STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225431	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Reading	1364 Main Street Reading, MA 01867

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48990 Based on observation, record review and interview the facility failed to provide a dignified existence for one Resident (#13) out of a total sample of 27 residents. Specifically, the facility failed to provide requested incontinence care before meals resulting in Resident #13 repeatedly eating breakfast while sitting in a soiled brief, on multiple days of survey, in a room that smelled strongly of feces. Findings include: Review of the facility policy titled Dignity/Quality of Life, revised 12/6/21, indicated: - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. - Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed by: promptly responding to the resident's request for toileting assistance. Resident #13 was admitted to the facility in June 2024 with diagnoses including diabetes and heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/11/24, indicated Resident #13 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. Review of the most recent comprehensive MDS assessment, dated 6/13/24, indicated Resident #13 triggered for incontinence and the care area assessment indicated a need to develop an incontinence care plan. Review of Resident #13's medical record failed to indicate a care plan had been developed for incontinence care. Review of Resident #13's Documentation Survey Report, dated 10/24/24 to 10/30/24, indicated Resident #13 was incontinent six out of the seven days. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 9:21 A.M., the surveyor observed Resident #13 in bed and the room smelled strongly of feces. Resident #13 said he/she was very upset because he/she had no choice but to sit in feces for the breakfast meal, which he/she had finished eating. Resident #13 said that staff were aware as he/she had told them before his/her breakfast tray came that he/she had a bowel movement and needed incontinence care. Resident #13 said that staff said they couldn't assist him/her because they were passing meal trays to other residents. Resident #13 said he/she had told staff many times over the last few months that he/she would like to have incontinence care before meals, but staff said they were unable to. On 10/30/24 at 7:45 A.M., the surveyor observed Resident #13 in bed and the room smelled strongly of feces . Resident #13 expressed being very upset because he/she had no choice but to sit in feces for the breakfast meal. Resident #13 said he/she had told staff but was told they could not provide incontinence care because it was during mealtime. Resident #13 said he/she had not had any incontinence care this shift and asked the surveyor to ask staff for assistance with incontinence care stating please, I don't want to eat breakfast in my own feces again. During an interview on 10/30/24 at 9:45 A.M., the surveyor observed Resident #13 tell Nurse #3 that he/she was tired of not having incontinence care provided before meals and during the night and that he/she had asked for it many times before. Resident #13 asked Nurse #3 to change the rule that residents were not allowed to have incontinence care during meals. Nurse #3 said she didn't think staff was allowed to provide incontinence care during meals, but that she would make sure staff assisted Resident #13 with incontinence care before meals. On 10/31/24 at 7:51 A.M., the surveyor observed Resident #13 in bed with breakfast tray. Resident #13 said he/she was upset and said he/she did not have a bowel movement yet this morning but was incontinent of urine and waiting for incontinence care to be provided that he/she had asked for before his/her breakfast tray arrived. During an interview on 10/31/24 at 9:15 A.M., CNA #5 said Resident #13 requires assistance with incontinence care and toileting needs and never refuses care. During an interview on 10/31/24 at 12:24 P.M., the Director of Nursing (DON) said that no resident should have to sit in a soiled brief for meals. Further, the DON said that she was aware that Resident #13 was upset about this exact concern in the past and had addressed the need for this Resident to have incontinence care provided promptly and before meals with staff, so this should not be happening to Resident #13.

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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. 48990 Based on observations, interviews and record review, the facility failed to notify the physician of a significant change in the resident's skin condition and obtain wound treatment orders for two Residents (#4 and #269) out of a total sample of 27 residents. Specifically; 1a.) for Resident #4, the facility failed to notify the provider and obtain wound care orders for the newly re-developed pressure ulcer on the left upper Achilles heel; 1b.) for Resident #4, the facility failed to notify the provider and obtain wound care orders for a skin tear on his/her left hand; and 2.) for Resident #269, the facility failed to notify the provider and obtain wound care orders for a skin condition on his/her buttocks. Findings include: Review of the facility policy titled Skin Body Audit, revised 3/12/13, indicated: - Any significant abnormal findings are reported to the resident's physician. 1.) Resident #4 was admitted to the facility in December 2023 with diagnoses including end stage renal disease and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/11/24, indicated Resident #4 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. This MDS indicated Resident #4 required partial/moderate assistance with transferring from bed to chair, moving from a sitting to a standing position, and with lower body dressing. This MDS also indicated the Resident had one deep tissue pressure injury (DTI) and was at risk for developing pressure ulcers. Review of Resident #4's plan of care related to potential for new skin breakdown, revised 9/19/24, indicated: - Resident #4 has the potential for new skin breakdown due to impaired mobility, episodes of incontinence, and diagnosis of type 2 diabetes. - Assist with turning/ redistributing weight per facility protocol. - Complete skin checks weekly per facility protocol. Pay particular attention to the bony prominences. - Notify MD if any skin breakdown occurs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.) Review of Resident #4's assessment titled Weekly Skin Checks, dated 10/18/24, failed to indicate a pressure related wound on his/her left upper Achilles heel. Review of Resident #4's current physician's orders indicated: - Wound: left medial heel (the inner side of the heel below the Achilles heel), apply skin prep to area daily. Review of Resident #4's medical record failed to indicate the provider had been notified or that wound orders were obtained for his/her left upper Achilles heel unstageable pressure ulcer within the last three months. During an interview on 10/31/24 at 8:09 A.M., Resident #4 said he/she likes his/her heels elevated because of the wound on his/her left heel. During an interview on 10/31/24 at 8:33 A.M., Nurse #2 said she was a consistently assigned day shift nurse for Resident #4 during the last two weeks. Nurse #2 observed Resident #4's heels with the surveyor and said there was an unstageable pressure ulcer on his/her left upper Achilles heel that had been there since she started two weeks ago. Nurse #2 said there is no treatment in place for the pressure ulcer on left upper Achilles heel. Nurse #2 said she applies skin prep (a topical medication used to prevent skin breakdown) to the medial aspect of the heel only and never applies to the pressure ulcer on left upper Achilles heel because there is no order for it to be applied to that anatomical location. Nurse #2 said she never notified the provider or obtained wound orders because it had been there since she started. During an interview on 10/31/24 at 10:48 A.M., Nurse Unit Manager #1 said Resident #4 had a history of a having a healed pressure ulcer on the left upper Achilles heel, which healed in the Spring of 2024. Nurse Unit Manager #1 observed Resident #4's left upper Achilles heel and said there is now an unstageable pressure ulcer that she was unaware of. Nurse Unit Manager #1 said the order for skin prep to the left medial heel does not cover the left upper Achilles heel, and the provider should have been notified to obtain wound treatment orders, but had not been. During an interview on 10/31/24 at 12:30 P.M., the Director of Nursing (DON) said the provider should have been notified of the newly re-developed left upper Achilles heel unstageable pressure ulcer and wound orders should have been obtained. b.) Review of Resident #4's progress notes, assessments, and physician notes fail to indicate the presence of wound on his/her left hand. Review of Resident #4's medical record failed to indicate the provider had been notified or that wound orders were obtained for his/her left hand wound in the last month. On 10/29/24 at 9:01 A.M., and 10:34 A.M., 10/30/24 at 7:37 A.M., 9:16 A.M., and 10:01 A.M., and 10/31/24 at 8:09 A.M., the surveyor observed Resident #4 in bed with a white undated dressing on his/her left hand. There was dark brown drainage visible through the dressing in the same location during each observation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 8:09 A.M., Resident #4 said staff applied the dressing to his/her hand because he/she bumped the left hand on a door last week. Resident #4 said he/she was still wearing the original dressing from when the incident occurred. During an interview on 10/31/24 at 8:28 A.M., Certified Nurse Assistant (CNA) #7 said Resident #4 had a dressing on his/her right hand since at least Monday (10/28/24). During an interview on 10/31/24 at 8:33 A.M., Nurse #2 said all wound dressings require orders from the physician. Nurse #2 reviewed Resident #4's physician's order and said there was no physician's order for the dressing on his/her left hand but there should be. On 10/31/24 at 10:48 A.M., the surveyor observed Resident #4's left hand with Nurse Unit Manager #1. There was a new dressing in place, dated 10/31/24. Nurse Unit Manager #1 said she had just changed the dressing because she realized Resident #4 did not have an order in place. Nurse Unit Manager #1 said the physician had not been notified to obtain wound orders but should have been. During an interview on 10/31/24 at 12:21 P.M., the Director of Nursing (DON) said the provider should have been notified to obtain wound orders at the time the wound was identified, as all treatments require a physician's order. 2.) Resident #269 was admitted to the facility in October 2024 with diagnoses including diabetes and a right arm fracture. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/27/24, indicated Resident #269 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 14 out of 15. The MDS indicated that Resident #269 did not have any wounds. Review of Resident #269's Admission/ Readmission Nursing Assessment, dated 10/21/24, indicated the Resident had a pressure wound on his/her buttocks upon admission. Review of Resident #269's assessments titled Weekly Skin Checks, dated 10/22/24 and 10/28/24, indicated - Right and left buttock pressure wounds. Review of Resident #269's assessment titled Weekly Skin Checks, dated 10/30/24, indicated: - Reddish, darkened discoloration of inner right and left buttock and perianal area. Areas non-blanchable and non-painful. Review of Resident #269's medical record failed to indicate the provider had been notified of the wounds or that wound orders were obtained for his/her right and left buttocks and/or perianal area. During an interview on 10/30/24 at 9:38 A.M., Nurse Unit Manager #1 said the nurse told her on 10/28/24 that upon admission on 10/21/24 Resident #269 had two pressure areas on his/her buttocks. Nurse Unit Manager #1 said she had not had a chance to investigate yet and that there were no wound orders in place for the buttocks. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 9:48 A.M., the surveyor observed Resident #269's buttocks and perianal area with Nurse Unit Manager #1 and the MDS Nurse. The buttocks and perianal area were discolored deep purple/red. Nurse Unit Manager #1 and MDS Nurse said they did not believe it was pressure related because the discoloration extended throughout the entire perianal area and were unsure what they would describe this wound to be. During a follow-up interview on 10/30/24 at 10:05 A.M., Nurse Unit Manager #1 said she was not sure what type of wound this was but that the physician should have been notified of the skin condition on admission and wound orders should have been obtained, such as a topical cream or offloading, but were not. During an interview on 10/31/24 at 12:21 P.M., the Director of Nursing (DON) said the provider should have been notified of Resident's buttocks/perianal wound and wound orders should have been obtained. Refer to F686.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48990 Based on interview, record review, and policy review, the facility failed to ensure one Resident's (#31) grievances were addressed, out of 27 total sampled residents. Specifically, the facility failed to follow their grievance policy when Resident #31 expressed concern multiple times about the staff behavior of sleeping while on duty. Findings include: Review of the facility policy titled Grievances/Concerns, revised 12/6/21, indicated: - Residents or their representatives may file a grievance or complaint concerning treatment, medical care, behavior of other residents, or staff members. Employees of the facility will assist residents and their representatives in the grievance/complaint process when such requests are made. - Grievances/concerns may be submitted orally or in writing. The person/staff receiving an oral grievance/concern will fill out the Grievance/Concern Form for submission to leadership. - The grievance/concern investigation will be initiated upon receipt and a written report/resolution will be made available to the Administrator within five (5) days. - Grievances/Concerns will be recorded in the Grievance Log. Grievance/Concern forms will be kept for a minimum of three (3) years. Resident #31 was admitted to the facility in September 2023 with diagnoses including end stage renal disease and hypotension. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/24/24, indicated Resident #31 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. On 10/29/24 at 8:03 A.M., Resident #31 told the surveyor that there is an ongoing problem with staff sleeping during the night shift. Resident #31 said he/she has complained to the Director of Nursing (DON), a social worker who is no longer employed at the facility, many nurses, and Certified Nursing Assistants (CNAs) for close to a year. Resident #31 said when he/she continued to see staff sleeping instead of working over the summer he/she took a picture of the staff member sleeping. Resident #31 said after he/she complained to administration and showed them the picture, the social worker at the time, came to his/her room and asked him/her to delete the photograph. Resident #31 said that the staff member continued to be employed and sleep on the unit during the night. Resident #31 said he/she saw the staff member, who he/she had taken the picture of sleeping, again asleep in a chair in the hallway as recently as two weeks ago. Resident #31 said he/she again complained to the nurses on the floor about observing staff sleeping on the unit when it happened two weeks ago, but he/she feels like no matter how many times he/she complains it never gets resolved. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Grievance Log failed to indicate any grievances had been filed in the past year regarding Resident #31's complaints of staff sleeping on the unit instead of working. During the Resident Group interview on 10/30/24 at 10:03 P.M., six out of twelve residents were in attendance and reported that recently staff were sleeping when they were supposed to be working on the night shift. They said call lights do not get answered at night. Two of these residents had seen staff sleeping recently. - One resident said he/she came back from the hospital at night recently and two CNAs were sleeping on the unit. - Another resident said on Sunday morning he/she saw staff sleeping at 4:45 A.M. in the day room. During an interview on 11/1/24 at 6:32 A.M., CNA #9 said if a resident had a concern about staff behavior, such as sleeping, they would let the nurse know so they could follow up. CNA #9 said grievance forms are filled out by nurses. During an interview on 11/1/24 at 6:40 A.M., Nurse #4 said if a resident had a concern about staff behavior, such as sleeping, they would fill out a grievance form, which is kept at the nurse's station. During an interview on 10/30/24 at 1:28 P.M., the Director of Nursing (DON) said grievances forms should be completed when residents have complaints about inappropriate staff behavior, such as sleeping. The DON said she knew about the concerns Resident #31 had with staff sleeping and had spoken to him/her about his/her concerns. The DON said she had fired a few staff for sleeping at the time and thought the issue was resolved. The DON could not locate any grievance forms or investigations related to Resident #31's repeated concerns regarding a specific staff person sleeping. During an interview on 10/30/24 at 2:04 P.M., the Administrator said he would expect a grievance to have been completed for Resident #31 if he/she voiced concerns about staff sleeping.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41019 Based on record review and interview, the facility failed to follow their abuse policy for one Resident (#38) out of a total sample of 27 residents. Specifically, the facility did not implement the corrective actions after an abuse investigation was conducted. Findings include: Review of the facility policy titled Abuse Prohibition, dated 2/20/23, indicated the following: - Policy: Allegations of abuse will be reported promptly and thoroughly investigated. - The Administrator and Director of Nursing are responsible for investigating and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect, and/or misappropriation of property standards and procedures: - Implementation - Ongoing monitoring - Implementation of corrective actions and measures to prevent recurrence. Resident #38 was admitted to the facility in August 2022 with diagnoses including depression and unsteadiness on feet. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/4/24, indicated that Resident #38 had severe cognitive impairment. Review of the MDS indicated Resident #38 required substantial to maximal assist with transfers. Review of the incident report for Resident #38, dated 10/18/24, indicated a staff member alleged physical abuse by another nurse on Resident #38 when the staff member incorrectly transferred Resident #38. Review of the corrective measures for the allegation of abuse included updating the resident's care plan and follow up from the Social Worker for Resident #38. Review of the clinical record failed to indicate the care plan was updated or that the social worker assessed Resident #38 after an allegation of physical abuse. During an interview on 10/31/24 at 12:53 P.M., the Director of Nursing said that it was her fault for not updating the care plan, but that she provided education to staff. The Director of Nursing said she was not sure if the Social Worker followed up, but would find out. Review of the Social Worker's notes failed to indicate that a follow up occurred for Resident #38.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on record review and interviews, the facility failed to investigate allegations of neglect for two Residents (1a. discharged Resident #1 and 1b. discharged Resident #2) out of a total sample of 27 residents. Findings include: Review of the facility policy titled, Abuse Prohibition, dated as last revised 7/13/22, indicated the following: -Neglect - any failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. -Allegations of abuse will be promptly and thoroughly investigated. -The Administrator and Director of Nursing are responsible for investigation and reporting. -The investigation will begin immediately after reporting the actual or suspected incident. -Initiate the investigation using factual data. The investigation should be thorough with witness statements from staff, residents, visitors, and family members who may be interviewable and have information regarding the allegation. -The results of the investigation will be documented. -Conclusion must include whether the allegation was substantiated or not and what information supported the decision. The conclusion/summary must take into account an objective overview of the facts and a reason or basis for the decision, to substantiate or not substantiate the allegation. 1a. discharged Resident #1 was admitted to the facility in March 2024 with diagnoses including quadriplegia. Review of discharged Resident #1's most recent Minimum Data Set (MDS) dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated discharged Resident #1 was dependent on staff for toileting tasks. Review of the Grievance/Concern Form, dated 3/25/24 indicated the following: -Incontinence request for change. When (he/she) asked the aid (name) to change (him/her) that (he/she) was wet, (he/she) was told that they would change (him/her) when they go around and do everyone else later. -The Action Taken section of the grievance form was left blank. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Summary of Findings or Conclusions section of the grievance from said Incident was a miscommunication between the CNA (Certified Nursing Assistant) and the resident. 1b. discharged Resident #2 was admitted to the facility in September 2023 with diagnoses including congestive heart failure. Review of discharged Resident 2's most recent Minimum Data Set (MDS) dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated discharged Resident #2 required substantial/dependent. Review of the Grievance/Concern Form, dated 1/23/24 indicated the following: -Left without assistance to be put back to bed. I requested to be put back to bed more than 3 times each time I was told that I had to wait. I was in the chair for 9 hours. This is not the first time I was left in the chair for a long period of time. -Action Taken - spoke with CNAs on the unit - reviewed expectations. If issue arise that they are delayed, it needs to be communicated to the resident. Review of the Grievance/Concern Form, dated 3/29/24 indicated the following: -(he/she) did not get back to bed until PM. The 7-7 aid said (he/she) could get back to bed once the 2nd aid came. That did not happen and (he/she) is upset. -Action Taken - only listed the CNAs on duty. -Follow-Up - Educated staff regarding hoyer return to bed. Ask for help if necessary. -Additional steps - CNAs to be educated on customer service and patient care. Ask for assistance if necessary. During an interview on 10/30/24 at 1:27 P.M., the Director of Nursing (DON) said she has been responsible for handling the grievance in the building since the facility had been without a social worker for some months. The DON said she reads all grievances and if there is something she feels rises above the level of a grievance she would report this incident to the State Agency. The DON said she would consider it neglect if a resident was told to wait for incontinence care such as discharged Resident #1's grievance indicated. The DON also said it is not acceptable for any residents to wait for the next shift to be assisted back to bed. The DON said discharged Resident #2 was a bariatric resident and required up to three staff members at times to get back into bed. The DON said there may not have been enough staff at that time to assist the Resident. The DON said she looked at these grievances as more of a customer service concern. The DON said she may have paperwork on the follow-up she did with staff and would bring it to the surveyor. The DON was unable to provide any investigations for any of the three grievances listed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Reading	1364 Main Street Reading, MA 01867

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on observation, record review, and interview, the facility failed to develop a comprehensive person centered care plan and implement the plan of care for two Residents (#55 and #13) out of a total sample of 27 residents. Specifically: 1. for Resident #55, the facility failed to develop a Suicidal Ideation (SI) care plan, after vocalization of suicidal ideation, which resulted in the Resident attempted to commit suicide at the facility and; 2. for Resident #13, the facility failed to develop and implement a plan of care for incontinence. Findings include: The facility policy titled Comprehensive Care Plan, undated, indicated the following: - Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. - Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan. - The resident's comprehensive care plan is developed within seven (7) days of completion of the resident's comprehensive assessment (MDS) and no more than twenty-one (21) days after admission. 1. For Resident #55, the facility failed to develop a comprehensive person centered care plan for a Resident who admitted with a recent history of verbalizing Suicidal Ideation (SI). Resident #55 had another incidence of verbalizing SI and the facility failed to develop a plan of care related to SI, which resulted in an attempted suicide in December 2023. The facility policy titled Suicide Threats, dated 12/6/21, indicated the following: PURPOSE: To ensure residents that make suicide threats have timely intervention to ensure safety. POLICY: Resident suicide threats shall be taken seriously and addressed appropriately. PROCEDURE: - If the resident remains in the facility, the resident will remain on 1:1 observation. Staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined and documented that a risk of suicide does not appear to be present. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the facility assessment, reviewed 7/25/24, indicated the facility is able to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care for someone with cognitive impairment, care for individuals with depression, trauma/PTSD, other psychiatric diagnoses, and intellectual or developmental disabilities. The facility is able to care for and implement nonpharmacological interventions. On average, the facility manages about 40-65 residents with behavioral health needs at a time. Resident #55 was admitted to the facility in February 2023 and had diagnoses that include depression and dementia. Review of the Nurse Practitioner's admission note indicated that Resident #55 had a question of some passive suicidal ideation, reporting that he/she feels useless and cannot do much. Review of the admission Minimum Data Set (MDS) assessment, dated 2/23/23, indicated Resident #55 scored a 13 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of the Mood Interview indicated Resident #55 self-reported a PHQ9 score of 5, which indicates mild depression (score of 0-4=minimal depression, 5-9=mild depression). Review of the Resident's hospital discharge paperwork, given to the facility upon admission, indicated: -Resident's daughter states that her father/mother has been dosing [sic] some passive suicidal ideations, without any plans. I had asked patient about this as well, he/she does not have any active plans. He/she states that he/she feels 'useless and that he/she cannot do much'. He/she states that when it is time to go just let him/her go. He/she does not have any active plans, especially in the hospital. He/she states that he/she has been seeing things that other people may not see. DC instructions included: Patient does not have active SI and will not act upon thoughts. Therefore, I don't think he needs a 1:1 or safety tray at this time. Again, it may be reasonable to obtain psych consult for med recommendations for some of patient's hallucinations. At the time of admission to the facility, a psychosocial well-being care plan was developed for Resident #55 and indicated the following: Focus: Resident #55 has a potential for psychosocial well-being problem r/t Inability to meet role expectations, Recent Admission and current COVID status (initiated 2/15/23). Interventions: -Consult with: Pastoral care, Social services, Psych services, Other: (initiated 2/15/23) -Increase communication between resident/family/caregivers about care and living environment: Explain all procedures and Treatments, Medications, Results of labs/tests, Condition, All changes, Rules, Options. (initiated 2/15/23) -Initiate referrals as needed or increase social relationships: Invite and encourage Resident #55 to participate in activities. (initiated 2/15/23) (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	-Monitor/document residents feelings relative to (isolation, unhappiness, loss). (initiated 2/15/23) -Provide opportunities for I and family to participate in care. (initiated 2/15/23) -Provide support to Resident #55 in setting realistic goals. (initiated 2/15/23) -When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. (initiated 2/15/23) Review of Resident #55's other comprehensive care plans failed to indicate a care plan was developed for the Resident's history of suicidal ideation (SI), interventions related to the safety of Resident #55, or nonpharmacological interventions to manage thoughts of suicidal ideation. Review of the progress note, dated 8/5/23, indicated: Resident sent out at 7 PM for suicidal ideations w/ active plan. Reported to this writer that today was going to be his/her last day here i'm going out one way or another. Resident reported that he/she wants to end his/her life today and has a plan to do so. Resident declined to tell this writer what the plan is but repeatedly stated Anyway I can I'm getting it done tonight, there's lots of ways to do it. This writer stayed with resident and discussed further, Resident #55 voiced frustration with being in a LTC (long term care) facility and that at his/her age he/she should be able to end his/her life if he/she wants. Resident #55 further voiced being alone pertaining to his/her children and that they lied to get him/her here and now he/she is stuck. Resident #55 was teary eyed when discussing and also voiced concerns about his/her financial status and he/she feels his/her daughter lied to him/her and took over his/her money after agreeing placement here was only going to be temporary. This writer was able to talk with Resident #55 and he/she agreed to a hospital evaluation this evening d/t (due to) his/her current thoughts. He/she remained adamant about ending his/her life t/o (throughout) the conversation and was placed on a 1:1 (one to one supervision) until EMT's arrived for transport. Left in stable condition via stretcher accompanied by 2 EMT's, 2 police officers and local fire department. MD aware. HCP aware. (sic) Review of the hospital progress note, dated 8/5/23, indicated a Behavioral Health Crisis Consult-Initial Assessment: Reason for Consult: Patient made suicidal statement. According to the assessment presented to the hospital on 8/5/23, for Psychiatric evaluation. Behavioral health is consulted after he/she made suicidal statement, per staff from nursing home (Nurse named) patient told her that he/she is going to kill him/herself and did not share any specific plan, but patient denies making this specific statement. The trigger includes that the patient doesn't want to stay at the nursing program and he/she said that he/she wants to stay at his/her home. According to the assessment Resident #55 denied SI and then said that if he/she could get his/her hands on a gun then he/she would kill him/herself. Resident did not meet inpatient criteria and was to send back to the nursing facility with no new orders. Review of the clinical record failed to indicate that, upon readmission to the facility, Resident #55's plan of care was reviewed or updated, despite Resident #55's vocalization of suicidal ideation in the hospital and a section 12. The facility failed to develop a care plan related to suicidal ideation, that included nonpharmacological interventions, and interventions related to resident safety. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Behavioral Health Group note for medication management, dated 8/9/23, indicated: Patient can benefit from: Behavior mgmt; Psychiatric meds. Review of the record failed to indicate any changes were made to the plan of care at that time to include behavioral management interventions. Review of the social service progress note, dated 10/16/23 indicated: On this date, SS met with resident and offered emotional support as resident is grieving the death of his friend. SS provided active listening and validated resident's feelings. SS reminded the resident to reach out with any additional support needed. SS to remain in place for continued support and advocacy. Review of the record fails to indicate any changes were made to the plan of care at that time to address this loss, psychosocial stressors, or potential for SI. Review of the Behavioral Health Group note for medication management, dated 10/18/23, indicated Resident #55 was seen by the Psych NP due to increased anxiety and paranoia with recommendation to increase Buspar from 5mg to 10 mg BID for anxiety/agitation. Treatment Plan (completed today): Treatment Goal / Personal Family Vision: rt will remain stable with mood/behaviors Goals: 1. Problem: anxiety - Short Term Goals: client/staff will report no more than 1-2 episode of anxiety per day - Long Term Goals: client/staff will report no more than 2-3 episode of anxiety per week. Client unable to review treatment plan due to cognitive deficit. Review of the record failed to indicate that the recommended treatment plan was communicated to staff, implemented or tracked. Review of the behavior monitoring sheets since admission failed to indicate that the facility was monitoring for any change in Resident #55's daily mood and depression. Review of the progress note dated 12/18/23 indicated: During dinner this evening patient ambulated out to the second floor balcony, climbed up on a chair and attempted to jump off the balcony. Maintenance manager witnessed patient during this attempt and pulled him/her to safety. Patient became extremely agitated screaming at manager for stopping him/her. Patient returned to his/her room with a sitter . Patient continued making suicidal ideations stating I will try and try until I succeed .FD (fire department) transported patient to hospital .etc. Review of the clinical record indicated Resident #55 was psychiatrically hospitalized [DATE]-[DATE]. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the clinical record failed to indicate that upon readmission to the facility, Resident #55's plan of care was reviewed or updated, despite Resident #55's suicide attempt on 12/18/23. The record indicates that an SI care plan was developed on 1/9/24, 4 days after readmission to the facility. The SI care plan developed on 1/9/24 indicated the following: FOCUS: Resident #55 has a mood problem r/t dx's (diagnoses) of Depression and Anxiety d/o (disorder), as well as recent re-admission. He/she has also had a recent suicide attempt, more specifically on 12/18/23 where he attempted to jump off the facility balcony. INTERVENTIONS: -Start 1/9/24: Administer medications as ordered. Monitor/document for side effects and effectiveness. -Start 1/9/24: Assist I (individual) in developing /Provide I with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity. -Start 1/9/24: Assist I, family, caregivers to identify strengths, positive coping skills and reinforce these. -Start 1/9/24: Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) -Start 1/9/24: Educate I/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. -Start 1/9/24: Resident #55 needs encouragement to maintain as much independence and control as possible. Resident #55's strength's are: (he/she is. strong advocate for him/herself, he/she can ask for help, can express feelings etc.) -Start 1/9/24: Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. -Start 1/9/24: Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. -Start 1/9/24: Monitor/record/report to MD (physician) prn (as needed) acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills -Start 1/9/24: Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behavior monitoring protocols. -Start 1/9/24: Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	-Start 1/9/24: Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity. Review of a progress note dated 3/17/24: Receptionist informed nurse that she delivered a package to resident and offered to open package for resident. Resident said yes. Package was a plastic and when receptionist offered to throw it away resident stated no, I'm [NAME] to put it over my head.Resident refuse to give the plastic, was adamant but not aggressive. This nurse approached resident and sat on the bed beside resident and gently asked for the bag. Resident laughed and stated I was joking; I want to use it for trash This nurse explained to resident why the bag needed to be taken resident laughed and stated you don't want to go to my funeral? this nurse stated No sir Resident apologized stating the joke was in poor taste and handed the bag over to this nurse. Resident was pleasant, kind, and calm. Night shift staff made aware to keep an eye of resident for any further remarks or behaviors. Review of the record failed to indicate any changes had been made to Resident #55's plan of care, care plan, or that notification to the Physician, NP or family occurred after the Resident verbalized SI. Further review failed to indicate that the facility's policy regarding SI was implemented. Review of the record failed to indicate that the physician was aware or addressed Resident #55's suicidal ideation in March 2024. During an interview on 10/30/24 at 12:19 P.M., with the facility Social Worker (SW) #1 she said that she has worked at the facility for 2 months. She said that if a resident admits to the facility with a history of verbalizing SI, whether remote or recent, she would meet with the resident upon admission and determine the history in order to develop a person centered care plan. SW #1 said that for any resident that voices SI while at the facility, or if they are hospitalized for SI while at the facility, she would review the care plan and update it when this occurs. SW #1 said that she is the only social worker in the building and that she does not know Resident #55 and that she was not aware that he/she had attempted to commit suicide while residing at the facility. SW #1 said that she would expect to have been told thus so that she could have ensured a plan of care, including nonpharmacological interventions, was in place for Resident #55. During an interview on 10/30/24 at 12:35 P.M., with the Nurse Unit Manager #1 she said that she has been the nurse unit manager for 7 years and knows Resident #55 well. According to Nurse Unit Manager #1, a comprehensive care plan regarding Resident #55's SI should have been developed at admission and she is not sure why it was not. She said that it is the expectation that the team continuously update all SI care plans with any changes in SI status. Nurse Unit Manager #1 said that while she could not recall the SI in August 2023, that at that time an SI care plan should have already been in place and would have been reviewed and updated. During an interview on 10/31/24 at 12:34 P.M., with Resident #55's Physician he said that it is his expectation that the facility would develop and implement a care plan, that includes nonpharmacological interventions, for all residents with a history of SI. The physician said that he was under the impression that Resident #55 was being followed closely by the facility's Social Worker and was surprised to hear that the Social Worker learned only the day prior from the surveyor that Resident #55 had both a history of verbalizing SI and of an actual suicide attempt at the facility. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/31/24 at 1:01 P.M., the Director of Nursing said when a resident is admitted with a history of suicidal ideation, they should be assessed upon admission, and a care plan should be developed that includes nonpharmacological interventions to keep the Resident safe. The DON said that the care plan should be followed and updated any time the resident voices SI or requires intervention related to SI. The DON was surprised to learn that the current facility social worker was unaware that Resident #55 had a history of SI and actual suicide attempt at the facility, and would have expected that to have been important information for her to receive when she was trained 2 months prior. 48990 2. Resident #13 was admitted to the facility in June 2024 with diagnoses including diabetes and heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/11/24, indicated Resident #13 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. Review of the most recent comprehensive MDS assessment, dated 6/13/24, indicated Resident #13 triggered for incontinence and the care area assessment indicated a need to develop an incontinence care plan. Review of Resident #13's medical record failed to indicate a care plan had been developed for incontinence care. Review of Resident #13's Documentation Survey Report, dated 10/24/24 to 10/30/24, indicated Resident #13 was incontinent six out of the seven days. On 10/29/24 at 9:21 A.M., the surveyor observed Resident #13 in bed and the room smelled strongly of stool. Resident #13 said he/she was incontinent, and that staff were aware. Resident #13 said he/she had told staff many times over the last few months that he/she would like to have incontinence care before meals, but staff said they were unable to. Resident #13 said that the staff change him/her after breakfast. On 10/30/24 at 7:45 A.M., the surveyor observed Resident #13 in bed and the room smelled strongly of stool. Resident #13 expressed being very upset because he/she had no choice but to sit in feces for the breakfast meal. Resident #13 said he/she had told staff but was told they could not provide incontinence care because it was during mealtime. Resident #13 said he/she had not had any incontinence care this shift and asked the surveyor to ask staff for assistance with incontinence care stating please, I don't want to eat breakfast in my own feces again. During an interview on 10/30/24 at 9:45 A.M., the surveyor observed Resident #13 tell Nurse #3 that she was tired of not having incontinence care provided before meals and during the night and that she had asked for many times before. Resident #13 asked Nurse #3 to change the rule that residents were not allowed to have incontinence care during meals. Nurse #3 said she didn't think staff was allowed to provide incontinence care during meals, but that she would make sure staff assisted Resident #13 with incontinence care before meals. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	On 10/31/24 at 7:51 A.M., the surveyor observed Resident #13 in bed with breakfast tray. Resident #13 said that she was incontinent of urine and waiting for incontinence care to be provided. Resident #13 said that he/she had asked for the care before the breakfast tray arrived, but that it had not occurred. During an interview on 10/31/24 at 9:15 A.M., Certified Nurse Assistant (CNA) #5 said Resident #13 requires assistance with incontinence care and toileting needs and never refuses care. CNA #5 said that although Resident #13 did not have any specific incontinence care interventions that she was aware of, that it was the facility expectation to provide incontinence care promptly when necessary. During an interview on 10/31/24 at 12:24 P.M., the Director of Nursing (DON) said the MDS Nurse was responsible for developing incontinence care plans that triggered on an MDS, but that nurses on the floor can also create and update care plans when needed. The DON said she was surprised there was no incontinence care plan or interventions in Resident #13's medical record as the Resident had been incessant about incontinence care not being provided. The DON said because of the Resident's past concerns with incontinence care she had told staff Resident #13 should have incontinence care before each meal, and that this is an intervention that should be on an incontinence care plan. During an interview on 11/1/24 at 8:42 A.M., the MDS Nurse said Resident #13's comprehensive MDS triggered for incontinence and that an incontinence care plan should have been developed but never was.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48990 Based on observations, interviews, and record review, the facility to ensure that services provided met professional standards for two Residents (#14 and #16), out of 27 total sampled residents. Specifically, 1a.) for Resident #14, the facility failed to transcribe and implement a daily wound dressing according to the physician's order for ten days. 1b.) for Resident #14, the facility failed to implement a daily wound dressing according to the physician's order for two days. 2.) for Resident #16, the facility failed to implement physician orders for heel protection booties. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility policy titled Wound Care, dated 2001, indicated: - Verify there is a physician's order for this procedure. 1.) Resident #14 was admitted to the facility in June 2024 with diagnoses including diabetes and venous ulcers. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/18/24, indicated Resident #14 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. 1a.) Review of wound consultant physician progress notes, dated 10/21/24 and 10/28/24, indicated Resident #14's non-pressure wound of the right, upper, lateral buttock had a dressing treatment plan for: - Xeroform (a type of wound dressing) gauze apply once daily. - Tape (retention) apply once daily. - ABD pad (a type of wound dressing) apply once daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's medical record failed to indicate any wound treatment orders were implemented for the right upper lateral buttock. On 10/29/24 at 8:27 A.M., the surveyor observed Resident #14 in bed wearing only incontinence brief. There was a large wound with multiple scabbed, oozing ulcerations surrounded by a discolored rash-like area. Resident #14 said he/she has had that wound for a long time and there is supposed to be a dressing on it, but the nurses never apply one. During an interview on 10/31/24 at 8:16 A.M., Certified Nurse Assistant (CNA) #5 said Resident #14 has a wound on his/her right upper buttock that does not have a dressing. During an interview on 10/31/24 at 8:58 A.M., CNA #6 and CNA #8 showed the surveyor Resident #14's right upper lateral buttock wound and said sometimes the nurse sometimes puts a dressing on. During an interview on 10/31/24 at 12:49 P.M., Nurse #1 said there is no physician's order for a treatment to Resident #14's right upper lateral buttock wound. During an interview on 10/31/24 at 1:29 P.M., Nurse Unit Manager #1 said Resident #14 is followed by the consultant wound physician for his/her right upper lateral buttock wound. Nurse Unit Manager #1 said the physician expects the nurses to accept, transcribe, and implement all consultant wound physician orders for treatment of wounds. Nurse Unit Manager #1 said she printed the wound treatment orders, dated 10/21/24 and 10/28/24, for Resident #14's right upper lateral buttock wounds, but didn't get a chance to transcribe the orders to apply xeroform, tape, and ABD pad but should have. During an interview on 11/1/24 at 8:52 A.M., the Director of Nursing (DON) said the nurses should accept, transcribe, and implement all consultant wound physician orders for treatment of wounds because the facility physicians defer all wound care treatment to the consultant wound physician. The DON said Resident #14's right upper lateral buttock wound should have been transcribed and implemented but was not. 1b.) Review of Resident #14's physicians order, initiated 7/30/24, indicated: - Cleanse BLE (bilateral lower extremities) with Ns (normal saline, a sterile saltwater solution used to cleanse wounds), pat dry, apply xeroform and kling daily and as needed, every day shift for venous stasis ulcers. On 10/29/24 at 8:27 A.M., the surveyor observed Resident #14 in bed with no dressing on his/her right lower extremity and a dressing, which was dated 10/28/24, on his/her left lower extremity. Resident #14 said the nurses often don't offer to change his/her dressings. On 10/31/24 at 12:49 P.M., the surveyor observed Nurse #1 perform wound care for Resident #14's left calf. Nurse #1 said his/her right calf was not weeping so it did not require a dressing, but the nurse would apply as if necessary. Nurse #1 confirmed that the dressing on Resident #14's left calf was dated 10/28/24, which meant the dressing had not been changed the last two days on 10/29/24 or 10/30/24. Nurse #1 said the left calf dressing should have been changed daily as ordered but had not been. Nurse #1 said if Resident #14 had refused it should have been documented as refused, but she had not heard that he/she had refused any dressings in report. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's Treatment Administration Record (TAR), dated 10/29/24 and 10/30/24, indicated the wound treatment order for his/her bilateral lower extremity had been implemented. Review of Resident #14's medical record, dated 10/29/24 and 10/20/24, failed to indicate any refusal or rationale for bilateral lower extremity treatment orders not being implemented. During an interview on 11/1/24 at 8:52 A.M., the Director of Nursing (DON) said if a wound dressing is ordered to be changed daily, it should have been changed daily. The DON said if Resident #14 had refused the dressing change it should have been documented as refused and should never have been documented as implemented if it was not. 41019 2. Resident #16 was admitted to the facility in May 2018 with diagnoses including dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/2/24, indicated Resident #16 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of the MDS indicated Resident #16 was dependent on staff for lower body dressing and hygiene. Review of Resident #16's current physician orders indicated the following: - Please apply foot protection booties while in bed, remove for skin checks and patient care. (initiated 4/10/2023) During an observation on 10/29/24 at 9:26 A.M., Resident #16 was in bed without heel protection booties on. His/her heels were touching the bed. During an observation on 10/30/24 at 9:36 A.M., Resident #16 was in bed without heel protection booties on. His/her heels were touching the bed. During an observation on 10/31/24 at 8:19 A.M., Resident #16 was in bed without heel protection booties on. His/her heels were touching the bed. During an interview on 10/31/24 at 8:22 A.M., Nurse Unit Manager #1 said that the staff should be following the physician's orders and applying the foot protection booties when Resident #16 is in bed. AS well, she said that if a Resident refuses to wear the booties, then the refusal should be documented in the medical record. Nurse Unit Manager #1 said Resident #16 does refuse the booties sometimes, but staff should document that. Review of the clinical record failed to indicate Resident #16 refused his/her booties.

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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. 41456 Based on observations, record review and interviews, the facility failed to provide Activity of Daily Living (ADL) care to three Residents (#44, #14 and #54), by failing to provide weekly showers, out of a total sample of 27 residents. Findings include: During resident group meeting on 10/30/24 at 10:03 A.M., 6 of the 10 participating members said the facility does not provide weekly showers and it has been a persistent problem at the facility. Of the six residents, Resident #44, #14 and #6 were very vocal about their desires to have a shower to feel better. 1. Resident #44 was admitted to the facility in March 2024 with diagnoses of acute respiratory failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/4/24, indicated Resident #44 had a Brief Interview of Mental Status exam score of 15 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated Resident #44 was dependent on staff for shower/bathing tasks. During an interview on 10/31/24 at 8:02 A.M., Resident #44 said taking a shower is difficult because of his/her medical and mobility issues, however he/she would love a shower because it makes me feel good. Review of the shower schedule on the floor indicated Resident #44 is scheduled to have showers on Saturdays. Review of the Documentation Survey Report, indicated Resident #44 has had only one shower in the months of August, September and October 2024. Review of Resident #44's ADL care plan indicated the following intervention: -Staff will continue to provide support/assist needed for mobility/ADL completion. During an interview on 10/31/24 at 8:10 A.M., Certified Nursing Assistant (CNA) #2 said all residents are offered weekly showers. CNA #2 said Resident #44 is able to tell you when he/she wants a shower and the staff provide the shower upon Resident #44's request. CNA #2 said if a resident refuses a shower, the CNAs tell the nurse and the nurse will write a note of refusal. During an interview on 10/31/24 at 8:25 A.M., the Director of Nursing (DON) said all residents are showered 1-2 times a week or as requested/needed. The DON said she was aware residents had not been receiving regular showers months ago, however thought the issue was resolved. The DON said Resident #44 will often refuse showers, however if a refusal occurs the nurse is expected to document the refusal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's medical record failed to indicate the Resident refused showers. 2. Resident #14 was admitted to the facility in June 2024 with diagnoses which included chronic respiratory failure. Review of Resident #14's most recent Minimum Data Set (MDS) assessment, dated 9/18/24, indicated Resident #14 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated Resident required substantial assistance for bathing/showering tasks. During an interview on 10/31/24 at 7:59 A.M., Resident #14 said he/she has not had a shower in a very long time and would like to have one because it would make me feel human. Review of the shower schedule indicated Resident #14 is scheduled for showers on Tuesdays. Review of the Documentation Survey Report, indicated Resident #14 has not had any showers in the months of August, September and October 2024. Review of Resident #14's ADL care plan failed to indicate an intervention that addressed the Resident's shower needs or level of assistance. During an interview on 10/31/24 at 7:51 A.M., Certified Nursing Assistant (CNA) #1 said Resident #14 requires full assistance from staff for all bathing needs and he/she typically gets washed up in bed and then hoyered out of bed into his/her chair. CNA #1 said Resident #14 requires a bariatric shower chair and a lot of people to shower so he/she usually just gets a bed bath. CNA #1 was unable to say when Resident #14 last had a shower. During an interview on 10/31/24 at 8:23 A.M., Nurse Unit Manager #1 said all residents are offered 1-2 showers a week. Nurse Unit Manager #1 said nurses will document any refusals of showers. During an interview on 10/31/24 at 8:25 A.M., the Director of Nursing (DON) said all residents are showered 1-2 times a week or as requested/needed. The DON said she was aware residents had not been receiving regular showers months ago, however though the issue was resolved. The DON said Resident #14 will often refuse showers, however if a refusal occurs the nurse is expected to document the refusal. Review of Resident #14's medical record failed to indicate the Resident refused showers. 41019 3. Resident #54 was admitted in October 2022 with diagnoses including cerebral palsy and muscle weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/25/24, indicated Resident #54 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of the MDS indicated Resident #54 was dependent on staff for activities of daily living. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 10/29/24 at 9:15 A.M., Resident #54 said he/she hasn't had a shower in 2 years and would like to be showered. Resident #54 was in bed with greasy hair that looked unwashed. During an interview on 10/31/24 at 7:51 A.M., the Minimum Data Set (MDS) Nurse said showers are documented in the electronic medical record. Review of the Documentation Survey Report for October 2024 indicated Resident #54 did not receive a shower for the month of October 2024. Review of the Documentation Survey Report for September 2024 indicated Resident #54 received a shower only once, on September 18th. Review of the assignment sheets for the unit indicated Resident #54 was supposed to have a shower on Mondays and Thursdays every week. During an observation on 10/31/24 at 8:08 A.M., the day after Resident #54's scheduled shower day, Resident #54 said he/she had never received a shower for the week. During an interview on 10/31/24 at 8:25 A.M., the Director of Nursing (DON) said all residents are showered 1-2 times a week or as requested/needed. The DON said she was aware residents had not been receiving regular showers months ago, however though the issue was resolved. Review of Resident #54's medical record failed to indicate the Resident refused showers.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review, and interviews, the facility failed to ensure services to maintain hearing were implemented for one Resident (29), out of a total sample of 27 residents. Specifically, the facility failed to implement the treatment for ear wax removal timely resulting in a delay in the process of obtaining hearing aids. Findings include: Resident #29 was admitted to the facility in February 2022 with diagnoses including essential tremor, epilepsy, and cognitive communication deficit. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #28 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having intact cognition, and has minimal difficulty hearing-difficulty in some environments and does not use a hearing appliance or hearing aid. During an interview on 10/29/24 at 8:51 A.M., Resident #29 said he/she had not seen the audiologist and has been fighting for the past year for hearing aids, and staff say they are working on it. On 10/31/24 at 10:56 A.M., Resident #29 was observed resting on his/her bed and did not respond to the surveyor's greeting. On 10/31/24 at 1:30 P.M., Resident #29 was in his/her room. Resident #29 responded to the surveyor's louder tone. During an interview on 10/31/24 at 12:12 P.M., Nurse #5 said the Resident can communicate with staff okay. Nurse #5 said if the audiologist recommends ear wax removal an order is obtained for Debrox (a product used to remove ear wax). Review of Resident #29's medical record indicated the following: -A physician's order dated 2/17/22 Podiatry, audiology, dental, ophthalmology consult as needed. -A facility fax cover sheet dated 4/29/24 with a consent dated 3/25/22 for audiology services and a note signed by the facility social worker; Resident has requested hearing aids. Review of the facility's consulting audiologist document with an exam date of 12/21/24 and signed by an audiologist indicated the following: Recommendations for attending M.D. (medical doctor)/Nursing Staff; Wax needs removal left ear; Wax needs removal right ear; Continue with Current Means of Communication: HealthDrive should be notified when the canals are cleaned so impressions can be taken for new hearing aids. Resident #29's medical record had no further audiology consultant documentation. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's physician's active and completed orders indicated: A physician's order Carbamide Peroxide Solution 6.5 % Instill 5 drops in both ears two times a day for wax removal for 4 days, start date 9/20/24 end date 9/24/24. Resident #29's ear wax removal, so he/she could have impressions taken for hearing aids was implemented nearly nine months after the recommendation was made. During an interview on 10/31/24 at 12:39 P.M., the Medical Records staff person said audiology comes in once a year or if a resident has a problem. During a subsequent interview on 10/31/24 at 1:21 P.M., the Medical Records staff person said a request was made in April for the Resident to have an audiology consult and were called recently after the Resident had ear wax removal. During an interview on 10/31/24 at 1:57 P.M., the Director of Nursing said if there is a recommendation made by the audiologist for ear wax removal the order should be obtained that day or the next day or so. The DON reviewed Resident #29's orders and said she did not see any order for ear wax removal prior to the September.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observations, interviews and record review, the facility failed to provide necessary treatment, services, interventions to promote healing and prevent new ulcers from developing for one Resident (#4), who was assessed to be at risk for pressure ulcer development, out of 27 total sampled residents. Specifically, for Resident #4: a.) the facility failed to implement physician ordered pressure ulcer prevention interventions to offload heels and ensure correct air mattress settings were implemented consistently resulting in new skin breakdown including the re-opening of a previously healed pressure ulcer on the left upper Achilles heel; b.) the facility failed to obtain wound care orders for the newly re-developed pressure ulcer on the left upper Achilles heel; c.) the facility failed to ensure a right heel pressure related deep tissue injury (DTI) was assessed and measured weekly; and d.) the facility failed to ensure the weekly skin assessments were completed and documented. Findings include: Review of the facility policy titled Pressure Ulcer Prevention, revised 12/22/22, indicated: - The facility will implement interventions to minimize and/or eliminate contributing factors for pressure ulcer development on patients/residents at risk. - A weekly body audit will be completed on residents. - Wounds will have weekly assessments and documentation of each area until healed. Review of the facility policy titled Skin Body Audit, revised 3/12/13, indicated: - Purpose: To identify changes in skin integrity through weekly skin audits (head to toe) on all residents. - Licensed nurses will perform skin body audits on a weekly basis. - Any significant abnormal findings are reported to the resident's physician. Resident #4 was admitted to the facility in December 2023 with diagnoses including end stage renal disease and diabetes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 9/11/24, indicated Resident #4 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. This MDS indicated Resident #4 required partial/moderate assistance with transferring from bed to chair, moving from a sitting to a standing position, and with lower body dressing. This MDS also indicated the Resident had one deep tissue pressure injury (DTI) and was at risk for developing pressure ulcers. During an interview on 10/31/24 at 12:35 P.M., The MDS Nurse said the DTI on the MDS, dated [DATE], was for Resident #4's right heel. Review of Resident #4's assessment titled Norton Scale for Predicting Risk of Pressure Ulcer, dated 9/20/24, indicated the Resident was at high risk for pressure ulcer development as evidenced by a score of 10. Review of Resident #4's assessment titled Weekly Skin Checks, dated 10/18/24, failed to indicate a pressure related wound on his/her left upper Achilles heel. Review of Resident #4's plan of care related to potential for new skin breakdown, revised 9/19/24, indicated: - Resident #4 has the potential for new skin breakdown due to impaired mobility, episodes of incontinence, and diagnosis of type 2 diabetes. - Assist with turning/ redistributing weight per facility protocol. - Complete skin checks weekly per facility protocol. Pay particular attention to the bony prominences. - Notify MD if any skin breakdown occurs. a.) The facility failed to implement physician ordered pressure ulcer prevention interventions to offload heels and ensure correct air mattress settings were implemented consistently, resulting in new skin breakdown including the re-opening of a previously healed pressure ulcer on the left upper Achilles heel, as evidenced by the following: Review of Resident #4's physician's orders indicated: - Offload both heels at all times, every shift, initiated 8/13/24. - Offload right heel with 2-3 pillows under calf or apply offloading boots at all times while in bed, every shift, initiated 8/13/24. - Low air loss mattress - settings at 250 lbs. (pounds) alternating pressure. Check function and setting each shift, initiated 8/13/24. Review of Resident #4's medical record failed to indicate any refusal or rationale for his/her heels not being offloaded or the air mattress being set at 200 lbs. (instead of 250 lbs.) alternating pressure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24 at 9:01 A.M. and 10:34 A.M., 10/30/24 at 7:37 A.M., 9:16 A.M., and 10:01 A.M., and 10/31/24 at 8:09 A.M. and 10:18 A.M., the surveyor observed Resident #4 in bed with his/her heels directly on the mattress without any pillows or offloading boots. Resident #4 was on an air mattress which was set at 200 lbs. alternating pressure (instead of 250 lbs.). During an interview on 10/31/24 at 8:09 A.M., Resident #4 said staff used to help offload his/her heels with pillows and offloading boots, but they haven't in a long time. Resident #4 said he/she isn't sure why staff doesn't help offload his/her heels anymore because he/she has a new left heel wound. Resident #4 said he/she would like to have his/her heels offloaded and would never decline because he/she thinks it would make his/her sore heels feel better. Resident #4 said his/her air mattress is often not comfortable. During an interview on 10/31/24 at 8:23 A.M., CNA (Certified Nurse Assistant) #6 said she was currently assigned to care for Resident #4 and was unaware his/her heels should be offloaded. CNA #6 said the CNAs are made aware of specific interventions through report from nurses and the care card. CNA #6 said the nurse never reported that Resident #4 needed to have heels offloaded and his/her care card had no interventions to offload heels. During an interview on 10/31/24 at 8:28 A.M., CNA #7 said he was previously assigned to care for Resident #4 recently and was unaware his/her heels should be offloaded. CNA #7 said the CNAs are made aware of specific interventions to prevent skin breakdown through report from nurses and the care card. CNA #7 said the nurse never reported that Resident #4 needed to have heels offloaded. CNA #7 reviewed Resident #4's care card with the surveyor and said there were no interventions listed to offload heels. During an interview on 10/31/24 at 8:33 AM, Nurse #2 said she was a consistently assigned day shift nurse for Resident #4 during the last two weeks. Nurse #2 said she was unaware his/her heels should be offloaded. Nurse #2 observed Resident #4's heels with the surveyor and said the right heel is dark red and probably had pressure related damage and there is an unstageable pressure ulcer on his/her left upper Achilles heel that had been there since she started two weeks ago. Nurse #2 said there is no treatment in place for the pressure ulcer on left upper Achilles heel. Nurse #2 said she applies skin prep (a topical medication used to prevent skin breakdown) to the medial aspect of the heel only and never applies to the pressure ulcer on left upper Achilles heel because there is no order for it to be applied to that anatomical location. During an interview on 10/31/24 at 10:48 A.M., Nurse Unit Manager #1 said Resident #4 needed to have his/her heels offloaded to prevent skin breakdown because he/she was at high risk for skin breakdown relating to a history of pressure wounds on both heels. Nurse Unit Manager #1 said Resident #4 has a DTI on the right heel and a history of a healed pressure ulcer on the left upper Achilles heel, which in spring 2024. Nurse Unit Manager #1 also said Resident #4 is on an air mattress to prevent the development of pressure ulcers and nurses should check to ensure the correct air mattress settings are in place each shift. Nurse Unit Manager #1 observed Resident #4's heels with the surveyor. Nurse Unit Manager #1 said Resident #4's right heel is a pressure related DTI and the left Achilles is a new unstageable pressure ulcer where a past pressure ulcer had previously healed in spring 2024. Nurse Unit Manager #1 said she was unaware the pressure ulcer had re-developed, and this is exactly why his/her heels needed to be offloaded. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/31/24 at 12:30 P.M., the Director of Nursing (DON) said Resident #4's heels should have been offloaded and the air mattress should have been set to correct settings, and if he/she refused it should be documented. The DON said the nurses are responsible for check air mattress settings each shift and if found not at the physician ordered setting then should be adjusted and/or clarified. b.) The facility failed to obtain wound care orders for a new pressure ulcer, as evidenced by the following: Review of Resident #4's physician's orders indicated: - Wound: left medial heel, apply skin prep to area daily, imitated 8/13/24. Review of Resident #4's current physician's orders failed to indicate any wound orders for the left upper Achilles heel. During an interview on 10/31/24 at 8:33 AM, Nurse #2 said she was a consistently assigned day shift nurse for Resident #4 during the last two weeks. Nurse #2 observed Resident #4's heels with the surveyor and said there is an unstageable pressure ulcer on his/her left upper Achilles heel that has been there since she started two weeks ago. Nurse #2 said there is no treatment in place for the pressure ulcer on left upper Achilles heel. Nurse #2 said she applies skin prep (a topical medication used to prevent skin breakdown) to the medial aspect of the heel only and never applies to the pressure ulcer on left upper Achilles heel because there is no order for it to be applied to that anatomical location. During an interview on 10/31/24 at 10:48 A.M., Nurse Unit Manager #1 said Resident #4 had a history of a healed pressure ulcer on the left upper Achilles heel, which healed in spring 2024. Nurse Unit Manager #1 observed Resident #4's left upper Achilles heel and said there is now an unstageable pressure ulcer that she was unaware of. Nurse Unit Manager #1 said the order for skin prep to the left medial heel does not cover the left upper Achilles heel, and the provider should have been notified to obtain wound orders but had not been. During an interview on 10/31/24 at 12:30 P.M., the Director of Nursing (DON) said the provider should have been notified to obtain wound orders for the pressure ulcer on Resident #4's left upper Achilles heel. c.) The facility failed to ensure a pressure related deep tissue injury (DTI) was assessed and measured weekly, as evidenced by the following: Review of Resident #4's medical record failed to indicate any wound assessments or measurements for his/her right heel DTI in the past three months. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/31/24 at 10:48 A.M., Nurse Unit Manager #1 said Resident #4 had a DTI on his/her right heel. Nurse Unit Manager #1 observed Resident #4's right heel and said it currently is a pressure related DTI. Nurse Unit Manager #1 said the Resident had this DTI since at least August 2024 and it should have been assessed and measured weekly. Nurse Unit Manager #1 said the consultant wound physician should do this but is unsure why the consultant wound physician had not been following this Resident. Nurse Unit Manager #1 reviewed the record and said that since the consultant wound physician was not following Resident #4 then nursing should have been completing weekly wound assessments with measurements but had not been. During an interview on 10/31/24 at 12:30 P.M., the Director of Nursing (DON) said it was the expectation that if the consultant wound physician was not following Resident #4's right heel DTI, then Nurse Unit Manager #1 should have assessed and measured the heel weekly. d.) The facility failed to ensure weekly skin assessments were being completed, as evidenced by the following: Review of Resident #4's physician's orders indicated: - Weekly skin checks, initiated 8/16/24 and discontinued 10/15/24. - Weekly skin checks on Fridays, initiated 10/18/24 and discontinued 10/18/24. - Weekly skin checks on Fridays, initiated on 10/25/24. Review of Resident #4's medical record, dated 8/13/24 to 10/31/24, indicated skin assessments were only documented on 9/27/24, 10/4/24, and 10/18/24. Skin assessments were not completed eight out of the eleven weeks. During an interview on 10/31/24 at 10:48 A.M., Nurse Unit Manager #1 said skin assessments should be completed and documented every week. During an interview on 10/31/24 at 12:30 P.M., the Director of Nursing (DON) said skin assessments should be completed and documented every week. The DON said weekly skin assessments not being completed was an ongoing concern in the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41019 Based on record review and interview, the facility failed to update the plan of care or complete a falls assessment after falls for two Residents (#38 and #27) out of a total sample of 27 residents. Specifically, 1. for Resident #38, the facility failed to review and revise the plan of care after multiple falls resulting in a fall with a fracture; and 2. for Resident #27, the facility failed to update the plan of care following a fall with fracture. Findings include: Review of the facility policy titled Fall Reduction, dated 6/22/22, indicated the following: - The facility will identify residents at risk for falls through the use of a falls assessment tool. - The facility will implement interventions to minimize and/or eliminate contributing factors for falls for residents at risk based on the individual resident's needs. - The facility will provide education on fall prevention to caregivers, residents, and family. - In the event that a fall occurs, the facility will investigate the factors contributing to the fall and develop a plan of action to minimize further falls. 1. Resident #38 was admitted in August 2022 with diagnoses including depression and unsteadiness on feet. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/4/24, indicated that Resident #38 had severe cognitive impairment. The MDS further indicated Resident #38 required substantial to maximal assist with transfers. Review of Resident #38's care plan indicated the following: Focus: Resident #38 has had an actual fall(s) or is at risk for falls related to deconditioning and weakness, cognitive impairment and poor safety awareness. Interventions: - Bed in low position (initiated 1/26/23) - Resident #38 will stay in day room/common area or in activities while away (initiated 11/22/23) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Encourage use of proper footwear when out of bed and slipper socks. Keep items in reach. Encourage use of bilateral 1/4 side rails for bed mobility. PT (physical therapy)/OT (occupational therapy) evaluation and treat as indicated (initiated 12/20/22) - Medication review (initiated 7/2/24) - Offer toileting/change frequently (initiated 7/2/24) - Fall mats on floor next to bed when resident is in bed (initiated 7/5/24) Focus: Risk for Harm/injury r/t behavior of intentionally sliding out of wheelchair/bed and placing self on floor. (initiated 7/5/24) Review of the fall incident, dated 12/2023, indicated Resident #38 had an unwitnessed fall in his/her room. The incident report indicated Resident #38 put him/herself on the floor after getting out of bed. The intervention on the incident report was to move the Resident close to the nursing station for supervision in his/her wheelchair at the time of the fall. Review of the care plan did not indicate that it was reviewed or updated with interventions to prevent further falls. Review of the fall incident report, dated 1/25/24, indicated Resident #38 had an unwitnessed fall with no injury. The fall investigation did not include witness statements or any interventions to prevent future falls. Review of the fall incident report, dated 5/3/24, indicated Resident #38 slid from his/her wheelchair 5 times in a 30 minute time frame. Review of the fall incident report failed to indicate any witness statements or interventions to prevent further falls. Review of the incident report, dated 6/22/24, indicated Resident #38 had a witnessed fall from leaning forward in his/her wheelchair. Resident #38 sustained a skin tear on the bridge of his/her nose from the wheelchair foot rest. Review of Resident #38's hospital discharge paperwork, dated 6/26/24, indicated Resident #38 presented to the hospital with ecchymosis (bruising) on his/her nasal bridge due to a fall he/she had the week prior. Review of the discharge paperwork indicated Resident #38 had a fracture of the tip of the nasal bone. During an interview on 10/31/24 at 12:55 P.M., the Director of Nursing said Resident #38 has a habit of sliding out of his/her wheelchair. The Director of Nursing said when a fall occurs she expects the nurse to document if the resident had sustained an injury and obtain witness statements. The Director of Nursing said she expects the unit manager and the team to develop interventions that are appropriate and the care plan should be reviewed and updated when a new fall occurs. Review of the care plan for Resident #38 failed to indicate any interventions or revisions were implemented after the falls that occurred in 12/2023, and on 1/25/24 and 5/3/24. 2. Resident #27 was admitted in December 2018 with diagnoses including muscle weakness, difficulty walking, and abnormalities of gait. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 9/25/24, indicated Resident #27 scored a 9 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. The MDS further indicated Resident #27 required supervision to touching assistance with transfers. Review of the falls care plan for Resident #27 indicated the following: Focus: Resident #27 is at risk for falls related to CVA (cerebrovascular accident) with right hemi, fall risk assessment score, vision problems, decreased safety awareness, psychotropic med use. Interventions: - Anticipate and meet needs (revised 3/15/22) - Assess risk for falls . (revised 3/15/22) - Be sure the call light is within reach and encourage use for assistance as needed (revised 3/15/22) - Ensure a safe environment with even floors . (revised 3/15/22) - Follow facility fall protocol (initiated 4/17/20) - Monitor closely for side effects after vaccinations (revised 3/15/22) - Monitor medication for side effects that may increase risk for falls. Notify physician as appropriate. (initiated 4/17/20) - Provide non-skid footwear (initiated 4/17/20) - Re-evaluate on readmission from hospital (revised 3/15/22) - Refer to physical therapy and/or occupational and/or mental health therapy consult as needed (initiated 4/17/20) Review of the fall incident reports indicated Resident #27 had a fall on 1/28/24 while attempting to use his/her own bathroom without assistance, which resulted in a fracture of the right femur. Review of the falls care plan failed to indicate that the care plan was reviewed or revised after the fall on 1/28/24. During an interview on 10/31/24 at 12:55 P.M., the Director of Nursing said when a fall occurs she expects the nurse to document if the resident had sustained an injury and obtain witness statements. The Director of Nursing said she expects the unit manager and the team to develop interventions that are appropriate and the care plan should be reviewed and updated when a new fall occurs. The Director of Nursing said she was unaware of the Resident's fall that happened in May, but the care plan should have been updated after 2022.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48990 Based on interviews and record review, the facility failed to provide care and services consistent with professional standards including ongoing communication and collaboration with the dialysis facility for one Resident (#31), who required renal dialysis (a procedure to remove waste products and excess fluid from the body when the kidneys stop working), out of 27 total sampled residents. Specifically, the facility failed to ensure complete and accurate communication with the dialysis facility for Resident #31's dialysis appointments. Findings include: Review of the facility policy titled End-Stage Renal Disease, Care of a Resident with, undated, indicated: - Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Resident #31 was admitted to the facility in September 2023 with diagnoses including end stage renal disease and hypotension (low blood pressure). Review of the most recent Minimum Data Set (MDS) assessment, dated 9/24/24, indicated Resident #31 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #31 received dialysis. On 10/31/24 at 8:12 A.M., Resident #31 said he/she often must remind the staff to send his/her dialysis communication book to the dialysis center because they forget. Resident #31 said he/she does not look at the information inside of it because the communication book is for the dialysis center to communicate with the nurses at the facility. Review of Resident #31's physician's orders indicated: - Resident to have Dialysis on days: Tuesday - Thursday - Saturday, initiated 6/13/24. Review of Resident #31's plan of care related to dialysis, revised 9/19/24, indicated: - Send communication book to each dialysis treatment. Review of Resident #31's Medication Administration Record (MAR), dated 10/1/24 to 11/1/24, indicated the nurse documented the Resident went to his/her dialysis treatment on the 14 days it was scheduled. Review of Resident #31's dialysis communication book, dated 10/1/24 to 11/1/24, indicated on the dialysis communication sheet that post-dialysis weights must be obtained. Resident #31's dialysis communication book failed to indicate dialysis communication sheets, which contained the post-dialysis weights, were completed for 11 out of 14 scheduled dialysis treatment days. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #31's medical record, dated 10/1/24 to 11/1/24, failed to indicate any follow up on 11 missing dialysis communication sheets or post-dialysis weights. During an interview on 11/1/24 at 10:21 A.M., Nurse #2 said the nurse is responsible for ensuring post-dialysis weights were obtained and documented after every dialysis treatment because it is part of the dialysis plan of care. Nurse #2 said all residents who receive dialysis require post-dialysis weights after each treatment to monitor for complications. Nurse #2 said if a resident comes back from a dialysis treatment without a dialysis communication sheet filled out with a post dialysis weight the nurse is responsible for communicating with the dialysis center to request the post-dialysis weight. Nurse #2 said if they are unable to contact the dialysis center, the nurse should obtain and document a weight promptly in the resident's medical record. During an interview on 11/1/24 at 10:30 A.M., Nurse Unit Manager #1 said communication with Resident #31's dialysis center has been difficult and they have had trouble with them returning calls or clarifying information. Nurse Unit Manager #1 said the dialysis center's plan of care is to monitor post-dialysis weights after each treatment, but that the facility is not concerned with the post-dialysis weights because the dialysis center manages all aspects of Resident #31's end stage renal diseases and dialysis care. Nurse Unit Manager #1 said the facility is not responsible for managing Resident #31's end stage renal disease or dialysis care and would expect dialysis to notify them only if there was a concern that they needed the facility to follow up on. During an interview on 11/1/24 at 10:38 A.M., Nurse Practitioner (NP) #1 said Resident #31 needed to be weighed after every dialysis treatment to monitor for complications and she expects nurses to be monitoring the post-dialysis weights for any significant changes. NP #1 said that since the communication has not been good with Resident #31's dialysis center she would have expected the nurses to obtain any post-dialysis weights if not available through the dialysis communication sheets and report any changes to her. During an interview on 11/1/24 at 11:11 A.M., the Dietitian said communication with Resident #31's dialysis center had been tough. The Dietitian said the facility should have been monitoring his/her post-dialysis weights more closely because not monitoring post-dialysis weights three times a week puts the resident at risk for not recognizing complications such as fluid overload. The Dietitian said the facility should be ensuring post-dialysis weights are monitored after every dialysis treatment because that is the dialysis center's plan of care. During an interview on 10/31/24 at 12:41 P.M., the Director of Nursing (DON) said residents who receive dialysis need to be weighed after each dialysis treatment. The DON said if the dialysis communication sheet comes back not complete then the nurse should call and attempt to obtain their post-dialysis weight. The DON said if the nurse was unable to obtain this information from the dialysis center, it is expected that staff obtain a weight promptly and document in the Resident's medical record.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48990 Based on interviews, record review, staff education review, and facility assessment review, the facility failed to ensure the nursing staff were trained and demonstrated the competencies and skill sets necessary to provide the level and types of care and services needed as outlined in the Facility Assessment. Specifically, the facility failed to ensure licensed nursing staff were trained and demonstrated competency related to wound care. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Review of the Facility Assessment Tool, dated 7/25/24, included but was not limited to the following: - The facility accepts residents who may develop the following common diseases, conditions, physical and cognitive disabilities or combinations of conditions that require complex medical care and management, including, but not limited to the following: integumentary system: skin ulcers, injuries. - They type of care for residents that the facility provides includes the following: Skin Integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). - Staff training/education and competencies: Consider the following competencies: wound care/dressings. Review of the facility document titled Competency Assessment, dated 2/18/22, indicated the following required competencies must be completed by licensed nurses during initial orientation, 30/60/90 days after hire, and annually thereafter: - Knowledge and understanding of physical assessment as follows: Wound assessment and dressing techniques. - Identifies and utilizes the following Documentation Tools: Wound documentation, Skin and wound care protocols. Throughout the recertification survey (10/29/24 through 11/1/24 and 11/5/24) the surveyors identified multiple concerns regarding wound care including: - failure to implement pressure ulcer prevention interventions. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- failure to assess and measure wounds weekly. - failure to perform hand hygiene during wound care. - failure to obtain treatment orders for wounds. - failure to notify provider of new wounds. - failure to transcribe new wound care orders. - failure to complete weekly skin checks. The surveyor reviewed staff education files for wound competencies for three licensed nurses with identified concerns relating to wound care during the recertification survey. - 0 out of 3 had wound competencies completed within the last year. During an interview on 11/1/24 at 11:30 A.M., the Director of Nursing (DON) said the document titled Competency Assessment is the policy the facility follows. The DON said the wound competencies should have been completed annually, but there was not a staff development nurse employed from November 2023 to April 2024, and then again from August 2024 to present.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review and interview, the facility failed to maintain the highest practicable physical, mental, and psychosocial well being for one Resident's (#55) with a history of suicidal ideation (SI) and depression, out of a total sample of 27 residents. Specifically, Resident #55 was not provided with appropriate behavioral health services following verbalization of SI, and attempted to kill him/herself at the facility. Findings include: Review of the facility policy titled Suicidal Ideation/Risk for Harming Self, dated 10/2016, indicated but is not limited to the following: PURPOSE: To act as a guideline for residents who express/exhibits suicidal ideation or risk to harm self during their stay at the facility in assuring their safety. 2. Care plan initiated and communicated to relevant staff and family member. (sic) Review of the facility policy titled Behavioral Health Services, revised 12/7/21, indicated the following: PURPOSE: To provide our residents with the necessary Behavioral Health Services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. POLICY: It is the policy of the facility to provide Behavioral Health Services in accordance with State and Federal regulations. PROCEDURE: 1. The facility will ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post traumatic stress disorder, receives appropriate treatment and services. 2. The resident will receive, and the facility will provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 3. Behavioral health encompasses a resident's emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance abuse disorders. 4. The facility will initiate referrals to psychiatric services, having the resident or responsible party sign consent, as behavioral concerns are identified. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility assessment, dated as reviewed 7/25/24, indicated the facility is able to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior and identify and implement interventions, including non-pharmalogical interventions, to help support individuals with issues such as dealing with anxiety, cognitive impairment, depression, trauma/PTSD, and other psychiatric diagnoses. According to the facility assessment, the facility manages 40-65 residents with behavioral health needs at a time. Resident #55 was admitted to the facility in February 2023 and had diagnoses that include depression and dementia. Review of the admission Minimum Data Set (MDS) assessment, dated 2/23/23, indicated Resident #55 scored a 13 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of the Resident's hospital discharge paperwork, dated February 2023, given to the facility upon admission, indicated Resident #55 was admitted to the facility after vocalization of passive SI without a plan. Review of the psych discharge summary, dated February 2023, recommended the facility obtain a psych consult and med recommendations Review of the progress note, dated 8/5/23, indicated: Resident sent out at 7pm for suicidal ideations w/ active plan. Reported to this writer that today was going to be his/her last day here I'm going out one way or another. Resident reported that he/she wants to end his/her life today and has a plan to do so. Resident declined to tell this writer what the plan is but repeatedly stated Anyway I can I'm getting it done tonight, there's lots of ways to do it. This writer stayed with resident and discussed further, Resident #55 voiced frustration with being in a LTC (long term care) facility and that at his/her age he/she should be able to end his/her life if he/she wants. Resident #55 further voiced being alone pertaining to his/her children and that they lied to get him/her here and now he/she is stuck. This writer was able to talk with Resident #55 and he/she agreed to a hospital evaluation this evening d/t (due to) his/her current thoughts. He/she remained adamant about ending his/her life t/o (throughout) the conversation and was placed on a 1:1 until EMT's arrived for transport Review of the medical record failed to indicate a care plan was implemented for SI after Resident #55 returned from the hospital on 8/5/23. Further, the medical record failed to indicate a referral was made, or that Resident #55 was assessed by the behavioral health team for psychotherapy to address his/her feelings of SI. Review of the Behavioral Health Group note for medication management, dated 9/20/23, 34 days after his/her return from the hospitalization , indicated Resident #55 was alert and oriented and reports periods of anxiety, sadness and frustration around aspects of institutional living. The report indicates patient can benefit from behavior management, however; fails to indicate that a referral was made for talk therapy or that the plan of care was updated with specific behavioral management interventions. Review of the Social Work progress note dated 10/16/23 indicated the Social Worker met with Resident #55 after the death of his/her friend. Review of the medical record failed to indicate the care plan was reviewed, updated, or any interventions, to monitor Resident #55 for SI, were developed. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Behavioral Health Group note for medication management, dated 10/18/23, indicated Resident #55 was seen by the Psych NP (Nurse Practitioner) due to increased anxiety and paranoia with recommendation to increase Buspar from 5mg to 10 mg BID for anxiety/agitation. The Psych NP recommended the following goals for nursing to monitor: - Short Term Goals: client/staff will report no more than 1-2 episode of anxiety per day - Long Term Goals: client/staff will report no more than 2-3 episode of anxiety per week. Review of the record failed to indicate that the Psych NP's 10/18/23 recommended treatment plan was communicated to staff, implemented or tracked or that the plan of care was updated with specific behavioral management interventions to achieve these goals. On 12/18/23, Resident #55 attempted to commit suicide at the facility by attempting to jump over the second floor balcony, which was intervened by the Maintenance Director and Resident #55 was pulled to safety and sent to the hospital. Review of the clinical record indicated Resident #55 was psychiatrically hospitalized [DATE]-[DATE]. Review of the clinical record failed to indicate that upon readmission to the facility, Resident #55's plan of care was reviewed or updated, despite Resident #55's suicide attempt on 12/18/23. Review of the Behavioral Health Group note for Therapy, dated 1/23/24, 15 days after his/her return from the hospital, indicates a LICSW initial assessment note : Requested by nursing home SW to assess resident because of recent suicide attempt. According to the note Resident #55 declined services and the LICSW will only see the resident again if requested by the facility. During an interview on 10/30/24 at 12:19 P.M., with the facility Social Worker (SW) #1 she said that she has worked at the facility for 2 months. SW #1 said that the facility has psych services for both med management and talk therapy and for a resident that verbalizes SI she would refer them to be evaluated for talk therapy. SW #1 said that she is the only social worker in the building and that she does not know Resident #55 and that she was not aware that he/she had attempted to commit suicide while residing at the facility/ SW #1 said that she would expect to have been told because that is a resident she would have followed to provide nonpharmacological types of interventions such as regular visits and encouraging him/her to spend time them out of his/her room at activities. During an interview on 10/30/24 at 12:35 P.M., with the Nurse Unit Manager #1 said Resident #55 had a history of verbalizing SI and should have been evaluated by psych therapy for talk therapy and she is not sure why that did not happen, as they are in the building once a week and a referral can be made at any time. (continued on next page)

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	225431	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Reading	1364 Main Street Reading, MA 01867

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/31/24 at 9:02 A.M., with the facility's current Psych Nurse Practitioner (NP) #2 she said that she provides the medication management at the facility and that if the facility wants someone seen by psych services they place a referral in the book on the unit which she checks weekly. Psych NP #2 said she relies on the referrals in the green book rather than asking staff if they have new referrals because most of the time there is agency staff. NP #2 said that she was not the NP at the time of the incidents and that possibly Resident #55 would have benefited from supportive talk therapy services because of his/her history, but that those services are provided by another provider. The Psych NP said that she can directly refer residents for talk therapy and that if she feels a resident would benefit from those services she communicates this directly to the Behavioral Health Group's LICSW that provides that service. During an interview on 10/31/24 at 12:34 P.M., with Resident #55's Physician, he said that it is his expectation that residents admitted with a history of SI be seen by both the psych services NP as well as be assessed for psychotherapy services. The physician said that he was under the impression that Resident #55 was being followed closely by the facility's Social Worker and was surprised to hear that the Social Worker learned only the day prior from the surveyor that Resident #55 had both a history of verbalizing SI and of an actual suicide attempt at the facility. During an interview on 10/31/24 at 1:01 P.M., the Director of Nursing said when a resident is admitted with a history of suicidal ideation, they should be assessed upon admission by psych services for both medication management and psychotherapy. As well, she said that she would expect the resident to be followed closely by social service and that the visit notes would be documented in the medical record. The DON was surprised to learn that the current facility social worker was unaware that Resident #55 had a history of SI and actual suicide attempt at the facility, and would have expected that to have been important information for her to receive when she was trained 2 months prior.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review and interview, the facility failed to provide the appropriate treatment and services for one Resident (#55), with a known history of depression, suicidal ideation, and adjustment difficulty, out of a total sample of 27 residents. Specifically, the facility failed to develop, implement, and update the plan of care, resulting in an attempted suicide after the vocalization of suicidal ideation (SI). Findings include: Review of the facility policy titled Suicidal Ideation/Risk for Harming Self, dated 10/2016, indicated but is not limited to the following: PURPOSE: To act as a guideline for residents who express/exhibits suicidal ideation or risk to harm self during their stay at the facility in assuring their safety. 2. Care plan initiated and communicated to relevant staff and family member. Review of the facility policy titled Behavioral Health Services, revised 12/7/21, indicated the following: PURPOSE: To provide our residents with the necessary Behavioral Health Services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. POLICY: It is the policy of the facility to provide Behavioral Health Services in accordance with State and Federal regulations. PROCEDURE: 1. The facility will ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post traumatic stress disorder, receives appropriate treatment and services. 2. The resident will receive, and the facility will provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 3. Behavioral health encompasses a resident's emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance abuse disorders. 4. The facility will initiate referrals to psychiatric services, having the resident or responsible party sign consent, as behavioral concerns are identified. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility assessment, dated as reviewed 7/25/24, indicated the facility is able to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior and identify and implement interventions, including non-pharmalogical interventions, to help support individuals with issues such as dealing with anxiety, cognitive impairment, depression, trauma/PTSD, and other psychiatric diagnoses. According to the facility assessment, the facility manages 40-65 residents with behavioral health needs at a time. Resident #55 was admitted to the facility in February 2023 and had diagnoses that include depression and dementia. Review of the admission Minimum Data Set (MDS) assessment, dated 2/23/23, indicated Resident #55 scored a 13 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of the Resident's hospital discharge paperwork, dated February 2023, given to the facility upon admission, indicated Resident #55 was admitted to the facility after vocalization of passive SI without a plan. Review of the psych discharge summary, dated February 2023, recommended the facility obtain a psych consult and med recommendations Review of the progress note, dated 8/5/23, indicated: Resident sent out at 7pm for suicidal ideations w/ active plan. Reported to this writer that today was going to be his/her last day here I'm going out one way or another. Resident reported that he/she wants to end his/her life today and has a plan to do so. Resident declined to tell this writer what the plan is but repeatedly stated Anyway I can I'm getting it done tonight, there's lots of ways to do it. This writer stayed with resident and discussed further, Resident #55 voiced frustration with being in a LTC (long term care) facility and that at his/her age he/she should be able to end his/her life if he/she wants. Resident #55 further voiced being alone pertaining to his/her children and that they lied to get him/her here and now he/she is stuck. This writer was able to talk with Resident #55 and he/she agreed to a hospital evaluation this evening d/t (due to) his/her current thoughts. He/she remained adamant about ending his/her life t/o (throughout) the conversation and was placed on a 1:1 until EMT's arrived for transport Review of the medical record failed to indicate a care plan was implemented for SI after Resident #55 returned from the hospital on 8/5/23 Review of the Behavioral Health Group note for medication management, dated 9/20/23, 34 days after his/her return from the hospitalization , indicated Resident #55 was alert and oriented and reports periods of anxiety, sadness and frustration around aspects of institutional living. The report indicates patient can benefit from behavior management, however; fails to indicate that a referral was made for talk therapy or that the plan of care was updated with specific behavioral management interventions. Review of the Social Work progress note dated 10/16/23 indicated the Social Worker met with Resident #55 after the death of his/her friend. Review of the medical record failed to indicate the care plan was reviewed, updated, or any interventions, to monitor Resident #55 for SI, were developed. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Behavioral Health Group note for medication management, dated 10/18/23, indicated Resident #55 was seen by the Psych NP (Nurse Practitioner) due to increased anxiety and paranoia with recommendation to increase Buspar from 5mg to 10 mg BID for anxiety/agitation. The Psych NP recommended the following goals for nursing to monitor: - Short Term Goals: client/staff will report no more than 1-2 episode of anxiety per day - Long Term Goals: client/staff will report no more than 2-3 episode of anxiety per week. Review of the record failed to indicate that the Psych NP's 10/18/23 recommended treatment plan was communicated to staff, implemented or tracked or that the plan of care was updated with specific behavioral management interventions to achieve these goals. On 12/18/23, Resident #55 attempted to commit suicide at the facility by attempting to jump over the second floor balcony , which was intervened by the Maintenance Director and Resident #55 was pulled to safety and sent to the hospital. Review of the clinical record indicated Resident #55 was psychiatrically hospitalized [DATE]-[DATE]. Review of the clinical record failed to indicate that upon readmission to the facility, Resident #55's plan of care was reviewed or updated, despite Resident #55's suicide attempt on 12/18/23. The medical record indicated that an SI care plan was developed on 1/9/24, 4 days after readmission to the facility. The SI care plan developed on 1/9/24 indicated the following: Review of the Behavioral Health Group note for Therapy, dated 1/23/24, 15 days after his/her return from the hospital, indicates a LICSW initial assessment note : Requested by nursing home SW to assess resident because of recent suicide attempt. According to the note Resident #55 declined services and the LICSW will only see the resident again if requested by the facility. During an interview on 10/30/24 at 12:19 P.M., with the facility Social Worker (SW) #1 she said that she has worked at the facility for 2 months. She said that if a resident admits to the facility with a history of verbalizing SI, whether remote or recent, she would meet with the resident upon admission and determine the history in order to develop a person centered care plan. SW #1 said that for any resident that voices SI while at the facility or if they are hospitalized for SI while at the facility, she would review the care plan and update it when this occurs. SW #1 said that the facility has psych services for both med management and talk therapy and for a resident that verbalizes SI she would refer them to be evaluated for talk therapy. SW #1 said that she is the only social worker in the building and that she does not know Resident #55 and that she was not aware that he/she had attempted to commit suicide while residing at the facility. SW #1 said that she would expect to have been told because that is a Resident she would have followed to provide nonpharmacological types of interventions such as regular visits and encouraging him/her to spend time them out of his/her room at activities. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 10/30/24 at 12:35 P.M., with the Nurse Unit Manager #1 she said that she has been a nurse unit manager for 7 years and knows Resident #55 well. According to Nurse Unit Manager #1 a baseline care plan, and then a comprehensive care plan, regarding Resident #55's SI should have been developed at admission and she is not sure why it was not. She said that it is the expectation that the team continuously update all SI care plans with any changes in SI status. She said that while she could not recall the SI in August 2023, that at that time an SI care plan should have already been in place and would have been reviewed and updated. As well, Nurse Unit Manager #1 said Resident #55 should have been evaluated by psych therapy for talk therapy and she is not sure why that did not happen, as they are in the building once a week and a referral can be made at any time. During an interview on 10/31/24 at 9:02 A.M., with the facility's current Psych Nurse Practitioner (NP) #2 she said that she provides the medication management at the facility and that if the facility wants someone seen by psych services they place a referral in the book on the unit which she checks weekly. Psych NP #2 said she relies on the referrals in the green book rather than asking staff if they have new referrals because most of the time there is agency staff. NP #2 said that she was not the NP at the time of the incidents and that possibly Resident #55 would have benefited from supportive talk therapy services because of his/her history, but that those services are provided by another provider. The Psych NP said that she can directly refer residents for talk therapy and that if she feels a resident would benefit from those services she communicates this directly to the LICSW that provides that service. During an interview on 10/31/24 at 12:34 P.M., with Resident #55's Physician he said that it is his expectation that residents admitted with a history of SI be seen by both the psych services NP as well as be assessed for psychotherapy services. Additionally, it is his expectation that the facility would develop and implement a care plan, that includes nonpharmacological interventions, for all residents with a history of SI. The physician said that he was under the impression that Resident #55 was being followed closely by the facility's Social Worker and was surprised to hear that the Social Worker learned only the day prior from the surveyor that Resident #55 had both a history of verbalizing SI and of an actual suicide attempt at the facility. During an interview on 10/31/24 at 1:01 P.M., the Director of Nursing said when a resident is admitted with a history of suicidal ideation, they should be assessed upon admission, or shortly thereafter, by psych services for both medication management and psychotherapy and that a care plan should be developed that includes nonpharmacological interventions to keep the Resident safe. The DON said that the care plan should be followed and updated any time the resident voices SI or requires intervention related to SI. As well, she said that she would expect the resident to be followed closely by social service and that the visit notes would be documented in the medical record. The DON was surprised to learn that the current facility social worker was unaware that Resident #55 had a history of SI and actual suicide attempt at the facility, and would have expected that to have been important information for her to receive when she was trained 2 months prior.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41019 Based on record review and interview, the facility failed to review and address pharmacy recommendations for one Resident (#38) out of a total sample of 27 residents. Findings include: Resident #38 was admitted in August 2022 with diagnoses including depression and unsteadiness on feet. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/4/24, indicated that Resident #38 had severe cognitive impairment. Review of the MDS indicated Resident #38 required substantial to maximal assist with transfers. Review of the pharmacist note, dated 9/4/24, indicated the following: - MD (physician) REC (recommendation): Please evaluated [sic] continued need and add stop dated to Enoxaparin - Nursing REC: Atorvastatin order says at bedtime, please change to bedtime (now 1700) Review of the pharmacist note, dated 10/3/24, indicated the following: -MD REC: Please evaluated [sic] continued need and add stop dated to Enoxaparin - Nursing REC: Atorvastatin order says at bedtime, please change to bedtime (now 1700) Review of the physician's orders failed to indicate that the recommendations were reviewed or implemented. During an interview on 10/31/24 at 8:31 A.M., Nurse Unit Manager #1 said she was out for some time in September 2024 and therefore the pharmacy recommendations never got to the physician. Nurse Unit Manager #1 said that a few days ago, the physician signed the recommendations and they were to be implemented. Nurse Unit Manager #1 said the pharmacy recommendations should have been addressed within a couple of days, but were not.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48990 Based on observations, interviews, and record review for one Resident (#9) out of four residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. One out of three nurses observed made two errors out of 31 opportunities resulting in a medication error rate of 6.45%. Specifically, Nurse #3 administered the incorrect calcium carbonate without clarifying a missing dosage and administered ferrous sulfate without clarifying a missing dosage. Findings include: Review of the facility policy titled Administering Medications, revised April 2019, indicated: - Medications are administered in accordance with prescriber orders. - The individual administering the medication checks the label THREE (3) times to verify the right dosage before giving the medication. Resident #9 was admitted to the facility in August 2024 with diagnoses including diabetes and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/13/24, indicated Resident #9 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 6 out of 15, indicating severe cognitive impairment. During the medication pass observation on 10/30/24 at 8:06 A.M., the surveyor observed Nurse #3 prepare and administer the following medications to Resident #9: - One calcium carbonate 500 mg (milligram) chewable tablet. - One ferrous sulfate 325 mg tablet. Review of Resident #9's current physician orders indicated: - Calcium carbonate - vitamin d w/ (with) minerals, give one tablet by mouth two times a day, initiated 8/12/24. - Ferrous sulfate oral tablet, give one tablet by mouth one time a day, initiated 8/13/24. During an interview on 10/30/24 at 9:54 A.M., Nurse #3 said she was unaware that these medications required a dosage. Nurse #3 said she gave the calcium carbonate, even though it did not have vitamin d with minerals, because it was the only calcium carbonate available. Nurse #3 said she was unaware if there was expectation to clarify the order if medications are unavailable. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 9:59 A.M., Nurse Unit Manager #1 said medications, such as ferrous sulfate and calcium carbonate with vitamin d and minerals, require dosages for administration. Nurse Unit Manager #1 said these orders should have been clarified before being administered. Nurse Unit Manager #1 further said Nurse #3 administered the incorrect type of calcium carbonate and that should have been clarified because that type of calcium carbonate with vitamin d and minerals is not available in the facility. During an interview on 10/30/24 at 1:28 P.M., the Director of Nursing (DON) said medications, even supplements, require dosages to administer. The DON said Nurse #3 should have clarified the orders when it was noted to not have a dosage and when the type of calcium carbonate was not available in the facility.

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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. 48990 Based on observation and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure medications were stored in the original, labeled containers. Findings include: Review of the facility policy titled Storage of Medications, undated, indicated: - All medications dispensed by the pharmacy are stored in the container with the pharmacy label. On 10/30/24 at 12:34 P.M., the surveyor and Nurse #2 observed two uncovered medication cups filled with unlabeled pills in the 2nd floor back hallway medication cart. In one medication cup there were two white pills. In the other medication cup there were two white pills and one blue pill. During an interview on 10/30/24 at 12:36 P.M., Nurse #2 said she had poured the medications a few hours prior but had not given them to the residents because they were unavailable. Nurse #2 said the medication should have been discarded at that time but that she was planning to go back to administer the medication to the residents later. During an interview on 10/30/24 at 1:28 P.M., the Director of Nursing (DON) said pills should never be stored in a medication cup in the medication cart. The DON said if a resident is unavailable or refuses the pills, then the pills should be discarded at that time, instead of stored in the medication cart.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observations, interviews, and record review, the facility failed to maintain accurate medical records for three Residents (#14, #6, and #44), out of a total sample of 27 residents. Specifically, 1. for Resident #14, the nurses documented a physician's order for his/her bilateral lower extremity wounds as implemented when it was not; 2. for Residents #14, #6 and #44 the facility failed to complete daily documentation; Findings Include: 1. Resident #14 was admitted to the facility in June 2024 with diagnoses including diabetes, venous ulcers, and chronic respiratory failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/18/24, indicated Resident #14 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. The MDS further indicated Resident required substantial assistance for bathing/showering tasks. Review of Resident #14's physician's order, initiated 7/30/24, indicated: - Cleanse BLE (bilateral lower extremities) with Ns (normal saline, a sterile saltwater solution used to cleanse wounds), pat dry, apply xeroform and kling daily and as needed, every day shift for venous stasis ulcers. Review of Resident #14's Treatment Administration Record (TAR) indicated the physician's order to cleanse BLE with Ns, pat dry, apply xeroform and kling daily and as needed was documented as implemented on 10/29/24 and 10/30/24. Review of Resident #14's medical record, dated 10/29/24 and 10/30/24, failed to indicate any refusal or rationale for bilateral lower extremity treatment orders not being implemented. On 10/29/24 at 8:27 A.M., the surveyor observed Resident #14 in bed with no dressing on his/her right lower extremity and a dressing, which was dated 10/28/24, on his/her left lower extremity. Resident #14 said the nurses often don't offer to change his/her dressings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 12:49 P.M., the surveyor observed Nurse #1 perform wound care for Resident #14's left calf. Nurse #1 said his/her right calf was not weeping so it did not require a dressing, but the nurse would apply as if necessary. Nurse #1 confirmed that the dressing on Resident #14's left calf was dated 10/28/24, which meant the dressing had not been changed the last two days on 10/29/24 or 10/30/24. Nurse #1 said the left calf dressing should have been changed daily as ordered but had not been. Nurse #1 said if Resident #14 had refused it should have been documented as refused, but she had not heard that he/she had refused any dressings in report. Nurse #1 said the wound treatment orders for Resident #14's bilateral lower extremities should not have been documented as implemented since it was not. During an interview on 11/1/24 at 8:52 A.M., the Director of Nursing (DON) said if a wound dressing is ordered to be changed daily, it should have been changed daily. The DON said if Resident #14 had refused the dressing change it should have been documented as refused and should never have been documented as implemented if it was not. 41456 2a. Resident #14 was admitted to the facility in June 2024 with diagnoses including diabetes, venous ulcers, and chronic respiratory failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/18/24, indicated Resident #14 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. The MDS further indicated Resident required substantial assistance for bathing/showering tasks. Review of the Documentation Survey Report (a report which displays daily documentation of certified nursing assistants) indicated the following: -Bathing documentation was only completed for 3 shifts out of a possible 93 shifts in August 2024. -Bathing documentation was only completed for 9 shifts out of a possible 90 shifts in September 2024. -Bathing documentation was only completed for 4 shifts out of a possible 93 shifts in October 2024. During an interview on 10/31/24 at 7:51 A.M., Certified Nursing Assistant (CNA) #1 said all CNAs should be documenting all care provided on all shifts. During an interview on 10/31/24 at 8:25 A.M., the Director of Nursing said she expects the CNAs to document all care provided on all shifts. The Director of Nursing said she is aware of significant missing documentation. 2b. Resident #6 was admitted to the facility in November 2019 with diagnoses including dementia. Review of Resident #6's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15, which indicated he/she had moderate cognitive impairment. The MDS also indicated the Resident required moderate assistance for bathing tasks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225431	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Reading	1364 Main Street Reading, MA 01867

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Documentation Survey Report (a report which displays daily documentation of certified nursing assistants) indicated the following: -Bathing documentation was only completed for 20 shifts out of a possible 93 shifts in August 2024. -Bathing documentation was only completed for 10 shifts out of a possible 90 shifts in September 2024. -Bathing documentation was only completed for 6 shifts out of a possible 93 shifts in October 2024. During an interview on 10/31/24 at 7:51 A.M., Certified Nursing Assistant (CNA) #1 said all CNAs should be documenting all care provided on all shifts. During an interview on 10/31/24 at 8:25 A.M., the Director of Nursing said she expects the CNAs to document all care provided on all shifts. The Director of Nursing said she is aware of significant missing documentation. 2c. Resident #44 was admitted to the facility in March 2024 with diagnoses of acute respiratory failure. Review of the most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview of Mental Status score of 15 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated Resident #44 was dependent on staff for shower/bathing tasks. Review of the Documentation Survey Report (a report which displays daily documentation of certified nursing assistants) indicated the following: -Bathing documentation was only completed for 15 shifts out of a possible 93 shifts in August 2024. -Bathing documentation was only completed for 7 shifts out of a possible 90 shifts in September 2024. -Bathing documentation was only completed for 10 shifts out of a possible 93 shifts in October 2024. During an interview on 10/31/24 at 7:51 A.M., Certified Nursing Assistant (CNA) #1 said all CNAs should be documenting all care provided on all shifts. During an interview on 10/31/24 at 8:25 A.M., the Director of Nursing said she expects the CNAs to document all care provided on all shifts. The Director of Nursing said she is aware of significant missing documentation.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 41019 Based on interview and record review, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) plan related to resident's concerns of not receiving showers. Findings include: Review of the Resident Council minutes, dated 6/26/24, indicated that Residents in attendance stated showers were not happening in the facility. Review of the Resident Council minutes, dated 9/25/24, indicated that Residents in attendance stated showers were not happening as scheduled. During the Resident Group meeting on 10/30/24 at 10:03 A.M., 7 out of 12 participants said they haven't had a shower in a long time and do not feel clean. During an interview on 11/1/24 at 9:35 A.M., the Director of Nursing said if something is becoming an increased issue of concern or has been brought up multiple times by the residents, then the issue will be brought to QAPI. The Director of Nursing said the Activities Director, who runs the resident council meetings, has not been providing her with the minutes so she was unaware that there was an issue with showers not being received. The Director of Nursing said that going forward she will start to collect the resident council minutes. The Director of Nursing said a QAPI was not completed for showers not being done in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48990 Based on observations and interviews, the facility failed to implement the infection prevention and control program. Specifically, 1.) the facility failed to ensure a nurse performed appropriate hand hygiene after removing gloves during wound care; and 2.) the facility failed to ensure a nurse performed appropriate hand hygiene after contact with body fluids during tracheotomy (a surgically created opening in the neck that provides an alternative airway for breathing) care. Findings include: Review of the facility policy titled Hand Hygiene, revised 2/22/22, indicated: - Perform hand hygiene before putting on gloves and immediately after removing gloves. - Use an alcohol-based hand rub after contact with blood, body fluids or contaminated surfaces. 1.) On 10/31/24 at 12:49 P.M., the surveyor observed Nurse #1 perform wound care. Nurse #1 wore gloves to remove a soiled dressing from a resident's lower leg and cleansed the wound. Nurse #1 removed her gloves and put on new gloves without performing hand hygiene. Nurse #1 applied a new dressing to the lower leg wound. Nurse #1 removed her gloves and put on new gloves without performing hand hygiene. Nurse #1 then cleansed a different surgical abdominal wound. Nurse #1 removed her gloves and put on new gloves without performing hand hygiene. Nurse #1 applied a new dressing to the surgical abdominal wound. Nurse #1 said she was done with wound care, removed her gloves, and began to gather supplies and organize the resident's bedside table without performing hand hygiene. During an interview on 10/31/24 at 1:20 P.M., Nurse #1 said she should have performed hand hygiene every time she removed her gloves, but did not. During an interview on 11/1/24 at 8:52 A.M., the Director of Nursing (DON) said Nurse #1 should have performed hand hygiene every time she removed her gloves. 2.) On 10/31/24 at 12:49 P.M., the surveyor observed Nurse #1 perform tracheotomy care. Nurse #1 wore sterile gloves to remove and cleanse the tracheotomy tube. Nurse #1 re-inserted the tracheotomy tube and then cleansed the tracheotomy of secretions (which is a body fluid). Nurse #1 then removed soiled tracheotomy ties (which are used to secure the tracheotomy tube). Nurse #1 did not change her gloves before applying new, clean tracheotomy ties using soiled gloves. During an interview on 10/31/24 at 1:20 P.M., Nurse #1 said she was unaware she needed to remove soiled gloves, perform hand hygiene, and use clean gloves to apply clean tracheotomy ties. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/24 at 8:52 A.M., the Director of Nursing (DON) said gloves should be removed and hand hygiene performed immediately after cleansing tracheotomy secretions. The DON said new, clean gloves should have been worn to apply clean tracheotomy ties, since the gloves had contact with body fluids, to prevent the tracheotomy ties from being contaminated by secretions.