STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225430	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Patrick's Manor	863 Central Street Framingham, MA 01701

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on record review, and interview, the facility failed to ensure that Advance Directives (a written statement about a resident's wishes regarding medical treatment) were accurately executed for one Resident (#411) out of a total sample of 36 Residents. Specifically, for Resident #411, the facility failed to: -offer the Resident/ Responsible Party the opportunity to formulate and/or review an Advanced Directive for the Resident. -obtain a Physician's order to indicate an accurate code status when the Resident was admitted to the facility with an illegible Massachusetts Medical Order for Life-Sustaining Treatment (MOLST) form and a handwritten, incomplete code status card. Findings include: Review of the facility policy titled Advance Directives, dated [DATE], indicated: -Upon admission, MD/Nursing will identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance directive. -The MOLST will be in the front of the paper chart and all other advance directive document copies will be obtained and located in the legal section of the paper chart. -All advance directive document copies will be communicated to the staff via the care plan and communicated to the resident's physician. -The resident will be assessed upon admission, quarterly, and with change of condition for their ability to make decisions and for changes in resident preferences and choices. -Identify, clarify and review the existing care instructions and whether the resident wishes to change or continue instructions from the advance directive. Resident #411 was admitted to the facility in February 2025 with diagnoses including Falls, Alzheimer's Disease, Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #411's February 2025 Physician's orders did not include orders for Advance Directives. Review of Resident #411's Care Plan initiated [DATE], indicated that the Resident was a full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive). Review of Resident #411's medical record indicated a MOLST form that was primarily black/dark, and illegible. Further review of the MOLST form could not determine the Resident's care decisions if a change in condition occurred in which CPR might be necessary. Further review of Resident #411's medical record indicated a handwritten card, titled Referral Info, that was undated and unsigned, and indicated Resident #411 was Do Not Resuscitate (DNR) and Do Not Intubate (DNI). During an interview on [DATE] at 11:13 A.M., the surveyor and Unit Manager (UM) #3 reviewed Resident #411's medical record and UM #3 said the Resident was DNR/DNI according to the black/dark, illegible MOLST form and the handwritten card titled Referral Info that was undated and unsigned. UM #3 also reviewed Resident #411's Physician's orders and said there was no order for the Resident's Advance Directives. The surveyor and UM #3 reviewed the Resident's Care Plan and UM #3 said the Care Plan indicated the Resident was a full code. During an interview on [DATE] at 11:18 A.M., Social Worker (SW) #2 said Resident #411 was presumed a full code as the MOLST was unreadable. During a follow-up interview on [DATE] at 12:35 P.M., UM #3 said the MOLST form should have been reviewed with Resident #411 when the Resident was admitted to the facility. UM #3 said a new MOLST should have been completed, and a Physician order should have been obtained but an updated MOLST and a Physician's order had not been completed.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 51466 Based on observation, interview, and record review, the facility failed to ensure that one Resident (#232), out of a total sample of 36 residents, was free from physical restraints. Specifically, the facility failed to ensure that Resident #232 was assessed for the use of a potential restraint (two stationary chairs), which were positioned in a way to prevent the Resident from moving freely around the room. Findings include: Review of the facility policy titled Restraints-Physical/Chemical, dated 6/14/24, indicated each resident shall be free from physical and/or chemical restraints imposed for the purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. The policy also included the following: -All resident's will be assessed for appropriateness of devices to treat their medical symptoms and ensure the least restrictive alternative is utilized for the least amount of time, to allow each resident and maintain his/her highest practicable well-being. -The facility prohibits the use of restraints to unnecessarily inhibit a resident's freedom of movement or activity. -When a restraint is used, the facility will: >Assess the resident's physical condition and cognitive status as contributing factors in determining whether the resident can remove the restraint if physical or is overly sedated, subdued or limited in his/her functional capacity if chemical. Resident #232 was admitted to the facility in December 2023 with diagnoses including Alzheimer's Disease with early onset, Dementia with moderate behavioral disturbances, Major Depression Disorder, and Generalized Anxiety. Review of Resident #232's Behavior Care Plan, initiated 12/23/23, indicated: -the Resident was at risk for behaviors associated with cognitive decline r/t (related to) Alzheimer's Disease. -the Resident had a behavior to sit self on the floor. Review of Resident #232's Activity Deficit Care Plan, initiated 12/20/23, indicated the following interventions: -Resident had stationary chairs in his/her room positioned in the corner as an activity. He/she continuously stands, pivots, and sits alternating in chairs - initiated 7/15/24. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #232's Activities of Daily Living (ADL) Self-care Deficit Care Plan, initiated 12/19/23, indicated the following interventions: -Resident required hand held assist of one staff member. Review of the Resident's Restraint Assessment, dated 12/19/23, indicated: -no restraints were in use. Review of the Minimum Data Set (MDS) Assessment, dated 12/24/24, indicated Resident #232: -Scored 0 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) Assessment, indicating severe cognitive deficit. -was unable to make him/herself understood. -was unable to understand others. -required maximum assistance for transfers. -required maximum assistance for ambulation. -did not utilize restraints. On 2/19/25 at 11:02 A.M., the surveyor observed Resident #232 sitting in his/her room in a stationary chair facing the wall in the corner of the room. The surveyor further observed a closed bathroom door to his/her right side and another stationary chair was positioned on his/her left side, limiting the ability for the Resident to move about or exit the room. The Resident was observed to be repeatedly pushing up from the arms of the chair into the standing position, then sitting back down in the chair. On 2/19/25 at 3:24 P.M., the surveyor observed Resident #232 sitting in his/her room in a stationary chair facing the wall in the corner of the room, a closed bathroom door to his/her right side and another stationary chair positioned on his/her left side, limiting the ability for the Resident to move around or exit the room. During an interview on 2/19/25 at 3:24 P.M., Nurse #3 said staff initiated the intervention of two stationary chairs in the Resident's room as a safety intervention to prevent the Resident from falling. Nurse #3 further said she did not know why the chairs were cornering the Resident into the room and how far apart the chairs should be from one another to allow the Resident to move around the room. Nurse #3 said that the Resident requires assistance from one staff member for ambulation and could not move the chairs his/herself. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 11:48 A.M., the surveyor and the Director of Nursing (DON) observed Resident #232 sitting in his/her room in a stationary chair facing the wall in the corner of the room, a closed bathroom door was to his/her right side and another stationary chair was positioned on his/her left side, preventing the Resident from moving around or exiting the room. During an interview at the time, the DON said the stationary chairs are set up as a behavior solution for the Resident continuously standing up. The DON was unable to determine if the chairs limited the Resident's movement in the room. The DON said that the stationary chairs intervention was not assessed as a potential restraint but according to their policy, it should have been. During an interview on 2/20/25 at 12:04 P.M., the DON said the interdisciplinary team (IDT) assessed the stationary chairs as a restraint after it was brought to their attention from the surveyor. The DON further said the position of the stationary chairs had limited Resident #232's ability to move freely in the room and changing the position of the chairs would avoid them being a restraint. During an interview on 2/20/25 at 1:56 P.M., the DON said that the facility should have assessed the stationary chairs as a possible restraint when the intervention was initiated, but did not complete an assessment.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50320 Based on record review, and interview, the facility failed to ensure a written notification of transfer or discharge was completed for one Resident (#156) out of a total sample size of 36 Residents. Specifically, the facility failed to: 1. Provide the Resident/Resident Representative with written notice of transfer or discharge when the Resident was transferred to the hospital. 2. Notify the Office of the State Long-Term Care Ombudsman of the Resident's transfer to the hospital. Findings include: Resident #156 was admitted to the facility in June 2022, with diagnoses including End Stage Renal Disease (ESRD), Diabetes Mellitus Type 2 (DM II), Chronic Kidney Disease (CKD) Stage 4. Review of Resident #156's medical record indicated: -12/10/24: A Physician's order was obtained to send Resident #156 to the Hospital for worsening renal function. -A Nurses note dated 12/10/24, indicated the Resident had been transferred to the hospital. -No evidence a written notice of transfer or discharge had been provided to the Resident/Resident Representative upon the Resident's transfer to the hospital -No evidence that the Office of the State Long-Term Care Ombudsman had been notified of the Resident's transfer to the hospital. During an interview on 2/20/25 at 1:04 P.M., Social Worker (SW) #1 said she was unable to provide evidence that written notice of transfer or discharge was provided to the Resident/Resident Representative when he/she was transferred to the Hospital on 12/10/24. SW #1 said she could not provide any evidence the Office of the State Long-Term Care Ombudsman had been notified of Resident #156 being transferred to the hospital. SW #1 said the written notice of transfer or discharge should have been completed when the Resident was transferred to the hospital and should have been added to the notification list of transfers/discharges that is sent to the Ombudsman every two weeks.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 50320 Based on record review, and interview, the facility failed to ensure a Bed Hold Policy Notice was issued upon transfer to the hospital for one Resident (#156) out of a total sample of 36 Residents. Specifically, for Resident #156, the facility failed to provide the Resident/Resident Representative with written notice of the facility's bed-hold policy when the Resident was transferred to the hospital. Findings include: Review of the facility's Bed Hold and Return to Facility Policy effective 12/8/18, reviewed 3/2020 indicated: -It is the policy of the facility that residents and/or resident representatives are notified of the Bed Hold and Return to Facility Policy upon admission and transfer, and to ensure that the resident is informed of the State's bed hold duration and payment as well as their right to return to the facility from a hospitalization or therapeutic leave if appropriate. -The facility will document the provision of the Bed Hold and Return to Facility notice to the resident and information given to the representative in the resident's record. Resident #156 was admitted to the facility in June 2022 with diagnoses including End Stage Renal Disease (ESRD), Diabetes Mellitus Type 2 (DM II), Chronic Kidney Disease (CKD) Stage 4. Review of Resident #156's Medical Record indicated: -12/10/24: A Physician's order was obtained to send Resident #156 out to an acute care hospital for evaluation of worsening renal status. -12/10/24: A Nurse's note indicating the Resident was transferred out of the facility to an acute care hospital. During an interview on 2/20/25 at 1:04 P.M., Social Worker (SW) #1 said she was unable to provide evidence that written notice of the Bed Hold and Return to Facility notice had been given to Resident #156 or the Resident Representative upon the Resident's transfer to the hospital.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51466 Based on interview, and record review, the facility failed to accurately complete Minimum Data Set (MDS) Assessments for two Residents (#253 and #254) out of three closed records reviewed. Specifically, the facility failed to ensure that MDS assessments for Resident's #253 and #254 were completed accurately, relative to discharge location. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2023, indicated the following: -This item documents the location to which the resident is being discharged at the time of discharge. >Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. >Code 04, Short-Term General Hospital (acute hospital/IPPS): if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care and accepts a predetermined rate as payment in full. 1. Resident #253 was admitted to the facility in December 2024, with diagnoses including unspecified fall and Adult Failure to Thrive. Review of the Resident #253's MDS Assessment, dated 1/1/25 indicated the Resident was discharged to a Short- Term General Hospital (Acute Care Hospital). Review of Resident #253's Nursing Progress Notes and Discharge Summary indicated the Resident returned home on 1/1/25. During an interview on 2/24/25 at 2:56 P.M., MDS Nurse #1 said Resident #253 was discharged from the facility to home on 1/1/25, and the discharge MDS assessment dated [DATE] was coded inaccurately. MDS Nurse #1 said the MDS Assessment code should have reflected the accurate discharge location to home. 45429 2. Resident #254 was admitted to the facility in September 2023, with diagnoses including Alzheimer's Disease and age-related osteoporosis. Review of Resident #254's Discharge MDS assessment dated [DATE], indicated the Resident was discharged from the facility to his/her home in the community. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the Resident's SBAR (Situation Background Appearance Review and Notify) Communication Form dated 12/5/24, indicated that the Resident was sent out to the hospital for further evaluation. Review of Resident #254's Nursing Progress Notes indicated that the Resident was transferred to the hospital on 12/5/24. During an interview on 2/24/25 at 2:56 P.M., MDS Nurse #1 said Resident #254 was discharged from the facility to the hospital and the MDS assessment dated [DATE], was coded inaccurately and should be modified to reflect that the Resident had been discharged to the hospital.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on record review, and interview, the facility failed to provide care consistent with professional standards of practice relative to the administration of prescribed medication for one Resident (#145) out of a total sample of 36 residents. Specifically, for Resident #145, the facility failed to administer a Physician ordered antihypotensive medication (used to treat low blood pressure) as needed (PRN) when Systolic Blood Pressure (SBP - the top number of the blood pressure reading which indicates the force of circulating blood pushing against the artery when the heart beats) measurements were documented below 100 mmHg (millimeters of mercury) for the Resident. Findings include: Review of the facility policy titled Specific Medication Administration Procedures, dated 2017, included but was not limited to: -Purpose: To administer oral medications in a safe, accurate, and effective manner. -Review and confirm medication orders for each individual resident on the Medication Administration Record (MAR) PRIOR to administering medications to each resident. -Review administration medication record for any tests or vital signs that need to be determined prior to preparing the medications. -Discuss with resident and determine if there is a need for any as needed medication such as for pain. Resident #145 was admitted to the facility in March 2021 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, End Stage Renal Disease (ESRD), dependence on Renal Dialysis, Heart Failure - unspecified, and Type 2 Diabetes. Review of the most recent Minimum Data Set, dated dated dated [DATE], indicated that the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status Score of 15 out of 15 possible points. Review of Resident #145's February 2025 Physician's orders indicated: -Vital Sign [sic] Daily every day shift -Midodrine HCl Oral Tablet 5 mg (milligrams) (Midodrine HCl) 1 tablet by mouth as needed (PRN) for low Systolic Blood Pressure (less than 100) twice daily (order active, initiated 4/10/24) Review of Resident #145's Medication Administration Records (MARs) for December 2024, January 2025, and February 2025 indicated the following SBP readings: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	>December 2024: -12/23/24: SBP 56 mmHg -12/29/24: SBP 96 and SBP 95 mmHg -12/31/24: SBP 98 mmHg >January 2025: -1/3/25: SBP 94 mmHg -1/4/25: SBP 97 mmHg and SBP 90 mmHg -1/5/25: SBP 96 mmHg and SBP 94 mmHg -1/12/25: SBP 95 mmHg -1/25/25: SBP 89 mmHg -1/26/25: SBP 98 mmHg -1/27/25: SBP 98 mmHg >February 2025: -2/3/25: SBP 93 mmHg -2/5/25: SBP 99 mmHg -2/7/25: SBP 90 mmHg -2/8/25: SBP 94 mmHg -2/13/25: SBP 98 mmHg -2/15/25: SBP 92 mmHg and SBP 98 mmHg -2/16/25: SBP 64 mmHg and SBP 95 mmHg Further review of the December 2024, January 2025, and February 2025 MARs indicated no evidence that the as needed (PRN) Midodrine medication was administered per Physician orders when Resident #145's SBP was measured below 100 mmHg. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/25 at 9:39 A.M., the surveyor and the Director of Nursing (DON) reviewed Resident #145's MARs for December 2024, January 2025, and February 2025 and observed that the MARs did not indicate that the Midodrine medication was administered as ordered when the Resident's SBP was measured below 100 mmHg. The surveyor and the DON identified 4 occasions in December 2024, and 9 occasions respectively in January 2025, and February 2025, when the Resident's SBP was measured below 100 mmHg, and there was no indication that Midodrine medication was administered as ordered to manage the Resident's hypotension. The DON said that the Nurse should have administered the Midodrine for a SBP below 100 mmHg on the identified dates but there was no evidence that the Nurses had done so. The DON further said that whenever the Resident's SBP was below 100 mmHg, the nursing staff should administer the as needed (PRN) Midodrine as ordered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51571 Based on observation, interview, and record review, the facility failed to provide assistance for activities of daily living (ADL - basic life care tasks that individuals perform on a daily basis to maintain their well-being which include grooming) for two Residents (#164 and #556) out of a total sample size of 36 residents. Specifically, the facility failed to: 1. For Resident #164, ensure the Resident was offered and/or provided with grooming of facial hair when the Resident was dependent on facility staff for assist with grooming. 2. For Resident #556, ensure the Resident was offered and/or provided grooming of the fingernails when the Resident was dependent on facility staff for grooming. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs), dated 11/2024 indicated but was not limited to the following: -The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. -Care and services will be provided for the following activities of daily living: <Grooming <A resident who is unable to carry out activities of daily living will receive the necessary services to maintain personal hygiene. 1. Resident #164 was admitted to the facility in February 2024 with diagnoses of Hemiplegia, Hemiparesis and Cognitive Communication Deficit. Review of Resident #164's comprehensive, person-centered care plan for ADL's, initiated 2/14/24 and revised 2/12/25, indicated: -The Resident was dependent for personal hygiene and grooming. Review of Resident #164's Minimum Data Set (MDS) Assessment, dated 1/30/25, indicated the Resident: -was moderately cognitively impaired as evidenced by a Brief interview for Mental Status (BIMS) score of 10 out of a total possible score of 15. -was dependent on staff for assist for personal hygiene (grooming). (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had not demonstrated any refusal of care. Review of Resident #164's February 2025 Certified Nurses Aides (CNA) Documentation indicated: -The Resident required assistance of another person for personal hygiene, including grooming. -The Resident had not exhibited any refusals of care relative to personal hygiene. On 2/19/25 at 10:42 A.M., the surveyor observed the Resident seated in a recliner in his/her room with facial hair approximately one inch in length present on his/her chin. On 2/19/25 at 4:25 P.M., Resident #164 was observed sitting in a recliner next to the bed in his/her room and remained with approximately one inch of facial hair observed on his/her chin. On 2/20/25 at 11:16 A.M., the surveyor observed the Resident lying in bed and one inch long facial hair remained on his/her chin. On 2/20/25 at 2:41 P.M., the surveyor observed the Resident seated in a recliner in his/her room with one inch long facial hair present on his/her chin. On 2/20/25 at 2:59 P.M., the surveyor observed that CNA #3 was present in Resident #164's room. During an interview at the time, CNA #3 said that the Resident has never refused ADL care or facial hair removal. CNA #3 was observed asking Resident #164 if he/she would like his/her facial hair shaved, and the Resident nodded his/her head yes in response. During an interview on 2/20/25 at 3:15 P.M., the Director of Nursing (DON) said that it was her expectation that the CNA staff would offer and provide facial hair removal with daily care for all residents. 50320 2. Resident #556 was admitted to the facility in December 2024 with diagnoses including Adult Failure to Thrive, Chronic Kidney Disease (CKD) Stage 3, and Depression. Review of Resident #556's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident: -was moderately cognitively impaired as evidenced by a score of 11 out of 15 points on the Brief Interview for Mental Status (BIMS) assessment. -required supervision or touching assistance with personal hygiene. -had no rejection of care. Review of the Resident #556's Care Plan initiated 12/31/24 and revised on 2/13/25 indicated: -the Resident had potential impairment to skin integrity due to decreased mobility, Neuropathy and Osteoarthritis. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-interventions initiated on 12/31/24 for potential impairment of skin integrity indicated: >to avoid scratching and keep hand and body parts from excessive moisture. >Keep fingernails short. Further review of the Resident's Care Plan did not indicate a functional status related to assistance required for nail care. Review of the February 2025 CNA Care Card indicated that Resident #556's fingernails should be kept short. On 2/19/25 at 9:27 A.M., the surveyor observed Resident #556 to have long untrimmed nails on all fingers of the left hand with dark brown debris under the fingernails, and a thick buildup of debris at the free edge of the nails and around the edges of the fingernails. The surveyor observed that the Resident's right hand also had long untrimmed jagged nails that were absent of debris. During an interview at the time, the Resident said someone had attempted to cut his/her nails once, but they did not have strong enough nail trimmers to cut his/her fingernails. Resident #556 said no one had attempted to trim his/her fingernails since that time. Resident #556 was unable to recall when the staff had attempted to cut his/her fingernails. Resident #556 said he would like his/her nails trimmed and cleaned. On 2/19/25 at 3:37 P.M., the surveyor observed that the Resident's fingernails remained unchanged from the morning observation with long untrimmed nails on both the left and right hand and brown debris under and around the fingernails of the left hand. During an interview at the time, Resident #556 said he/she was washed-up earlier in the day by a CNA. Review of Resident #556's clinical record did not indicate any refusal of care provided by the staff. Review of the CNA Daily Care Record for 2/19/25, indicated that no fingernail care had been provided to Resident #556 on that day (2/19/25). On 2/20/25 at 8:06 A.M., the surveyor observed that Resident #556 remained with long untrimmed nails on both the left and right hands and brown debris under and around the free edge of the fingernails of the left fingers. During an interview on 2/20/25 at 8:15 A.M, CNA #1 said Resident #556 does not refuse care that she is aware of. CNA #1 said the Resident requires assistance with all his/her ADL care. CNA #1 also said the CNA's do nail care on all residents when they provide care to the residents and whenever nail care needs to be done. CNA #1 said she had not seen Resident #556's fingernails recently. On 2/20/25 at 8:25 A.M., the surveyor observed Nurse #5 assisting the Resident with his/her breakfast meal. During an interview at the time, Nurse #5 said she did notice that the Resident's fingernails needed to be trimmed and cleaned and she would make sure it got done that day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 8:52 A.M., the surveyor and the DON observed that the Resident's fingernails on both the left and the right hands remained untrimmed with brown debris under and around the fingernails of his/her left hand. The DON said the Resident's nails needed to be trimmed and cleaned. The DON said nail care should be done by the CNAs with morning care, and she would make sure Resident #556's nails were trimmed and cleaned right away.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45429 Based on observation, interview, and record review, the facility failed to ensure that assistive devices to maintain hearing and enhance communication were utilized for one Resident (#234), out of a total sample of 36 residents. Specifically, for Resident #234, the facility failed to ensure that ordered hearing aids were applied daily when the Resident required staff assistance for insertion and manipulation of the hearing aids so he/she could maintain hearing and communication abilities. Finding Included: Review of the facility policy titled Hearing Aid Placement, last revised 11/2022, indicated the following: -The facility will provide a system to safely maintain resident hearing aids in support of their resident rights and quality of life. -Hearing aid placement and removal will be documented on the electronic medical record. Resident #234 was admitted to the facility in June 2024 with diagnoses including bilateral glaucoma and auditory hallucinations. Review of Resident #234's Audiology Consult dated 9/24/24, indicated: -Patient requires assistance with insertion and manipulation of hearing aids daily. -Patient to wear hearing aids daily. -Continue with current means of communication. Review of Resident #234's February 2025 Physicians orders indicated: -Bilateral hearing aid, every Day Shift (7 A.M. - 3 P.M.) apply, initiated 6/21/24. Review of Resident #234's Treatment Administration Record (TAR) for February 2025 indicated that he/she has had his/her hearing aids inserted daily in his/her ears. On 2/19/25 at 9:01 A.M., Resident #234 was observed seated in the dining room eating breakfast. The surveyor did not observe that Resident #234 had his/her hearing aids inserted and in use. During an interview at the time, Resident #234 said he/she was unable to hear the surveyor clearly and that he/she usually wears hearing aids. Resident #234 also said that the nursing staff puts the hearing aids in for him/her and he/she would like to have them in while he/she is eating breakfast, so that he/she can hear everyone. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 8:02 A.M., the surveyor observed Resident #234 sitting in front of the nurses station and that he/she did not have his/her hearing aids inserted in his/her ears. The surveyor also observed multiple nursing staff and Certified Nurses Aides (CNA) staff walking past the Resident while expressing greetings to him/her. During an interview at the time, Resident #234 said that he/she wished he/she could hear the surveyor better, but he/she did not have on his/her hearing aids, and he/she was waiting for staff to put in his/her hearing aids. On 2/20/25 at 9:07 A.M., the surveyor observed Resident #234 sitting in the unit dining room eating breakfast and seated next to other residents. The surveyor observed that Resident #234 did not have his/her hearing aids inserted and in use. On 2/24/25 at 7:52 A.M., the surveyor observed that Resident #234 was up and dressed for the day. Resident #234 was observed ambulating down the hallway with his/her rolling walker and attempting to communicate with staff on the unit. During an interview at the time, Resident #234 said that he/she could not hear because he/she did not have on his/her hearing aids. Review of Resident #234's medical record failed to indicate any refusals by the Resident to wearing his/her hearing aids. During an interview on 2/24/25 at 8:24 A.M., Nurse #4 said that the hearing aids should be applied by the Nurse once Resident #234 wakes up for the day. Nurse #4 said that the hearing aids instructions are listed on both the Physician's orders and the TAR. Nurse #4 said that she gives the residents their hearing aids before they enter the dining room to eat breakfast. During an interview on 2/24/25 at 11:04 A.M., Unit Manager (UM) #1 said that the staff should be applying the residents hearing aids once they wake up for the day and should be monitoring the residents to see if they have their hearing aids in place. UM #1 also said that residents should have on their hearing aids by the time they eat breakfast and Resident #234 did not have on his/her hearing aids.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on observation, interview, and record review, the facility failed to provide necessary care and services relative to enteral feeding (nutrients provided directly into the stomach), for one Resident (#111) out of a total sample of 36 residents. Specifically, for Resident #111, the facility failed to ensure that enteral feeds and fluids being administered to the Resident were labeled and dated as appropriate. Findings include: Review of the facility policy titled Nursing Service: Enteral Feeding Management, dated 3/15/23, indicated the following: -Labeling: To avoid misinterpretation, a label should be affixed to all EN (enteral nutrition) formula administration containers (bags, bottles, syringes [used in syringe pump]). -The label should include: >patient demographics >formula type >enteral access delivery site >administration method >initials of the individual hanging the formula >time formula hung >date formula hung > Not for IV (intravenous) Use. -Labels should be standardized with standard components to decrease potential confusion if resident is transferred or when a new Nurse takes over the resident's care. -Clear concise labeling allows for final check by the administering Nurse with the Prescriber's order. Resident #111 was admitted to the facility in September 2022, with diagnoses including Vascular Dementia, dysphagia, and moderate protein-calorie malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #111: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was rarely/never understood and rarely/never understood others. -was severely cognitively impaired, rarely/never made medical decisions, and demonstrated short and long term memory deficits per staff assessment. -received nutrition via a feeding tube and received over 51% of their calories via tube feed. -received fluid intake via a feeding tube and received over 501cc (cubic centimeters) of fluid for hydration per day. Review of Resident #111's February 2025 Physician's orders indicated: -Enteral Feed order: Two times a day for feeding tube, Jevity 1.5 @60 ml/hr (milliliters per hour), initiated 11/21/24. -Enteral Feed order: In the morning (11-7 shift please add an additional 80 ml of Jevity 1.5 for total input = 1080 ml daily), initiated 2/20/25. -Enteral Feed order: Every shift flush enteral tube with (50) ml of water before and after feedings and before and after medication administration, initiated 11/19/23. -Enteral Feed order: Every shift flush feeding tube with (150 ml) of water every (4 hours), initiated 11/7/24. On 2/19/25 at 9:07 A.M., the surveyor observed Resident #111 lying in bed sleeping and the enteral feed machine was running. The surveyor observed two graduated clear plastic bags hanging from the IV pole, one bag had approximately 100 ml of a beige colored liquid remaining, and the second bag had approximately 300 ml of a clear liquid remaining. The surveyor observed that enteral feeding machine was connected to the Resident and set at 60 ml/hr with a total feed of 847 ml dispensed and time of 235 minutes remaining. The surveyor did not observe a label, date, and content on either of the two bags hanging on the IV pole and being administered to Resident #111. On 2/20/25 at 8:22 A.M., the surveyor observed Resident #111 lying in bed sleeping. The surveyor observed the enteral feed machine was running at 60 ml/hr, with a dispensed total of 905 ml of enteral feed and 195 ml remaining. The surveyor observed two graduated clear plastic bags hung from the IV pole and connected to the Resident, one bag contained a beige liquid and the second bag contained a clear liquid, and both bags did not have a label, date, and time they were hung. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 8:32 A.M., the surveyor and Nurse #6 observed Resident #111 lying in bed with the enteral feed machine running. During an interview at the time, Nurse #6 said that she typically works the 7:00 A.M. to 3:00 P.M. shift, and the Resident would already have the enteral feed running from prior shifts. Nurse #6 said that the enteral feeding is hung at 4 P.M. by the 3:00 P.M. to 11:00 P.M. shift and she would take the enteral feeding down around 10:00 A.M. when it was completed. Nurse #6 said that the rate of enteral feeding and water flushes are programmed by a Nurse into the enteral feed machine and Resident #111 received Jevity 1.5 at 60 ml/hr with automatic water flushes every 4 hours. The surveyor observed approximately 100 ml of beige liquid remaining in one of the graduated plastic bags, which Nurse #6 identified as Jevity product and the bag of clear liquid was identified as water for water flushes. Nurse #6 further said that Resident #111 usually has about 100 ml of the Jevity enteral feeding remaining at this time of day. Nurse #6 said she knew how much Jevity and water had been administered from the enteral feed machine which read that 905 ml had been administered with 195 ml remaining. Nurse #6 said that the water bag and Jevity bag were not labeled or dated, and should have been. Nurse #6 said that the nursing staff who hung the two bags should have dated and labeled the water and Jevity bags, but did not do so as required.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, and record review, the facility failed to provide respiratory care and services that were consistent with professional standards of practice, for one Resident (#246), out of a total sample of 36 residents. Specifically, for Resident #246, the facility failed to ensure that the Resident's nebulizer setup equipment was appropriately labeled and dated and stored in a storage bag to prevent equipment contamination. Findings include: Review of the facility policy titled Nebulizer Therapy, last reviewed November 2024, indicated the following: -the 11 P.M. to 7 A.M. (night) nursing shift will date and label the tubing and bag. After the equipment has dried, place it in the labeled and dated plastic bag for storage until next use. -equipment to be changed weekly by the 11 P.M. to 7 A.M. nursing shift. The nebulizer machine will also be cleaned weekly by the 11 P.M. to 7 A.M. nursing shift. -mask and bag are changed weekly by the 11 P.M. to 7 A.M. nursing shift or as needed. -documentation of equipment change will be on the resident's treatment sheet. Resident #246 was admitted to the facility in October 2024, with diagnoses including Alzheimer's and Asthma. Review of the Minimum Data Set (MDS) dated [DATE], indicated Resident #246: -was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of a total score of 15. -required supervision with Activities of Daily Living (ADLs) -was diagnosed with Asthma. Review of the Resident's Care Plan for Asthma, last revised 1/21/25, indicated: -the Resident will remain free from complications of Asthma through the review date. -give medications as ordered. Monitor/document side effects and effectiveness. -give nebulizer treatments and inhalers as ordered. Review of Resident #246's Physician's orders indicated the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ipratropium - Albuterol Solution 0.5 - 2.5 (3) milligrams (MG)/ 3 milliliters (ML), 3 ML inhale orally every 6 hours as needed for shortness of breath (SOB), CLE = Clear, ADV = Adventitious, DIM = Diminished [breath sounds], start date 10/1/24 -Change nebulizer mask or handheld piece, tubing and bag. Date and initial - include Resident's name on the bag, every night shift, every Saturday, start date 2/1/25. -Albuterol - Budesonide Inhalation Aerosol 90 - 80 micrograms (MCG)/actuation (ACT) (Albuterol - Budesonide), 2 puffs inhale orally every 6 hours as needed for shortness of breath and 2 puffs inhale orally in the morning related to Asthma, rinse mouth after use, start date 11/12/24. Review of the Resident's Medication Administration Record (MAR) for February 2025 indicated that the Resident received the Ipratropium - Albuterol inhalation treatment on 2/28/25. Review of Resident #246's Treatment Administration Record (TAR) for February 2025 indicated: >the nebulizer mask/handheld piece, tubing and storage bag had been changed >the storage bag had been dated, initialed, and included the Resident's name on the following Saturdays: -2/1/25 -2/8/25 -2/15/25 -2/22/25 On 2/19/25 at 9:52 A.M., the surveyor observed Resident #246's nebulizer tubing and handheld piece attached to the nebulizer machine was laying on an upholstered chair cushion in the Resident's room. The nebulizer setup and tubing were unlabeled/undated and was not stored in a bag. On 2/20/25 at 8:12 A.M., the surveyor observed that Resident #246's nebulizer, tubing and handheld piece were located on a shelf in a bedside table in the Resident's room. The nebulizer setup and tubing were unlabeled/undated and not observed in a storage bag. On 2/20/25 at 2:22 P.M., the surveyor and Nurse #1 observed Resident #246's nebulizer, tubing and handheld piece laying on a shelf in the bedside table in the Resident's room. The nebulizer tubing and handheld piece remained unbagged, unlabeled and undated. During an interview at the time, Nurse #1 said that it was important for the nebulizer tubing and handheld piece to be bagged as microorganisms can become an infection control problem if they are inhaled by the Resident. Nurse #1 also said that the equipment should be labeled and dated so that staff can know when the equipment was last changed, that the nebulizer equipment should be changed weekly, and it was not. During an interview on 2/20/25 at 3:32 P.M., the Director of Nursing (DON) said that the nebulizer tubing and handheld piece should be bagged when not in use. The DON also said that the nebulizer equipment should be labeled with a date and changed weekly.

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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. 44222 Based on observation, and interview, the facility failed to ensure that medications were stored in a secure manner in one medication storage room (Sacred Heart Unit) out of four medication storage rooms observed, out of a total of eight medication storage rooms. Specifically, the facility failed to ensure that only authorized personnel had access to the medication storage room where prescription medications were stored on the Sacred Heart Unit. Findings include: Review of the facility policy titled Medication Storage Safety, initiated 9/14/15, last reviewed/revised 11/2024, included but was not limited to: -The focus is the secure locking of the medication room on each unit. -The unit Nurses are responsible to maintain security of the medication room on their shift. -Each medication Nurse is informed of the need to keep the medication room Closed and Locked at all times. -Access to the medication room is by a key which is on the keychain of the Unit Nurse. On 2/20/25 at 9:15 A.M., the surveyor observed the Central Supply Manager (CSM) in the medication storage room on the Sacred Heart Unit. The CSM was observed standing inside the medication storage room with a cart of supplies propped in the doorway, holding the door open. The surveyor did not observe any other staff in the immediate area. During an interview at the time, the CSM said that he gained access to the medication storage room by unlocking the door with the key. The CSM said that he did not have the key, but Nurse #2 had given him the nursing key ring and he had unlocked the medication storage room door and then returned the keys to Nurse #2. The CSM said that he goes into the medication storage rooms unsupervised all the time to stock over-the-counter medications. The surveyor observed that the following medications were stored in the medication storage room: -prescription medication cards stored in bins on the counter. -two emergency medication kits (e-Kits) containing Narcan (opioid antagonist used to reverse the effects of opiates). -Anaphylaxis medications (used to treat allergic reactions). -a refrigerator containing Insulin (prescription medication used to treat diabetes). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/25 at 9:41 A.M., Nurse #2 said he had given his medication key ring to the CSM, so that the CSM could open the medication room door to stock the over-the-counter medications. Nurse #2 who was observed to be around the corner and out of sight of the medication room, said that the CSM brought the keys back to him after unlocking the medication room door. Nurse #2 said he realized afterward that he should not give his nursing key ring to anyone else who was not a Nurse. During an interview on 2/20/25 at 12:15 P.M., the Administrator said that the CSM should not have received the nursing keys from Nurse #2, and should not have been in the medication storage room unsupervised. The Administrator said that the only staff who should have access to the medication storage room were the Licensed Nurses that have the nursing keys and the Licensed Nurse management team.