray table in Resident #7's room. Review of Resident #7's Physician's Orders, dated 08/27/24, indicated there was no documentation to support Nystatin Powder had been prescribed by his/her physician as a current treatment. During an interview on 08/27/24 at 8:55 P.M., Resident #7 said that he/she recently returned from the hospital, and the hospital had provided him/her with Nystatin Powder to be use under his/her breasts. Resident #7 said he/she applies it when he/she feels that he/she needs it. Review of Resident #7's Medical Record, indicated that there was no document to support he/she had been assessed for and had physician's order to self-administer any medications. During an interview on 08/27/24 at 9:25 A.M., Nurse #10 said that no medications were to be left by the resident's bedside unless they had been assessed as being able to self-administer medications. Nurse #10 said that Resident #7 had not been assessed to self-administer any medications at that time. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During an observation on 08/27/24 at 2:18 P.M., Surveyor #1 observed the medication room door on Unit #4 was unlocked and that access to medications had not been secured. During an interview on 08/27/24 at 2:30 P.M., Nurse #8 said she was unaware that the medication room door had been unlocked and said medication room doors should always be locked and secure. During an observation on 08/28/24 at 7:53 A.M., Surveyor #1 again observed the medication room door on Unit #4 was unlocked and access to the medication room had not been secured. During an interview on 08/28/24 at 7:55 A.M., Nurse #11 said she had not noticed that the Medication room door had been left unlocked and said that medication room doors should always be locked. During an interview on 8/28/24 at 3:57 P.M., the Director of Nurses (DON) said if any residents are found with medications at their bedside, that nursing should be obtaining a physician's order, and a self-administration of medications evaluation form should be filled out. The DON said it is expected that all required documentation should be completed prior to any resident self-administrating any of their own medication and should be kept locked in the resident's room. The DON said that all medications room doors should be locked and always secured.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40702 Based on observations, records reviewed, and interviews, for one of four resident care units (Unit 5), the Facility failed to ensure they 1) maintained a functioning call bell system that allows residents to call for staff assistance through a communication system which relays to a centralized staff work area from resident's bedside and 2) for one of seven sampled residents (Resident #4), the facility failed to ensure the call bell system was functioning properly in his/her room. Findings include: The Facility Policy, titled Call Bell, undated, indicated the following: -providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes -consistent with the goal of improving resident clinical outcomes this process monitors and periodically evaluates the response time by clinical nursing staff of residents requesting assistance -be sure that the call light is plugged in at all times -report all defective call lights to the Nurse Supervisor promptly During a tour on 08/27/24 on Unit #5, at 1:35 P.M., Surveyor #1 and Surveyor #2 observed there were no call bell cords plugged into the wall outlets above the beds in room [ROOM NUMBER]-A and B. During an interview on 08/27/24 at 1:35 P.M., Nurse #1 said call bell lights are not used on Unit #5 for resident's safety because there are a lot of residents with behaviors and the noise of the call bell lights also bothers the residents. During a telephone interview on 09/04/24 at 10:51 A.M., the Director of Maintenance said Unit #5 had been closed for about ten months and said when the unit was reopened, he was told to remove all call bell system cords from all residents' rooms. The Surveyors also observed both beds had long over the bed light pull strings and electric control cords for their beds. When Nurse #1 was asked, if the concerns about the call light pull cords was resident safety related to behaviors, why the resident rooms still had strings on the lights and bed cords were accessible, Nurse #1 said she did not know why, and said that she just knew that call bell cords were not being used. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an in-person interview on 08/28/24 at 3:57 P.M. and a telephone interview on 09/04/24 at 11:08 A.M., the Director of Nurses (DON) said there are no long call bell cords in any resident rooms on Unit #5 for safety purposes because a lot of the residents have behaviors. The DON said that Unit #5 has the ability for a functioning electronic call bell system, but it was not being used. The DON said Unit #5 opened as a behavioral unit in October 2023 and per the [NAME] President of Clinical Services all call bell cords were removed for residents' safety and all residents were given handheld bells to call for assistance. 2) During an observation and interview on 08/27/24 at 11:52 A.M., Surveyor #1 observed Resident #4 lying in bed, the call bell was hanging on the wall and out of reach of his/her reach. Resident #4 said he/she could not reach his/her call bell and said that he/she has to get up and tells staff when he/she needs help The Surveyor put Resident #4's call bell on at approximately 12:00 P.M. (with his/her permission) and there was no response from staff for 20 minutes. The Surveyor then observed the light outside of Resident #4's room (209-B) did not light up and went to the Nurse's station to inquire about it. At the Nurse's station the Surveyor observed there was no visible light on the call bell board for Resident #4's room (209-B) and informed Nurse #7 that the call bell was not working. On 08/27/24 at 2:00 P.M., Surveyor #1 tested Resident #4's call bell again and it was still not working. The Surveyor reviewed the maintenance logbook and there was no recording that the call bell was not working in Resident #4's room or that maintenance was notified. During an interview on 08/27/24 at 8:55 A.M. and on 08/28/24 at 3:10 P.M., the Director of Maintenance said no one had reported to him that the call bell light in room [ROOM NUMBER]-B was broken and said that it is something staff should call him right away for, because it could be an emergency.