STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225440	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on observations, interviews and policy review the facility 1) failed to provide a dignified existence for three Residents (#26, #7, #39) while dining, 2) failed to provide dignity during care for two Residents (#62 and #45) and 3) failed to provide a dignified dining experience in 2 of 3 unit dining rooms. Specifically: 1. For Residents #26, #7 and #39, the residents did not receive the needed assistance at meals and resorted to eating non-finger food items with their hands at meals. 2. For Residents #62 and #45 staff failed to provide privacy during Activity of Daily Living Care. 3. For residents on the [NAME] and Pondview Units the staff failed to ensure dignity while dining. Findings include: Review of the facility policy titled, Dignity, dated 8/1/23, indicated the following: -Each residents shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self- esteem. -Residents are treated with dignity and respect at all times. -The facility culture supports dignity and respect for residents by honoring residents goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. -When assisting with care, residents are supported in exercising their rights. For example. residents are: c. encouraged to dress in the clothing they prefer e. provided with a dignified dining experience. (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 - Some	-Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. -Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 1a. For Resident #26 the facility failed to provide a dignified dining experience; Resident #26 did not receive the needed assistance with feeding and resorted to eating non-finger food items with his/her hands, staff stood while feeding Resident #26 and when food spilled in between Resident #26's legs in his/her lap staff used a spoon to scoop it out. Resident #26 was admitted to the facility in May 2022 and has diagnoses that include dysphagia (difficulty chewing and swallowing) and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/24, indicated that on the Brief Interview for Mental Status exam Resident #26 scored a 7 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated that Resident #26 had no behaviors and required partial/moderate assistance with eating. Review of a clinical progress note, dated 3/3/24, indicated the following: -Requiring full 1A (1 person assistance) assist feed from staff. Review of the current Activity of Daily Living (ADL) care plan, dated as created 10/31/23, indicated that Resident #26 has been identified as having potential or actual deficits in Activities of Daily living while a resident at our facility. Interventions on the care plan include: -Eating: I am Dependent, dated as initiated 10/31/23. The care plan failed to indicate a behavior of eating non-finger food items with his/her hands. Review of Resident #26's current Resident ADL Guide/Kardex indicated the following care instructions for Resident #26: -Partial/moderate assistance with eating. On 3/05/24 at 12:27 P.M., the surveyor observed Resident #26 in his/her room with lunch on a tray table directly in front of him/her. Resident #26 was alert but confused, was not responding to verbal interactions and had food all over his/her chest. There were no staff present to assist the Resident with the meal and at 12:31 P.M., Resident #26 began eating sweet potato with his/her hands. On 3/06/24 at 12:31 P.M., the surveyor observed Resident #26 in his/her room with a lunch tray directly in front of him/her. There were no staff present to assist Resident #26 with the meal and Resident #26 was eating coleslaw with his/her hands and had a pile of food on his/her chest. The surveyor continued to make the following observations: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:33 P.M., Certified Nursing Assistant (CNA) #2 entered the room. Resident #26 was placing coleslaw in his/her mouth with his/her hands as CNA #2 approached. CNA #2 walked up to Resident #26, said here and, while standing and looking down at Resident #26, placed a spoonful of food in Resident #26's mouth. Moments later, while Resident #26 was still chewing, CNA #2 placed another spoonful of food in Resident #26's mouth then turned around and walked out of the room. -At 12:35 P.M., CNA #2 returned to the room and used a spoon to scoop up food that had fallen between Resident legs in his/her lap, then walked out of the room without speaking to the Resident. During an interview on 3/06/24 at 2:37 P.M., CNA #2 said he is supposed to be seated at eye level when feeding residents and verbally engaging with him/her while providing assistance. During an interview on 3/06/24 at 2:46 P.M., with the Nurse Unit Manager #2 and Charge Nurse #1 both said staff should always be seated at eye level when feeding residents and engaging with the residents while providing care. On 3/07/24 at 5:19 P.M., a CNA delivered dinner in to Resident #26's room. The Resident was sleeping and without waking the Resident first, the CNA used the bed remote to raise the head of the bed. The CNA then put the dinner tray on a tray table in front of Resident #26, while at the same time saying honey, are you going to eat. The surveyor continued to make the following observations: -At 5:24 P.M., while standing beside the bed, looking down at Resident #26, the CNA began feeding him/her the meal. During an interview on 3/11/24 at 12:13 P.M., the Assistant Director of Nursing (ADON) said it is the expectation that staff be seated at eye level while feeding residents and that residents be referred to by their name. 1b. For Resident #7 the facility failed to provide a dignified dining experience; Resident #7 did not receive the needed assistance with feeding and resorted to eating non-finger food items with his/her hands and staff referred to Resident #7 as a feeder rather than by his/her name. Resident #7 was admitted to the facility in December 2021 and has diagnoses that include cerebral infarction (stroke) and dysphagia (difficulty chewing and swallowing). Review of the most recent Minimum Data Set (MDS) assessment, dated 1/6/24, indicated that on the Brief Interview for Mental Status exam Resident #7 scored an 11 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated Resident #7 required supervision and or touching assistance with feeding. Review of Resident #7's current Activity of Daily Living (ADL) indicated the following interventions: -Eating: I am partial to moderate assistance. The care plan failed to indicate a behavior of eating non-finger food items with his/her hands. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's current Resident ADL Guide/Kardex failed to indicate care instructions for Resident #7 for eating, however staff documented daily in the month of March 2024 that Resident #7 was provided with substantial/maximal assistance with eating 3 meals daily. On 3/05/24 at 8:50 A.M., a Certified Nursing Assistant (CNA) delivered breakfast to Resident #7, who was in bed. The CNA set up the tray on a tray table directly in front of Resident #7 and exited the room, leaving Resident #7 without any supervision or assistance. The surveyor continued to make the following observations: -Between 8:50 A.M., and 9:10 A.M., Resident #7 stared at the plate of food. -At 9:11 A.M., Resident #7 began to eat scrambled eggs with his/her hands. On 3/07/24 at 5:36 P.M., a nurse delivered dinner to Resident #7 who was laying in bed. The surveyor continued to make the following observations: -Until 5:43 P.M., the nurse stood at Resident #7's bedside, looking down at the Resident while feeding him/her. On 3/08/24 at 8:26 A.M., a staff person entered Resident #7's room, placed the breakfast tray on a tray table out of reach and exited the room. The surveyor continued to make the following observations: -At 8:57 A.M., CNA #9 entered the room and offered assistance Resident #7. The surveyor entered the room and CNA #9 said Resident #7 is a feeder. During an interview on 3/11/24 at 12:13 P.M., the Assistant Director of Nursing (ADON) said it is the facility expectation that staff be seated at eye level while feeding residents and that staff refer to resident's by their name, not with labels such as feeder. 1c. For Resident #39 the facility failed to provide a dignified dining experience; Resident #39 did not receive the needed assistance with feeding and resorted to eating non-finger food items with his/her hands Resident #39 was admitted to the facility in October 2017 and had diagnoses that include dementia and senile degeneration of the brain. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/16/23, indicated that on the Brief Interview for Mental Status exam Resident #39 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #39 required supervision with eating. Review of Resident #39's current Activity of Daily Living (ADL) care plan indicated the following intervention: -Eating: supervised at meal times. The care plan failed to indicate a behavior of eating non-finger food items with his/her hands. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current Resident ADL guide/Kardex indicated Resident #39 is dependent on staff for eating. On 3/11/24 at 8:45 A.M., Resident #39 was in bed with a breakfast tray directly in front of him/her and there were no staff present to supervise or assist the Resident. The surveyor continued to make the following observations: -At 8:50 A.M., Resident #39 remained without staff present and food had dropped all over his/her chest. Resident #39 was observed slouched to the left side of the bed, with his/her eyes closed, and reached forward, picked up a hand full of eggs and placed them in his/her mouth. -By 9:01 A.M., no staff had entered the room to assist Resident #39 with the meal since he/she was initially observed 16 minutes prior, and Resident #39 continued to eat eggs with his/her hands. During an interview on 3/11/24 at 12:29 P.M., with the Director of Nursing (DON), the surveyor shared the observations of Resident #39 without assist for breakfast and resorting to eating non-finger food items with his/her hands. The DON said residents should receive assist as needed with meals and that eating with hands is a dignity issue. During an interview on 3/11/24 at 12:38 P.M., with Resident #39's Certified Nursing Assistant (CNA) #10 she said that Resident #39 needs assistance with meals or he/she will eat with his/her hands but that she was busy feeding another resident at breakfast that day. 2a. For Resident #62 the facility failed to provide a dignified existence during ADL care, when his/her Certified Nursing Assistant (CNA) was on his cell phone, during care. Resident #62 was admitted to the facility in June 2020 and had diagnoses that include neuromuscular dysfunction of bladder. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/06/24, indicated that on the Brief Interview for Mental Status exam Resident #62 scored a 1 out of possible 15, indicating severely impaired cognition. The MDS further indicated Resident #62 had no behavior of rejecting care, is incontinent of bowel and bladder and is dependent for toileting hygiene. Review of Resident #62's current Activity of Daily Living (ADL) care plan indicated Resident #62 is dependent for toileting care. On 3/11/24 at 10:41 A.M., the surveyor observed Certified Nursing Assistant (CNA) #8 enter Resident #62's room and pull the curtain to provide care. The surveyor continued to make the following observations: -From 10:42 A.M., to 10:44 A.M., the Surveyor observed CNA #8's silhouette standing motionless beside Resident #62's bed. -At 10:44 A.M., the surveyor observed CNA #8, standing over Resident #62, with Resident #62's johnny pulled up to the belly area and a brief exposed. CNA #8 was on his/her phone, not providing care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/24 at 10:45 A.M., with the Nurse Supervisor, he was notified of the observation and the Nurse Supervisor intervened with CNA #8. The Nurse Supervisor then returned to the surveyor and indicated that it is a dignity and privacy issue and that staff are expected to provide care when with the residents, not be on their phone. During an interview on 3/11/24 at 11:15 A.M., the Administrator said staff should not be on their phone in resident rooms, they should be providing care. 41456 2b. For Resident #45, the facility failed to provide a dignified existence during incontnence care by not having the privacy curtain drawn and leaving the Resident exposed. Resident #45 was admitted to the facility in December 2022 with diagnoses including anxiety and muscle weakness. Review of Resident #45 most recent Minimum Data Set (MDS) dated [DATE], indicated he/she had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, which indicated he/she is cognitively intact. The MDS also indicated Resident #45 is dependent on staff for toileting tasks. On 3/07/24 at 6:19 A.M., Resident #45 was being provided with incontinent care by Certified Nursing Assistant (CNA) #6. The privacy curtain was not drawn, leaving the Resident exposed from the hallway. During an interview on 3/11/24 at 11:58 A.M., Resident #45 said he/she expects privacy During an interview on 3/7/24 at 6:26 A.M., CNA #6 said she typically pulls the privacy curtain when providing care to residents in their beds. CNA #6 said she was unaware Resident #45 was visible from the hallway when his/her incontinent care was being provided. CNA #6 said she was distracted and must have forgotten to pull the privacy curtain. During an interview on 3/07/24 at 11:02 A.M., Nurse #7 [NAME] said all residents should have privacy when care is being provided. During an interview on 3/07/24 at 11:08 A.M., Unit Manager #2 said the privacy curtain should be drawn when residents are receiving care so they are not exposed and visible from the hallway or other parts of the room. During an interview 3/07/24 at 11:36 A.M., the Director of Nursing said she expects all residents to have privacy when care is being provided. 3. The facility failed to provide a dignified dining experience. The following was observed during the lunch meal on the [NAME] Unity on 3/05/24 at 12:37 P.M. *A nurse referred to a resident as feeder at the entrance of the dining room, audible for all present to hear. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*A Certified Nursing Assistant was handing residents clothing protecters, referring to them as bibs. * A nurse referred to a resident as more of a supervision than a feed at the entrance of the dining room, audible for all present to hear. *A resident was given her meal at 12:39 P.M. The Resident was unable to feed herself. At 12:44 a nurse gave the resident a forkful of food while standing and then went to assist another resident. At 12:47 P.M., eight minutes after receiving her meal, a Certified Nursing Assistant (CNA) walked by the residents and said, don't forget to eat and walked away. At 12:50, eleven minutes after receiving her meal, a CNA sat next to the resident and began to feed her. The following was observed during the lunch meal on the [NAME] Unit on 3/06/24 at 12:32 P.M.: *There were three residents seated at a table. The first resident received and started eating lunch at 12:23 P. M., The third resident received his meal at 1244 P.M., twenty-one minutes later. *There were five residents seated at a table. The first resident received and started eating lunch at 12:23 P. M. The fifth resident received her meal at 1249 P.M., twenty-six minutes later. The Following was observed on the Pondview Unit during the breakfast meal on 3/07/24 at 08:11 A.M.: *A staff member referred to a resident as a feeder in a common area within 5 feet, and earshot, of three other residents. The staff member then repeated she's a feeder while tapping on the table of the resident he was referencing. *A CNA was observed standing while providing feeding assistance to resident in his/her room. Resident sitting in wheelchair and the CNA was not at the resident's eye level. The Following was observed on the Pondview Unit during thelunch meal on 3/07/24 at 11:43 A.M.: *A staff member referred to a resident as a feeder in the dining room within earshot of four other residents. *A staff member was standing while providing feeding assistance to a resident who was lying in bed. The bed was not raised for the staff to be at the eye level of the resident. *At 11:57 A.M., the surveyor observed a staff member using her cellphone to send a text (staff member observed typing on her phone and hitting the send icon, and a text sending sound was heard) in the dining room while providing feeding assistance to a resident. 216a 03/07/24 12:06 PM staff member observed standing while providing feeding assistance, resident was in bed, bed was not raised, staff was not at eye level On 3/08/24 at 8:10 A.M. the surveyor observed a staff member standing while providing feeding assistance to a resident in the common area of the Pondview unit in front of the nurse's station. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/07/24 at 11:36 A.M., the Director of nursing said staff should provide a dignified dining experience to the residents of the facility. The Director of Nursing said this is done by not referring to residents with labels such as feed/feeder, by serving all residents eating at the same table at the same time, and but sitting at the level of the resident while providing assistance during meals.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 48671 Based on record review and interviews, the facility failed to obtain consents for psychotropic medication, outlining the risks and benefits of treatment, prior to administering psychotropic medication for two Residents (#97, and #82) out of a sample of 41 residents. Findings include: A review of the facility's policy titled Psychotropic Medication Use, dated August of 2023, indicated the following: -Residents, families, and/or representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying, and responding to adverse consequences. 1. Resident #97 was admitted to the facility in October 2023 with diagnoses including: Alzheimer's, major depressive disorder, anxiety, dementia, adult failure to thrive, aphasia, and dysphagia. Review of the Minimum Data Set (MDS) assessment, dated 12/2/23, indicated Resident #97 had a Brief Interview for Mental Status (BIMS) score of 0 out of a possible 15 which indicated severe cognitive impairment. Further review of the MDS indicated Resident #97 is dependent on staff for all functional tasks. A review of the medical record indicated an invoked health care proxy with an invocation since October 2023. Review of Resident #97's physician orders indicated the following psychotropic medication orders: -Citalopram Hydrobromide (an anti-depressant medication)Tablet 20 mg. Give 1 tablet by mouth one time a day for depression related to MAJOR DEPRESSIVE DISORDER. Dated 10/20/23. -LORazepam Concentrate (an anti-anxiety medication) 2 MG/ML, Give 0.25 ml by mouth two times a day related to DEMENTIA. Start date 10/19/23 and discontinued 10/19/23. -LORazepam Concentrate 2 MG/ML, Give 0.25 ml by mouth two times a day related to DEMENTIA. Start date 10/20/23. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-QUEtiapine Fumarate (an antipsychotic medication) Tablet 25 mg. Give 1 tablet by mouth two times a day related to DEMENTIA. Review of the medical record failed to include signed consent for all three psychotropic medications. A review of Resident #97's Medication Administration Record (MAR) October 2023, November 2023, December 2023, January 2024, February 2024, and March 2024 indicated the following: Resident #97 received 141 doses of Citalopram Hydrobromide 20 mg from October 2023 through March 2024 without proper consent. Resident #97 received 1 dose of LORazepam Concentrate 2 MG/ML, during the month of October 2023 without proper consent. Resident #97 received 253 doses of LORazepam Concentrate 2 MG/ML, from October 2023 through March 2024 without proper consent. Resident #97 received 284 doses of QUEtiapine Fumarate Tablet 25 mg., from October 2023 through March 2024 without proper consent. During an interview on 3/6/24 at 8:38 A.M., Unit Manager #1 looked through Resident #97's medical record and said the Resident does not have a signed consent for any of the three psychotropic medications on file. Unit manager #1 said psychotropic medications must have a signed consent on file prior to use. During an interview with the Assistant Director of Nurses (ADON) on 3/7/24 at 5:48 P.M., the ADON she would expect to see signed consent forms in the chart prior to the administration of medication and said psychotropic consents must be updated annually and with any dose change. The ADON said medications should not be administered without signed consent from the Health Care Proxy (HCP). 2. Resident #82 was admitted to the facility in September 2023 with diagnoses including: dementia with severe agitation, delusional disorders, adjustment disorder, and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 12/30/23, indicated Resident #82 had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 which indicated severe cognitive impairment. Further review of the MDS indicated Resident #82 is dependent on staff for all functional tasks. A review of the medical record indicated an invoked health care proxy with an invocation on September 15, 2023. Review of Resident #82's physician orders indicated the following psychotropic medication order: Mirtazapine (an anti-depressant medication) Tablet 7.5 mg. Give 1 tablet by mouth at bedtime for improved depression and appetite. Order dated 9/22/23. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #82's medical record failed to include signed consent for psychotropic medication. A review of Resident #82's Medication Administration Record (MAR) September 2023, November 2023, December 2023, January 2024, February 2024, and March 2024 indicated the following: Resident #82 received 284 doses Mirtazapine Tablet 7.5 mg., from 9/22/23 through 3/7/24 without proper consent. During an interview on 3/6/24 at 8:38 A.M., Unit Manager #1 looked through Resident #82's medical record and said the Resident does not have a signed consent for any of the psychotropic medication on file and said verbal consent is not accepted. Unit manager #1 said psychotropic medications must have a signed consent on file prior to use. During an interview with the Assistant Director of Nurses (ADON) on 3/7/24 at 5:48 P.M., the ADON she would expect to see signed consent forms in the chart prior to the administration of medication and said psychotropic consents must be updated annually and with any dose change. The ADON said medications should not be administered without signed consent from the HCP.

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Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48671 Based on observation, record review and interview, the facility failed to ensure one Resident (#50) was assessed for the ability to self-administer medications out of a total sample of 41 residents. Findings include: Review of the facility policy titled Administering Medications, dated 8/1/23, indicated the following: 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making ability to do so safely. Resident #50 was admitted to the facility in February 2023 with diagnoses including cognitive communication deficit, muscle weakness, and diabetes. Review of Resident #50's most recent Minimum Data Set (MDS) assessment, dated 12/21/23, indicated Resident #50 had a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15 which indicated moderate cognitive impairment. Further review of the MDS indicated that he/she is dependent on staff for functional tasks. During an observation on 3/5/24 at 7:52 A.M., Resident #50 was sitting in his/her room. There was a 1.6 oz tube of Voltaren Arthritis Pain gel (gel used to treat arthritic pain) on his/her nightstand next to the Resident. Resident #50 says he/she uses the cream at night for knee pain. During an observation on 3/6/24 at 10:20 A.M., Resident #50 was sitting in his/her room. There was a 1.6 oz tube of Voltaren Arthritis Pain cream observed inside the open drawer of his/her nightstand, next to the Resident. Review of the current physician's orders failed to indicate an order for Voltaren Arthritis Pain topical gel. Review of the current physician's orders failed to indicate an order to self-administer medication. Review of the medical record failed to indicate an assessment was completed to self-administer medication. Review of the current care plan failed to indicate a care plan that Resident #50 self-administers medication. During an interview on 3/7/23 at 8:12 P.M., Unit Manager #1 said Resident #50 does not take medications on his/her own and would need a signed consent on file. Unit Manager #1 said the Resident should not have medications kept in his/her nightstand. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/8/224 at 11:13 A.M., the Assistant Director of Nursing (ADON) said, Resident #50 should not be self-administering medications without being assessed and having a physician's order.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 41456 Based on observations, record review and interview, the facility failed to ensure a call light was within reach for one Resident (#7) out of a total sample of 41 residents. Findings include: Review of the policy titled, Call System, Residents, dated 8/1/23, indicated the following: -Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. -Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Resident #7 was admitted to the facility in November 2023 with diagnoses including stroke, heart failure and anxiety. Review of Resident #7's most recent Minimum Data Set (MDS) assessment, dated 1/6/24, indicated Resident #7 had a Brief Interview for Mental Status exam score of 11 out of a possible 15, which indicated the Resident had moderate cognitive impairment. The MDS also indicated Resident #7 required assistance from staff for all functional tasks. On 3/07/24 from 6:20 A.M., to 6:48 A.M., Resident #7 was observed calling out for water. The surveyor entered the room and observed Resident #7 lying in bed and his/her call light was not within reach. On 3/07/24 at approximately 11:00 A.M., Resident #7 was heard calling out for water. The surveyor observed Resident #7 in his/her room, was lying in bed and his/her call light was not within reach. Resident #7 said he/she needed water and would use his/her call light to ask for help but did not know where it was. On 3/08/24 at 6:21 A.M., Resident #7 was heard calling out for help. The surveyor observed Resident #7 in his/her room and his/her call light was not within reach. Review of Resident #7's fall care plan, last revised on 3/6/24, indicated the following interventions: -Call light within reach. Check resident if unable to use call light. During an interview on 3/11/24 at 12:20 P.M., the Director of Nursing said she expects call lights to be in reach for all residents who are able to use them. During an interview on 3/11/24 at 3:42 P.M., the Director of Nursing said she expects all residents who are able to use call lights to have them within their reach.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 41456 Based on record review and interview, the facility failed to file and resolve grievances brought to the Resident Council group for four months. Findings include: Review of the policy titled, Grievances, dated 8/1/23, indicated the following: -Our facility will assist residents, their representatives, family members or resident advocates in filing a grievance/concern form when concerns are expressed, which may not be able to be handled immediately by the facility staff, requires further investigation or requires consultation with other facility staff, the attending physicians or outside service providers. -Any resident, his/her representative, family member or advocate may file a grievance/concern form regarding treatment, facility services, medical care, behavior or other residents or staff members, theft of property, missing items, discrimination, etc. without fear of threat or reprisal in any form. -The facility will post information on how to file a grievance and information on the name, phone number and contact information (including mail and email) for the facility grievance officer. Grievances may be reviewed in writing, orally or anonymously. -The same process will be followed regardless of the method in which a grievance/concern is conveyed or the setting of the grievance, i.e. resident or family group, care conference, etc. Review of the Resident Council minutes for the month of October 2023, November 2023, December 2023, February 2024, and March 2024, indicated the following: -October 2023: the group complained about staff not wearing their name badges, long call bell wait times, menus do not match with what food is being served. -November 2023: the group complained about staff not wearing their name badges, long call bell wait times, menus do not match with what food is being served. -December 2023: the group complained about staff not wearing their name badges, long call bell wait times, menus do not match with what food is being served. -February 2024: the group complained about staff not wearing their name badges, long call bell wait times, menus do not match with what food is being served. -March 2024: the group complained about staff not wearing their name badges, long call bell wait times, menus do not match with what food is being served. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident group was held on 3/06/24 at 11:00 A.M. Nine of nine participating residents said they complain about the same issues month after month and they feel the facility does not respond to grievances brought up in the group meeting. Nine out of nine residents said they feel frustrated and feel they are not being listened to. Review of the Grievance log for 2023 and 2024 failed to indicate any grievances had been filed for the issues repeatedly reported in resident council meetings. During an interview on 3/11/24 at 3:58 P.M., the Administrator said he has been overseeing the grievance process in the building since the social worker is new to long term care and he is aware of how the grievance process works in long term care. The Administrator said he would expect that any concerns brought up by residents be addressed, especially if the same concerns were repeatedly brought up. The Administrator said complaints brought up in resident council meetings should be filed as a grievance and be resolved. The Administrator said he was unaware that the repeated concerns from resident group were not addressed and said grievances should have been made for all those concerns.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 36797 Based on observations and interviews, the facility failed to ensure resident's Protected Health Information (PHI) was secure and not visible to others on two of three nursing units. Findings include: Review of the facility policy titled Resident Rights, updated 8/1/23, indicated that residents have the right to privacy and confidentiality. On 4/29/24, at 7:00 A.M., the surveyor observed a medication cart on the Glenside unit to have the computer screen open and exposing a resident's personal medical information. The surveyor also observed 3 nurses at the nurse's station approximately 25 feet away with their backs towards the medication cart. The surveyor also observed several residents in the hallway, passing by the open screen. On 4/29/24, at 7:15 A.M., the surveyor observed a medication cart on the Pond View unit to have the computer screen open and exposing a resident's personal medical information. The surveyor also observed that the nurse was not on the unit and the cart was not in their line of site. The surveyor also observed several residents in the hallway able to visualize the protected medical information. The surveyor then observed the nurse enter the unit from the stairs at the end of the hallway. During an interview on 4/29/24, at 7:18 A.M., Nurse #2 said that it was not appropriate to have the computer screen open, exposing a resident's personal medical information. On 4/29/24, at 7:21 A.M., the surveyor observed a medication cart on the Glenside unit to have the computer screen open and exposing a resident's personal medical information. The surveyor also observed that the nurse was in a resident's room and the cart was not in their line of site. The surveyor observed several residents in the hallway able to visualize the protected medical information. During an interview on 4/29/24, at 7:21 A.M., Nurse #1 said that it was not appropriate to have the computer screen open, exposing a resident's personal medical information. During an interview on 4/29/24, at 10:50 A.M., the Corporate Nurse said that leaving the screens open on the medication carts with personal medical information exposed is inappropriate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on record review and interview, the facility 1. failed to make information on how to file a grievance or complaint available to the residents of the facility and 2. failed to file and resolve grievances for three Residents (#47, #100 and #5) out of a total sample of 41 residents. Findings include: Review of the policy titled, Grievances, dated 8/1/23, indicated the following: -Our facility will assist residents, their representatives, family members or resident advocates in filing a grievance/concern form when concerns are expressed, which may not be able to be handled immediately by the facility staff, requires further investigation or requires consultation with other facility staff, the attending physicians or outside service providers. -Any resident, his/her representative, family member or advocate may file a grievance/concern form regarding treatment, facility services, medical care, behavior or other residents or staff members, theft of property, missing items, discrimination, etc. without fear of threat or reprisal in any form. -All new residents will be informed of the information on how to file a grievance/concern and who he grievance officer is at the facility. -The facility will post information on how to file a grievance and information on the name, phone number and contact information (including mail and email) for the facility grievance officer. Grievances may be reviewed in writing, orally or anonymously. -The same process will be followed regardless of the method in which a grievance/concern is conveyed or the setting of the grievance, i.e. resident or family group, care conference, etc. -Upon request, the facility will provide a copy of the grievance policy to the resident or resident representative. -As necessary, take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. -The grievance official at the facility will ensure that all written grievance decisions include the date the grievance/concern was received, a summary statement of the residence grievance/concern, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance/concern was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance/concern, and the date the written decision was issued. -The facility will maintain evidence demonstrating the results of the grievances for a period of no less than three years from the issue of the grievance decision. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Grievance concern forms may be submitted orally or in writing to any facility staff member or anonymously. Staff receiving the concern will immediately report the issue to the unit manager on duty. The unit manager or RN Supervisor will resolve the issue or assist the resident, resident representative or concerned person to complete a grievance/concern form or complete the form, if accepting an oral complaint which cannot be immediately resolved. -The grievance form will be submitted to the Grievance Official if the concern was not adequately resolved by the Unit Manager or RN Supervisor. The Grievance Official or designee will bring the concern to the Administrators or Director of Nursing's attention as soon as possible, if unresolved. -Upon receipt of a written grievance/concern form the Grievance Official or designee will forward the concern form to the appropriate department for investigation. The investigating department will submit a written report of findings and resolutions to the Grievance Official. -The resident and/or resident representative or person who presented the grievance will be informed of the findings of the investigation and the actions that will be taken to resolve the issue or problem orally in person or phone or in written if requested. -The original written grievance/concern form, investigation report with resolution, and written summary will be filed in the facility concern log in the social service office. The Grievance Official will complete the resident concern log. -The social worker or designee will follow up within one week to ensure that the resident/right resident representative remained satisfied with the initial resolution and that there were no further occurrences. 1. Resident group was held on 3/06/24 at 11:00 A.M. Nine of nine participating residents said they complain about the same issues month after month, and they feel the facility does not respond to grievances brought up in the group meeting. Nine out of nine residents said they feel frustrated and feel they are not being listened to. All participating residents said they are unaware how to file a formal grievance and have no grievance forms available to them. The surveyor was unable to find grievance forms on any of the three resident units. Review of the grievance log indicated the last grievance written for the facility was in October 2023. During an interview on 3/07/24 at 11:08 A.M., Nurse Unit Manager #2 said grievance forms should be available to all residents and she is aware there are no forms for residents on the [NAME] Unit. During an interview on 3/11/24 at 3:58 P.M., the Administrator said grievance forms should be available to all residents and when concerns are brought up, they should be addressed immediately. 2a. Resident #47 was admitted to the facility in March 2020 with diagnoses including Alzheimer's Disease and stroke. (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 Resident #47's most recent Minimum Data Set (MDS) assessment, dated 12/30/23, indicated Resident #47 was unable to complete the Brief Interview for Mental Status exam and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #47 is dependent on staff for daily hygiene. During an interview on 3/11/24 at 9:53 A.M., Resident #47's daughter said she had made multiple grievances to the facility regarding the Resident's care and has never had a resolution. Specifically, Resident #47's daughter said she emailed the facility on 12/06/23 with the complaint that the Resident had not been fed dinner, on 1/03/24 with complaints regarding the Resident being put to bed too early (prior to dinner) and his/her positioning in bed and on 1/20/24 with the complaint that the Resident's fingernails were consistently not clean with feces under the nails. The daughter provided copies of these emails to the surveyor. Nurse Unit Manager #1 was the consistent staff member emailed on all three emails. Review of the grievance log indicated the last grievance written for the facility was in October 2023. The were no grievances made for the above complaints made by Resident #47's daughter. During an interview on 3/11/24 at 3:58 P.M., the Administrator said he has been overseeing the grievance process in the building since the social worker is new to long term care and he is aware of how the grievance process works in long term care. The Administrator said he would expect that any concerns brought up by residents or resident representatives be addressed, especially if the same concerns were repeatedly brought up. The Administrator said concerns regarding care, such as not being fed, hygiene and positioning, would be appropriate to have been made filed as formal grievances. The Administrator said he was unaware there had been no formal grievances filed and/or resolved since October 2023, 6 months ago. The Administrator said Resident #74's daughter's complaints should have been filed as grievances and followed up with by staff. During an interview on 3/11/24 at 6:20 P.M., Nurse Unit Manager #1 said the building is starting to complete the grievance process again as it had not been done for a while. Nurse Unit Manager #1 said for a while I didn't use grievance forms at all. Nurse Unit Manager #1 said complaints of not being fed or not having care would be appropriate to be filed as a formal grievance. She said when she was made aware of complaints by Resident #47's daughter, she would try to fix the problems quickly and would not file a formal grievance as she was managing two units, and she would only have enough time to talk to nursing about the issues, not fill out a grievance form. 2b. Resident #100 was admitted to the facility in March 2022 with diagnoses including Alzheimer's disease, benign prostatic hyperplasia, and muscle weakness. Review of Resident #100's most recent Minimum Data Set assessment, dated 12/02/24, indicated the Resident was unable to complete the Brief interview for Mental Status exam and the staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #100 is dependent on staff for functional daily tasks. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/08/24 at 11:06 A.M., Resident #100's daughter said she has made multiple grievances to the facility regarding the Resident's care and has never had a resolution. Specifically, Resident #100's daughter said she emailed the facility on 7/22/23 with complaints the Resident, who has a history of eating nonedible items, was left with plastic on his/her dinner tray and was unsupervised, on 9/26/23 with complaints the nursing staff did not promptly notify the physician of the Resident vomiting coffee ground emesis (a possible sign of a stomach bleed), on 12/18/23 with complaints of the Resident being dressed in the opposite sex clothing which was not his/her own, and on 1/20/24 with complaints the Resident was not fed his/her lunch. Review of the grievance log indicated the last grievance written for the facility was in October 2023. The were no grievances made for the above complaints made by Resident #100's daughter. During an interview on 3/11/24 at 3:58 P.M., the Administrator said he has been overseeing the grievance process in the building since the social worker is new to long term care and he is aware of how the grievance process works in long term care. The Administrator said he would expect that any concerns brought up by residents or resident representatives be addressed, especially if the same concerns were repeatedly brought up. The Administrator said concerns regarding care, such as not being fed, hygiene and a resident wearing another person's clothes, would be appropriate to have been filed as formal grievances. The Administrator said he was unaware there had been no formal grievances filed and/or resolved since October 2023, 6 months ago. The Administrator said Resident #100's daughter's complaints should have been filed as grievances and followed up with by staff. During an interview on 3/11/24 at 6:20 P.M., Nurse Unit Manager #1 said the building is starting to complete the grievance process again as it had not been done for a while. Nurse Unit Manager #1 said for a while I didn't use grievance forms at all. Nurse Unit Manager #1 said complaints of not being fed or not having care would be appropriate to be filed as a formal grievance. She explained that she would try to fix problems quickly and would not file a formal grievance as she was managing two units, and she would only have enough time to talk to nursing about the issues, not fill out a grievance form. 48671 2c. Resident #5 was admitted to the facility in May 2023 with diagnoses including dysphagia (difficulty chewing and swallowing), cerebral infarction and depression. Review of Resident #5's most recent Minimum Data Set Assessment (MDS) assessment, dated 12/17/23, indicated Resident #5 had a Brief Interview for Mental Status exam score of 11 out of a possible 15, indicating moderate cognitive impairment The MDS further indicated Resident #5 required assistance with feeding tasks. During an interview on 3/07/24 at 12:30 P.M., with Resident #5 and Resident #5's Family Member (#2), Resident #5 reported that his/her dentures went missing at the facility. Family Member (#2) said Resident #5 had the dentures during breakfast on 2/09/24 but during lunch the bottom dentures were noted to be missing. Family Member #2 said she notified the Nurse Unit Manager (#1) who told her they would file a claim, but that has not been updated on the status of the claim since. Family Member #2 said they have notified several staff that since that time Resident #5 has had difficulty eating. Family Member #2 said that they took Resident #5 to get impressions for new dentures, but wants the facility to resolve the claim related to the replacement. (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 grievance log failed to include a grievance for Resident #5's lost dentures. During an interview on 3/11/24 at 3:58 P.M., the Administrator said he has been overseeing the grievance process in the building since the social worker is new to long term care and he is aware of how the grievance process works in long term care. The Administrator said he would expect that any concerns brought up by residents or resident representatives be addressed, especially if the same concerns were repeatedly brought up. The Administrator said concerns regarding care, such as missing dentures, would be appropriate to have been filed as formal grievances.

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on record reviews and interviews, the facility failed to protect seven Residents (#5, #100, #19 #108, #26, #62 and #90) from abuse and neglect by staff out of a total sample of 41 residents. Specifically, the facility failed to prevent abuse 1a) after one Resident (#5) alleged that Certified Nursing Assistant (CNA) #16 forced him/her to take a shower and sprayed water in his/her face, causing emotional distress and 2) by neglecting to complete incontinence care for Residents #100, #19, #108, #26, #62 and #90. Findings include: Review of the Facility policy titled, Resident Rights/Abuse, undated, indicated the following: -Federal requirements state that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion; And that we may not mistreat, neglect, abuse, or misappropriate the resident's property. -Emotional abuse happens when a resident is humiliated, harassed or feels threatened. -Psychological abuse - causing emotional pain or distress to a resident. Psychological abuse includes but is not limited to: humiliation. -Signs of psychological abuse may include the resident suddenly becoming fearful, withdrawn, refuses to eat, sleeps poorly at night, ringing the bell more frequently because the resident is afraid. -Neglect - the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect includes but is not limited to: failing to provide medical, dental, nursing, physical therapy, pharmacy, psychological, speech or other treatments or services; failing to carry out medical or nursing care plans or specific treatments; failing to provide for the dietary requirements of a resident; and failing to provide safety measures. Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, dated 8/1/23, indicated the following: -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -The staff, with the physicians input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. Review of the Facility policy titled Abuse and Neglect-Clinical Protocol, dated as updated 8/1/23, indicated the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Neglect as defines at 483.5, means the failure of the facility, its employer or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. -The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. 1a. Resident #5 was admitted to the facility in May 2023 with diagnoses including legal blindness, cerebral infarction, anxiety, and depression. Review of Resident #5's most recent Minimum Data Set Assessment (MDS) assessment, dated 12/17/23, indicated Resident #5 had a Brief Interview for Mental Status score of 11 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated Resident #5 required substantial-maximal assistance with bathing. During an interview on 3/07/24 at 12:30 P.M., with Resident #5 and Resident #5's Family Member (#2), Resident #5 reported that staff ignored his/her requests to not take a shower and not have his/hair washed and that he/she feels ignored. Resident #5 said Certified Nursing Assistant (CNA) #16 forced him/her to take a shower on 2/28/24. Resident #5 said he/she goes to the hair salon on Tuesdays and told CNA #16 he/she did not want a shower or to have his/her hair washed the following day. Resident #5 said She picked me up and made me take a shower, sprayed water in my face and used a whole bottle of shampoo. She scrubbed my nose and was a big, awful person and scared me even after I kept telling her no, she would not stop spraying me and scrubbing my hair. Resident #5 said CNA (#16) shouldn't be working and that he/she told his/her privately paid helper what had happened that afternoon. Resident #5 said, I was overpowered, and no one could help. I was frightened and I was afraid. Family Member #2 said she received a call from the privately paid aide and was notified of the incident and went to visit Resident #5 that evening and was told the same information by Resident #5. The Resident's Family Member #2 said a formal complaint was made to Unit Manager #1, and to the Director of Nurses (DON) on 2/28/24 by Resident #5's Health Care Proxy. During an interview on 3/08/24 at 2:57 P.M., with Resident #5, and Family Member (#3), the family member said the Resident and family are upset and concerned about this incident. Family Member #3 said he spoke with Nurse Unit Manager #1 a few days after the incident again because Resident #5 was still afraid and scared and had been refusing showers for 9 days. Resident #5 said I don't want a shower because I am afraid and scared still. Family Member #3 said he was very upset because this has put fear into Resident #5 and the Resident does not want family to leave him/her alone since this incident. During an interview on 3/08/24 at 3:14 P.M., Family Member (#1) said Resident #5 was very upset and crying during a phone call and said he/she felt overpowered, frightened, and afraid of this staff member. Family Member #1 said Resident #5 told CNA #16 he/she did not want a shower and that he/she had a shower on Monday. Family member #1 said Resident #5 said CNA #16 said he/she must take a shower because her family told him/her to and brought him/her into the shower very upset and proceeded to shower him/her. Resident #5 reported that CNA #16 continued to spray water on the Resident after repeat attempts at telling the CNA to stop. Resident #5 said please don't do my hair, I just paid to have it done, and the CNA took the hose and put it over Resident #5's head and sprayed water down his/her face and head. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Family Member #1 said the Resident started screaming and said to the CNA you son of a bitch I told you not to wash my hair and I told you no. I just had my hair done!. Resident #5 said CNA #16 continued washing his/her hair and continued to spray water over his/her face and hair. Resident #5 said he/she was man powered and had no control when the CNA overtook her, and said and none of his/her family could protect him/her. Family Member #1 said she immediately reported all the information to the Director of Nursing on 2/28/24 and told her she wanted to file a grievance regarding all of the information reported by Resident #5. The family member said she has not heard back from the facility since the incident and has not received a copy of the grievance report. Family Member #1 said she also spoke with Unit Manager #1 on 2/28/24 and was told that a formal grievance was in the works. Family Member # 1 said she feels this was emotional abuse and it has caused Resident #5 to refuse showers since the incident because he/she is scared. During an interview on 3/07/24 at 12:40 P.M., the hairdresser said she provides salon services to Resident #5 and washed and styled his/her hair and the Resident has been very upset since then, because the CNA made him/her take a shower. During an interview on 3/07/24 at 3:12 P.M., the Director of Nursing (DON) said she does not remember this incident and will check her list of incidents tomorrow. The DON said if Resident #5 refused a shower the CNA should not have forced her to take a shower and should have documented the refusal, notified the nurse and the nurse would enter a note into the computer. The DON said if a resident is forced into doing something, that would be considered a type of abuse. During an interview on 3/08/24 at 4:01 P.M., Nurse Unit Manager #1 said she was made aware of the situation on 2/28/24 by Resident #5's family member and notified the DON of the incident. Nurse Unit manager #1 said the CNA should not have made Resident #5 take a shower, and it is a form of abuse. Unit manager #1 said if Resident #5 said no, and she did it anyway, that is abuse. During an interview on 3/08/24 at 4:08 P.M., with the DON and Administrator, the DON said she was notified of the incident that took place on 2/28/24 and that she spoke with Resident #5's family member on the day of the incident. The DON said CNA #16 should not have showered him/her after the Resident said no. The DON and Administrator said forcing a resident to do something against their will is a form of abuse. 41456 2a. Resident #100 was admitted to the facility in March 2022 with diagnoses including Alzheimer's disease, benign prostatic hyperplasia, and muscle weakness. Review of Resident #100's most recent Minimum Data Set (MDS) assessment, dated 12/02/24, indicated Resident #100 was unable to complete the Brief interview for Mental Status exam and the staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #100 is dependent on staff for toileting. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 3/07/24 from 2:28 P.M. to 7:19 P.M., Resident #100 was observed out of bed in his/her wheelchair without incontinence care being provided to him/her or any staff members checking the Resident to assess if incontinence had occurred. At 7:19 P.M., the surveyor observed a puddle of urine smelling liquid dripping from the bottom of Resident #100's wheelchair seat. The puddle was gathering enough liquid that it began to stream from his/her chair to approximately 4 feet across the floor. At this time, the surveyor had Resident #100's nurse observe the Resident and the liquid, and the Nurse said he would get the Resident's Certified Nursing Assistant (CNA) to provide incontinence care for the Resident. On 3/07/24 at 7:36 P.M., 17 minutes after the Nurse said he would be getting Resident #100 assistance, the Resident remained in his/her wheelchair and the surveyor and Administrator observed the Resident together. The Administrator said the expectation of the facility is that incontinent residents be toileted every two hours and as needed. On 3/08/24 at 7:03 A.M., the Surveyor observed Resident #100 lying in his/her bed. The Resident's wheelchair was observed in his/her room across from his/her bed. The Surveyor put on clean gloves and with a finger pushed on the wheelchair cushion which caused a yellow liquid to leak out of the cushion and around the Surveyor's finger. The Surveyor then lifted the saturated cushion and noted the seat of the wheelchair seat was observed to be soaked with yellow liquid and had an ammonia smell similar to urine. During an interview on 3/08/24 at 11:06 A.M., Resident #100's daughter said she has been very upset with the level of care provided to the Resident. The Resident's daughter said she has often come in to visit Resident #100 and the Resident is soiled with feces and his/her pants are wet from an incontinent episode with a strong smell of urine. Review of Resident #100's current Activity of Daily Living (ADL) care plan, last revised, 12/28/23, indicated the following: -Bladder: (the Resident) is incontinent of bladder. -Bowel: (the Resident) is incontinent of bowel. -Toilet hygiene: (the Resident) is dependent. -Toilet transfer: (the Resident) is dependent. Review of Resident #100's current bowel incontinence care plan, last revised 12/28/23 indicated the following interventions: -Keep resident clean and dry -Provide peri-care after each incontinent episode. Review of Resident #100's current bladder incontinence care plan, last revised 12/28/23 indicated the following interventions: -Clean peri-area with each incontinence episode (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Monitor skin during incontinence care and s/s of UTI. -Remedy cream to be used with incontinent care Review of Resident #100's current potential for pressure area care plan, last revised 12/28/23 indicated the following interventions: -Follow facility policies/protocols for the prevention/treatment of skin breakdown. Review of Resident #100's most recent bowel and bladder assessment, dated 3/1/24, indicated Resident #108 was incontinent of both bowel and bladder, was totally incontinent, and had an inconsistent voiding pattern. The assessment also indicated Resident transferred back to bed BID to be toileted/changed and cleaned before final transfer back to be at night to sleep. Review of Resident #100's Kardex (a form indicating the level of assistance a resident requires) indicated Resident #100 is incontinent of both bladder and bowel and was dependent on staff for toileting tasks. Review of the nursing note, dated 3/8/24, the day after the incontinence care was not provided, indicated the following: -This am during am care, (the Resident) was noted to have a 0.125 x 1 cm (centimeter) slightly raised blister/pustule on buttocks, pustule is red with surrounding skin pink, md updated order for nystatin cream area until healed. During an interview on 3/08/24 at 7:23 A.M., Nurse Unit Manager #2 observed Resident #100's skin and said he/she definitely had a new area that was not there prior to today. Nurse Unit Manager #2 said she couldn't say if the skin area was open, but it was definitely a new skin alteration area. Nurse Unit Manager #2 said Resident #100 is incontinent and should receive incontinence care as needed. During an interview on 3/07/24 at 2:48 P.M., the Director of Nursing (DON) said it is her expectation that staff provide incontinence care every two hours. The DON said residents who are incontinent should be both checked and changed every two hours, as well as changed as needed at other times. During an interview on 3/07/24 at 7:36 P.M., the Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/08/24 at 12:44 P.M., the facility submitted a report that 6 residents did not receive incontinence care the evening of 3/08/24. During a follow-up interview on 3/12/24 at 10:49 A.M., the Administrator said that for staff to not have provided the incontinence care for the length of time they did on 3/07/24 was neglect. 2b. Resident #19 was admitted to the facility in July 2021 with diagnoses including Alzheimer's Disease and dysphagia (difficulty chewing and swallowing). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #19's most recent Minimum Data Set (MDS) assessment, dated 12/20/23, indicated Resident #19 had a Brief Interview for Mental Status exam score of 3 out of a possible 15, which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident # 19 required moderate assistance with self-feeding tasks. On 3/07/24 from approximately 8:25 A.M. to 11:45 A.M., and from 2:28 P.M. to 7:19 P.M., Resident #19 was observed out of bed in his/her wheelchair without incontinence care being provided to him/her or any staff members checking the Resident to assess if incontinence had occurred. On 3/07/24 at 7:36 P.M., the surveyor and Administrator observed the Resident together. The Administrator said the expectation of the facility is that incontinent residents be toileted every two hours and as needed. Review of Resident #19's current Activity of Daily Living (ADL) care plan, last revised 1/02/24, indicated the following: -Bladder: (the Resident) is incontinent of bladder. -Bowel: (the Resident) is incontinent of bowel. -Toilet hygiene: (the Resident) is substantial to max assist. -Toilet transfer: (the Resident) is substantial to max assist. Review of Resident #19's current incontinence care plan, last revised 1/02/24, indicated the following interventions: -Check as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN (as needed) after incontinence episodes. -Clean peri-area with each incontinence episode. Review of Resident #19's current potential for pressure areas care plan, last revised 1/02/24, included the following intervention: -Follow facility policies/protocols for the prevention/treatment of skin breakdown. Review of Resident #19's most recent bowel and bladder assessment, dated 12/30/23, indicated Resident #19 was incontinent of both bowel and bladder, was totally incontinent, had an inconsistent voiding pattern, and needed to be toileted during care and around meals to reduce episodes of incontinence. Review of Resident #19's Kardex (a form indicating the level of assistance a resident requires) indicated Resident #19 is incontinent of both bladder and bowel and was dependent on staff for toileting tasks. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/07/24 at 2:48 P.M., the Director of Nursing (DON) said it is her expectation that staff provide incontinence care every two hours. The DON said residents who are incontinent should be both checked and changed every two hours, as well as changed as needed at other times. During an interview on 3/07/24 at 7:36 P.M., the Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/08/24 at 12:44 P.M., the facility submitted a report that 6 residents did not receive incontinence care the evening of 3/08/24. During a follow-up interview on 3/12/24 at 10:49 A.M., the Administrator said that for staff to not have provided the incontinence care for the length of time they did on 3/07/24 was neglect. 2c. Resident #108 was admitted to the facility in July 2023 with diagnoses including dementia, chronic kidney disease, and benign prostatic hyperplasia. Review of Resident #108's most recent Minimum Data Set (MDS) assessment, dated 1/27/24, indicated Resident #108 was unable to complete the Brief Interview for Mental Status (BIMS) and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated the Resident required moderate assistance from staff for toileting hygiene. On 3/07/24 from approximately 2:28 P.M. to 7:19 P.M., Resident #108 was observed out of bed in his/her wheelchair without incontinence care being provided to him/her or any staff members checking the Resident to assess if incontinence had occurred. The Resident was not toileted after either the lunch or dinner meals. On 3/07/24 at 7:36 P.M., the surveyor and Administrator observed the Resident together. The Administrator said the expectation of the facility is that incontinent residents be toileted every two hours and as needed. During an interview on 3/08/24 at 11:30 A.M., Resident #108's spouse said she had to request that Resident #108 be toileted after every meal to keep him/her clean because incontinence care was not being provided regularly. Review of Resident #108's Activity of Daily Living care plan, last revised 2/01/24, indicated the following: -Bladder: (the Resident) is incontinent of bladder. -Bowel: (the Resident) is incontinent of bowel. -Toilet hygiene: (the Resident) is dependent. -Toilet transfer: (the Resident) is substantial to max assist. Review of Resident #108's incontinence care plan, last revised 1/02/24, indicated the following interventions: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Incontinent: check as well as prompt toilet around meals and care times to decrease episodes as (he/she) allows and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. -Offer toileting to (the Resident) immediately after leaving the dining room. -Brief Use: the resident uses disposable briefs. Change PRN. -Clean peri-area with each incontinence episode. Review of Resident #108's most recent bowel and bladder assessment dated [DATE], indicated Resident #108 was incontinent of both bowel and bladder, was totally incontinent, and had an inconsistent voiding pattern. Review of Resident #108's Kardex (a form indicating the level of assistance a resident requires) indicated the Resident is incontinent of both bladder and bowel and was dependent on staff for toileting tasks. During an interview on 3/07/24 at 2:48 P.M., the Director of Nursing (DON) said it is her expectation that staff provide incontinence care every two hours. The DON said residents who are incontinent should be both checked and changed every two hours, as well as changed as needed at other times. During an interview on 3/07/24 at 7:36 P.M., the Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/08/24 at 12:44 P.M., the facility submitted a report that 6 residents did not receive incontinence care the evening of 3/08/24. During a follow-up interview on 3/12/24 at 10:49 A.M., the Administrator said that for staff to not have provided the incontinence care for the length of time they did on 3/07/24 was neglect. 41105 2d. Resident #26 was admitted to the facility in May 2022 and has diagnoses that includes dementia without behavioral disturbance. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/24, indicated that Resident #26 scored a 7 out of a possible 15 on Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS further indicated that Resident #26 had no behaviors, is dependent on staff for toileting hygiene and is always incontinent of bowel and bladder. Review of the current Activities of Daily Living (ADL) care plan, dated 10/31/23, indicated that Resident #26 has been identified as having potential or actual deficits in Activities of Daily living while a resident at our facility. Interventions on the care plan include: -Toilet hygiene: Resident #26 is dependent; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Bladder: Resident #26 is incontinent of bladder; -Bowel: Resident #26 is incontinent of bowel. Review of the current bowel and bladder incontinence care plan, indicated the following interventions: -INCONTINENT: check (as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN (as needed) after incontinence episodes. -Remedy cream to be used with incontinent care. Review of the current skin integrity care plan, indicated that Resident #26 had the potential for skin impairment due to incontinence. Interventions included: -Incontinent care if applicable. Review of Resident #26's current Resident ADL Guide/Kardex indicated the following care instructions for Resident #26: -Is incontinent; -Dependent for toileting hygiene. On 3/07/24 between 10:30 A.M., to 1:30 P.M., the surveyors were on the unit and observed that Resident #26 was not provided with incontinence care. The Resident was observed in his/her room, sitting on a hoyer pad (the pad used on a mechanical lift), in his/her wheelchair during that entire time. During an interview on 3/07/24 at 2:30 P.M., Certified Nursing Assistant (CNA) #2 said that he was assigned to Resident #26 that day. CNA #2 said that he changes residents on his assignment twice a shift (8 hours). CNA #2 said that he first changed Resident #26 at approximately 7:30 A.M., that morning before he used a mechanical lift to transfer him/her out of bed to a wheelchair. According to CNA #2 he then provided incontinence care to Resident #26 again at 11:00 A.M., contrary to direct observation by 2 surveyors. CNA #2 said that with the assist of CNA #3 they used a mechanical lift to transfer Resident #26 back to bed and then he provided incontinence care. CNA #2 said that CNA #3 then assisted him to mechanically transfer Resident #26 back to the wheelchair. CNA #2 said that he had not checked or changed Resident #26 since 11:00 A.M., 3.5 hours earlier. CNA #2 also said that since he just got back from his break, Resident #26 could next be changed by the staff on the 3-11 shift. During an interview on 3/07/24 at 2:36 P.M., with CNA #3 she said that she had not assisted CNA #2 at any point that day with using the mechanical lift to transfer Resident #26 to or from bed and that she was unsure who had provided Resident #26 with incontinence care. During an interview on 3/07/24 at 2:48 P.M., with the Director of Nursing (DON) she was updated on the observations and interviews and the DON said the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-It is her expectation that staff provide incontinence care every two hours; She said that every two hours incontinent residents should be both checked and changed, as well as changed as needed at other times. On 3/07/23 between 3:15 P.M., and 7:16 P.M., the surveyor observed Resident #26 seated in a wheelchair in his/her room. During that time Resident #26 was not observed to have been checked for incontinence, nor was he/she changed. At 7:16 P.M., 4 hours and 1 minute since the last time Resident #26 received incontinence care, CNA #9 entered Resident #26's room carrying incontinence supplies and pulled the curtain around him/her. During an interview on 3/07/24 at 7:36 P.M., with the Administrator (NHA) he was updated on the observations. The NHA reiterated the expectation that incontinent residents be changed every two hours and as needed. Review of the CNA assignment on 3/08/24 at 7:20 A.M., indicated CNA #2 was presently working and was again assigned to Resident #26. During an interview with the DON on 3/08/24 at 7:26 A.M., she said that she had not yet had a chance to look at statements collected regarding the allegation of neglect twice the previous day. The DON said that CNA #2 should not be working and should not be assigned to Resident #26 when she had not yet completed the neglect investigation. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/08/24 at 10:33 A.M., the facility submitted a report that Resident #26 did not receive incontinence care the morning of 3/7/24. During a follow-up interview on 3/12/24 at 10:49 A.M., the NHA said that for staff to not have provided the incontinence care for Resident #26, for the length of time they did on 3/07/24, was neglect. 2e. Resident #62 was admitted to the facility in June 2020 and had diagnoses that include neuromuscular dysfunction of bladder. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/06/24, indicated that on the Brief Interview for Mental Status exam Resident #62 scored a 1 out of possible 15, indicating severely impaired cognition. The MDS further indicated Resident #62 had no behavior of rejecting care, is incontinent of bowel and bladder and is dependent for toileting hygiene. Review of Resident #62's current Activity of Daily Living (ADL) care plan indicated Resident #62 is dependent for toileting care. The care plan failed to indicate refusal of incontinence care. Review of Resident #62's current bowel incontinence care plan indicated the following interventions: -Please keep me clean and dry; -Skin care after incontinent episodes. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #62's current Resident ADL Guide/Kardex indicated the following care instructions for Resident #62: -Is incontinent; -Dependent for toileting hygiene. Review of the most recent Bladder assessment, dated 1/6/24, indicated: -voiding pattern inconsistent -Staff continues to check and change resident when incontinent. Resident offered urinal/bedpan at care times to decrease episodes when possible. Staff to monitor skin for s/sx of breakdown/infection during care and address as needed. Resident OOB daily for meals. Briefs provided for dignity and containment. On 3/07/23 between 3:15 P.M., and 7:16 P.M., the surveyor observed Resident #62. Resident #62 was not checked for incontinence during that time, nor was he/she changed. During an interview on 3/07/24 at 6:55 P.M., with Certified Nursing Assistant (CNA) #9, who was supervising the unit dining room where Resident #62 was seated, he said that he had been supervising the dining room since approximately 4:30 P.M., which is why the residents present had not been checked or changed for incontinence. CNA #9 said that Resident #62 was on his assignment, however said that he hadn't had a chance to provide incontinence care since his shift started at 3:00 P.M., 3 hours and 55 minutes earlier, and that he wasn't sure when he was going to be able to, as he was responsible to supervise the dining room. On 3/11/24 between 7:28 A.M., and 10:42 A.M., Resident #62 was observed in bed. During that time no staff checked Resident #62 for incontinence or provided incontinence care. During an interview on 3/07/24 at 2:48 P.M., the Director of Nursing (DON) said it is her expectation that staff provide incontinence care every two hours. The DON said residents who are incontinent should be both checked and changed every two hours, as well as changed as needed at other times. During an interview on 3/07/24 at 7:36 P.M., the Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/08/24 at 12:44 P.M., the facility submitted a report that 6 residents did not receive incontinence care the evening of 3/08/24. During a follow-up interview on 3/12/24 at 10:49 A.M., the Administrator said that for staff to not have provided the incontinence care for the length of time they did on 3/07/24 was neglect. During a follow-up interview on 3/12/24 at 10:49 A.M., the NHA said that for staff to not have provided the incontinence care for the length of time they did on 3/07/24 was neglect. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	2f. Resident #90 was admitted to the facility in November 2023 and had diagnoses that include vascular dementia and unspecified urinary incontinence. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/27/24, indicated that on the Brief Interview for Mental Status exam Resident #90 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #90 is frequently incontinent of bladder and occasionally incontinent of bowel. Review of Resident #90's current ADL care plan indicated Resident #90 is dependent for toileting care. The care plan failed to indicate refusal of incontinence care. Review of Resident #90's current Resident ADL Guide/Kardex indicated the following care instructions for Resident #90: -Is incontinent; -Dependent for toileting hygiene. Review of the most recent Bladder assessment, dated 1/27/24, indicated: -voiding pattern inconsistent -cooperative with care On 3/07/23 between 3:15 P.M., and 7:16 P.M., the surveyor observed Resident #90. During that time Resident #90 was not checked for incontinence, nor was he/she changed. During an interview on 3/07/24 at 6:55 P.M., with Certified Nursing Assistant (CNA) #9, who was supervising the unit dining room where Resident #90 was seated, he said that he had been supervising the dining room since approximately 4:30 P.M., which is why the residents present had not been checked for incontinence or changed. During an interview on 3/07/24 at 2:48 P.M., the Director of Nursing (DON) said it is her expectation that staff provide incontinence care every two hours. The DON said residents who are incontinent should be both checked and changed every two hours, as well as changed as needed at other times. During an interview on 3/07/24 at 7:36 P.M., the Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/08/24 at 12:44 P.M., the facility submitted a report that 6 residents did not receive incontinence care the evening of 3/08/24. During a follow-up interview on 3/12/24 at 10:49 A.M., the Administrator said that for staff to not have provided

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 48671 Based on observations, interviews and records reviewed for one resident (Resident #101) of 41 sampled residents, the facility failed to prevent the use of restraints without appropriate assessment. Findings include: Review of the facility policy titled, Use of Restraints dated 8/1/23, indicated the following: -Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. -Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience or for the prevention of falls. -Physical restraints are defined as any manual method or physical or medical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove, which restricts freedom of movement or restricts normal access to one's body. -Prior to placing a resident in restraints, there shall be a prerestraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. -Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). -The order shall include the following: a. a specific reason for the restraint (as it relates to the residents medical symptom); b. how the restraint will be used to benefit the residents medical symptom; and c. the type of restraint, and period of time for the use of the restraint. Resident #101 was admitted to the facility in January 2024 with diagnoses including bell's palsy (weakness in the muscles on one half of the face), gastro esophageal reflux disease, unspecified protein calorie malnutrition, delusional disorders, bipolar disorder, cerebral infarction, delirium, and chronic respiratory failure. Review of the Minimum Data Set (MDS) assessment, dated 2/16/24, indicated Resident #101 had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 which indicated intact cognition. The surveyor made the following observations: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/24 at 8:18 A.M., Resident #101 was sleeping in bed, two blankets, and two pillows were stuffed and built up under the fitted sheet going the length of the mattress on both sides of the Resident. On 3/6/24 at 7:53 A.M., Resident #101 was sleeping in bed, three blankets, and two pillows were stuffed and built up under the fitted sheet going the length of the mattress on both sides of the Resident. Review of Resident #101's medical record indicated a restraint assessment had been completed on 1/23/24 and did not indicate the use of a restraint. Review of Resident #101's medical record did not indicate the use of a restraint, or a device assessment. Review of Resident #101's care plans failed to indicate a care plan for the Resident to be positioned this way in bed or for use of a restraint. Further review of the care plan dated 1/22/23, indicated the following intervention related to laceration to left forearm: -Use pillows or padding when in bed, if appropriate. During an interview on 3/06/24 at 8:25 A.M., Nurse #13 said Resident #101 had many falls and tried to get up all the time and the use of pillows is for comfort. Nurse #13 said the blankets and pillows placed under the fitted sheet are not a restraint because the Resident will try to put his/her legs over the edge. During an interview on 3/6/24 at 8:36 A.M., Unit Manager #1 said Resident #101 has a history of falls and that he/she is able to get up and out of bed quickly. Unit Manager #1 said, the blankets and pillows should not be under the sheet, because it prevents the Resident from putting his/her legs over the edge and prevents the Resident from banging his/her legs. During an interview on 3/7/24 at 5:51 P.M., the Director of Nursing (DON) said blankets and pillows should not be placed under fitted sheets because it is a restraint. The DON said residents should be assessed for restraints and blankets and pillows could be considered a restraint if they prevent a resident from getting out of bed by restricting movement.

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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. 48671 Based on record review, policy review, and interviews, the facility failed to implement their abuse policy for one Resident (#5) out of a total sample of 41 residents. Specifically, the facility failed to implement a timely investigation and report within the required two hour time frame to the Department of Public Health's (DPH's) Health Care Facility Reporting System (HCFRS) when Resident #5 reported that a Certified Nursing Assistant (CNA) forced Resident #5, against his/her will, to take a shower and purposefully sprayed water in his/her face during the process. Review of the Facility policy titled, Resident Rights/Abuse, undated, indicated the following: -Federal requirements state that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion; And that we may not mistreat, neglect, abuse, or misappropriate the resident's property. -Emotional abuse happens when a resident is humiliated, harassed or feels threatened. -Psychological abuse - causing emotional pain or distress to a resident. Cytological abuse includes but is not limited to: humiliation. -Signs of psychological abuse may include the resident suddenly becoming fearful, withdrawn, refuses to eat, sleeps poorly at night, ringing the bell more frequently because the resident is afraid. -Neglect - the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect includes but is not limited to: failing to provide medical, dental, nursing, physical therapy, pharmacy, psychological, speech or other treatments or services; failing to carry out medical or nursing care plans or specific treatments; failing to provide for the dietary requirements of a resident; and failing to provide safety measures. Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, dated 8/1/23, indicated the following: -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Neglect means the failure of the facility, its employees or service providers to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. -The staff, with the physicians input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. -The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: Resident #5 was admitted to the facility in May 2023 with diagnoses including legal blindness, cerebral infarction, anxiety, and depression. Review of Resident #5's most recent Minimum Data Set Assessment (MDS) assessment, dated 12/17/23, indicated Resident #5 had a Brief Interview for Mental Status score of 11 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated Resident #5 required substantial-maximal assistance with bathing. Review of Resident #5's February 2024 Kardex (resident specific care instructions) indicated the following: -Substantial /Max assistance with shower/bathing. Review of Resident #5's medical record failed to indicate Resident #5 had behaviors. Review of Resident #5's shower schedule indicated documented showers on 2/26/24 and 2/28/24. During an interview on 3/07/24 at 12:30 P.M., with Resident #5 and Resident #5's Family Member (#2), Resident #5 said that on 2/28/24 staff ignored his/her requests to not take a shower and not have his/her hair washed. Resident #5 said Certified Nursing Assistant (CNA) #16 forced him/her to take a shower on 2/28/24. Resident #5 said despite refusing the shower CNA #16 picked me up and made me take a shower, sprayed water on my face and used a whole bottle of shampoo. She scrubbed my nose and was a big, awful person and scared me even after I kept telling her no, she would not stop spraying me and scrubbing my hair. Resident #5 said CNA #16 shouldn't be working and told the surveyor that on 2/28/24 he/she reported what had happened to a private duty aide that he/she has. Family Member #2 said she received a call on 2/28/24 from the private duty aide, was notified of the incident and went to visit Resident #5 that evening and was told the same information by Resident #5. Family Member #2 said Resident #5's Health Care Proxy filed a formal complaint regarding the incident with the Director of Nurses (DON) on 2/28/24. During an interview on 3/07/24 at 3:12 P.M., the DON said she could not recall the incident and that she would have to review her incident logs. The DON said if Resident #5 refused a shower, CNA #16 should not have forced him/her to take a shower. The DON explained the expected process if a resident refuses care: -document the refusal on the Kardex; and -notify the nurse who would write a progress note regarding the refusal. During an interview on 3/08/24 at 4:01 P.M., Unit Manager #1 said that on 2/28/24 Resident #5's family member informed her of the incident and that she notified the DON. Unit Manager #1 said that if CNA #16 forced Resident #5 to take a shower, after he/she refused, that is abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/08/24 at 4:08 P.M., with the DON, Nursing Home Administrator (NHA) and Nurse Consultant #2, the DON said she was notified on 2/28/24 of the incident and spoke with Resident #5's family member on that day, but had not done anything further. The NHA said he was aware of the issue regarding the shower and was happy to reimburse the family for the cost of the hair. Nurse Consultant #2 said the incident was an abuse allegation and should have been handled as such, including a full investigation, obtaining statements from staff and reporting within the required two hour time frame to HCFRS; in this case none of this happened. Review of HCFRS indicated the abuse allegation was submitted on 3/08/24, 9 days after the allegation was made to the Nurse Unit Manager and Director of Nursing.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on record review, policy review and interview, the facility failed to report allegations of abuse for seven Residents (#5,#26, #62, #90, #100, #19 and #108) within the required two hour time frame out of a total sample of 41 residents. Findings include: Review of the Facility policy titled, Resident Rights/Abuse, undated, indicated the following: -Federal requirements state that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion; And that we may not mistreat, neglect, abuse, or misappropriate the resident's property. -Emotional abuse happens when a resident is humiliated, harassed or feels threatened. -Psychological abuse - causing emotional pain or distress to a resident. Cytological abuse includes but is not limited to: humiliation. -Signs of psychological abuse may include the resident suddenly becoming fearful, withdrawn, refuses to eat, sleeps poorly at night, ringing the bell more frequently because the resident is afraid. -Neglect - the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect includes but is not limited to: failing to provide medical, dental, nursing, physical therapy, pharmacy, psychological, speech or other treatments or services; failing to carry out medical or nursing care plans or specific treatments; failing to provide for the dietary requirements of a resident; and failing to provide safety measures. Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, dated 8/1/23, indicated the following: -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Neglect means the failure of the facility, its employees or service providers to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. -The staff, with the physicians input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. -The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #5 was admitted to the facility in May 2023 with diagnoses including legal blindness, cerebral infarction, anxiety, and depression. Review of Resident #5's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating he/she has moderate impaired cognition. The MDS further indicated Resident #5 required substantial-maximal assistance with bathing. During an interview on 3/7/24, at 12:30 P.M., with Resident #5 and Resident #5's Family Member #2, Resident #5 reported that staff ignored his/her requests to not take a shower and not have his/hair washed and that he/she feels ignored. Resident #5 said Certified Nursing Assistant (CNA) #16 forced him/her to take a shower on 2/28/24. Resident #5 said he/she goes to the hair salon on Tuesday and did not want a shower or to have his/her hair washed. Resident #5 said She picked me up and made me take a shower, sprayed water in my face and used a whole bottle of shampoo. She scrubbed my nose and was a big, awful person and scared me even after I kept telling her no, she would not stop spraying me and scrubbing my hair. Resident #5 said CNA #16 shouldn't be working and that he/she told her privately paid helper what had happened that afternoon. Resident #5 said, I was overpowered, and no one could help. I was frightened and I was afraid. Family Member #2 said she received a call from the privately paid aid and was notified of the incident and went to visit the Resident that evening and was told the same information by Resident #5. The Resident's Family Member #2 said a formal complaint was made to Unit Manager #1 and to the Director of Nurses (DON) on 2/28/24 by Resident #5's Health Care Proxy. During an interview on 3/08/24 at 2:57 P.M., Family Member #3 said the Resident and family are upset and concerned about this incident. Family Member #3 said he spoke with Unit Manager #1 a few days after the incident again because Resident #5 is still afraid and scared and has been refusing showers for 9 days. Resident #5 said: I don't want a shower because I am afraid. Family Member #3 said he is very upset because this has put fear into Resident #5 and the Resident does not want family to leave her alone since this incident. During an interview on 3/08/24 at 3:14 P.M., Family Member (#1) said Resident #5 was very upset and crying during a phone call and said he/she felt overpowered, frightened, and afraid of this staff member. Family Member #1 said Resident #5 told CNA #16 he/she did not want a shower and that he/she had a shower on Monday. Family member #1 said Resident #5 said CNA #16 said he/she must take a shower because her family told him/her to and brought him/her into the shower very upset and proceeded to shower him/her. Resident #5 reported that CNA #16 continued to spray water on the Resident after repeat attempts at telling the CNA to stop. Resident #5 said please don't do my hair, I just paid to have it done, and the CNA took the hose and put it over Resident #5's head and sprayed water down his/her face and head. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Family Member #1 said the Resident started screaming and said to the CNA you son of a bitch I told you not to wash my hair and I told you no. I just had my hair done!. Resident #5 said CNA #16 continued washing his/her hair and continued to spray water over his/her face and hair. Resident #5 said he/she was man powered and had no control when the CNA overtook her, and said and none of his/her family could protect him/her. Family Member #1 said she immediately reported all the information to the Director of Nursing on 2/28/24 and told her she wanted to file a grievance regarding all of the information reported by Resident #5. The family member said she has not heard back from the facility since the incident and has not received a copy of the grievance report. Family Member #1 said she also spoke with Unit Manager #1 on 2/28/24 and was told that a formal grievance was in the works. Family Member #1 said she feels this was emotional abuse and it has caused Resident #5 to refuse showers since the incident because he/she is scared. During an interview on 3/7/24 at 12:40 P.M., the hairdresser said she provides salon services to Resident #5 and washed and styled his/her hair and the Resident has been very upset because the CNA made him/her take a shower. During an interview on 3/7/24 at 3:12 P.M., the Director of Nursing (DON) said she does not remember this incident and will check her list of incidents tomorrow. The DON said if Resident #5 refused a shower the CNA should not have forced her to take a shower and should have documented the refusal, notified the nurse and the nurse would enter a note into the computer. The DON said if a resident is forced into doing something, that is a type of abuse and should be reported. The DON said the facility tracks incidents using a risk management system and a report should be entered in this system. During an interview on 3/8/24 at 4:01 P.M., Unit Manager #1 said she was made aware of the situation on 2/28/24 by Resident #5's family member and notified the DON of the incident. Unit manager #1 said the CNA should not have made the resident take a shower, and it is a form of abuse. Unit manager #1 said if Resident #5 said no, and she did it anyway, that is abuse. During an interview on 3/8/24 at 4:08 P.M., with the DON and Administrator, the DON said she was notified of the incident that took place on 2/28/24 and that she spoke with Resident #5's family member on the day of the incident. Nurse Consultant #2 said the incident should have been reported because it is an abuse allegation and needs to be reported within 2 hrs. The DON said CNA #16 should not have showered him/her after the Resident said no. The DON and Administrator said forcing a resident to do something against their will is a form of abuse. The DON said she was waiting for the grievance form to be completed before reporting this incident. The Administrator said this incident should have been reported to the state agency. The facility failed to report the abuse allegation and ensure CNA #16 was removed from the nursing schedule after Resident #5 reported abuse; potentially exposing Resident #5 and other residents in the facility to abuse. 41105 2. Resident #26 was admitted to the facility in May 2022 and has diagnoses that includes dementia without behavioral disturbance. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/24, indicated that on the Brief Interview for Mental Status exam Resident #26 scored a 7 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated that Resident #26 had no behaviors, is dependent on staff for toileting hygiene and is always incontinent of bowel and bladder. Review of the current ADL care plan, dated as created 10/31/23, indicated that Resident #26 has been identified as having potential or actual deficits in Activities of Daily living while a resident at our facility. Interventions on the care plan include: -Toilet hygiene: Resident #26 is dependent; On 3/7/24 between 10:30 A.M., to 1:30 P.M., the surveyors were on the unit and observed that Resident #26 was not provided with incontinence care. The Resident was observed in his/her room, sitting on a hoyer pad (the pad used on a mechanical lift), in his/her wheelchair during that entire time. During an interview on 3/07/24 at 2:48 P.M., with the Director of Nursing (DON) she was updated informed of the surveyors observation that staff neglected to provide Resident #26 incontinence care. On 3/07/23 between 3:15 P.M., and 7:16 P.M., the surveyor observed Resident #26 seated in a wheelchair in his/her room. During that time Resident #26 was not checked for incontinence, nor was he/she changed. At 7:16 P.M., 4 hours and 1 minute since the last time Resident #26 received incontinence care, CNA #9 entered Resident #26's room carrying incontinence supplies and pulled the curtain around him/her. During an interview on 3/07/24 at 2:48 P.M., the Director of Nursing (DON) said it is her expectation that staff provide incontinence care every two hours. She said that every two hours incontinent residents should be both checked and changed, as well as changed as needed at other times. During an interview on 3/07/24 at 7:36 P.M., the Administrator was updated on the observations. The Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. The surveyor expressed concern that staff neglected to provide incontinence care to Resident #26 during the 7-3 shift that day and again between 3:15 P.M., and 7:16 P.M. that evening. The surveyor requested the facility come up with a plan that evening to ensure all residents would receive incontinence care as needed. During an interview with the DON on 3/8/24 at 7:26 A.M., she said that the facility had not reported the allegation that staff neglected to provide incontinence care for 4 hour time frames twice on 3/7/24. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/8/24 at 10:33 A.M., the facility submitted a report that Resident #26 did not receive incontinence care the morning of 3/7/24, approximately 20 hours after the facility was notified of the allegation. As of 3/15/24 at 10:30 A.M., the facility has failed to report the allegation of neglect the evening of 3/07/24. 3. Resident #62 was admitted to the facility in June 2020 and had diagnoses that include neuromuscular dysfunction of bladder. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 1/06/24, indicated that on the Brief Interview for Mental Status exam Resident #62 scored a 1 out of possible 15, indicating severely impaired cognition. The MDS further indicated Resident #62 had no behavior of rejecting care, is incontinent of bowel and bladder and is dependent for toileting hygiene. Review of Resident #62's current ADL care plan indicated Resident #62 is dependent for toileting care. The care plan failed to indicate refusal of incontinence care. On 3/07/23 between 3:15 P.M., and 7:16 P.M., the surveyor observed Resident #62. Resident #62 was not checked for incontinence during that time, nor was he/she changed. During an interview on 3/07/24 at 6:55 P.M., with Certified Nursing Assistant (CNA) #9, who was supervising the unit dining room where Resident #62 was seated, he said that he had been supervising the dining room since approximately 4:30 P.M., which is why the residents present had not been checked or changed for incontinence. CNA #9 said that Resident #62 was on his assignment, however said that he hadn't had a chance to provide incontinence care since his shift started at 3:00 P.M., and that he wasn't sure when he was going to be able to, as he was responsible to supervise the dining room. During an interview on 3/07/24 at 2:48 P.M., the Director of Nursing (DON) said it is her expectation that staff provide incontinence care every two hours. She said that every two hours incontinent residents should be both checked and changed, as well as changed as needed at other times. During an interview on 3/07/24 at 7:36 P.M., the Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. The surveyor notified him that staff neglected to check Resident #62 for incontinence since the start of the shift that evening, over 4.5 hours earlier. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/8/24 at 12:44 P.M., the facility submitted a report that 6 residents did not receive incontinence care the evening of 3/7/24, approximately 17 hours after having been made aware of the allegation. 4. Resident #90 was admitted to the facility in November 2023 and had diagnoses that include vascular dementia and unspecified urinary incontinence. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/27/24, indicated that on the Brief Interview for Mental Status exam Resident #90 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #90 is frequently incontinent of bladder and occasionally incontinent of bowel. Review of Resident #90's current ADL care plan indicated Resident #90 is dependent for toileting care. The care plan failed to indicate refusal of incontinence care. Review of Resident #90's current Resident ADL Guide/Kardex indicated the following care instructions for Resident #90: -Is incontinent; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent for toileting hygiene. On 3/07/23 between 3:15 P.M., and 7:16 P.M., the surveyor observed Resident #90. During that time Resident #90 was not checked for incontinence, nor was he/she changed. During an interview on 3/07/24 at 2:48 P.M., the Director of Nursing (DON) said it is her expectation that staff provide incontinence care every two hours. She said that every two hours incontinent residents should be both checked and changed, as well as changed as needed at other times. During an interview on 3/07/24 at 7:36 P.M., the Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. The surveyor notified him that staff neglected to check Resident #90 for incontinence and neglected to provide incontinence care to Resident #90 between 3:15 P.M. , and 7:16 P.M. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/8/24 at 12:44 P.M., the facility submitted a report that 6 residents did not receive incontinence care the evening of 3/7/24, approximately 17 hours after having been made aware of the allegation. 41456 5. Resident #100 was admitted to the facility in March 2022 with diagnoses including Alzheimer's disease, benign prostatic hyperplasia, and muscle weakness. Review of Resident #100's most recent Minimum Data Set, dated dated dated [DATE], indicated the Resident was unable to complete the Brief interview for Mental Status (BIMS) and the staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #100 is dependent on staff for toileting. On 3/7/24 from 2:28 P.M. to 7:19 P.M., Resident #100 was observed out of bed in his/her wheelchair without incontinence care being provided to him/her or any staff members checking the Resident to assess if incontinence had occurred. At 7:19 P.M., the surveyor observed a puddle of urine smelling liquid dripping from the bottom of Resident #100's wheelchair seat. The puddle was gathering enough liquid that it began to stream from his/her chair to approximately 4 feet across the floor. At this time, the surveyor had Resident #100's nurse observe the Resident and the liquid, and the Nurse said he would get the Resident's Certified Nursing Assistant (CNA) to provide incontinence care for the Resident. On 3/07/24 at 7:36 P.M., 17 minutes after the Nurse said he would be getting Resident #100 assistance, the Resident remained in his/her wheelchair and the surveyor and Administrator observed the Resident together. The Administrator said the expectation of the facility is that incontinent residents be toileted every two hours and as needed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/07/24 at 7:36 P.M., the Administrator was updated on the observations. The Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. The surveyor expressed concern that staff neglected to provide incontinence care to Resident #100 during the 7-3 shift that day and again between 3:15 P.M., and 7:16 P.M. that evening. The surveyor requested the facility come up with a plan that evening to ensure all residents would receive incontinence care as needed. During an interview on 3/8/24 at 7:26 A.M., the Director of Nursing said the facility had not reported the allegation that staff neglected to provide incontinence care for 4-hour time frames twice on 3/7/24. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/8/24 at 10:33 A.M., the facility submitted a report that Resident #100 did not receive incontinence care the morning of 3/7/24, approximately 20 hours after the facility was notified of the allegation. As of 3/15/24 at 10:30 A.M., the facility has failed to report the allegation of neglect from the evening of 3/07/24. 6. Resident #19 was admitted to the facility in July 2021 with diagnoses including Alzheimer's Disease and dysphagia (difficulty swallowing). Review of Resident #19's most recent Minimum Data Set (MDS) dated [DATE], indicated he/she had a Brief Interview for mental Status (BIMS) score of 3 out of a possible 15, which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident # 19 required moderate assistance with self-feeding tasks. On 3/7/24 from approximately 8:25 A.M., to 11:45 A.M., and from 2:28 P.M. to 7:19 P.M., Resident #19 was observed out of bed in his/her wheelchair without incontinence care being provided to him/her or any staff members checking the Resident to assess if incontinence had occurred. During an interview on 3/07/24 at 7:36 P.M., the Administrator was updated on the observations. The Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. The surveyor expressed concern that staff neglected to provide incontinence care to Resident #19 during the 7-3 shift that day and again between 3:15 P.M., and 7:16 P.M. that evening. The surveyor requested the facility come up with a plan that evening to ensure all residents would receive incontinence care as needed. During an interview on 3/8/24 at 7:26 A.M., the Director of Nursing said the facility had not reported the allegation that staff neglected to provide incontinence care for 4-hour time frames twice on 3/7/24. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/8/24 at 10:33 A.M., the facility submitted a report that Resident #19 did not receive incontinence care the morning of 3/7/24, approximately 20 hours after the facility was notified of the allegation. As of 3/15/24 at 10:30 A.M., the facility has failed to report the allegation of neglect from the evening of 3/07/24. 7. Resident #108 was admitted to the facility in July 2023 with diagnoses including dementia, chronic kidney disease, and benign prostatic hyperplasia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #108's most recent Minimum Data Set (MDS) dated [DATE], indicated he/she was unable to complete the Brief Interview for Mental Status (BIMS) and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated the Resident required moderate assistance from staff for toileting hygiene. On 3/7/24 from approximately and from 2:28 P.M. to 7:19 P.M., Resident #19 was observed out of bed in his/her wheelchair without incontinence care being provided to him/her or any staff members checking the Resident to assess if incontinence had occurred. The Resident was not toileted after either the lunch or dinner meals. During an interview on 3/07/24 at 7:36 P.M., the Administrator was updated on the observations. The Administrator reiterated the expectation that incontinent residents be toileted every two hours and as needed. The surveyor expressed concern that staff neglected to provide incontinence care to Resident #108 during the 7-3 shift that day and again between 3:15 P.M., and 7:16 P.M. that evening. The surveyor requested the facility come up with a plan that evening to ensure all residents would receive incontinence care as needed. During an interview on 3/8/24 at 7:26 A.M., the Director of Nursing said the facility had not reported the allegation that staff neglected to provide incontinence care for 4-hour time frames twice on 3/7/24. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 3/8/24 at 10:33 A.M., the facility submitted a report that Resident #108 did not receive incontinence care the morning of 3/7/24, approximately 20 hours after the facility was notified of the allegation. As of 3/15/24 at 10:30 A.M., the facility has failed to report the allegation of neglect from the evening of 3/07/24.

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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** 48671 Based on interviews, record review and policy review, the facility failed to investigate allegations of abuse for 2 Residents (#5 and #47) out of a total sample of 41 residents. Findings include: Review of the Facility policy titled, Resident Rights/Abuse, undated, indicated the following: -Federal requirements state that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion; And that we may not mistreat, neglect, abuse, or misappropriate the resident's property. -Emotional abuse happens when a resident is humiliated, harassed or feels threatened. -Psychological abuse - causing emotional pain or distress to a resident. Cytological abuse includes but is not limited to: humiliation. -Signs of psychological abuse may include the resident suddenly becoming fearful, withdrawn, refuses to eat, sleeps poorly at night, ringing the bell more frequently because the resident is afraid. -Neglect - the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect includes but is not limited to: failing to provide medical, dental, nursing, physical therapy, pharmacy, psychological, speech or other treatments or services; failing to carry out medical or nursing care plans or specific treatments; failing to provide for the dietary requirements of a resident; and failing to provide safety measures. Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, dated 8/1/23, indicated the following: -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. -Neglect means the failure of the facility, its employees or service providers to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. -The staff, with the physicians input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. 1. Resident #5 was admitted to the facility in May 2023 with diagnoses including legal blindness, cerebral infarction, anxiety, and depression. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating he/she has moderate impaired cognition. The MDS further indicated Resident #5 required substantial-maximal assistance with bathing. During an interview on 3/7/24, at 12:30 P.M., with Resident #5 and Resident #5's Family Member #2, Resident #5 reported that staff ignored his/her requests to not take a shower and not have his/her hair washed and that he/she feels ignored. Resident #5 said Certified Nursing Assistant (CNA) #16 forced him/her to take a shower on 2/28/24, even after he/she told the CNA he/she did not want a shower because he/she had a shower two days prior. Resident #5 said he/she goes to the hair salon on Tuesday and did not want a shower or to have his/her hair washed. Resident #5 said She picked me up and made me take a shower, sprayed water in my face and used a whole bottle of shampoo. She scrubbed my nose and was a big, awful person and scared me even after I kept telling her no, she would not stop spraying me and scrubbing my hair. Resident #5 said CNA #16 shouldn't be working and that he/she told her privately paid helper what had happened that afternoon. Resident #5 said, I was overpowered, and no one could help. I was frightened and I was afraid. Family Member #2 said she received a call from the privately paid aid and was notified of the incident and went to visit Resident #5 that evening and was told the same information by Resident #5. The Resident's Family Member #2 said Resident #5 said a formal complaint was made to Unit Manager #1 and to the Director of Nurses (DON) on 2/28/24 by Resident #5's Health Care Proxy. During an interview on 3/08/24 at 2:57 P.M., Family Member #3 said the Resident and family are upset and concerned about this incident. Family Member #3 said he spoke with Unit Manager #1 a few days after the incident again because Resident #5 was still afraid and scared and had been refusing showers for 9 days. Resident #5 said I don't want a shower because I am afraid. Family Member #3 said he is very upset because this had put fear into Resident #5 and the Resident does not want family to leave him/her alone since this incident. During an interview on 3/08/24 at 3:14 P.M., Family Member (#1) said Resident #5 was very upset and crying during a phone call and said he/she felt overpowered, frightened, and afraid of this staff member. Family Member #1 said Resident #5 told CNA #16 he/she did not want a shower and that he/she had a shower on Monday. Family member #1 said Resident #5 said CNA #16 said he/she must take a shower because her family told him/her to and brought him/her into the shower very upset and proceeded to shower him/her. Resident #5 reported that CNA #16 continued to spray water on the Resident after repeat attempts at telling the CNA to stop. Resident #5 said please don't do my hair, I just paid to have it done, and the CNA took the hose and put it over Resident #5's head and sprayed water down his/her face and head. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family Member #1 said the Resident started screaming and said to the CNA you son of a bitch I told you not to wash my hair and I told you no. I just had my hair done!. Resident #5 said CNA #16 continued washing his/her hair and continued to spray water over his/her face and hair. Resident #5 said he/she was man powered and had no control when the CNA overtook her, and said and none of his/her family could protect him/her. Family Member #1 said she immediately reported all the information to the Director of Nursing on 2/28/24 and told her she wanted to file a grievance regarding all of the information reported by Resident #5. The family member said she has not heard back from the facility since the incident and has not received a copy of the grievance report. Family Member #1 said she also spoke with Unit Manager #1 on 2/28/24 and was told that a formal grievance was in the works. Family Member #1 said she feels this was emotional abuse and it has caused Resident #5 to refuse showers since the incident because he/she is scared. During an interview on 3/7/24 at 12:40 P.M., the hairdresser said she provides salon services to Resident #5 and washed and styled his/her hair and the Resident had been very upset because the CNA made him/her take a shower. During an interview on 3/7/24 at 3:12 P.M., the Director of Nursing (DON) said she does not remember this incident and will check her list of incidents tomorrow. The DON said if Resident #5 refused a shower the CNA should not have forced her to take a shower and should have documented the refusal, notified the nurse and the nurse would enter a note into the computer. The DON said a grievance and incident report should have been created and the abuse allegation should have been investigated including interviews with residents and staff to collect statements. On 3/7/24 The facility failed to provide any information regarding the abuse allegation. During an interview on 3/8/24 at 4:01 P.M., Unit Manager #1 said she was made aware of the situation on 2/28/24 by Resident #5's family member and notified the DON of the incident. Unit manager #1 said she started to fill out the grievance form but did not submit the form because she needed to see who the CNA was at the time of the incident. Unit manager #1 told the surveyor it was CNA #16 and said the CNA should not have made the resident take a shower, and it is a form of abuse. Unit manager #1 said if Resident #5 said no, and she did it anyway, that is abuse. During an interview on 3/8/24 at 4:08 P.M., with the DON, Administrator and Nurse Consultant #2, the DON said she was notified of the incident that took place on 2/28/24 and that she spoke with Resident #5's family member on the day of the incident. The DON said CNA #16 should not have showered him/her after the Resident said no. Nurse Consultant #2 said the incident should have been investigated because it is an abuse allegation. The NHA said he was aware of the issue regarding the shower and was happy to reimburse the family for the cost of the hair. The DON said she did not get staff statements or complete an investigation into the situation. The DON said she was waiting for the grievance form to be completed. During an interview on 3/12/24 at 10:22 A.M., with the Assistant Director of Nurses (ADON) and the Administrator, the Administrator said he was not aware of staff having issues with providing care and reports of abuse or neglect should be reported. The ADON said an investigation into the allegation should have been investigated immediately. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to investigate the abuse allegation and ensure CNA #16 was removed from the nursing schedule after Resident #5 reported abuse exposing Resident #5 and other residents in the facility to abuse. 41456 2. Resident #47 was admitted to the facility in March 2020 with diagnoses including Alzheimer's Disease and stroke. Review of Resident #47's most recent Minimum Data Set (MDS) dated [DATE], indicated he/she was unable to complete the Brief Interview for Mental Status (BIMS) and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #47 is dependent on staff for daily hygiene. During an interview on 3/11/24 at 9:53 A.M., Resident #47's daughter said she has made multiple complaints to the facility regarding the Resident's care and has never had a resolution. Specifically, Resident #47's daughter said she emailed the facility on 1/21/23 saying she felt Resident #47 was being neglected by the staff and was at risk of not being safe. The daughter provided copies of the email to the surveyor. The facility failed to produce any investigative reports into Resident #47's allegation of neglect. During an interview on 3/11/24 at 3:58 P.M., the Administrator said any allegations of neglect should be fully investigated. The Administrator said this incident occurred before his time at the facility so he can't speak to why an investigation was not completed.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 36797 Based on record review and interview, the facility failed to provide a copy of the transfer/discharge notice upon transfer to the hospital for one Resident (#121) out of a total sample of 41 residents. Findings include: The facility failed to produce a policy for the transfer/discharge of a resident upon request by the surveyor. Resident #121 was admitted to the facility in January 2024 with diagnoses including Covid-19 and heart failure. Review of the medical record indicated that Resident #121 was discharged to the hospital on 1/10/24. Further review failed to indicate that Resident #121, or his/her representative, was given the required transfer/discharge notice. During an interview on 3/06/24 at 10:03 A.M., the Director of Nursing said that she had not been able to locate the transfer/discharge notice for Resident #121 and this notice should have been provided to the Resident or his/her representative.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 36797 Based on record review and interview, the facility failed to provide a copy of the bed-hold notice upon transfer to the hospital for one Resident (#121) out of a total of 41 sampled Residents. Findings include: Review of the facility policy titled, Bed-Hold and Returns, updated 8/1/23, indicated that all residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at the time of transfer (or, if the transfer was an emergency, within 24 hours). Resident #121 was admitted to the facility in January 2024 with diagnoses including Covid-19 and heart failure. Review of the medical record indicated that Resident #121 was discharged to the hospital on 1/10/24. Further review failed to indicate that Resident #121, or his/her representative, was given a notice of bed hold notice. During an interview on 3/06/24 at 10:03 A.M., the Director of Nursing said that she had not been able to locate the bed-hold notice for Resident #121 and it should have been provided to the Resident or his/her representative.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview the facility failed to complete a significant change Minimum Data Set (MDS) assessment within the required time frame for two Residents (#22 and #51) out of a total sample of 41 residents. Findings include: 1. Resident #22 was admitted to the facility in July 2021 with diagnoses including depression and malnutrition. Review of Resident #22's current physician's orders, dated 1/04/24, indicated an order for a hospice evaluation and admit if appropriate. Review of the clinical progress notes indicated a note, dated 1/12/2024, that Resident #22 was admitted to hospice on 1/12/24. Review of the medical record failed to indicate that a significant change MDS was completed within the required time frame following an admission to hospice services. During an interview on 3/07/24 at 11:00 A.M., the Assistant Director of Nursing (ADON) said that when a resident is admitted to hospice services a significant change MDS must be completed. During an interview on 3/11/24, at 12:41 P.M., the MDS coordinator said that she was asked to complete a significant change MDS after the surveyor brought it to the attention of the ADON that a significant change MDS had not been completed when the Resident was admitted to hospice. The MDS nurse reviewed Resident #22's chart and said that Resident #22 should have had a significant change of status MDS completed in January 2024 due to the admission to hospice services. 41456 2. Resident #51 was admitted to the facility in August 2022 with diagnoses including dementia, osteoporosis, anxiety and depression. Review of section G of the Minimum Data Set (MDS) assessment, dated 8/13/23, indicated Resident #51 required partial assistance from staff for transfers, toileting, and ambulation. Review of Resident #51's medical record indicated he/she had a fall resulting in fractures and was sent to hospital with non-operable fractures on 10/04/23. The Resident was readmitted to facility on 10/10/23. Review of section GG of the MDS dated [DATE] indicated Resident #51 was dependent on staff for transfers, toileting, and ambulation. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/24 at 12:29 P.M., the MDS nurse said a significant change MDS is completed when there is a decline in more than two areas. The MDS nurse reviewed Resident #51's chart and said that Resident #51 should have had a significant change of status MDS completed in October due to decline in two or more areas.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record reviews, interviews and policy reviews, the facility failed to follow the plan of care and develop personalized care plans for six Residents (#39, #49, #100, #34, #60 and #71). Specifically, 1. for Resident #39, the facility failed to ensure Fall Eaze mats were in place, as ordered by the physician; 2. For Resident #49, the facility failed to develop a cognitive care plan to address dementia; 3. For Resident #100, the facility failed to a) follow the plan of care to off load the Resident's heel and b) develop a care plan for the diagnosis and behaviors of [NAME] (An eating disorder characterized by a tendency to eat substances that provide no nutritive value such as soil, chalk, hair, paper, etc.); 4. For Resident #34, the facility failed to develop a care plan for the Resident's contracture's; 5. For Resident #60, the facility failed to ensure fall mats were in place as ordered; and 6. For Resident #71, the facility failed to develop and subsequently follow a care plan for [NAME] behaviors. Findings include: 1. Resident #39 was admitted to the facility in October 2017 and had diagnoses that include dementia and senile degeneration of the brain. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/16/23, indicated that on the Brief Interview for Mental Status exam Resident #39 scored a 3 out of a possible 15, indicating severely impaired cognition. Review of the current Physician orders included the following order: -An order started 4/20/20, Fall Eaze Mats: check every shift to insure that mats on each side of the bed when in bed. On 3/05/24 at 7:46 A.M., Resident #39 was observed in bed asleep bed with a Fall Eaze mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; nor was there a second fall mat in the room. On 3/05/24 at 12:18 P.M., Resident #39 was observed in bed with a Fall Eaze mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; nor was there a second fall mat in the room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/24 at 8:45 A.M., Resident #39 was observed in bed with a Fall Eaze mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; nor was there a second fall mat in the room. On 3/11/24 at 11:00 A.M., Resident #39 was observed in bed with a Fall Eaze mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; nor was there a second fall mat in the room. On 03/11/24 at 12:25 P.M., Resident #39 was observed in bed with a Fall Eaze mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; nor was there a second fall mat in the room. During an interview on 3/11/24 at 12:38 P.M., with Resident #39's Certified Nursing Assistant (CNA) #10 she said that she is not sure if Resident #39 has one or two fall mats and told the surveyor to ask the nurse. On 3/12/24 at 7:57 A.M., Resident #39 was observed in bed asleep bed with a Fall Eaze mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; Nor was there a second fall mat in the room. During an interview on 3/12/24 at 8:16 A.M., with the Nurse Supervisor, he and the surveyor observed Resident #39 in bed with a Fall Eaze mat only on the right side of the bed. The Nurse Supervisor said that Resident #39 has a physician's order for Fall Eaze mats to both sides of the bed and that the mats should be in place at all times when the Resident is in bed. 41456 2. Resident #49 was admitted to the facility in September 2020 with diagnoses including dementia. Review of Resident #49's care plans failed to indicate a care plan for dementia with goals and interventions to address the Resident's cognitive level and needs. During an interview on 3/12/24 at 8:05 A.M., the Nursing Supervisor said care plans should be made for all diagnoses or medical concerns. The Nursing Supervisor said any resident who has a diagnosis of dementia should have a cognitive care plan with interventions regarding the resident's cognitive level and how to best interact with that resident. During an interview on 3/12/24 at 1:04 P.M., the Assistant Director of Nursing said she would expect any resident with a diagnosis of dementia to have a cognitive care plan. 3. Resident #100 was admitted to the facility in March 2022 with diagnoses including Alzheimer's disease, benign prostatic hyperplasia, and muscle weakness. Review of Resident #100's most recent Minimum Data Set (MDS) assessment, dated 12/02/24, indicated Resident #100 was unable to complete the Brief interview for Mental Status exam and the staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #100 is dependent on staff for functional daily tasks. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 3/05/24 at 7:44 A.M., Resident #100 was observed lying in bed. Both of his/her feet were resting directly on the mattress. There were no pressure relieving booties observed in the room. On 3/07/24 at 6:30 A.M., Resident #100 was observed lying in bed. Both of his/her feet were resting directly on the mattress. There were no pressure relieving booties observed in the room. On 3/12/24 at 7:56 A.M., and 9:36 A.M., Resident #100 was observed lying in bed. Both of his/her feet were resting directly on the mattress. There were no pressure relieving booties observed in the room. Review of Resident #100's physician orders indicated the following order initiated on 9/20/23: -Apply boot to left foot. Check placement when in bed and adjust as needed. Every shift for wound. Review of Resident #100's current potential for pressure ulcer care plan, last revised 12/26/23, indicated the following intervention: -Please assist me with my boot to (L) foot in bed check placement and functioning and adjust as needed. During an interview on 3/12/24 at 9:45 A.M., Certified Nursing Assistant (CNA) #11 said Resident #100 used to have a wound on his/her foot but it has healed. CNA #11 said that the Resident no longer requires a pressure relieving boot since his/her wound had healed. During an interview on 3/12/24 at 9:55 A.M., Nurse #9 said Resident #100 did not need to wear a boot in bed and just needed a boot when out of bed. During an interview on 3/07/24 at 11:08 A.M., Nurse Unit Manager #2 said she expects all orders and care plans to be followed as written. During an interview on 3/07/24 at 11:36 A.M., the Director of Nursing said she expects all orders and care plans to be followed as written. b. Review of Resident #100's medical record indicated the following nursing notes dated 9/14/23: -Resident was observed to have a lump in cheek by nurse giving medications. Upon inspection it was noted to be 2 nonedible food items the resident had returned from the hospital within (his/her) mouth. One item was a rounded green piece of plastic the size of a quarter. The second item was an IV cap noted to have the piece still inside. No injury appeared to be present in mouth and no further items were located near resident. NP was notified and dx of PICA was approved to add to chart. An order to monitor mouth Q (every) shift was placed on TAR (Treatment Administration Record) to monitor resident and staff will be educated to keep non-food items out of reach and to supervise resident for seeking items to place in mouth. -Staff reports combative behavior during care, talkative and yelling out re-direction effective at times. Episodes of taking to (his/her) mouth nonedible objects see Dx (diagnosis) list for Dx of [NAME] staff provides frequent safety checks every shift and remove for foreign object w/in (his/her) reach. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician note dated 9/15/23 indicated: Nursing staff reported that patient lacks the capacity to determine what is edible vs non-edible. Found IV caps in patient's mouth when returning from the hospital. This was a concern that HCP raised in the past, she found patient eating napkins. Review of the physician note, dated 10/2/23, indicated continue with pica precautions. Review of Resident #100's medical record failed to indicate the diagnosis of [NAME] was added to his/her diagnosis list or that a care plan was developed with interventions on how to approach and treat this condition. During an interview on 3/07/24 at 3:58 P.M., the Director of Nursing said there should be a diagnosis of [NAME] in Resident #100's medical record and nursing should have developed a care plan with individualized interventions for Pica. 45763 4) For Resident #34 the facility failed to develop a care plan for contractures. Review of the facility policy titled Care Planning - Interdisciplinary Team, updated August 2023, indicated the following: -Comprehensive, person centered care plans are based on resident assessment and developed by an interdisciplinary team (IDT). Review of the facility policy titled Resident Mobility and Range of Motion, updated August 2023, indicated the following: -The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. -The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. -Interventions may include therapies, the provision of necessary equipment, and/or exercise and will be based on professional standards of practice and be consistent with state laws and practice acts. -The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives. Resident #34 was admitted to the facility in October 2020 with diagnosis including contracture of left and right ankle and foot. Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated that Resident #34 was unable to complete a Brief Interview for Mental Status exam, as the Resident was rarely or never understood. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #34's active diagnosis list indicated a diagnosis for contracture of left and right ankle and foot. Review of Resident #34's most recent physical therapy discharge summary, dated 2/14/22, indicated Resident #34 had contractures of both ankles. Review of a health status progress note, dated 11/01/23, indicated Resident #34 had contractures of bilateral (both) ankle and feet. Review of Resident #34's care plans failed to indicate a care plan addressing his/her ankle contractures. During an interview on 3/07/24 at 12:05 P.M., Certified Nursing Assistant (CNA) #12 said Resident #34 cant move his/her ankles. During an interview on 3/07/24 at 12:25 P.M., the Physical Therapist (PT) said Resident #34 currently had contractures of his/her ankles. During an interview on 3/08/24 at 11:43 A.M., Nurse (#12) said she would expect a care plan for contractures/limited range of motion to be developed for all residents with contractures/limited range of motion. Nurse #12 said the care plan should be individualized and include interventions for regular evaluations from physical therapy and monitoring for pain related to the contracture/limited range of motion. During an interview on 3/08/24 at 11:58 A.M., Nurse Unit Manager #1 said all residents with contractures should have a care plan specifically addressing contractures/limited range of motion. Nurse Unit Manager #1 said Resident #34 did not have a care plan addressing contractures/limited range of motion and that one should have been developed and periodically revised. During an interview on 3/11/24 at 3:10 P.M., the Director of Nursing (DON) said she would expect nursing to develop a care plan specific to range of motion and contracture for all residents who have contractures/limited range of motion. The DON said the contracture/limited range of motion care plan would include individualized interventions for each resident. 48671 5. Resident #60 was admitted to the facility in September 2023 with diagnoses including dementia, history of falling, and fracture of shaft of humerus and left arm. Review of Resident #60's most recent Minimum Data Set (MDS) assessment, dated 12/16/23, indicated Resident #60 had a Brief Interview for Mental Status exam score of 3 out of a possible 15, which indicated severe cognitive impairment. The MDS further indicated Resident #60 was total dependence for functional tasks. Review of Resident #60's current falls care plan indicated the following: -Fall mats to each side of bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Fall risk assessment upon admission and every 90 days and PRN (as needed). -Keep bed in lower position when in bed. Review of Resident #60's Fall Risk Assessment, dated 12/15/23, indicated Resident #60 has a history of falls and scored 13 on the assessment, indicating the Resident is high risk for falls. On 3/05/24 at 7:47 A.M., the surveyor observed Resident #60 lying in bed. There were two fall mats in the room, however, the fall mat on the left side of the bed was folded and placed against the wall and the fall mat on the right side of the bed was folded on the floor. On 3/06/24 at 7:57 A.M., the surveyor observed Resident #60 lying in bed. There were two fall mats in the room, however, the fall mat on the left side of the bed was folded and placed against the wall and the fall mat on the right side of the bed was folded on the floor. On 3/07/24 at 7:59 A.M., the surveyor observed Resident #60 lying in bed. There were two fall mats in the room, however, the fall mat on the left side of the bed was folded and placed against the wall and the fall mat on the right side of the bed was folded on the floor. During an interview on 3/07/24 at 4:48 P.M., Certified Nursing Assistant (CNA) #4 said Resident #60 should have fall mats on both sides of the bed when in bed, due to his/her history of falling. During an interview on 3/07/24 at 5:27 P.M., Unit Manager #1 said Resident #60 needs to have fall mats placed next to the bed when he/she is in bed due to the history of falling. Unit Manager #1 said the fall mats should not be folded, alongside the wall or bed and need to be placed down correctly. During an interview on 3/07/24 at 6:07 P.M., the Director of Nursing (DON) said fall mats should not be folded or against the wall if the Resident is in bed and she expects the plan of care to be followed. 6. For Resident #71 the facility failed to develop, and subsequently follow, a care plan for a known history of [NAME] behaviors (an eating disorder, persistent eating of non-food items). Resident #71 was admitted to the facility in January 2024 and has diagnoses that include picks disease, aphagia (a swallowing disorder), and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/23/24, indicated that Resident #71 was assessed by staff to have had severely impaired cognition. The MDS further indicated Resident #71 is dependent on staff for functional tasks and requires supervision or touching assistance with eating. Review of the Nursing Assessment, dated 1/16/24, indicated Resident # 71 needs assistance with eating. Review of the nutrition care plan, dated 1/24/24, indicated: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor resident during meals and report for s/sx (signs and symptoms) of choking and/or swallowing difficulty. Review of the Activities of Daily Living care plan, revised on 1/29/24, indicated: -Supervise/cue resident during meals. Review of the Activities care plan, revised on 2/21/24 indicated: -Provide materials for self-initiated activities. Review of Resident #71's medical record failed to indicate the diagnosis of [NAME] was added to his/her diagnosis list or that a care plan was developed with resident specific interventions on how to approach and treat this condition. On 3/08/24 at 11:25 A.M., the surveyor observed Resident #71 seated in the hall in front of the Pond view nurse's station. Resident #71 was holding a yellow plastic sensory item with 13 small plastic balls detached from the plastic, Resident #71 placed one blue small ball into her mouth and then removed the ball. Resident #71 continued to place the ball into her mouth two times while unsupervised. During an interview on 3/08/24 at 11:43 A.M., Nurse (#6) said that Resident #71 should not have that item because he/she can choke on it and that Resident #71 has ongoing behavior of putting things in his/her mouth. During an interview on 3/08/24 at 12:02 P.M., Unit manager (#1) said Resident #71 is a choking risk and requires supervision at all times. Unit manager #1 said the Resident should not have access to items that are small and could come apart because the Resident has behaviors and diagnosis of Pica. Unit manager #1 said staff are required to provide supervision at all times to Resident #71 who should not be left unattended as he/she is impulsive and puts things into his/her mouth. She further said Resident #71 should have an order and care plan in place with resident specific interventions to address this issue. During a dining observation on 3/08/24 at 12:15 P.M., Resident #71 was observed seated in the dining room unsupervised, placing plastic wrap from the utensils into his/her mouth and removing it three times. Two staff members were across the dining room assisting Residents with meals with their back to Resident #71. The surveyor alerted Unit manager #1, who immediately went over and removed the plastic from Resident #71's mouth. During a follow-up interview on 3/08/24 at 12:25 P.M., Unit manager #1 reiterated that Resident #71 requires supervision at all times including meals and that leaving a plastic bag created a significant choking risk. After speaking with the surveyor, Unit manager #1, developed a care plan with a focus for [NAME] for Resident #71. The care plan indicated: The resident will not have access to non-food items within reach to place in mouth. Interventions indicated: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Food tray should not have packets, plastic wrap, or tops to containers left within arm's reach. -Resident should have access to safe activities without small pieces that could be put in mouth. -Resident should have supervision at all times to keep non-food items out of mouth. Additionally, Unit manager #1, added a physicians order on 3/8/24, for Pica. The order: -OTHER SPECIFIED EATING DISORDER. During an interview on 3/08/24 at 1:20 P.M., Family Member #3 said Resident #71 is a choking risk due to his/her condition and that the [NAME] symptoms started getting worse 2-3 weeks ago. Resident #71's family member said Unit manager #1 and the Certified Nursing Assistant's are aware of the choking risk and his/her need for constant supervision at all times. During an observation on 3/11/24 at 5:19 P.M., the surveyor observed Resident #71 sitting in the hallway near the nurses station eating dinner, the Resident had non-edible items placed on the dinner tray. As the surveyor stood up to see the items, the surveyor observed Resident #71 place a sugar packet into his/her mouth and the unit manager walked over and removed the sugar packet from the Residents mouth and removed all non-edible items off the dinner tray. The unit manager then walked away from the Resident. The surveyor then observed Residnet #71 remove a small plastic cap out of his/her bag, and place it into his/her mouth. The surveyor observed the Resident self remove the plastic cap from his/her mouth. Staff were in the vicinity of the resident but did not show any indication of seeing the plastic cap go into or out of Resident #71's mouth. During an interview on 3/12/24 at 9:50 A.M., the Assistant Director of Nursing (ADON) said Resident #71 must have supervision at all times and cannot be left unsupervised because he/she is always putting items in his/her mouth, as indicated on the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41456 Based on interview, record review and policy review, the facility failed to complete quarterly care plan meetings for two Residents (#48 and #51) out of a total sample of 41 residents. Findings include: Review of the facility policy titled, Care Planning - Interdisciplinary Team, indicated the following: -The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. -Care plan meetings are scheduled at the best time of the day for the resident and family when possible. -If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record. 1. Resident #48 was admitted to the facility in March 2015 with diagnoses including arthritis and neuropathy. Review of Resident #48's most recent Minimum Data Set (MDS) assessment, dated 1/06/24, indicated Resident #48 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated the Resident is cognitively intact. The MDS also indicated the Resident requires assistance for all functional daily tasks. The Resident group meeting was held on 3/07/24 at 11:00 A.M. During this meeting, nine of nine participating group members said they were unaware of what care plan meetings were and said they were not informed of when meetings would be occurring. Resident #48 was one of the residents who said they hadn't had a care plan meeting in a long time. Review of Resident #48's medical record indicated he/she last had a care plan meeting on 11/02/23, over three months prior. During an interview on 3/07/24 at 1:20 P.M., the Social Worker (#1) said the receptionist is responsible for creating the schedule for care plan meetings. Social Worker #1 said the care plan meetings were typically held on the days she is not in the building, so she has not attended any care plan meeting since working at the building. On 3/08/24 at 12:03 P.M., both the Receptionist and Administrator were interviewed. The Receptionist said she is responsible for keeping the schedule of the care plan meetings and sending invitations to attend to both residents and their representatives. The Administrator said care plan meetings are scheduled according to the MDS schedule and should be held quarterly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #51 was readmitted to the facility in October 2023 with diagnoses including hip fracture after a fall. Review of Resident #51's most recent Minimum Data Set (MDS) assessment, dated 2/03/24, indicated Resident #51 had a Brief Interview for Mental Status exam score of 9 out of a possible 15, which indicated the Resident had moderate cognitive impairment. The MDS also indicated Resident #51 is dependent on staff for functional daily tasks. The Resident group meeting was held on 3/07/24 at 11:00 A.M. During this meeting, nine of nine participating group members said they were unaware of what care plan meetings were and said they were not informed of when meetings would be occurring. Review of Resident #51's medical record on 3/06/23 indicated his/her last care plan meeting took place on 9/27/23. Since that meeting, Resident #51 had sustained a fall resulting in a hip fracture and had declined in multiple areas of mobility and self-care. The Surveyor then asked the facility to provide the Resident's care planning schedule. The schedule listed Resident #51 as due for a care plan meeting on 11/30/23. On 3/07/24, the facility provided the surveyor with a care plan meeting note dated 3/07/24 as a late entry for a care plan meeting that took place on 2/22/24. The care plan meeting note indicated: Care plan meeting held this am - daughter was unable to attend. (The Resident) was present. Plan of care updated with patient in agreement with future goals. The note failed to indicate if the interdisciplinary team was present at the meeting. During an interview on 3/07/24 at 1:20 P.M., Social Worker (#1) said the receptionist is responsible for creating the schedule for care plan meetings. Social Worker #1 said the care plan meetings were typically held on the days she is not in the building, so she has not attended any care plan meeting since working at the building. On 3/08/24 at 12:03 P.M., both the Receptionist and Administrator were interviewed. The Receptionist said she is responsible for keeping the schedule of the care plan meetings and sending invitations to attend to both residents and their representatives. The Administrator said care plan meetings are scheduled according to the MDS schedule and should be held quarterly. During an interview on 3/11/24 at 12:29 P.M., the MDS Nurse reviewed the care plan schedule from 2023 and said Resident #51 was planned for a care plan meeting on 11/20/23. Review of Resident #51's record at the time failed to indicate any notes from the meeting. The MDS Nurse said with no notes written about the meeting, there is no way to know if the meeting took place.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on record review, policy review, observation, and interview, the facility failed to ensure staff administered medication in a manner that met professional standards of care for one Resident (#48) out of a total sample of 10 residents. Specifically, staff failed to administer lidocaine patches per the physician's order. Findings include: Review of the facility policy, titled Administering Medications, updated August 2023, indicated, but was not limited to, the following: -Medications are administered in accordance with prescriber orders, including any required time frame. -Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interactions; and c. honoring resident choices and preferences, consistent with his or her care plan. -Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). -The individual administering the medication initials the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next ones. Resident #48 was admitted to the facility in March 2016 with diagnosis including osteoarthritis. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #48 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. Review of Resident #48's current physician orders indicated the following, active orders: - Lidocaine External Patch (lidocaine), apply to right wrist topically every morning and at bedtime for pain in right wrist each AM shift. Remove at bedtime - initiated 1/31/24 - Lidocan External Patch (lidocaine), apply to lidocaine 4% right knee topically in the morning for pain apply 8 A.M., off at 8 P.M. (sic.) - initiated 3/8/24 Review of Resident #48's care plans indicated that the Resident had a potential for pain related to chronic back and knee pain, osteoarthritis, and neuropathy, with the following intervention: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Administer pain med as ordered by my physician. During an interview and observation on 4/29/24 at 1:55 P.M., Resident #48 said that the nurse is supposed to apply lidocaine patches to his/her right wrist and right knee every morning, and that the lidocaine patches were not applied today. Resident #48 said he/she was experiencing discomfort and would have liked the lidocaine patches to have been applied to his/her right wrist and right knee this morning. The surveyor observed that there was no lidocaine patch on Resident #48's right wrist. Review of Resident #48's MAR failed to indicate that the right wrist, or right knee lidocaine patches were administered on 4/29/24. Review of Resident #48's medical record failed to indicate that Resident #48 had refused his/her lidocaine patches on 4/29/24. During an interview on 4/29/24 at 2:22 P.M., Nurse #4 said medications should be administered within an hour of a specified time, and that Resident #48 is supposed to have lidocaine patches applied around 9 A.M. each morning. Nurse #4 said he had administered Resident #48's other medications around 9 A.M. this morning, but did not apply the lidocaine patches. Nurse #4 said that the resident had not refused the lidocaine patches, and that if a resident does refuse a medication or treatment that this would be documented. During an interview on 4/29/24 at 2:27 P.M., the Assistant Director of Nursing (ADON) said she would expect medications and treatments to be administered at the time specified in the physician's order, and that if a resident refuses a medication or treatment that this would be documented in the medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observation, interview and record the facility failed to ensure assistance with Activities of Daily Living (ADLs) was provided for 16 Residents (#5, #50, #60, #62, #82, #97, #26, #39, #224, #62, #90, #19, #100, #108 #97, #47) out of a total sample of 41 residents. Specifically, 1. for Residents #5, #50, #60, #82, #97, #26, #39 and #224 the facility failed to ensure feeding assistance and supervision with meals was provided. Resident #5's lack of supervision resulted in the Resident having a burn from hot coffee; 2. For Resident #26, #62, #90 #19, #100, #108 #97 and #82, the facility failed to ensure incontinence care was provided as required. 3. For Resident #47, the facility failed to provide assistance with hygiene. Findings include: Review of the facility policy titled, Activities of Daily Living, Supporting, dated 8/1/23, indicated the following: -Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. -Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming and oral care), elimination (toileting), dining (meals and snacks). -Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. -The resident's response to interventions will be monitored, evaluated and revised as appropriate. Review of the facility policy titled, Dignity, dated 8/1/23, indicated the following: -Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, for example: b. Promptly responding to a resident's request for toileting assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1a. Resident #5 was admitted to the facility in May 2023 with diagnoses including dysphagia, legal blindness, cerebral infarction, anxiety, and depression. Review of Resident #5's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating he/she has moderate impaired cognition. The MDS also indicated Resident #5 required assistance with feeding tasks. Review of Resident #5's Kardex (form indicating level of assistance needed) indicated, Resident #5 is dependent for all functional tasks related to Activities of Daily Living (ADL) and requires supervision or touching assistance with eating. A review of the Resident's ADL care plan dated 5/22/23, and last revised on 6/2/23, indicated but was not limited to, ADL self-care performance deficit r/t (related to) disease process anxiety legally blind, and impaired memory. Interventions included: -Supervision with meals. -Explain all procedures. -Extensive assist of one with ADL's. -Explain all procedures Review of Resident #5's nutrition/dietary progress notes dated 8/21/23, and 12/7/23, indicated: Resident receives supervision with eating per ADL care plan. Review of the facility incident report titled #968 Burns, dated 12/24/23, indicated that Resident #5 suffered a burn to the thigh when he/she spilled hot coffee during breakfast. Further review of the incident report indicated the following: Resident C/O (complained of) being wet during medication administration. Resident was asked by writer what had happened, stated (his/her) coffee spilled on (his/her) clothes. Upon assessment resident noted with slight redness on the left hip, no blister noted. Resident did C/O pain. Resident stated after eating (his/her) toast (his/her) fingers were slippery when (he/she) held (his/her) cup causing it to spill over. Review of the incident note dated 12/24/23 at 12:54 P.M., indicated the following: Situation: Coffee spills, on her lap at breakfast time. Background: Resident is alert and oriented to situation, event and place. Able to make her needs known. Legally blind. Stated (he/she) spilled coffee over (his/her) lap this Am at breakfast time, due to (his/her) greasy finger from eating (his/her) buttered toast. C/O pain after incident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assessment (RN)/Appearance (LPN): found with wet pajama bottom during med administration by 8:30 AM, stated (he/she) poured hot coffee over (his/her) lap. Left thigh noted with slight redness, no blister noted. Wet clothes were removed and were cold to touch. Recommendations: Needs lids on coffee mug or sippy cups to prevent further incident. Family notified, HCP. NP notified. Cool compress applied A/O. by 10 AM no redness noted, resident denies pain and discomfort. Review of the health status note dated 12/24/23, indicated the following: Alert and verbally responsive, C/O pain to left hip, area noted to be pink this afternoon last assessed by PM prior of (his/her) leaving facility for an SLOA with HCP, no blister nor breakdown noted on left hip. Due to return by PM. The following physician orders were implemented to treat the left thigh: - Vaseline ointment to left hip redness TID for 5 days. Monitor for blister, and S/SX of infection every shift for 5 days. Dated 12/24/23. -Apply cold towel to left hip area x 1, keep in place for 2 minutes. One time only for prevention. Dated 12/24/23. -Apply ice pack to left hip area x 1, keep in place for 2 minutes. One time only for prevention. Dated 12/24/23. During an observation 3/5/24 at 8:30 A.M., the surveyor observed the Resident in his/her room sitting in a wheelchair eating breakfast alone and could not be seen from the hallway. No staff members were in the room or in the hallway. There was no staff member in the area supervising the Resident while he/she was eating. During an observation 3/5/24 at 12:30 P.M., the surveyor observed the Resident in his/her room sitting in a wheelchair eating lunch alone and could not be seen from the hallway. No staff members were in the room or in the hallway. There was no staff member in the area supervising the Resident while he/she was eating. During an observation 3/6/24 at 8:21 A.M., the surveyor observed the Resident in his/her room sitting in a wheelchair eating breakfast alone and could not be seen from the hallway. No staff members were in the room or in the hallway. There was no staff member in the area supervising the Resident while he/she was eating. During an observation 3/6/24 at 12:24 P.M., the surveyor observed the Resident in his/her room sitting in a wheelchair eating lunch alone and could not be seen from the hallway. No staff members were in the room or in the hallway. Review of Resident #5's physician orders indicated the following: Review of Resident #5's visual function care plan dated 5/22/23, and revised on 12/29/23 indicated the following interventions: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provide meal identification and placement. -Supervision with meals. I need frequent visual and physical cues for tray set up. -Tell the resident where you are placing their items. Be consistent. A review of Resident #5's nutrition/dietary progress note dated 2/29/24, indicated: -Receives supervision with eating per ADL care plan. During an interview on 3/7/24 at 3:29 P.M., the Dietician said Resident #5 is on a ground diet and requires supervision with meals. During an interview on 3/7/24 at 4:19 P.M., Nurse #5 said Resident # 5 requires assistance with meals because he/she is blind and needs help. During an interview on 3/7/24 at 5:31 P.M., the ADON said Resident #5 should not be eating alone unsupervised in his/her room and requires assistance with meals. The ADON said she expects staff to follow the plan of care, and provide assistance as indicated on the Kardex. During an interview on 3/7/24 at 6:00 P.M., the Director of Nursing (DON) said Resident #5 spilled hot coffee on his/her leg during breakfast and told the nurse when she went in to administer medications. The DON said Resident #5 should not have been eating alone in his/her room unsupervised as he/she requires supervision. The DON said she expects the plan of care and nursing interventions to be followed. 1b. Resident #50 was admitted to the facility in February 2023 with diagnoses including diabetes, cognitive communication deficit, muscle weakness and hyperlipidemia. Resident #50 was admitted to the facility in February 2023 with diagnoses including esophageal reflux disease, hyperlipidemia, weakness and cognitive communication deficit. Review of Resident #50's most recent Minimum Data Set (MDS) assessment, dated 12/21/23, indicated Resident #50 had a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15 which indicated moderate cognitive impairment. Further review of the MDS indicated that he/she is dependent on staff for functional tasks. Review of Resident #50's Kardex (form indicating level of assistance needed) indicated, Resident #50 is dependent for all functional tasks related to Activities of Daily Living (ADL) and requires supervision or touching assistance with eating. During an observation 3/5/24 at 8:23 A.M., the surveyor observed the Resident in his/her room sitting in a wheelchair eating breakfast alone and could not be seen from the hallway. Adaptive equipment was observed on the breakfast tray. Food was observed on the Residents' clothing. No staff members were in the room or in the hallway. There was no staff member in the area supervising the Resident while he/she was eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/5/24 at 12:25 P.M., the surveyor observed the Resident in his/her room sitting in a wheelchair eating lunch alone and could not be seen from the hallway. Adaptive equipment was observed on the lunch tray. No staff members were in the room or in the hallway. During an observation on 3/6/24 at 8:25 A.M., the surveyor observed the Resident in his/her room sitting in a wheelchair eating breakfast alone and could not be seen from the hallway. Adaptive equipment was observed on the breakfast tray. No staff members were in the room or in the hallway. Review of Resident #50's physician orders indicated the following: -Diet Order: HCC diet House texture, Regular/Thin consistency. Dated 11/25/23. -Document meal percentages every meal - with meals. Dated 11/25/23. A review of the Resident's ADL care plan dated 2/28/23, and last revised on 3/20/23 indicated the following: -Resident is supervised with meals (1:8) A review of the Resident's nutrition care plan dated 3/6/23, and last revised on 12/8/23 indicated the following: -Build up utensils with meals. Soup in mug. -Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Review of the dietary quarterly review note dated 12/8/23 indicated the following: -Receives supervision with eating per ADL care plan. During an interview on 3/7/24 at 4:59 P.M., Certified Nurse's Assistant (CNA)#4 said the Resident can eat alone and does not require supervision. The CNA said, care plan information is located on the Kardex. During an interview on 3/8/24 at 9:53 A.M., Unit manager #1 said Resident #50 requires supervision with all meals and should not be left alone. Unit manager #1 said all Residents should not eat alone if they require supervision or assistance during meals. During an interview on 3/11/24 at 12:11 P.M., the Assistant Director of Nursing (ADON) said residents who require supervision should not be left alone during meals. During an interview on 3/11/24 at 1:16 P.M., The Director of Nursing (DON) said residents who require supervision should not be left alone without supervision during meals. The DON said Resident #50 should not be left alone while eating, and she would expect the plan of care to be followed. (continued on next page)

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Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. Resident #60 was admitted to the facility in September 2023 with diagnoses including dementia, gastro esophageal reflux disease, cognitive communication deficit, and dysphagia (difficulty swallowing). Review of Resident #60's most recent Minimum Data Set (MDS) dated [DATE], indicated he/she had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident # 60 required total dependence with feeding tasks. Review of Resident #60's Kardex (form indicating level of assistance needed) indicated, Resident #60 is dependent for all functional tasks related to Activities of Daily Living (ADL) and requires supervision or touching assistance with eating. During an observation on 3/5/24 at 7:47 A.M., the surveyor observed Resident #60 in his/her room sitting in bed, eating breakfast alone. The Resident could not be seen from the hallway and no staff were assisting the resident. During an observation on 3/6/24 at 8:11 A.M., the surveyor observed Resident #60 in his/her room sitting in bed, eating breakfast alone. The Resident could not be seen from the hallway and no staff were assisting the Resident. During an observation on 3/6/24 at 11:30 A.M., the surveyor observed Resident #60 sitting in his/her wheelchair outside of his/her bedroom doorway, eating a plate of hard potato chips and a crunch sound could be heard when chewing. There was no staff member in the area supervising the Resident while he/she was eating. During an observation on 3/8/24 at 11:17 P.M., Resident #60 was observed eating a plate of potato chips. He/she had three hard individually wrapped round candies on her tray table with one wrapper opened. There was no staff member in the area supervising the Resident while he/she was eating. Review of Resident #60's physician orders indicated the following order: -House diet. Ground texture, Regular/Thin consistency, for safety due to poor dentition. Review of Resident #60's nutritional care plan dated 10/16/23, indicated the following interventions: -Provide house ground diet. Document meal consumption. -Monitor/record/report to MD PRN (as needed) s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. During an interview on 3/07/24 at 4:19 P.M., Nurse #5 said the Resident requires assistance and supervision with meals and should not be left unsupervised. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/07/24 at 3:32 P.M., the Dietician said Resident #60 should not be eating potato chips because he/she is on a ground diet and he/she should not be left unsupervised as he/she is at risk for aspiration. During an interview on 3/08/24 at 11:20 A.M., Unit manager #1 said Resident #60 should not be eating potato chips or candy that his/her family brings in and staff should not give those items to him/her because he/she requires a ground diet. Unit manager #1 said the Resident requires supervision with meals and should not be eating alone in his/her room or left alone eating snacks unsupervised. During an interview on 3/11/24 at 12:11 P.M., the Assistant Director of Nursing (ADON) said Resident #60 requires supervision when eating and Residents who require supervision should not be left alone during meals. During an interview on 3/11/24 at 1:16 P.M., The Director of Nursing (DON) said Residents who require supervision should not be left alone without supervision during meals. The DON said Resident #60 should not be left alone while eating, and she would expect the plan or care to be followed. 1d. Resident #82 was admitted to the facility in September 2023 with diagnoses including anorexia, abnormal weight loss, moderate protein calorie malnutrition, dementia, legal blindness, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 1/3/24, indicated Resident #82 had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 which indicated severe cognitive impairment. Further review of the MDS indicated Resident #101 is dependent on staff for all functional tasks. Review of Resident #82's Kardex (form indicating level of assistance needed) indicated, Resident #82 is dependent for all functional tasks related to Activities of Daily Living (ADL) and requires supervision or touching assistance for eating. During an observation 3/5/24 at 8:02 A.M., the surveyor observed the Resident in his/her room sitting up in bed, eating breakfast. The Resident was eating a blueberry muffin and there were broken pieces of muffin and crumbs on the overbed tray table, on the bed linens and across the front part of the Residents clothing. Resident #82 was eating alone and could not be seen from the hallway. No staff members were in the room or in the hallway. The surveyor observed Unit Manager #1 walk into Resident #82's room and asked the Resident if he/she wanted tea and the Resident said no, and the Unit Manager then walked out of the room and did not return. During an observation 3/6/24 at 8:22 A.M., the surveyor observed the Resident in his/her room sitting up in bed, eating breakfast. The breakfast tray was observed on the overbed table and Resident #82 was reaching for food items. Resident #82 was eating alone and could not be seen from the hallway. No staff members were in the room or in the hallway. During an observation 3/7/24 at 8:36 A.M., the surveyor observed the Resident in his/her room sitting up in bed, eating breakfast. The breakfast tray was observed on the overbed table and Resident #82 was reaching for food items. Resident #82 was eating alone and could not be seen from the hallway. No staff members were in the room or in the hallway. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #82's physician dietary orders indicated the following orders: -House diet ground texture, Regular/Thin consistency, for Nutrition related to abnormal weight loss. Dated 11/1/23. Review of Resident #82's ADL care plan dated 9/14/23, and revised on 10/8/23, indicated the following interventions: -Extensive to dependent with bathing, dressing, grooming, transfers, toileting, bed and chair mobility and eating. Review of Resident #82's care plan related to impaired visual function, dated 9/13/23, and revised on 10/5/23, indicated the following interventions: -Provide Meal identification and meal placement. Review of Resident #82's nutritional assessment dated [DATE], indicated the following: -Ground diet. -Feeding ability: Extensive assist, Total dependence. During an interview on 3/7/24 at 4:59 P.M., CNA #4 said the Resident does not require supervision with meals as long as staff tell the Resident where items are located because he/she is blind. The CNA said, care plan information is located on the Kardex. During an Interview on 3/8/24 at 10:41 P.M., Unit Manager #1 said Resident #82 is dependent on staff for all ADL care including eating and needs supervision. The unit manager said Resident #82 should not be left unattended during meals and would expect the care plan to be followed. During an interview on 3/11/24 at 12:15 P.M., the Assistant Director of Nursing (ADON) said residents who require supervision should not be left alone during meals. During an interview on 3/11/24 at 1:20 P.M., The Director of Nursing (DON) said residents who require supervision should not be left alone without supervision during meals. The DON said Resident #82 should not be left alone while eating, and she would expect the plan of care to be followed. 1e. Resident #97 was admitted to the facility in October 2023 with diagnoses including Alzheimer's Disease, dementia, adult failure to thrive, aphasia, dysphagia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 10/25/23, indicated Resident #97 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15 indicating severe cognitive impairment. Review of Resident #97's Kardex (form indicating level of assistance needed) indicated, Resident #97 is dependent for all functional tasks related to Activities of Daily Living (ADL) and dependent on staff for eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/5/24 at 8:10 A.M. the surveyor observed Resident #97 in his/her room sitting in a wheelchair. A breakfast tray was on the overbed table next to the Resident. The Resident could not reach the food but was attempting to do so. The Resident could not be seen from the hallway and no staff were assisting the resident. During an observation on 3/5/24 at 12:16 P.M., the surveyor observed Resident #97 sitting in the dining area, the lunch tray was observed on the table in front of the Resident. Resident #97 was observed reaching for his/her food items placing his/her fingers into a bowl. There was one staff member standing up assisting another Resident across the room, with his back facing Resident #97. The surveyor continued to watch Resident #97 try to reach his/her food and bring food to his/her mouth unsuccessfully. During an observation on 3/6/24 at 8:17 A.M. the surveyor observed Resident #97 in his/her room sitting in a wheelchair, a breakfast tray was on the overbed table next to the Resident. The Resident could not reach the food but was attempting to do so. The Resident could not be seen from the hallway and no staff were assisting the Resident. Review of Resident #97's physician dietary orders indicated the following order: -House diet ground texture, Regular/Thin consistency. Dated 1/22/24. Review of Resident #97's nutritional care plan dated 10/26/23, indicated the following interventions: -Provide, served diet as ordered- Ground. Monitor intake and record q (every) meal. -Diet appropriate snacks and drinks available PRN Review of Resident #97 nutritional assessment dated [DATE] indicated the following: -Diet in place to decrease aspiration risk. -Ground diet -Feeding ability: Extensive assist. During an interview on 3/7/24 at 4:56 P.M., CNA #4 said the Resident is on hospice and he/she needs supervision at all times and needs assistance with meals. During an Interview on 3/8/24 at 10:38 P.M., Unit Manager #1 said Resident #97 is on hospice and is dependent on staff for all ADL care including eating. The Unit Manager said Resident #97 should not be left unattended during meals. During an interview on 3/11/24 at 12:11 P.M., the Assistant Director of Nursing (ADON) said residents who require supervision should not be left alone during meals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/24 at 1:16 P.M., The Director of Nursing (DON) said residents who require supervision should not be left alone without supervision during meals. The DON said Resident #97 should not be left alone while eating, and she would expect the plan or care to be followed. 41105 1f. Resident #26 was admitted to the facility in May 2022 and has diagnoses that include dysphagia (difficulty chewing and swallowing) and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/24, indicated that on the Brief Interview for Mental Status exam Resident #26 scored a 7 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated that Resident #26 had no behaviors and required partial/moderate assistance with eating. Review of a clinical progress note, dated 3/03/24, indicated the following: -Requiring full 1A (1 person assistance) assist feed from staff. Review of the current Activity of Daily Living (ADL) care plan, dated as created 10/31/23, indicated that Resident #26 has been identified as having potential or actual deficits in Activities of Daily living while a resident at our facility. Interventions on the care plan include: -Eating: I am Dependent, dated as initiated 10/31/23. Review of Resident #26's current Resident ADL Guide/Kardex indicated the following care instructions for Resident #26: -Partial/moderate assistance with eating. Review of the current Nutrition care plan, dated as revised 5/11/23, indicated: NUTRITION: I have potential nutritional problem r/t (related to) receives therapeutic diet, interventions include: -Monitor/document/report PRN any s/sx (signs or symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. On 3/05/24 at 12:27 P.M., the surveyor observed Resident #26 in his/her room with lunch on a tray table directly in front of him/her. Resident #26 appeared alert and confused, was not responding to verbal interactions and had food all over his/her chest. There were no staff present to supervise or assist the Resident with the meal. The surveyor continued to make the following observations: -At 12:31 P.M., Resident #26 remained without supervision or assistance and began eating sweet potato with his/her hands. On 3/06/24 at 8:15 A.M., the surveyor observed Resident #26 seated in a chair in his/her room. A Certified Nursing Assistant (CNA) delivered a breakfast tray, placed it on the dresser and exited the room, without offering assistance with the meal. The surveyor continued to make the following observations: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 8:19 A.M., the CNA returned, and set up the breakfast tray on the tray table directly in front of Resident #26, then exited the room to continue passing trays to other residents. Resident #26 was left without any supervision or assistance with the meal. -At 8:25 A.M., Resident #26 remained without supervision or assistance and ate scrambled eggs with his/her hands. -At 8:27 A.M., a CNA walked in to the room, handed Resident #26 a spoon and exited the room. -At 8:29 A.M., after multiple unsuccessful attempts to use the spoon, Resident #26 began eating the eggs with his/her hands again. -At 8:38 A.M., Resident #26 began eating the food that had fallen in his/her lap with his/her hands. On 3/06/24 at 12:19 P.M., the Nurse Unit Manager (#2) delivered lunch to Resident #26 and at 12:24 P.M., she exited the room, leaving Resident #26 alone and unsupervised/unassisted. The surveyor continued to make the following observations: -At 12:28 P.M., while attempting to pick up a cup of coffee, Resident #26 accidentally stuck his/her hand in the coffee. Staff were not present to supervise or assist with the coffee. -At 12:31 P.M., Resident #26 remained without supervision or assistance and began eating coleslaw with his/her hands. During an interview on 3/06/24 at 2:37 P.M., CNA #2 he said that Resident #26 needs reminders at meals to use his/her utensils. CNA #2 said that he does not stay and supervise or assist Resident #26 with meals, rather he said he checks in on Resident #26 during the meal. During an interview on 3/06/24 at 2:46 P.M., with Charge Nurse (#1) he said that when a resident requires partial to moderate assistance with meals, it means staff should stay and supervise the entire meal, as the resident's ability to feed self may fluctuate. Charge Nurse #1 said that staff should be with Resident #26 for the entire meal. During an interview on 3/07/24 at 4:11 P.M., with the Director of Nursing (DON) she said that it is the expectation that staff be with Resident #26 for the entire meal providing supervision and feeding assistance. On 3/12/24 at 8:27 A.M., Resident #26 was observed in bed. A staff person placed a breakfast tray in the room, then without offering assistance with the meal, left the room. During a follow-up interview on 3/12/24 at 8:33 A.M., with the DON, the surveyor and the DON observed the tray left in Resident #26's room. The DON said that staff should not deliver a dependent Resident their meal until they are ready to provide the feeding assistance. 1g. For Resident #39, who is dependent on staff for feeding, staff failed to ensure the assistance was provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #39 was admitted to the facility in October 2017 and had diagnoses that include dementia and senile degeneration of the brain. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/16/23, indicated that on the Brief Interview for Mental Status exam Resident #39 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #39 required supervision with eating. Review of Resident #39's current Activity of Daily Living (ADL) care plan indicated the following intervention: -Eating: supervised at meal times. Review of the current Resident ADL guide/Kardex indicated Resident #39 is dependent on staff for eating. On 3/11/24 at 8:45 A.M., Resident #39 was observed in bed with a breakfast tray directly in front of him/her. There were no staff present to supervise or assist the Resident with the meal. The surveyor continued to make the following observations: -At 8:50 A.M., Resident #39 remained without staff present, food had dropped all over his/her chest and Resident #39 was eating scrambled eggs with his/her hands. -By 9:01 A.M., no staff had entered the room to assist Resident #39 with the meal since he/she was initially observed 16 minutes prior, and Resident #39 continued to eat eggs with his/her hands. During an interview on 3/11/24 at 12:29 P.M., with the Director of Nursing (DON) she said Resident #39 should have the needed supervision and assistance for the entire meal. During an interview on 3/11/24 at 12:38 P.M., Certified Nursing Assistant (CNA) #10 said that Resident #39 needs assistance with meals but that she was busy feeding another resident at breakfast that day. 1h. Resident #224 was admitted to the facility in February 2024 with diagnoses including Parkinson's disease, dementia and dysphagia (difficulty chewing and swallowing). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/04/24, indicated in Section K that Resident #224 experienced coughing or choking during meals or when swallowing medications. Review of the current Activity of Daily Living (ADL) care plan indicated that Resident #224 is to be supervised with meals secondary to a history of dysphagia. Review of the Speech Therapy note, dated 3/05/24, indicated Resident #224 requires distant supervision to provide cues for slowing down and not mixing in another bite while food is in the mouth, monitor for pocketing and cue to swallow before taking the next bite. On 3/05/24 at 8:40 A.M., the surveyor observed a staff person deliver Resident #224's breakfast tray and leave the room. Resident #224 was lying in bed, eating his/her meal with no staff present to provide supervision or cueing with the meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/06/24 at 8:28 A.M., the surveyor observed a Certified Nurse's Assistant (CNA) deliver Resident #224's breakfast tray and leave the room. Resident #224 was lying in bed, eating his/her meal with no staff present to provide supervision or cueing with the meal. On 3/07/24 at 8:26 A.M. the surveyor observed Resident #224 sitting on the edge of the bed, eating. There were no staff present to supervise or cue the Resident during the meal. During an interview on 3/07/24 at 8:30 A.M., CNA (#1) said that the CNA's become aware of who requires supervision with eating from the nurses. CNA #1 said that she was not aware that Resident #224 requir[TRUNCATED]

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 45763 Based on observations, interviews, and policy review the facility failed to provide an activities program that met the interest of, and supported the physical, mental, and psychosocial well-being of one Resident (#54) out of a total sample of 41 residents. Findings include: Review of the facility policy titled Activities, updated August 2023, indicated the following: -Activities department will develop activities suited for our residents in accordance with all state and federal regulations. -Activities will be developed under the direction of the activity coordinator. - The calendar shall reflect planned group activities, be posted, and large enough for the vision impaired. -The activity assistants shall be responsible for distributing the calendars within the nursing home. -An activity program shall be developed for each and every resident, according his/her needs and interest (sic.) -All residents shall be encouraged and assisted to be involved in whatever level is appropriate for the resident. -Individual programming shall include one or more of the following: a. Group activities b. Special events c. Outings d. One on one visits e. Sensory stimulation f. Individual activities -Each resident has the right to refuse participation in an activity, if a resident refused to participate the activity staff shall make attempts to encourage the resident to participate and then seek alternative means to keep the resident active either, physically, mentally and or socially. Documentation: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Activities will develop written documentation specific for each resident that will include but not limited to a comprehensive care plan, activities notes and MDS (minimum data set)/facility assessments as needed. This documentation should include but not limited to: 1. Participation 2. Refusal 3. Preferences 4. History 5. Behaviors 6. Any pertinent information regarding resident activity Resident #54 was admitted to the facility in January 2024 with a diagnosis including unspecified fracture of left calcaneus (a large bone forming the heel). Review of the most recent Minimum Data Set (MDS) assessment, dated 1/13/24, indicated Resident #54 scored a 4 out of 15 on the Brief Interview for Mental Status exam which indicated he/she had severe cognitive impairment. The MDS further indicated that it was somewhat important for Resident #54 to have books, newspapers, or magazines to read, music to listen to, do things with groups of people, do his/her favorite activities, and participate in religious services. Review of Resident #54's current psychosocial/adjustment care plan indicated that the Resident was a recent admission to the facility. The care plan included the following interventions: -1:1 visits as needed to assist with any adjustment issues. -Offer choices around care and routine. -Invite and escort him/her to activities daily. -Monitor for signs and symptoms of mood/behavioral concerns and report to nursing and social work for follow up as indicated. Further review of Resident #54's care plans failed to indicate a care plan specific to Activities or a care plan that specified Resident #54's likes, dislikes, or preferences in regards to activities. (continued on next page)

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Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/05/24 at 8:30 A.M., Resident #54 said he/she was bored and would like to participate in activities. Resident #54 said he/she was aware that activities were taking place in the facility but did not know what those activities were or when they occurred but would be interested in participating. Resident #54 said he/she had not received a calendar of activities and was unable to see the calendar posted on his/her bathroom door as he/she is unable to get up out of bed by him/herself. The surveyor observed a calendar posted on the bathroom door which was not visible from the Resident's bed; there was not a handheld copy of the activities calendar present, or any form of handheld activities such as reading materials or puzzles observed in the room. Resident #54 said he/she was not interested in bingo or chair exercises but would be interested in music, movies, live entertainment, and one to one visits. Resident #54 said he/she was catholic and would be interested in catholic activities such as rosary or mass. On 3/05/24 at 11:47 A.M., the surveyor observed Resident #54 in his/her room in bed and Resident #54's television was off. The calendar of activities was posted on the bathroom door and there remained no handheld copies of the activities calendar in the room. Additionally, there were no handheld activities such as reading materials or puzzles observed in the room. Resident #54 did not participate in the rosary activity scheduled from 10:15 - 11:30 A.M., that day. On 3/06/24 from 8:38 A.M. to 9:51 A.M., the surveyor observed Resident #54 in bed in his/her room in bed. Review of the Activity Calendar indicated Morning Greeting or Daily Chronicle was scheduled for 9:30 A.M. The surveyor observed that no staff offered Resident #54 the morning greeting or daily chronical On 3/06/24 from 11:16 A.M. to 12:10 P.M., the surveyor observed Resident #54 in his/her room in bed. The Resident's television was off, and he/she was attempting to watch his/her roommates television. There was a rosary activity occurring downstairs. On 3/07/24 from 9:27 A.M. to 10:25 A.M., the surveyor observed Resident #54 in his/her room in bed. No staff member offered a morning greeting or daily chronicle as scheduled for 9:30 A.M. per the activity calendar. There were no handheld copies of the activities calendar, or any form of handheld activities such as reading materials or puzzles observed in the room. On 3/07/24 at 12:58 P.M., the surveyor observed Resident #54 in bed in his/her room, the Resident's television was off and he/she was attempting to watch the roommates television. The surveyor heard Resident #54 say I wonder if this T.V. works. There were no handheld copies of the activities calendar, or any form of handheld activities such as reading materials or puzzles observed in the room. On 3/08/24 at 9:30 A.M. the surveyor observed Resident #54 in his/her room in bed. No staff member offered a morning greeting or daily chronicle as scheduled for 9:30 A.M. per the activity calendar. There were no handheld copies of the activities calendar, or any form of handheld activities such as reading materials or puzzles observed in the room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/08/24 from 12:55 P.M. to 1:20 P.M., the surveyor observed Resident #54 in bed in his/her room. No staff member came in to offer to take Resident #54 to mass which was scheduled from 1:00 - 2:00 P.M. in the chapel. Resident #54 recognized the surveyor from the previous day and said no staff member had offered to take him/her to mass, and that he/she would be interested in attending mass as he/she was catholic. Resident #53 said he/she was upset that he/she was not participating in activities. There were no handheld copies of the activities calendar, or any form of handheld activities such as reading materials or puzzles observed in the room. On 3/08/24 at 1:30 A.M., the surveyor observed catholic mass taking place in the chapel, Resident #54 was not present. During an interview on 3/08/24 at 2:56 P.M., Resident #54's daughter said the Resident was catholic. On 3/08/24 at 3:15 A.M. the surveyor observed Resident #54 in his/her room in bed and not participating in any activities. There were no handheld copies of the activities calendar, or any form of handheld activities such as reading materials or puzzles observed in the room. On 3/11/24 from 1:44 P.M. to 2:42 P.M., the surveyor observed Resident #54 in his/her room. The resident was in bed and his/her television was off, no staff member offered activities to the Resident. There was a word game activity, scheduled from 2:00 - 3:00 P.M., occurring downstairs. During an interview on 3/11/24 at 1:53 P.M., Certified Nursing Assistant (CNA) #5 said activities calendars are placed in areas visible to the Resident. CNA #5 said Resident #54 is resistive to get out of bed but has gotten out of bed and attended group activities in the past. During an interview on 3/11/24 at 2:13 P.M., the Activities Director said residents will know which activities are taking place by referring to the activities calendar which should be posted in an area visible to the resident; the residents should also be provided a handheld activities calendar for reference. The Activities Director said the CNAs, her assistant, and herself will offer activities to residents daily. The Activities Director said her assistant is responsible for the Morning Greetings and Daily Chronicles activity which is scheduled for 9:15 A.M. Tuesday through Saturday which consists of greeting each resident and offering to bring them to the dayroom on the unit for discussion of the daily chronicle. The Activities Director said the assistant also conducts one on one visits with residents who prefer to stay in their rooms. The Activities Director said all residents should have a care plan developed specific to activities which includes preferences for activities and religious denomination. The Activities Director said there was currently no system in place to track when residents participate in group or one on one activities. During an interview on 3/11/24 at 3:35 P.M. the Activities Assistant said she obtains activity preferences from each resident. The Activities Assistant said they used to track participation in activities but stopped in November of 2023 after the previous Activities Director left. The Activities Assistant said it was much easier to keep track of who she'd seen for one-to-one activities, and who she needed to see, when there was a tracking system in place. The Activities Assistant said she does not recall the last time she conducted a one-to-one visit with Resident #54.

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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. 48671 Based on observation, interview and record review, the facility failed to maintain a safe environment for two Residents (#71, and #12) out of a total sample of 41 residents to prevent accidents/incidents. Specifically: 1. For Resident #71 the facility failed to provide supervision to prevent the Resident from placing non edible items into his/her mouth creating a choking risk. 2. For Resident #12 the facility failed to provide supervision while consuming hot coffee. Findings include: The facility policy titled Accidents and Incidents-Investigating and Reporting, dated 8/1/23, indicated the following: -All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. 1. The nurse supervisor/charge nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place; b. The nature of the injury/illness (e.g., bruise, fall nausea, etc.); c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident;if any f. The injured person's account of the accident or incident; if able g. The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, including his/her vital signs; j. The disposition of the injured (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. Any corrective action taken; l. Follow-up information; m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report 1. For Resident #71, with a diagnosis of Picks's disease (a form of dementia that can cause changes in diet or mouth-centered behaviors), and aphagia (loss of the ability to swallow) the staff failed to provide continual supervision and Resident #71 placed a small plastic ball into his/her mouth four times. Staff failed to provide continual supervision with meals and Resident #71 placed a plastic bag into his/her mouth three times during lunch. When the staff became aware of this behavior, the facility implemented continual supervision for Resident #71 and plan to remove small items from Resident #71's tray table. Resident #71 continued to be unsupervised and was given a sugar packet which he/she put into his/her mouth and took a small plastic cap out of a bag and put it into his/her mouth. Resident #71 was admitted to the facility in January 2024 and has diagnoses that include Picks disease, aphagia (a swallowing disorder), and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/23/24, indicated that Resident #71 was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #71 was dependent on staff for functional tasks and requires supervision or touching assistance with eating. On 3/08/24 at 11:25 A.M., the surveyor observed Resident #71 seated in the hall in front of the Pond View nurse's station. Resident #71 was holding a yellow plastic sensory item with 13 small plastic balls detached from the plastic. Resident #71 placed one small ball into his/her mouth and then removed the ball. Resident #71 continued to place the ball into his/her mouth two more times while unsupervised. Unit Manager #1 was sitting at the nurse's station but not observing the Resident. Unit Manager #1 then left the unit, and no staff were in the hallway to supervise Resident #71. The surveyor observed Resident #71 continue to place the small ball in and out of his/her mouth four more times. Staff were across the hall, out of the eyesight of the Resident. The surveyor immediately notified Certified Nursing Assistant (CNA) #5. CNA #5 walked over to Resident #71 and removed the yellow plastic sensory item and 12 balls from the tray table. CNA #5 said the resident puts things in his/ her mouth all the time we have to keep an eye on him/her because he/she is a choking risk and can't have small items. CNA #5 began looking at the items on the tray table and picked up the ball and said he/she has had this toy for about a week, I didn't know that it can come apart. (He/she) can't have loose items. CNA #5 then removed a loose shoestring and a small plastic sandwich bag from the right pocket of Resident #71's pants. CNA #5 said How did you get those? You should not have those!. CNA #5 said Resident #71 requires supervision at all times because he/she is impulsive and should not have access to small items. During an interview on 3/08/24 at 11:43 A.M., Nurse #6 said that Resident #71 should not have the sensory item with small loose balls because he/she can choke on it and that Resident #71 has ongoing behavior of putting things in his/her mouth. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/08/24 at 12:02 P.M., Unit Manager #1 said Resident #71 is a choking risk and requires supervision at all times. Nurse Unit Manager #1 said the Resident should not have access to items that are small and could come apart because the Resident has behaviors and diagnosis of Pica. Nurse Unit Manager #1 said staff are required to provide supervision at all times to Resident #71 who should not be left unattended as he/she is impulsive and puts things into his/her mouth. She further said Resident #71 should have an order and care plan in place with resident specific interventions to address this issue. Review of the Nursing Assessment, dated 1/16/24, indicated Resident # 71 needs assistance with eating. Review of the nutrition care plan, dated 1/24/24, indicated: -Monitor resident during meals and report for s/sx (signs and symptoms) of choking and/or swallowing difficulty. Review of the Activities of Daily Living care plan, revised on 1/29/24, indicated: -Supervise/cue resident during meals. Review of the Activities care plan, revised on 2/21/24 indicated: -Provide materials for self-initiated activities. Review of Resident #71's medical record failed to indicate the diagnosis of [NAME] was added to his/her diagnosis list or that a care plan was developed with resident specific interventions on how to approach and treat this condition. During a dining observation on 3/08/24 at 12:15 P.M., Resident #71 was observed sitting in the dining room unsupervised, placing plastic wrap from the utensils into his/her mouth and removing it three times. Two staff members were across the dining room assisting other residents with meals. Resident #71 had his/her back facing the two staff members and was not visible to staff. The surveyor alerted Unit Manager #1 and she immediately removed the plastic from Resident #71's mouth. During a follow-up interview on 3/08/24 at 12:25 P.M., Nurse Unit Manager #1 reiterated that Resident #71 requires supervision at all times including meals and that leaving a plastic bag created a significant choking risk. During an interview on 3/08/24 at 1:20 P.M., Family Member #6 said Resident #71 is a choking risk due to his/her condition and that the [NAME] symptoms started getting worse 2-3 weeks ago. Resident #71's family member said Nurse Unit Manager #1 and the Certified Nursing Assistant's are aware of the choking risk and his/her need for constant supervision at all times. During an interview on 3/08/24 at 4:10 P.M., with the Administrator, Director of Nursing (DON) and Consultant Staff #2, the surveyor discussed concerns that had been identified during the survey process regarding the supervision of Resident #71. The DON said she is aware of the choking risk and that Residents requiring supervision should not be left unsupervised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/11/24 at 5:19 P.M., the surveyor observed Resident #71 sitting in the hallway near the nurses station eating dinner, the Resident had non-edible items placed on the dinner tray. As the surveyor stood up to see the items, the surveyor observed Resident #71 place a sugar packet into his/her mouth and the Unit Manager walked over and removed the sugar packet from the Residents mouth and removed all non-edible items off the dinner tray. The Unit Manager then walked away from the Resident. The surveyor then observed Resident #71 remove a small plastic cap out of his/her bag, and place it into his/her mouth. Staff were in the vicinity of the Resident but did not show any indication of seeing the plastic cap go into or out of Resident #71's mouth. During an interview on 3/12/24 at 9:50 A.M., the Assistant Director of Nursing (ADON) said Resident #71 must have supervision at all times and cannot be left unsupervised because he/she is always putting items in his/her mouth, as indicated on the care plan. During an interview on 3/12/24 at 10:18 A.M., with the Director of Nursing (DON) and Administrator the surveyor again discussed concerns that had been identified during the survey process regarding the supervision of Resident #71. The DON and Administrator said all Residents who require supervision must be supervised. 2. For Resident #12, the staff failed to provide the required supervision and Resident #12 was observed reaching for hot coffee off of the coffee cart during lunch to hold while being pushed in a wheelchair by staff, which caused Resident #12 to spill the hot coffee onto his/her wheelchair and floor. Resident #12 was observed reaching for a second cup of hot coffee while in the dining room and was unsupervised. Resident #12 picked up the cup of hot coffee with his/her shaking hand causing the coffee to spill out on to the table. Resident #12 was admitted to the facility in October of 2023 and has diagnoses that include dysphagia, anxiety, and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/02/24, indicated that Resident #12 was assessed by staff to have had severely impaired cognition. The MDS further indicated Resident #12 is dependent on staff for functional tasks and requires supervision or touching assistance with eating. Review of the nutrition assessment, dated 10/26/23, indicated Resident #12 required continual supervision/ extensive assistance with feeding, and chewing difficulty. Further review of the nutrition assessment plan indicated diet consistency in place to decrease choking risks. Review of the most recent dietary progress note dated 2/05/24 indicated that Resident #12 continues to receive house chopped diet. Review of Resident #12's nutrition care plan indicated the following interventions: -Monitor /document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. -Provide and serve diet as ordered-chopped. Monitor intact and record every meal. (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 Resident #12's Kardex (form indicating level of care required) indicated the following: -Supervision or touching assistance for eating. On 3/08/24 at 12:20 A.M., Resident #12 was observed reaching for hot coffee off of the coffee cart during lunch and grabbed a cup of hot coffee to hold while being pushed in a wheelchair by staff, causing Resident #12 to spill the hot coffee onto his/her wheelchair and floor. The Unit Manager #1 was observed removing the hot coffee cup from Resident #12's hand and proceeded to wipe up the spilled coffee off the floor. Resident #12 began shouting loudly (inaudible) and CNA #5 wheeled him/her over to dining room table and walked out of the dining room. Resident #12 was seated with his/her back towards two staff members assisting other residents with meals. Resident #12 picked up the cup of hot coffee with his/her shaking hand causing the coffee to spill out on to the table. There were no staff present or providing supervision when Resident #12 picked up the hot cup of coffee. The Unit Manager entered the dining room and observed the surveyor watching Resident #12 and quickly removed the hot cup of coffee from the Resident's hand. Resident #12 is at increased risk for burns caused by scalding. These conditions include: decreased cognition or dementia, decreased mobility, and decreased ability to communicate. Risk for burns can occur even at water temperatures below those identified, depending on an individual's condition and the length of exposure. Hot water temperature of 155 degrees Fahrenheit /65 degrees Celsius can cause a 3rd degree burn to occur in 1 second. The temperature of the hot coffee was tested at 165 degrees Fahrenheit 10 minutes after Resident #12 was observed picking up the hot cup of coffee in the dining room. During an interview on 3/08/24 at 12:30 P.M., Unit Manager #1 said Residents are not getting the level of care they need and require competent staff to provide the level of supervision the Residents need. The Unit Manager said Resident #12 should not have been pushed in the wheelchair with the hot cup of coffee and should not be left unattended during meals because he/she could have been burned by the hot coffee. The Unit Manager #1 said the residents sitting at the table should not be sitting alone with their backs toward staff in the dining room. During an interview on 3/08/24 at 4:10 P.M., with the Nursing Home Administrator (NH), Director of Nursing (DON) and Consultant Staff #2, the surveyor discussed concerns that had been identified during the survey process regarding the supervision of Resident #12. The DON said staff should not give coffee to residents who require supervision as they are at risk for burns and Residents requiring supervision should not be left unsupervised.

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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. 36797 Based on in-service documentation review, employee record review and interview, the facility failed to ensure that the nursing staff received the appropriate competencies and skill sets necessary for the care and treatment of residents. Specifically, the facility failed to ensure annual competencies were completed and documented for four out of four Certified Nursing Assistants (CNAs), and four out of four licensed nurses whose education records were reviewed. Findings include: The facility failed to produce a policy and procedure for ensuring nursing staff competency. Review of four out of four CNA employee records and four out of four licensed nurse's employee records failed to indicate yearly competencies, as determined by the needs of the residents based on the facility assessment, were completed. During an interview on 3/11/24 at 4:30 P.M., the Assistant Director of Nursing (ADON) said that she was not able to locate competencies for 8 out of 8 of the employee records reviewed. The ADON said that she did not know who was responsible for oversight of the completion of staff competencies.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 36797 Based on employee record review and interview, the facility failed to complete a performance review of Certified Nursing Assistants (CNAs) at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews for 4 out of 4 CNAs employee records reviewed. Findings include: Review of the facility policy titled In-Service Training, Nurse Aide, dated as updated 8/1/23, indicated that annual in-services are to address areas of weakness as determined by nurse aide performance reviews. During an interview on 3/11/24 at 4:30 P.M., the Assistant Director of Nursing (ADON) said that she was not able to locate performance reviews for 4 out of 4 of the CNA records reviewed. The ADON said that she did not know who was responsible for oversight of CNA performance reviews.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, policy review, and interviews the facility failed to 1.) ensure that medications were properly labeled after opening in three of three medication carts observed on three of three nursing units. 2.) ensure medication carts were locked when unattended on one of three nursing units. Findings include: Review of the facility policy titled Medication Labeling and Storage. dated [DATE], indicated the following: -The facility stores medications and biologicals in locked compartments. -Compartments containing medications, including carts, are locked when not in use. -The medication label includes, at a minimum: expiration date, when applicable. -Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date or the open vial. 1. The following was observed in the medication carts: On [DATE] at 7:21 A.M., the surveyor observed the following In the Glenside medication cart: -1 bottle of Liquacel protein supplement, open and without a date. Review of the manufacturer's directions indicated that the supplement expires 3 months after opening. -1 bottle of UTI -stat open and without a date. Review of the manufacturer's directions indicated that the supplement expires 3 months after opening. -1 Anoro Ellipta inhaler (used to treat asthma) open without a date. Review of the manufacturer's directions indicated that it expires 6 weeks after opening. During an interview on [DATE] at 7:21 A.M., Nurse #2 was unable to answer when asked what to do with the potentially expired, undated medications. On [DATE] at 7:21 A.M., the surveyor observed the following In the Pond view medication cart: -1 bottle of Carboxymethylcellulose Sodium ophthalmic drops open without a date. -1 bottle of Liquacel Protein supplement, open and without a date. Review of the manufacturer's directions indicated that the protein supplement expires 3 months after opening. (continued on next page)

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Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 7:42 A.M., Nurse #3 said that the medication should be dated when opened. On [DATE] at 7:53 A.M., the surveyor observed the following in the [NAME] medication cart: -1 bottle of UTI -stat open and without a date. Review of the manufacturer's directions indicated that the supplement expires 3 months after opening. -2 bottles of artificial tears open without a date -1 tube Erythromycin antibiotic eye ointment, open without a date when opened. -1 bottle of Latanoprost eye drops, open without a date when opened. During an interview on [DATE] at 7:53 A.M., Nurse #4 said that the medication should be dated when opened. 2. On [DATE] at 12:31 P.M., the surveyor observed a treatment cart Brooknoll unit unlocked and without a nurse within view. On [DATE] at 6:14 A.M., the surveyor observed a treatment cart on the Brooknoll unit unlocked and without a nurse within view. During an interview on [DATE] at 12:31 P.M., Nurse #9 said the treatment carts should always be locked. On [DATE] at 8:00 A.M., the surveyor observed an unlocked and unattended medication cart on the Brooknoll unit. No staff within view and the surveyor was able to open and access the cart. During an interview on [DATE] at 8:03 A.M., Nurse (#11) turned the corner and walked down the hallway to return to the medication cart. Nurse #11 said that the medication cart was supposed to be locked when unattended. 41105

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 41456 Based on observations, interviews and record reviews, the facility failed to provide dental services for one Resident (#64) out of a total of 41 residents. Findings include: Review of the policy titled, Dental Services, dated 8/1/23, indicated the following: *Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. *Routine and 24-hour emergency dental services are provided to our residents through: a. A contract agreement with a licensed dentist that comes to the facility monthly; b. Referral to the resident's personal dentist. c. Referral to community dentist; d. Referral to other health care organizations that provide dental services. Social Service representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. *Dentures will be protected from loss or damage, to the extent practicable, while being stored. *Lost or damaged dentures will be replaced at the resident's expense unless and employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures. *If dentures are damaged or lost, residents will be referred to dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay. *All dental services provided are recorded in the resident's medical record. A copy of the resident's dental record is provided to any facility to which the resident is transferred to. Resident #64 was admitted to the facility in March 2022 with diagnoses including dementia. Review of Resident #64's most recent Minimum Data Set assessment, dated 11/19/23, indicated Resident #64 had a Brief Interview for Mental Status exam score of 12 out of a possible 15, which indicated the Resident had moderate cognitive impairment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/05/24 at 9:11 A.M., Resident #64 said his/her teeth hurt at times and he/she would like to be seen by the dentist. The Resident said he/she could not remember the last time he/she was seen by the dentist. Review of Resident #64's medical record indicated the following: -A consent form dated 3/04/22 requesting dental services for Resident #64. -A physician order dated 3/03/22 for dentist, audiologist, optometrist and podiatrist consult and treatment as needed. The medical record failed to indicate Resident #64 was seen by the dentist in the last year. Review of the dental visit summary log from the consulting dental company for the year 2023 failed to indicate Resident #64 was seen by the dentist. During an interview on 3/11/24 at 12:10 P.M., the Assistant Director of Nursing (ADON) said the facility expectation is that all residents who have consented to be seen by the dentist are seen. The ADON said she was unaware Resident #64 was not seen in 2023.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interview, the facility failed to provide the correct ordered therapeutic diet to ensure safety while eating for three Residents (#19 #5 and #60) out of a total sample of 41 residents. Specifically, 1) Resident #19 was not provided with pureed vegetables as ordered, 2) Resident #5 was not provided with ground diet as ordered, 3) Resident #60 was provided with foods not adhering to his/her ground diet. Findings include: Review of the facility policy titled Therapeutic Diets, dated 8/1/23, indicated the following: -Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. -A therapeutic diet: is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: d. altered consistency diet. -If a mechanically altered diet is ordered, the provider will specify the texture modification. -Snacks will be compatible with the therapeutic diet. 1. Resident #19 was admitted to the facility in July 2021 with diagnoses including Alzheimer's Disease and dysphagia (difficulty swallowing). Review of Resident #19's most recent Minimum Data Set (MDS) dated [DATE], indicated he/she had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident # 19 required moderate assistance with self-feeding tasks. On 3/5/24 at 12:30 P.M. Resident #19 was observed eating lunch. He/she had regular textured broccoli on his/her plate. On 3/6/24 at 12:25 P.M., Resident #19 was observed eating lunch. He/she had regular textured collared greens on his/her plate. On 3/5/24 at 12:33 P.M. Resident #19 was observed eating lunch. He/she had regular textured green beans on his/her plate. Review of Resident #19's physician orders indicated the following order: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*House diet. Ground texture, Regular/Thin consistency, ground with puree fruit and vegetables, initiated on 10/5/23. Review of Resident #19's nutritional care plan last revised 1/2/24, indicated the following interventions: *Provide Ground with puree fruit and vegetables diet. Document amount consumed at all meals, Receives sandwich in place of hot meal at lunch. Review of the nutrition note dated 1/24/24 indicated: *Continues to receive Ground with puree fruit and vegetables. The kitchen provided the surveyor with Resident #19's meal tickets for the days of survey. The meal ticket has house Ground listed on the top of the ticket and lists all vegetables and fruits as needing to be pureed. Review of Resident #19's medical record indicated he/she was treated by speech therapy from 1/2/23 to 2/3/23. The discharge summary dated 2/3/23 indicated the Resident's safest diet to consume was mechanical soft/ground textures with pureed consistencies for fruits and vegetables. On 3/07/24 at 12:37 P.M., the Nursing Supervisor and Director of Nursing were interviewed. Both the Nursing Supervisor and Director of Nursing said all meal trays need to be checked by a nurse prior to giving it to a resident to ensure the correct textured diet is provided. The Nursing Supervisor and Director of Nursing then observed Resident #19's lunch meal and lunch ticket. Both read the lunch ticket and said the Resident is supposed to have pureed vegetables and said that he/she had regular textured green beans and did not receive the accurate diet. The Director of Nursing said she expects the kitchen to serve the correct diet and the nurses check the meals on the unit to ensure residents are not given the wrong textured diet. During an interview on 3/07/24 at 12:45 P.M., Nurse #4 said she does not look at the vegetables when checking the meal trays. Nurse #7 said she typically only checks the meat and doesn't look to see if the vegetables or sides are the appropriate texture. During an interview on 3/07/24 at 2:01 P.M., the Food Service Director (FSD) said Resident #19 has a diet order for pureed fruits and veggies. The FSD was unaware the Resident received the wrong texture for three meals served. During an interview on 3/07/24 at 2:16 P.M., the Speech Language Pathologist (SLP) said Resident #19 should have pureed fruits and vegetables with his/her meal. The (SLP) said the facility does not provide enough supervision during meals and the kitchen does not like to serve mixed consistencies so following therapeutic diets can be difficult at times. 48671 2. Resident #5 was admitted to the facility in May 2023 with diagnoses including dysphagia, legal blindness, cerebral infarction, anxiety, and depression. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating he/she has moderate impaired cognition. The MDS also indicated Resident #5 required assistance with feeding tasks. On 3/5/24 at 8:30 A.M. Resident #5 was observed eating breakfast. He/she had regular textured toast on his/her plate. On 3/6/24 at 12:24 P.M., Resident #5 was observed eating lunch. He/she had regular textured fried fish, and collard greens on his/her plate. Review of Resident #5's physician orders indicated the following orders: *House diet. Ground texture, Regular/Thin consistency, will be getting new dentures for nutrition related to dysphagia. Dated 2/20/24. -Clear liquids diet House texture, Regular/Thin consistency. Dated 2/29/24 and discontinued on 3/1/24. Review of Resident #5's nutritional care plan dated 2/26/24, indicated the following interventions: -Ground diet until new dentures arrive. -RD (Registered Dietician) to evaluate and make diet change recommendations PRN (As needed). The kitchen provided the surveyor with Resident #5's meal tickets for the days of survey. The meal ticket has Clear Liquids House printed on the top. Review of Resident #5's dietary progress note indicated diet consistency changed to ground consistency r/t (related to) needs new dentures. Dietary aware of diet change. On 3/07/24 at 12:37 P.M., the Director of Nursing (DON) said all meal trays need to be checked by a nurse prior to giving it to a resident to ensure the correct textured diet is provided. The DON then observed Resident #5's lunch ticket and said the Resident is supposed to have ground vegetables and said that he/she had regular textured collard greens and fish and did not receive the accurate diet. The DON said Resident #5 is not on a clear liquid diet and said the diet slip was not updated correctly. The DON said she expects the kitchen to serve the correct diet and the nurses check the meals on the unit to ensure residents are not given the wrong textured diet. During an interview on 3/07/24 at 4:19 P.M., Nurse #5 said she did not notice that the meal ticket was incorrect or that the Resident received food that was not ground. Nurse #5 said staff must check the ticket before serving meals to prevent choking. During an interview on 3/07/24 at 2:01 P.M., the Food Service Director (FSD) said Resident #5 has a ground diet order and the food ticket should not say clear liquid diet. The FSD said Resident #5's diet slip should have been changed to ground texture and she was unaware the Resident received the wrong texture for two meals served. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/07/24 at 2:16 P.M., the Speech Language Pathologist (SLP) said Resident #5 should have ground foods with his/her meal. The (SLP) said the facility does not provide enough supervision during meals and the kitchen does not like to serve mixed consistencies so following therapeutic diets can be difficult at times. 3. Resident #60 was admitted to the facility in September 2023 with diagnoses including dementia, gastro esophageal reflux disease, cognitive communication deficit, and dysphagia (difficulty swallowing). Review of Resident #60's most recent Minimum Data Set (MDS) dated [DATE], indicated he/she had a Brief Interview for mental Status (BIMS) score of 3 out of a possible 15, which indicated the Resident had severe cognitive impairment. The MDS also indicated Resident # 60 required total dependence with feeding tasks. On 3/5/24 at 7:47 A.M. Resident #60 was observed eating breakfast. He/she had regular textured toast on his/her plate. On 3/6/24 at 11:30 A.M., Resident #60 was observed eating a plate of hard potato chips and crunch sound could be heard when chewing. On 3/6/24 at 12:20 P.M., Resident #60 was observed eating lunch. He/she had regular textured chicken, and collard greens on his/her plate. On 3/8/24 at 11:17 P.M., Resident #60 was observed eating a plate of potato chips. He/she had three hard individually wrapped round candies on her tray table with one wrapper opened. Review of Resident #60's physician orders indicated the following order: -House diet. Ground texture, Regular/Thin consistency, for safety due to poor dentition. Review of Resident #60's nutritional care plan dated 10/16/23, indicated the following interventions: -Provide house ground diet. Document meal consumption. -Monitor/record/report to MD PRN (as needed) s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. -RD to evaluate and make diet change recommendations PRN. The kitchen provided the surveyor with Resident #60's meal tickets for the days of survey. The meal ticket has House Ground printed on the top. Review of Resident #60's dietary progress note dated 2/29/24 indicated the continues to receive ground diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/07/24 at 12:37 P.M., the Director of Nursing (DON) said all meal trays need to be checked by a nurse prior to giving it to a resident to ensure the correct textured diet is provided. The DON then observed Resident #60's lunch ticket and said the Resident is supposed to have ground foods and said that he/she had regular textured collard greens, and chips, and did not receive the accurate diet. The DON said she expects the kitchen to serve the correct diet and the nurses check the meals and snacks on the unit to ensure residents are not given the wrong textured diet. The DON said Resident #60 should not be eating potato chips. During an interview on 3/07/24 at 4:19 P.M., Nurse #5 said she did not notice that the meal ticket was incorrect or that the Resident received food that was not ground. Nurse #5 said staff must check the ticket before serving meals and checking snacks to prevent choking. During an interview on 3/07/24 at 2:01 P.M., the Food Service Director (FSD) said Resident #5 has a ground diet order and the food ticket should not say clear liquid diet. The FSD said Resident #5's diet slip should have been changed to ground texture and she was unaware the Resident received the wrong texture for two meals served. During an interview on 3/07/24 at 2:16 P.M., the Speech Language Pathologist (SLP) said Resident #5 should have ground foods with his/her meal and with snacks. The (SLP) said the facility does not provide enough supervision during meals and the kitchen does not like to serve mixed consistencies so following therapeutic diets can be difficult at times. During an interview on 3/07/24 at 3:32 P.M., the Dietician said Resident #60 should not be eating potato chips because he/she is on a ground diet. During an interview on 3/08/24 at 11:20 A.M., Unit Manager #1 said Resident #60 should not be eating potato chips or candy that his/her family brings in and staff should not give those items to him/her because he/she requires a ground diet. Unit manager #1 said the Resident would need an assessment to change his/her diet for safety.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41456 Based on observations and interviews the facility failed to ensure it was administered in a manner that enabled the facility to use its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility administration failed to 1) ensure education and training was provided to all staff to provide competent, safe, and effective resident care, 2) ensure the grievance procedure was being completed in the facility and 3) ensuring the governance and leadership members sustain a sufficient Quality Assurance Performance Improvement (QAPI) program. 1. During the survey process, the following was identified: Review of the facility assessment indicated the following competencies need to be completed by staff: -Self-testing competency for staff to perform COVID-19 binax testing weekly and according to DPH guidelines. -Person centered care - this should include but not be limited to person centered care planning, education or resident and family resident/representative about treatments and medications, documentation of resident treatment preferences, end of life care, and advanced care planning. -Activities of daily living - bathing (e.g. tub, shower, sitz, bed), bed making (occupied and unoccupied), bedpan, dressing, feeding, nail and hair care, perennial care (female and male), mouth care (brushing teeth or dentures), providing resident privacy, range of motion (upper and lower extremity, transfers, using gate belt, using mechanical lifts.) -Infection control - hand hygiene, isolation, standard universal precautions including use of personal protective equipment, MRSA/VRE/CDI precautions, environmental cleaning. -Medication administration - injectable, oral, subcutaneous, topical. -Measurements: blood pressure, orthostatic blood pressure, body temperature, urinary output including urinary drainage bags, height and weight, radical and apical pulse, respirations, recording intake and output, urine test for glucose/acetone. -Resident assessment and examinations - emission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment. -Caring for persons with Alzheimer's or another dementia. -Specialized care - catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op and post-op care, trach care suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder and implementing nonpharmacological interventions. Review of four out of four Certified Nursing Assistant (CNA) employee records and four out of four licensed nurse's employee records failed to indicate yearly competencies as determined by the needs of the residents based on the facility assessment. Review of CNA #6's employee records failed to indicate any education/orientation trainings since the date of hire. Further review indicated that the 8-hour initial dementia training did not occur until 1/26/24, 3 months after hire. Review of CNA #5's employee records failed to indicate the 8-hour initial dementia education training was provided until 1/26/24, 6 months after date of hire. Further review failed to indicate the number of hours of training provided yearly. Review of CNA #13's employee records failed to indicate the 4-hour dementia education training was provided yearly. Further review indicated that the last dementia training took place in 2014. Further review failed to indicate the number of hours of training provided yearly. Review of CNA #14's employee records failed to indicate the 4-hour dementia education training was provided yearly. Further review indicated that the last dementia training took place in 2014. Further review failed to indicate the number of hours of training provided yearly. During an interview on 3/11/24 at 4:30 P.M., the Assistant Director of Nursing (ADON) said that she was not able to locate competencies for 8 out of 8 of the employee records reviewed. The ADON said that she did not know who was responsible for oversight of staff competencies. During follow up interviews on 3/12/24, at 10:44 A.M. and 1:18 P.M., the ADON said that she identified the lack of the required 4-hour yearly dementia training in September 2023. The ADON then said that she had just started a QAPI for the required 4-hour yearly dementia training, despite identifying the concern 6 months prior, and didn't have any documentation on how much training had occurred since. The ADON said she did not know how many hours of training the CNA's had completed because the training sign-off sheets (to indicate completion of the trainings) and the corresponding tests, did not have the time spent on each training documented. During an interview on 3/07/24 at 7:36 P.M., the Administrator said the facility does not have a problem with the number of staff available and working, but rather had an ongoing issue ensuring the staff complete their responsibilities when on duty. During an interview on 3/12/24 at 12:10 P.M., the Facility's Owner said he expects the staff to complete all competencies as required. The Facility's owner said he expects the building to communicate to him the competency of the staff and he is unsure if the annual competencies are being completed at the building. The Facility's Owner was informed the facility could not find proof of competencies being completed and he said he was unaware of that. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Resident group was held on 3/6/24 at 11:00 A.M. Nine of nine participating residents said they complain about the same issues month after month, and they feel the facility does not respond to grievances brought up in the group meeting. Nine out of nine residents said they feel frustrated and feel they are not being listened to. All participating residents said they are unaware how to file a formal grievance and have no grievance forms available to them. The surveyor was unable to find grievance forms on any of the three resident units. Review of the grievance log indicated the last grievance written for the facility was in October 2023, six months ago. During the survey process, two family members expressed concerns to the surveyors about complaints not being heard or resolved by the facility. During an interview on 3/11/24 at 3:58 P.M., the Administrator said he has been overseeing the grievance process in the building since the social worker is new to long term care and he is aware of how the grievance process works in long term care. The Administrator said he would expect that any concerns brought up by residents or resident representatives be addressed, especially if the same concerns were repeatedly brought up. The Administrator said he was unaware there had been no formal grievances filed and/or resolved since October 2023. The Administrator said he has control of running the building and reports any major concerns or systemic concerns to the owner. During an interview on 3/11/24 at 6:20 P.M., Unit Manager #1 said the building is starting to complete the grievance process again as it had not been done for a while. Unit Manager #1 said for a while I didn't use grievance forms at all. Unit Manager said when she was made aware of complaints by residents' families, she would try to fix the problems quickly and would not make a formal grievance. Unit Manager #1 said she was managing two units, and she would only have enough time to talk to nursing about the issues, not file a grievance. During an interview on 3/12/24 at 12:10 P.M., the Facility's Owner said the Administrator runs the building and oversight to the building is provided by the owner. The Facility's Owner said he is present in the building once a week and the Administrator provides updates regarding the building as needed. The Facility's Owner said he expects to be updated on family concerns and expects the staff to file grievances when a concern arises. The Facility's Owner said he expects the grievance procedure to be completed per the facility policy and was unaware no grievances had been filed since October. 3. Review of the Resident Council minutes for the month of October 2023, November 2023, December 2023, February 2024, and March 2024, indicated the following: -October 2023: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served; -November 2023: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served; -December 2023: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-February 2024: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served; -March 2024: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served. During an interview on 3/12/24 at 10:22 A.M., the Administrator said meetings for the QAPI (Quality Assurance/Performance Improvement) program are held monthly and he is responsible for overseeing this process in the building. The Administrator said any areas for improvement in the building are discussed at these monthly meetings and an improvement plan is then put into place. When reviewing the repeated concerns from resident group, the Administrator said these concerns should have been made into QAPI projects so concerns could be addressed, and care could improve. During an interview on 3/12/24 at 12:10 P.M., the Facility's Owner said he was not aware of the reoccurring concerns from the residents, and these should have been made into QAPI programs and improved. The Facility's Owner said he was not aware of any of the QAPI projects the facility is currently working on.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on interview and record review including the Facility Assessment and facility policies, the facility failed to ensure that the governing body provided oversight and accountability for: 1. ensuring the facility was following the grievance process and completing grievances; 2. ensuring education and competencies were completed per Facility Assessment process/program; 3. ensuring quality of care related to abuse was maintained for two Residents (#5 and #47); 4. ensuring the governance and leadership members sustain a sufficient QAPI program during transitions in leadership and staffing. As a result of the governing body's failure, the facility failed to develop a plan to ensure the facility could safely provide the services to meet the needs of the residents as well as implement an effective QAPI program. Findings include: Review of the Facility Assessment, dated as reviewed on 1/4/24, failed to list who was a member of the Governing Body for the facility. During an interview on 3/12/24 at 12:10 P.M., the Facility's Owner said he, his mother and his father were the governing body of the facility. The Facility's owner said the responsibility mainly falls on him since his parents are now over [AGE] years old. 1. Resident group was held on 3/06/24 at 11:00 A.M. Nine of nine participating residents said they complain about the same issues month after month, and they feel the facility does not respond to grievances brought up in the group meeting. Nine out of nine residents said they feel frustrated and feel they are not being listened to. All participating residents said they are unaware how to file a formal grievance and have no grievance forms available to them. The surveyor was unable to find grievance forms on any of the three resident units. Review of the grievance log indicated the last grievance written for the facility was in October 2023, six months ago. During the survey process, two family members expressed concerns to the surveyors about complaints not being heard or resolved by the facility. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/11/24 at 3:58 P.M., the Administrator said he has been overseeing the grievance process in the building since the social worker is new to long term care and he is aware of how the grievance process works in long term care. The Administrator said he would expect that any concerns brought up by residents, or resident representatives be addressed, especially if the same concerns were repeatedly brought up. The Administrator said he was unaware there had been no formal grievances filed and/or resolved since October 2023. The Administrator said he has control of running the building and reports any major concerns or systemic concerns to the owner. During an interview on 3/11/24 at 6:20 P.M., Unit Manager #1 said the building is starting to complete the grievance process again as it had not been done for a while. Unit Manager #1 said for a while I didn't use grievance forms at all. Unit Manager said when she was made aware of complaints by residents' families, she would try to fix the problems quickly and would not make a formal grievance. Unit Manager #1 said she was managing two units, and she would only have enough time to talk to nursing about the issues, not file a grievance. During an interview on 3/12/24 at 12:10 P.M., the Facility's Owner said the Administrator runs the building and oversight to the building is provided by the owner. The Facility's Owner said he is present in the building once a week and the Administrator provides updates regarding the building as needed. The Facility's Owner said he expects to be updated on family concerns and expects the staff to file grievances when a concern arises. The Facility's Owner said he expects the grievance procedure to be completed per the facility policy and was unaware no grievances had been filed since October. 2. Review of the facility assessment indicated the following competencies need to be completed by staff: -Self-testing competency for staff to perform COVID-19 binax testing weekly and according to DPH guidelines. -Person centered care - this should include but not be limited to person centered care planning, education or resident and family resident/representative about treatments and medications, documentation of resident treatment preferences, end of life care, and advanced care planning. -Activities of daily living - bathing (e.g. tub, shower, sitz, bed), bed making (occupied and unoccupied), bedpan, dressing, feeding, nail and hair care, perennial care (female and male), mouth care (brushing teeth or dentures), providing resident privacy, range of motion (upper and lower extremity, transfers, using gate belt, using mechanical lifts.) -Infection control - hand hygiene, isolation, standard universal precautions including use of personal protective equipment, MRSA/VRE/CDI precautions, environmental cleaning. -Medication administration - injectable, oral, subcutaneous, topical. -Measurements: blood pressure, orthostatic blood pressure, body temperature, urinary output including urinary drainage bags, height and weight, radical and apical pulse, respirations, recording intake and output, urine test for glucose/acetone. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Resident assessment and examinations - emission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment. -Caring for persons with Alzheimer's or another dementia. -Specialized care - catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op and post-op care, trach care suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care. -Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder and implementing nonpharmacological interventions. Review of four out of four Certified Nursing Assistant (CNA) employee records and four out of four licensed nurse's employee records failed to indicate yearly competencies as determined by the needs of the residents based on the facility assessment. Review of CNA #6's employee records failed to indicate any education/orientation trainings since the date of hire. Further review indicated that the 8-hour initial dementia training did not occur until 1/26/24, 3 months after hire. Review of CNA #5's employee records failed to indicate the 8-hour initial dementia education training was provided until 1/26/24, 6 months after date of hire. Further review failed to indicate the number of hours of training provided yearly. Review of CNA #13's employee records failed to indicate the 4-hour dementia education training was provided yearly. Further review indicated that the last dementia training took place in 2014. Further review failed to indicate the number of hours of training provided yearly. Review of CNA #14's employee records failed to indicate the 4-hour dementia education training was provided yearly. Further review indicated that the last dementia training took place in 2014. Further review failed to indicate the number of hours of training provided yearly. During an interview on 3/11/24 at 4:30 P.M., the Assistant Director of Nursing (ADON) said that she was not able to locate competencies for 8 out of 8 of the employee records reviewed. The ADON said that she did not know who was responsible for oversight of staff competencies. During follow up interviews on 3/12/24, at 10:44 A.M. and 1:18 P.M., the ADON said that she identified the lack of the required 4-hour yearly dementia training in September 2023. The ADON then said that she had just started a QAPI for the required 4-hour yearly dementia training, despite identifying the concern 6 months prior, and didn't have any documentation on how much training had occurred since. The ADON said she did not know how many hours of training the CNA's had completed because the training sign-off sheets (to indicate completion of the trainings) and the corresponding tests, did not have the time spent on each training documented. During an interview on 3/07/24 at 7:36 P.M., the Administrator said the facility does not have a problem with the number of staff available and working, but rather had an ongoing issue ensuring the staff complete their responsibilities when on duty. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/12/24 at 12:10 P.M., the Facility's Owner said he expects the staff to complete all competencies as required. The Facility's owner said he expects the building to communicate to him the competency of the staff and he is unsure if the annual competencies are being completed at the building. The Facility's Owner was informed the facility could not find proof of competencies being completed and he said he was unaware of that. 3a. Resident #5 was admitted to the facility in May 2023 with diagnoses including legal blindness, cerebral infarction, anxiety, and depression. Review of Resident #5's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, which indicated he/she had moderate impaired cognition. Further review indicated Resident #5 requires assistance for functional tasks. During an interview on 3/7/24, at 12:30 P.M., with Resident #5 and Resident #5's family member #2, Resident #5 reported that staff ignored his/her requests to not take a shower and not have his/hair washed and that he/she feels ignored. Resident #5 said Certified Nursing Assistant (CNA) #16 forced her to take a shower on 2/28/24, even after he/she told the CNA he/she did not want a shower because he/she had a shower two days prior. Resident #5 said he/she goes to the hair salon on Tuesday and did not want a shower or to have his/her hair washed following that appointment. Resident #5 said She picked me up and made me take a shower, sprayed water in my face and used a whole bottle of shampoo. She scrubbed my nose and was a big, awful person and scared me even after I kept telling her no, she would not stop spraying me and scrubbing my hair. Resident #5 said CNA #16 shouldn't be working and that he/she told her privately paid helper what had happened the afternoon that it happened. Family member #2 said she received a call from the privately paid aide and was notified of the incident and went to visit Resident #5 that evening and was told the same information by Resident #5. The Residents family member #2 said Resident #5 informed her of the situation during a visit that evening and said a formal complaint was made to the Director of Nurses (DON) on 2/28/24 by Resident #5's Health Care Proxy. Review of the facility incident reports failed to indicate an investigation for potential abuse was conducted. During an interview on 3/7/24 at 3:58 P.M., the Administrator said any allegations of abuse or neglect should be fully investigated by the facility. During an interview on 3/12/24 at 12:10 P.M., the Facility's Owner said the facility does not keep him up to date with concerns about abuse. 3b. Resident #47 was admitted to the facility in March 2020 with diagnoses including Alzheimer's Disease and stroke. Review of Resident #47's most recent Minimum Data Set (MDS) assessment, dated 12/30/23, indicated he/she was unable to complete the Brief Interview for Mental Status exam and staff had assessed him/her to have severe cognitive impairment. The MDS further indicated Resident #47 is dependent on staff for daily hygiene. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36797 Based on record review and interview the facility failed to maintain accurate medical records for five Residents (#122 #26, #39, #48, #84) out of a total sample of 41 residents. Findings include: 1. Resident #122 was admitted to the facility in January 2024 with diagnoses including cancer, malnutrition and depression. Review of a nurse's note dated 1/12/24 at 2:59 P.M., indicated Resident #122 was scheduled for an appointment with a pick up time of 8:00 A.M Review of a nurse's note dated 1/12/24 at 4:33 P.M., indicated Resident #122 refused a skin check. Review of the Medication Administration Record dated 1/12/24, indicated that Resident #122 was not in the facility after 8:00 A.M., and was not in the facility to refuse the skin check at 4:33 P.M Review of a nurse's note dated 1/13/24 at 4:44 P.M., indicated Resident #122 was discharged against medical advice. Further review failed to indicate when the Resident was discharged , where the Resident was discharged to, with whom the Resident was discharged or that the doctor had been notified of the discharge. Review of the medical record failed to indicate an order to discharge the Resident. During an interview on 3/06/24, at 3:30 P.M., Nurse #1 said that the medical record was not accurate and had conflicting information regarding the refusal of a skin check during a time when the Resident was not in the facility. During an interview on 3/06/24, at 3:30 P.M., the Director of Nursing (DON) said that she would expect that the nurse would follow up with the facility that the Resident was sent to and eventually discharged from and document where the Resident went. The DON then said that the nurse should have notified the doctor, obtained an order for discharge and documented in the Resident's medical record. Review of the nurse's note dated 3/6/24, at 7:41 P.M., indicated the following: Pt alert, responsive and able to make needs known. Pt left the facility at 8:00 A.M., for a blood transfusion and hematology appointment and did not return from his/her appointment. We discovered that he/she transferred from his/her appointment to (another skilled nursing facility), when family came to pick up his/her belongings. Dr. (#1) was aware of the resident's transfer. During an interview on 3/07/24 at 7:30 A.M., Doctor #1 said that she was made aware of the Resident's discharge by the Resident's Nurse Practitioner and did not give an order for discharge against medical advice. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled Notice of Intent to Discharge Resident, dated 1/11/24, indicated the following condition had been met for discharge: * The resident's health had improved sufficiently so the resident no longer needs the services provided by the facility. Further review indicated that SW #1 signed and hand delivered the document to the Resident on 1/11/24, the day before the Resident did not return from the doctor's appointment. During an interview on 3/07/24 at 1:24 P.M., the Social Worker (SW) #1 said she obtained the information she documented on the discharge notice from the medical record including the doctor's orders and the progress notes. When the surveyor informed SW #1 that there was no doctor's order for discharge and there was no progress note indicating that Resident #122's health had improved sufficiently so the Resident no longer needs the services provided by the facility, SW #1 was not able to explain why the information documented on the Notice of Intent to Discharge Resident did not match the information documented in the medical record. SW #1 then said that a discharge planning meeting had not taken place and was not scheduled until 1/16/24. 41105 2. Resident #26 was admitted to the facility in May 2022 and has diagnoses that include dysphagia (difficulty chewing and swallowing) and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/24, indicated that on the Brief Interview for Mental Status exam Resident #26 scored a 7 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated that Resident #26 required partial/moderate assistance with eating. Review of the current ADL care plan, dated as created 10/31/23, indicated that Resident #26 has been identified as having potential or actual deficits in Activities of Daily living while a resident at our facility. Interventions on the care plan include: -Eating: I am Dependent, dated as initiated 10/31/23. On 3/05/24 at 12:27 P.M., the surveyor observed Resident #26 in his/her room with lunch on a tray table directly in front of him/her and Resident #26 had food all over his/her chest. There were no staff present to assist the Resident with the meal. The surveyor continued to make the following observations: -At 12:31 P.M., Resident #26 remained without assistance with the meal and began eating with his/her hands. On 3/06/24 at 8:15 A.M., the surveyor observed Resident #26 seated in a chair in his/her room. a Certified Nursing Assistant (CNA) delivered tray placed on dresser and exited the room, without offering assistance with the meal. The surveyor continued to make the following observations -At 8:25 A.M., Resident #26 remained without assistance and ate scrambled eggs with his/her hands. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/06/24 at 12:19 P.M., the Nurse Unit Manager (#2) delivered lunch to Resident #26 and at 12:24 P.M., she exited the room, leaving Resident #26 without assistance for the meal. The surveyor continued to make the following observations: -At 12:31 P.M., Resident #26 remained without assistance and began eating coleslaw with his/her hands. Review of the March 2024 Certified Nursing Assistant documentation indicated staff documented the following: -For breakfast on 3/06/24 Resident #26 was provided with partial/moderate assistance with eating. -For lunch on 3/05/24 and 3/06/24 Resident #26 was provided with partial/moderate assistance with eating. This documentation is contrary to the observations of the surveyor. During an interview on 3/12/24 at 10:49 A.M., with the Assistant Director of Nursing (ADON) and the Administrator, they both said they were aware that the documentation by the Certified Nursing Assistants was often inaccurate/incomplete. The ADON said that it is the expectation that the documentation be completed accurately and completely. 3. Resident #39 was admitted to the facility in October 2017 and had diagnoses that include dementia and senile degeneration of the brain. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/16/23, indicated that on the Brief Interview for Mental Status exam Resident #39 scored a 3 out of a possible 15, indicating severely impaired cognition. Review of the current Physician orders included the following order: -An order started 4/20/20, Fall Eaze Mats: check every shift to insure that mats on each side of the bed when in bed On 3/05/24 at 7:46 A.M., Resident #39 was observed in bed asleep bed with a fall mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; Nor was there a second fall mat in the room. On 3/05/24 at 12:18 P.M., Resident #39 was observed in bed with a fall mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; Nor was there a second fall mat in the room. On 3/11/24 at 8:45 A.M., Resident #39 was observed in bed with a fall mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; Nor was there a second fall mat in the room. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/24 at 11:00 A.M., Resident #39 was observed in bed with a fall mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; Nor was there a second fall mat in the room. On 03/11/24 12:25 PM observed Resident #39 in bed, bed with a fall mat on the right side of bed; there was no fall mat on the left side of the bed as ordered by the physician; Nor was there a second fall mat in the room. During an interview on 3/12/24 at 8:16 A.M., with the Nurse Supervisor, he said Nurse's are expected to first verify that the fall Eaze mats are in place before they document in the TAR that they are in place. During an interview on 3/12/24 at 10:49 A.M., with the Assistant Director of Nursing (ADON) and the Administrator, they both said they were aware that the documentation by the Certified Nursing Assistants was often inaccurate/incomplete. The ADON said that it is the expectation that the documentation be completed accurately and completely. 41456 4. Resident #48 was admitted to the facility in March 2015 with diagnoses including arthritis and neuropathy. Review of Resident #48's most recent Minimum Data Set, dated dated dated [DATE] indicated he/she had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated the Resident is cognitively intact. The MDS also indicated the Resident requires assistance for all functional daily tasks. Review of Resident #48's physician orders indicated the following order: *Lidocaine External Patch (pain patch). Apply to right wrist topically every morning and at bedtime for pain in right wrist each AM shift. Remove at bedtime, initiated on 1/31/24. During an interview on 3/6/24 at 11:00 A.M., Resident #48 said he/she has had increasing pain in his/her right wrist. Resident #48 showed the surveyor his/her wrist, which did not have a medicated pain patch on. During a follow-up interview on 3/7/24 at 11:10 A.M., Resident #48 said he/she was not provided with a Lidocaine patch to his/her right wrist on 3/6/24 at any point in the day. Review of the Medication Administration Report for the month of March 2024 indicated the nurse checked the order for the Lidocaine patch as completed, even though the patch was never observed to be on Resident #48. During an interview on 3/07/24 at 11:08 A.M., Unit Manager #2 said orders should not be signed off as completed if not complete. Unit Manager #2 said doing so would lead to an inaccurate medical record. (continued on next page)

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Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/07/24 at 11:36 A.M., the Director of Nursing said orders should not be signed off as completed if not complete. 5. Resident #84 was admitted to the facility in December 2023 with diagnoses including diabetes and peripheral vascular disease. Review of Resident #84's most recent Minimum Data Set (MDS) dated [DATE], indicated he/she had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, which indicated the Resident had intact cognition. On 3/5/34 at 8:27 A.M., Resident #84 was observed lying in bed with both feet resting directly on the bed. There were no pressure relieving boots observed in the room. On 3/05/24 at 12:33 P.M., Resident #84 was observed sitting in his/her wheelchair with both feet on ground and was not wearing protective booties. There were no pressure relieving boots observed in the room. On 3/06/24 at 12:11 P.M., Resident #84 was observed sitting in his/her wheelchair with both feet on ground and was not wearing protective booties. There were no pressure relieving boots observed in the room. During an interview at this time, Resident #84 said he/she had never received pressure relieving booties and had never worn anything on his/her feet. On 3/07/24 at 6:30 A.M., and 7:53 A.M., Resident #84 was observed lying in bed with both feet resting directly on the bed. There were no pressure relieving boots observed in the room. Review of Resident #84's physician orders indicate the following order initiated on 1/11/24: *Booties to both feet at all times, every shift. Review of the Treatment Administration Report for the month of March 2024 indicated the nurse checked the order for the bilateral booties at all times as completed on 3/5/24, 3/6/24 and 3/7/24, even though the booties were never observed to be on Resident #84. During an interview on 3/07/24 at 11:08 A.M., Unit Manager #2 said orders should not be signed off as completed if not complete. Unit Manager #2 said doing so would lead to an inaccurate medical record. During an interview on 3/07/24 at 11:36 A.M., the Director of Nursing said orders should not be signed off as completed if not complete.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 36797 Based on record review, document review and interview the facility failed to ensure that hospice services meet professional standards and principles that apply to individuals providing services in the facility, and have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. Specifically: 1) the facility failed to ensure a coordinated person-centered care plan with individualized interventions were developed for the provision of hospice care services and failed to ensure ongoing documentation of hospice staff visits to ensure prompt and effective communication and continuity of care for for two Residents (#58 and #97) out of a total sample of 41 residents, 2) the facility failed to ensure a physician's order for the provision of Hospice care was obtained for one Resident (#97) and 3) the facility failed to have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. Findings include: Review of the facility's policies titled Hospice Program, last revised August 2023, included but were not limited to: Hospice providers who contract with this facility: - Must have a written agreement with the facility outlining in detail the responsibilities of the facility and the Hospice agency, and - The agreement with the Hospice provider will be signed by the facility representative and a representative from the Hospice agency before Hospice services are furnished to any resident. - In general it is the responsibility of the facility to meet the residents personal care and nursing needs in coordination with the Hospice representative and ensure that the level of care provided is appropriately based on the individual residence needs. These responsibilities include the following: -administering prescribed therapies including those therapies determined appropriate by the Hospice and delineated in the Hospice plan of care. -Communicating with the Hospice provider (and documenting such communication) to ensure the needs of the residents are addressed and met 24 hours per day. -Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services. Further review indicated that it is the responsibility of the facility to obtain the following from the hospice: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The hospice election form. -The most recent hospice plan of care specific to each resident. Further review indicated that coordinated care plans for residents receiving Hospice services will include the most recent Hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Resident #58 was admitted to the facility in August 2019 with diagnoses including stroke, kidney disease and heart disease. Review of the facility care plan indicated a focus for hospice dated 8/29/23. and interventions including the following: -Chaplin visit 1-3 x/month -HHA (home health aide) 3-5 x/week -RN (registered nurse) visit 1-3 x/week PRN (as needed) -Social work visit 1-3 x/month as needed Resident #58's medical record failed to indicate hospice was communicating with the facility during visits and failed to indicate that visits had occurred. Further review indicated that a hospice care plan was not put into the medical record until 3/6/24. Further review of Resident #58's medical record failed to indicate that a consent for hospice to admit or to treat Resident #58 was present. On 3/08/24 at 7:55 A.M., Nurse #11 and the surveyor reviewed Resident #58's medical record. Nurse #11 confirmed the medical record failed to indicate a consent for hospice to admit or to treat Resident #58 was present. communication from hospice to the facility during visits was present and the hospice care plan was not put into the medical record until 3/6/24. Nurse #11 also said the hospice plan detailing the services Resident #58 required was not present in the medical record. Nurse #11 said she wouldn't know how to see the hospice's paperwork. Nurse #11 then said that she can't say what Resident #58's hospice plan of care is and can only refer to the facility's care plan. During an interview on 3/12/24 at 10:54 A.M., the Assistant Director of Nursing (ADON) said that the unit managers are to oversee the care that is provided by the hospice and have ongoing communication with the hospice providers. The ADON then said that it is the expectation that the hospice put in place a resident specific plan of care. 48671 2. Resident #97 was admitted to the facility in October 2023 with diagnoses including Alzheimer's Disease, malignant neoplasm of right breast, major depressive disorder, anxiety, dementia, adult failure to thrive, aphasia, dysphagia, and cognitive communication deficit. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 10/25/23, indicated Resident #97 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 0 out of 15 indicating server cognitive impairment. Review of the facility care plan indicated a focus for hospice dated 10/26/23, and interventions including the following: -Chaplin visit 1-3 x/month -HHA (home health aide) 3-5 x/week -RN (registered nurse) visit 1-3 x/week PRN (as needed) -Social work visit 1-3 x/month as needed Review of Resident #97's medical record failed to indicate hospice was communicating with the facility during visits and failed to indicate that visits had occurred. Further review failed to indicate that a consent for hospice to admit or to treat, Resident #97. Review of the medical record indicated Hospice nursing care plan documentation identifying the provision of the following services dated 10/19/23: -Assess verbal and non-verbal signs of pain -Ineffective Coping -Spiritual Distress and a Sense of Abandonment & fear as the End-of-Life Approaches -Self-Care Deficit Review of the medical record failed to indicate a Home Health Aid (HHA) care plan. Review of the medical record had one hospice progress note written and dated 3/06/24, that indicated communication was made to nursing staff with no new recommendations. This was the only documentation found in the Residents chart. Further review of the medical record failed to indicate a physician's order was obtained for Hospice services to be provided to Resident #97 and failed to provide ongoing documentation of hospice staff visits to ensure prompt and effective communication and continuity of care for the Resident. Review of the physician progress note dated 10/23/23 indicated: Patient is currently under hospice care for the past year. I know the patient from the community. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/05/24 at 1:27 P.M., the surveyor reviewed Resident #97's medical record with Unit Manager #1. The Unit Manager confirmed there was no physician's order in place for Hospice services and said the facility does not receive visit update information from the hospice providers unless a recommendation is made. The unit manager was not aware of what care was provided to Resident #97 during the hospice visits and said Resident #97 has not needed care in a long time because he/she is stable. Unit manager #1 said the hospice binder should contain information regarding care needs, care plans and services provided by the HHA but the hospice binder was empty and contained no information or coordination of care for Resident #97. During an interview on 3/11/24 at 9:10 A.M., the Director of Nursing (DON) said hospice residents should have an order for hospice at the start of care and the facility must have a signed contract for hospice services. The DON said the facility did not have a hospice contract on file for the hospice provider assigned to Resident #97. The DON said communication should be documented between hospice and the facility. During an interview on 3/11/24 at 10:09 A.M., Hospice staff #1 said Resident #97 is scheduled for nursing visits one to three times per week, and HHA visits are scheduled five days per week for one hour, and the HHA care plan can be found in the Residents hospice record . Hospice Staff #1 said hospice visit notes are documented online or placed in the Residents chart if recommendations are needed. Hospice staff #1 said online visit notes are sent to the facility if requested only and said the facility has not requested any records. During an interview on 3/12/24 at 10:54 A.M., with the Administrator and the Assistant Director of Nursing (ADON), the ADON said that the unit managers are to oversee the care that is provided by hospice services and the unit managers must have ongoing communication with the hospice providers. The ADON said Resident #97 must have an order for hospice services and she would expect any hospice recommendations to be followed, develop a care plan for HHA, and documentation of what care was provide. The Administrator said the facility is required to have a hospice contract on file and all Residents receiving hospice services require a physician order at the start of care. The ADON and Administrator could not locate a hospice contract during the time of the survey.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 36797 Based on interview, document review, and policy review, the facility failed to develop, implement, and maintain a Quality Assurance and Performance Improvement (QAPI) program which addressed the full range of care and services, was comprehensive and data-driven, and focused on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility failed to: 1) ensure an ongoing, effective QAPI program is implemented and maintained, 2) identify and prioritize problems and opportunities that reflect organizational process, functions, and services provided to residents based on resident and staff input, and other information and 3) ensure the governance and leadership members sustain a QAPI program during transitions in leadership and staffing. Findings include: Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership, updated 8/1/23, indicated that the responsibilities of the QAPI committee are to identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services. Further review failed to indicate that the QAPI committee would prioritize QAPI activities, failed to develop benchmarks by which the effectiveness of the QAPI plan could be evaluated and failed to indicate the process that would occur should the outcomes of a QAPI did not meet the benchmark established. Review of the facility QAPI program failed to implement action plans, measure success of actions, track performances, and regularly review, analyze and act on data collected. The facility failed to meet regularly to review and analyze data, and maintain documentation of it's ongoing QAPI program. Review of the QAPI program notes failed to indicate the facility met during the months of March, May, June and August of 2023. No documentation was provided during survey. During an interview on 3/12/24, at 10:44 A.M., the ADON said that she had started in September 2023. The ADON said that she had not seen any annual performance reviews or competencies completed for the nursing staff as required and although she knew that they needed to be completed, no QAPI for annual reviews or competencies had been started. Review of the facility document titled Quality Assurance and Performance Improvement (QAPI) dated 7/18/23, indicated that a QAPI for dementia 4 hour update training was to start 8/1/23, with an expected completion date of 10/31/23. Review of the facility document titled Quality Assurance and Performance Improvement (QAPI) dated 11/3/23, failed to indicate any information regarding the QAPI for the 4 hour dementia training had been completed or any follow-up to the QAPI that had been started three months prior. Review of the facility document titled Quality Assurance and Performance Improvement (QAPI) dated 1/16/24, failed to indicate any information regarding the QAPI for the 4 hour dementia training had been completed or any follow-up to the QAPI that had been started five months prior. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/12/24, at 10:44 A.M., the ADON said that she identified the lack of the required 4 hour yearly dementia training in September 2023. The ADON then said that she had just started a QAPI for the required 4 hour yearly dementia training, in spite of identifying the concern 6 months prior, and didn't have any documentation on how much training had occurred since, what the benchmarks were set at, or what the expected completion date would be. During an interview on 3/12/24 at 10:49 A.M., with the Assistant Director of Nursing (ADON) and the Nursing Home Administrator (NHA) they said that there were aware that the documentation by Nurses on the Treatment Administration Record (TAR) and the documentation completed by the Certified Nursing Assistant's on the Kardex is often incomplete and inaccurate. The ADON said that it is the expectation that the documentation be completed accurately and completely. Both said that although they were aware that this is an ongoing problem they have not developed a QAPI to address the issue. Review of the Resident Council minutes for the month of October 2023, November 2023, December 2023, February 2024, and March 2024, indicated the following: -October 2023: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served; -November 2023: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served; -December 2023: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served; -February 2024: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served; -March 2024: the group complained about staff not wearing their name badges, long call wait times, menus do not match with what food is being served. During interviews on 3/11/24 at 3:58 P.M., and 3/12/24 at 10:22 A.M., the Administrator said he reports any concerns to the owner, but the owner does not dictate how the building is run. The Administrator said the Owner attends the quarterly QAPI meetings and should be aware of any patterns, however, does not know the day to day of the building. When reviewing the repeated concerns from resident group, the Administrator said these concerns should have been made into QAPI projects so concerns could be addressed, and care could improve. During an interview on 3/12/24 at 12:10 P.M., the Facility's Owner said he is ultimately responsible for reviewing the QAPI (Quality Assurance/Performance Improvement) program at the facility. The Facility's Owner said he was not aware of the reoccurring concerns from the residents, and these should have been made into QAPI programs. The Facility's Owner said he was not aware of any of the QAPI projects the facility is currently working on.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 36797 Based on record review and interview the facility failed to develop and implement policies addressing: (a) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (b) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems. (c) how the facility will develop acceptable performance benchmarks and; (d) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. Findings include: Review of the facility policy titled Quality Assurance Performance Improvement Plan (QAPI) Governance and Leadership, and updated 8/1/2023, failed to indicate the following: (a) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (b) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems. (c) how the facility will develop acceptable performance parameters and; (d) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. Review of the facility QAPI program failed to implement action plans, measure success of actions, track performances, and regularly review, analyze and act on data collected. The facility failed to meet regularly to review and analyze data, and maintain documentation of it's ongoing QAPI program. Review of the QAPI program notes failed to indicate the facility met during the months of March, May, June and August of 2023. No documentation was provided during survey. During an interview on 3/12/24, at 10:44 A.M., the ADON said no benchmarks or acceptable parameters were developed for QAPI projects. The ADON said that she could not locate QAPI projects that included documentation of specific outcomes, whether benchmarks had been reached or plans for when benchmarks were not reached.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 36797 Based on observation and policy review, the facility failed to ensure staff followed infection control standards. Specifically,: 1. the facility failed to ensure staff followed droplet precautions while providing care and housekeeping services in rooms with droplet precautions in place on two of three nursing units; and 2. failed to have measures in place to prevent the spread of water borne infections. Findings include: 1. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions, dated 8/1/23, indicated the following: -For a resident on droplet precautions masks are worn prior to entering thee room. -If there is a risk of spraying respiratory secretions, a gown, gloves and goggles are worn. -Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Contact Precautions include the wearing of a disposable gown upon entering the room and remove it before leaving the room. On 3/05/24 at 7:48 A.M., the surveyor observed a Certified Nursing Assistant (CNA) providing care to a resident who was positive for the flu. A precaution sign outside the room indicated anyone entering the room should be following droplet precautions which included wearing a gown, glove, mask and eye protection. The CNA providing care was not wearing eye protection. The room did not have a separate receptacle to hold dirty linen and the CNA added the dirty linen to the regular laundry bin. On 3/05/24 at 7:59 A.M., a CNA entered a room without donning any PPE (personal protective equipment). A sign on the door indicated the resident's in the room were on droplet precautions On 3/05/24 at 8:42 A.M., a CNA was observed walking down the hallway carrying dirty linen while wearing gloves. On 3/05/24 at 9:46 A.M., a housekeeper was observed cleaning the floor in a room with droplet precautions. The housekeeper was not wearing eye protection. On 3/07/24 at 6:14 A.M., a Nurse #8 entered a droplet precaution room. Nurse #8 was not wearing any PPE, including a mask. During an interview on 3/07/24 at 6:45 A.M., Nurse #8 said she did not have to wear any PPE or mask in the droplet precaution room as it was the preference of the staff if they wanted to put any PPE on. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/07/24, at approximately 6:35 A.M., a CNA was observed entering the room of a resident who was positive for Clostridium Difficile (a bacterium that causes an infection of the colon and whose spores can last up to five months on inanimate surfaces and cause infection). The CNA assisted the resident to the bathroom without donning a protective gown, potentially contaminating her clothes. During an interview on 3/07/24 at 11:08 A.M., Unit Manager #2 said gowns, gloves, eye protection and a mask is required when entering a room with droplet precautions. During an interview on 3/07/24 at 11:36 A.M., the Director of Nursing said the facility does frequent infection control training and staff should know the correct infection control procedures. The Director of Nursing said gowns, gloves, eye protection and a mask is required when entering a room with droplet precautions and a gown would be required when assisting any resident with Clostridium Difficile. 2. Review of the facility policy titled Legionella Water Management Program, dated 8/1/23, indicated that as part of the infection prevention and control program, the facility has a water management program which purpose is to identify areas in the water system where Legionella bacteria can grow and spread. Further review indicated that the water management program includes the following elements: a. an interdisciplinary water management team. b. a detailed description and diagram of the water system in the facility. c. identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. d. the identification of situations that can lead to Legionella growth. e. specific measures used to control Legionella. f. the control limits that are acceptable and that are monitored. g. a diagram of where control measures are applied. h. a system to monitor control limits and the effectiveness of control measures. i. a plan for when control limits are not met and/or control measures are not effective. j. documentation of the program. Further review indicated that the water management program is reviewed a least once a year. During an interview on 3/12/24 at 3:08 P.M., the Assistant Director of Nursing said that the facility was unable to locate documentation of a water management program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225440	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Green Nursing and Rehabilitation Center	45 Woburn Street Waltham, MA 02453

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48671 Based on review of the Facility Assessment, employee education record review, and interview, the facility failed to implement and maintain and effective training program per the facility assessment for all new and existing staff. Specifically, the facility failed to provide the required training necessary to meet the needs of each resident. Findings include: Review of the Facility Assessment, indicated but was not limited to: - Staff training/education and Competencies - Each employee at the facility is given competencies based on their position. Upon hire and annually, staff receive both education and competencies. Competency assessments are based upon the employee's job description/responsibilities and the relevant company policies and procedures that pertain to each particular position. - The facility provides continuous education and training for all our staff. We have a full-time registered nurse as our staff development coordinator (SDC). Our SDC is continually educating staff through presentations, educational fairs, and on the floor in services. - Additionally, the facility offers training topics by the SDC including but not limited to: a. Communication- effective communication for direct care staff b. Resident rights and facility responsibilities c. Abuse, neglect, and exploitation d. Infection control e. Compliance and Code of Conduct Review of four out of four nursing assistant employee records and four out of four licensed nurse's employee records failed to indicate yearly competencies as determined by the needs of the residents based on the facility assessment. Review of the staff education/competency records for 8 out of 8 staff personnel failed to indicate mandatory training was completed per the facility assessment to meet the needs of each resident. Training reviewed included but was not limited to effective communication, resident rights, abuse, neglect, and exploitation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225440	A. Building B. Wing	03/13/2024

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/24 04:30 PM the Assistant Director of Nursing (ADON) said she was not able to locate competencies for 8 out of 8 of the employee records reviewed. The ADON said that she did not know who was responsible for oversight of staff competencies. No further educational documents were provided during the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225440	A. Building B. Wing	03/13/2024

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 36797 Based on record review and interview the facility failed to ensure Certified Nurse's Assistants (CNAs) received the required in-service training. Specifically, the facility: 1.) failed to provide no less than 12 hours of training per year; 2.) failed to include dementia management training as required; and 3.) failed to address areas of weakness as determined in CNA's performance reviews, for four out of four CNA employee records reviewed. Findings include: Review of the facility policy titled In-Service Training, Nurse Aide. dated 8/1/23, indicated that Annual in-services are no less than 12 hours per employment year; include training in dementia. 1. Review of CNA #6's employee records failed to indicate any education/orientation trainings since the date of hire. Further review indicated that the 8 hour initial dementia training did not occur until 1/26/24, 3 months after hire. 2. Review of CNA #5's employee records failed to indicate the 8 hour initial dementia education training was provided until 1/26/24, 6 months after date of hire. Further review failed to indicate the number of hours of training provided yearly. 3. Review of CNA #13's employee records failed to indicate the 4 hour dementia education training was provided yearly. Further review indicated that the last dementia training took place in 2014. Further review failed to indicate the number of hours of training provided yearly. 4. Review of CNA #14's employee records failed to indicate the 4 hour dementia education training was provided yearly. Further review indicated that the last dementia training took place in 2014. Further review failed to indicate the number of hours of training provided yearly. During an interview on 3/12/24, at 10:44 A.M., the ADON said that she identified the lack of the required 4 hour yearly dementia training in September 2023. During an interview on 3/12/24 at 1:18 P.M., the Assistant Director of Nursing said she did not know how many hours of training the CNA's had had, because the training sign off sheets (to indicate completion of the trainings) and the corresponding tests, did not have the time spent on each training documented.