

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Catholic Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2446 Highland Avenue Fall River, MA 02720	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>49428</p> <p>Based on observation and interview, the facility failed to ensure for six residents of a total sample of 35 residents, that the Residents were provided respect and dignity in a manner and environment that promoted enhancement of the residents' quality of life and individuality. Specifically, the facility failed:</p> <p>To provide meal assistance in a respectful and dignified manner on units 1E, 2A, and 7.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Tray Pass Guidelines, undated, indicated but was not limited to the following:</p> <p>-A tray may not be placed in front of a dependent feeder until someone is ready to sit down and immediately feed them.</p> <p>On 4/14/25 at 8:53 A.M., the surveyor observed on Unit 1E, two Certified Nursing Assistants (CNAs) standing and feeding two seated Residents, of which one CNA was standing directly in front of a Resident with the Resident's head reaching the height of the CNA's chest.</p> <p>On 4/14/25 at 12:20 P.M., the surveyor observed CNA #6 standing while feeding a Resident in the Unit 7 dining room. CNA #6 was observed walking around the dining room, feeding several seated residents while standing.</p> <p>On 4/14/25 at 12:24 P.M., the surveyor observed CNA #7 standing while feeding an entire meal to a Resident.</p> <p>During an interview with observation on 4/16/25 at 8:44 A.M., the surveyor observed CNA #7 standing while feeding a Resident in the dining room. The Resident was sitting in a Broda chair with a tray table in front of the chair with a pureed breakfast meal. CNA #7 said she is constantly moving in the dining room trying to get residents to eat and she will go from resident to resident providing a spoonful of food. She said she thinks the residents eat better when she feeds them a mouthful of food and then walks away and feeds another resident and then goes back to the first resident. She said she never sits down in the dining room.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/25 at 12:05 P.M., the surveyor observed CNA #11 standing while feeding lunch to two Residents who were seated in the Unit 2A dining room.</p> <p>During an interview on 4/16/25 at 12:06 P.M., the Director of Nursing (DON) said she expected staff to be seated while feeding residents.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>15214</p> <p>Based on observations and interviews, the facility failed to ensure resident's privacy was maintained. Specifically the facility:</p> <ol style="list-style-type: none"> failed to perform a Brief Interview of Mental Status (BIMS) assessment in a private and confidential space. failed to ensure resident protected health information (PHI) was secure and not visible to others on one nursing unit of seven nursing units. <p>Findings include:</p> <p>Review of the facility's HIPAA Policy, undated, indicated but was not limited to, the following:</p> <ul style="list-style-type: none"> -HIPAA is the Health Insurance Portability and Accountability Act of 1996. It requires that all health care providers and organizations develop and follow procedures that ensure the confidentiality and security of health information of an individual. -Confidentiality includes all personal information (name, social security, age, occupation, medical record number, address, diagnosis, treatments, why the resident is here, medical condition or medications). -Do's: <ul style="list-style-type: none"> Close resident's doors when discussing information, doing treatments or performing procedures. Close curtains and speak softly in semi-private rooms when discussing treatments or performing procedures. -Don'ts: <ul style="list-style-type: none"> Don't talk about residents in public areas, such as an elevator or break room. <ol style="list-style-type: none"> Resident #143 was admitted to the facility in January 2024. <p>Review of the medical record indicated Resident #143 had moderate cognitive impairment as evidenced by a BIMS assessment (cognitive assessment) score of 12 out of 15.</p> <p>On 4/15/25 at 11:10 A.M., the surveyor observed the Minimum Data Set (MDS) Nurse conducting Resident #143's BIMS assessment in the Unit 3 hall corridor. The surveyor observed four female residents and other staff passing by who could have easily heard the MDS Nurse assessing the Resident's cognitive status. The MDS nurse was overheard asking the Resident questions like, Repeat the following words: blue, bed, and sock. The Resident was overheard saying to the MDS nurse that he/she could not remember all three of the words that the MDS nurse had asked him/her to try to remember.</p> <p>(continued on next page)</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/15/25 at 11:12 A.M., the MDS Nurse said that she should not have performed the BIMS assessment in the corridor; she did not follow the HIPAA policy. She said she should have conducted the assessment in a private space such as the Resident's room where others could not overhear so as to protect the Resident's privacy and dignity.</p> <p>During an interview on 4/17/25 at 11:27 A.M., the Director of Nursing (DON) said that she had heard about the MDS Nurse conducting the BIMS assessment in the corridor on the B Unit. The DON said that the MDS nurse should have conducted the assessment in a private location to protect the Resident's privacy and dignity.</p> <p>49424</p> <p>2. On 4/14/25 at 11:41 A.M., the surveyor observed a sign posted to the Unit 6 dining room door titled Feeding List for 7-3 and 3-11 which included 19 residents first and last names along with their room number. The residents were having lunch in the dining room at this time with staff feeding residents their meals.</p> <p>On 4/14/25 at 5:00 P.M., the surveyor observed the same sign posted while residents were having dinner. The surveyor observed visitors in the dining room at this time.</p> <p>During an interview with observation on 4/15/25 at 7:39 A.M., Certified Nurse Aide (CNA) #5 said that she uses the list posted on the door as a reference as to which residents need to be fed their meals. She said the Unit Manager made this list for the staff and posted it on the dining room door for ease of access to information.</p> <p>During an interview on 4/15/25 at 7:50 A.M., CNA #4 said the sign on the door has been posted for reference for well over a month. She said the list is updated by the Unit Manager if someone needs to be fed.</p> <p>During an interview on 4/15/25 at 8:17 A.M., Unit Manager #5 said she created and posted the sign on the door as a cheat sheet for staff to know which residents need to be fed and which residents they can just set up their meals. She said she updates it with changes. She said she also keeps the seating chart posted on this door with Resident names for the dining room but she was not sure where that sign was moved to.</p> <p>During an observation with an interview on 4/15/25 at 11:50 A.M., the Administrator said this information should not be posted publicly. She said the sign violated HIPAA and should not be visible to other residents or visitors.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542</p> <p>Based on observation, interview, and record review, the facility failed to implement the person-centered plan of care for one Resident (#173), out of 35 sampled residents. Specifically, the facility failed to implement the fall risk prevention intervention of having the call light within reach.</p> <p>Findings include:</p> <p>Resident #173 was admitted to the facility in May 2023 with diagnoses of dementia and a history of falling.</p> <p>Review of the care plans indicated Resident #173 had a history of falls with the following interventions:</p> <ul style="list-style-type: none"> -call light in reach at all times; may not always know how to use due to cognitive loss (effective 5/10/23) -remind and educate to call for assistance (effective 7/3/23) -remind to use call light for assistance (effective 11/18/24) <p>Review of the medical record indicated Resident #173 fell on [DATE], 12/24/24, 2/16/25, and 4/12/25.</p> <p>On 4/15/25 at 2:20 P.M., the surveyor observed Resident #173 in his/her room in a stationary reclining chair. The surveyor observed a red string attached to the wall call light box and on the Resident's bed. The call light cord was not within reach of the Resident.</p> <p>On 4/16/25 at 7:40 A.M., the surveyor observed Resident #173 lying in bed. The wall call light box was located towards the foot of the Resident's bed and the red string was hanging straight down at the Resident's foot of the bed and could not be easily reached by the Resident.</p> <p>On 4/16/25 at 9:02 A.M., the surveyor observed Resident #173 in his/her room in a stationary reclining chair with their breakfast on a table in front of them. The surveyor observed a red string attached to the wall call light box and on the Resident's bed. The call light cord was not within reach of the Resident.</p> <p>On 4/16/25 at 11:35 A.M., the surveyor observed Resident #173 in his/her room in a stationary reclining chair. The surveyor observed a red string attached to the wall call light box and on the Resident's bed. The call light cord was not within reach of the Resident.</p> <p>During an interview on 4/16/25 at 12:00 P.M., Certified Nursing Assistant (CNA) #2 said Resident #173 was able to ambulate with a rolling walker in his/her room and would attempt to get up on their own. She said the Resident preferred to sleep in their recliner on and off throughout the day. She said the Resident knew how to use the call light.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/16/25 at 1:46 P.M., Unit Manager #4 said Resident #173 needed supervision with walking and should be using the call light, although would forget at times. She said the call light should be within reach of the Resident and this was part of the care plan interventions.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>15214</p> <p>Based on observation and interview, the facility failed to ensure that medications were labeled and stored in accordance with accepted professional principles for two Residents (#144 and #103), of a total sample of 35 residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #103, to ensure medications were stored in the container with the pharmacy label; and 2. For Resident #144, to ensure that the Resident's topical medications were stored securely. <p>Findings include:</p> <p>Review of the facility policy titled Storage of Medications, dated March 2021 and reviewed on 4/17/25, indicated but was not limited to, the following:</p> <p>C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label.</p> <p>Review of the facility policy titled Medication Storage in the Facility, dated 1/9/17, indicated, but was not limited to, the following:</p> <p>-Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>-Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted [sic] to access medications. Medication rooms, carts, and medication supplies are locked when not in use or in direct view of persons with authorized access.</p> <p>1. On 4/15/25 at 8:30 A.M., the surveyor observed Nurse #5 administering medications to Resident #103. While preparing the Resident's medications, Nurse #5 opened the third drawer of the medication cart and the surveyor observed an unidentified, unlabeled, white pill in a plastic medication cup.</p> <p>During an interview on 4/15/25 at 8:35 A.M., Nurse #5 said she didn't know what the medication was, the dose of the medication, who the medication was for, when it was placed there, or when it was to be administered. Nurse #5 said that the unlabeled medication in the drawer likely belonged to Resident #103, and could be the Resident's 6 A.M. dose of levothyroxine, however she was not sure. Nurse #5 said she could not say why the night nurse would have left the pill unlabeled in the medication cup and that doing so was prohibited. Nurse #5 said that medications should never be left unlabeled and stored in the medication cart.</p> <p>During an interview on 4/17/25 at 11:13 A.M., the Director of Nurses (DON) said that medications should never be left unlabeled and stored in the medication cart for any reason.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50740</p> <p>2. During the course of survey, the surveyor made the following observations in Resident #144's room:</p> <p>-4/14/25 at 9:34 A.M.: two tubes of Mupirocin (a topical antibiotic ointment and Bacitracin (a topical antibiotic ointment) in a basin on top of the dresser.</p> <p>-4/15/25 at 9:30 A.M.: two tubes of Mupirocin and Bacitracin in a basin on top of the dresser.</p> <p>-4/16/25 at 7:35 A.M.: two tubes of Mupirocin and Bacitracin in a basin on top of the dresser.</p> <p>During an interview on 4/16/25 at 10:05 A.M., Unit Manager #1 said that Mupirocin and Bacitracin should not be stored, unsecured, in the Resident's room.</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>36542</p> <p>Based on observations, interviews, and record review, the facility failed to provide adaptive equipment for one Resident (#5), out of a total sample of 35 residents. Specifically, the facility failed to ensure Resident #5 was provided with built-up handles for utensils and a handled cup for beverages during meals.</p> <p>Findings include:</p> <p>During the entrance conference on 4/14/25 at 9:00 A.M., the Administrator said the facility had been making repairs in the kitchen and all residents were currently using disposable dishes and plastic utensils since February 2025.</p> <p>Resident #5 was admitted to the facility in September 2021 and had bilateral hand contractures.</p> <p>Review of the care plans indicated Resident #5 was received help with opening containers and cutting up food and was then independent with eating and drinking. The interventions included following any Occupational Therapy (OT) recommendations.</p> <p>Review of the OT Evaluation and Plan of Treatment, dated 2/25/25, indicated the following:</p> <ul style="list-style-type: none"> -prior level of function: self-feed after set-up -presents with increased difficulty grasping and manipulating utensils and standard cups during mealtimes resulting in decreased efficiency during meals <p>Review of the OT Discharge Summary, dated 3/4/25, indicated the following:</p> <ul style="list-style-type: none"> -skilled interventions: built-up handles for plastic utensils provided and two handled cups were recommended to maximize independence in feeding -progress: functional performance has improved as a result of instruction to caregivers -discharge recommendations: provide set-up assistance with included built-up handles, nursing staff aware to issue for meals and to clean as needed. <p>On 4/16/25 from 8:32 A.M. through 8:51 A.M., the surveyor observed Resident #5 in the unit dining room. The Resident was provided their breakfast meal in a disposable container and provided a plastic fork and a plastic spoon. The Resident was observed with bilateral hand contractures holding the plastic fork, without built-up handles on the utensil. The Resident was observed to have a standard disposable plastic cup of milk (without a handle) and a disposable container of orange juice. The Resident was observed to have difficulty holding the container of orange juice with both hands and trying to bring it to his/her mouth.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/16/25 at 11:48 A.M., the surveyor observed Resident #5 in the unit dining room. The Resident was provided their lunch meal in a disposable container and provided a plastic fork and a plastic spoon. The Resident was observed holding a plastic spoon, without a built-up handle, eating ice cream. The Resident then used the plastic fork, without a built-up handle, to eat the cut-up ham. The milk was in a plastic disposable cup, without a handle.</p> <p>During an interview on 4/16/25 at 11:57 A.M., Certified Nursing Assistant (CNA) #1 said Resident #5 previously had foam handles that would be put on the utensils to make for a better grip for the Resident, but the foam handles did not fit on the plastic utensils because the handles on the plastic utensils were too small. She said Resident #5 prefers to feed him/herself and will not let staff feed him/her.</p> <p>During an interview on 4/16/25 at 1:40 P.M., Unit Manager #4 said the process for when a resident discharged from a therapy service with adaptive equipment was for the OT to write up the recommendation, for the nurse to transcribe the order and for the Unit Manager to double check the order and then add any changes to the care plans. She said she would have to check on the process for when Resident #5 was discharged from OT on 3/4/25.</p> <p>During an interview on 4/16/25 at 2:39 P.M., Unit Manager #4 said she was unable to locate any documentation from when Resident #5 discharged from OT. She said based on the discharge summary the OT had educated the staff, but she was not sure who was educated. She said she found the red built-up foam handles for the utensils in the Resident's room and the staff had not been using them because the utensils moved when inside the handle, making it more difficult for the Resident to eat. She said the staff had not communicated this to her.</p> <p>During an interview on 4/17/25 at 8:10 A.M., the Occupational Therapist said Resident #5 had been referred for OT because of their decrease in self-feeding leading to a decrease in food intake. She said when she discharged the Resident from services the plan was for the red built-up handle covers to be added to the plastic utensils for a better grip and for all beverages to be provided in cups with handles (one or two handled cups). She said she had educated one of the CNAs but was not sure which one. She said she had not known at that time that the recommendations for staff to put the built-up handle on the plastic utensils needed to be in writing so the adaptive equipment could be added to the orders for effective implementation. She said the recommendation for cups with handles should have been communicated to the kitchen but it had not been done at that time.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49428</p> <p>Based on observation and interview, the facility failed to follow professional standards of practice for food safety to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure food items were properly dated and stored in three of three kitchenettes.</p> <p>Findings include:</p> <p>Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following:</p> <p>3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location.</p> <p>3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.</p> <p>(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety.</p> <p>(D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.</p> <p>On 4/15/25 at 2:31 P.M., the surveyor observed on Unit 6 three opened and undated containers of thickened liquids. One container had a manufacturer's label indicating to use the contents within seven days of opening. Two containers had a manufacturer's label indicating to discard the contents if not used within 10 days of opening.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/16/25 at 1:01 P.M., the surveyor observed on Unit 6, one opened and undated container of thickened liquid with a manufacturer's label indicating to use the contents within seven days of opening.</p> <p>During an interview on 4/16/25 at 1:30 P.M., CNA #3 said there was no date on the thickened liquid container to indicate when it was opened. CNA #3 said any food or drink that was opened should be dated so staff know when to discard it. CNA #3 said they did not know when the thickened liquid container was opened.</p> <p>During an interview on 4/17/25 at 10:50 A.M., the Food Service Director (FSD) said once a food or drink item is opened, staff should date the item with the date opened. The FSD said thickened liquids should be dated with the date opened and discarded per manufacturer's instructions.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740</p> <p>Based on record review and interview, the facility failed to ensure a complete and accurate medical record was maintained for one Resident (#36), out of a total sample of 35 residents. Specifically, for Resident #36, the Resident's medical record failed to reflect accurate health care proxy activation status.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Advance Directives Policy, dated ,d+[DATE], indicated, but was not limited to, the following:</p> <ul style="list-style-type: none"> -If the resident is incapacitated at the time of admission, information may be given to the resident's family or surrogate. If the resident's condition reverses and he/she is no longer incapacitated, information shall be given to the resident at the appropriate time. -Implementation of resident self-determination begins on admission. -If the resident lacks decision-making capacity, the responsible party that is present during the admission process will be asked if the resident has designated a Health Care Proxy (HCP). The HCP shall be contacted to determine if the resident ever discussed or drafted advanced directives. The physician shall activate the HCP and the HCP will be responsible for executing advance directives on the resident's behalf. <p>Resident #36 was admitted to the facility in [DATE] with diagnoses including left calf hematoma evacuation and wound debridement and atrial fibrillation.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated the Resident was moderately cognitively impaired, as evidenced by a Brief Interview for Mental Status (BIMS) score of eight out of 15. Further review of the MDS indicated Resident #36's Health Care Proxy was invoked.</p> <p>Review of the outside hospital's Discharge Summary, dated [DATE], indicated Resident #36 had mild cognitive impairment and had signed advanced directives, including a Medical Orders for Life Sustaining Treatment (MOLST) document and Health Care Proxy document, during his/her hospitalization . Further review of the Discharge Summary failed to indicate the Resident's Health Care Proxy had been invoked.</p> <p>Review of Resident #36's Physician's Orders indicated the Resident's Health Care Proxy was activated on [DATE].</p> <p>Review of Resident #36's Care Plan indicated, but was not limited to, the following:</p> <p>Problem: Advanced Directives - I am a DNR. I do not have any other advanced directives in place at this time. My healthcare proxy is activated.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Goal: My HCP has chosen the following advanced directives to be carried out this quarter.</p> <p>Approach:</p> <p>-DNR - Do Not Resuscitate order will be honored while resident is in the facility. Upon finding the resident without pulse or respiration, NO CPR will be initiated per resident/HCP request and MD order.</p> <p>-My family is to be called with any changes in my condition and a decision will be made at that time to follow through on this POC or change it.</p> <p>-Please monitor and assess my condition for system management and provide adjustments/additions to my medication.</p> <p>Review of the physician (MD) and nurse practitioner (NP) progress notes for Resident #36 indicated, but was not limited to, the following:</p> <p>-[DATE] NP note: HCP is not activated.</p> <p>-[DATE] MD note: HCP is not activated.</p> <p>-[DATE] MD note: HCP is not activated.</p> <p>-[DATE] NP note: HCP is not activated.</p> <p>During an interview on [DATE] at 8:25 A.M., Unit Manager #1 said the order entered in Resident #36's record indicating the Resident's HCP was activated may have been entered in error.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36542</p> <p>Based on observations and interviews, the facility failed to follow infection control prevention practices. Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure effective hand hygiene practices and appropriate PPE (personal protective equipment) were utilized when entering in and out of resident rooms, including residents on transmission based precautions; 2. Ensure staff utilized appropriate PPE while providing direct care to Resident #36 on Enhanced Barrier Precautions; 3. Ensure staff and resident hand hygiene was implemented during meals on Unit 7 and Unit 2A; 4. Ensure that medication carts were maintained in a clean, sanitary condition to prevent contamination and transmission of disease from resident to resident; and 5. Ensure that sanitary practices were used by nursing while preparing and administering medications. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled Precautions to Prevent Infection indicated,dated as reviewed in July 2025 but was not limited to the following: <ul style="list-style-type: none"> -standard precautions are intended to be applied to the care of all patients in healthcare settings, regardless of suspected or confirmed presence of an infectious agent -transmission-based precautions are for patients who are known or suspected to be infected or colonized with infectious agents -the category of transmission-based precaution determines the type of PPE (personal protective equipment) to be used -proper hand washing remains a key preventative measure, regardless of the type of transmission-based precaution employed -when implementing transmission based precautions: post clear signage on the door or wall outside of the resident room indicating the type of precaution and required PPE <p>Review of the transmission-based precautions signs indicated the following:</p> <ul style="list-style-type: none"> -Isolation Precaution sign: staff and providers must clean hands when entering and exiting the room <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Contact Plus precaution sign: staff and providers must clean hands before entering room, change gown and gloves between caring for each resident, wash hands with soap and water before exiting resident's room (hand sanitizer is not sufficient when exiting a resident's room), use bleach products to clean and disinfect resident rooms</p> <p>During an interview on 4/15/25 at 3:05 P.M., Unit Manager #5 said Resident #142 had been placed on Isolation precautions that morning related to an episode of vomiting and Resident #190 was on Contact Plus precautions related to loose stool.</p> <p>On 4/16/25 at 3:49 P.M., Certified Nursing Assistant (CNA) #9 was observed exiting the room of Resident #142 and placed a robe on the shoulders of Resident #142 who was sitting in the hallway. A sign on the room for Resident #142 indicated the Resident was on Isolation Precautions. CNA #9 was observed going back in the room of Resident #142 and coming out with an over the bed table with a stack of clean hospital gowns for residents. CNA #9 was not observed to perform hand hygiene when entering or exiting the room or following contact with the Resident and their clothing.</p> <p>CNA #9 then wheeled the over the bed table with the hospital gowns down the hall and entered the room of Resident #190 with the table, without performing hand hygiene prior to entering. CNA #9 was observed placing the resident gowns on the dresser of each resident in the room. CNA #9 exits the room of Resident #190 without performing hand hygiene, goes to the linen closet on the unit to obtain more briefs and returns to the room of Resident #190.</p> <p>CNA #9 then exits the room of Resident #190, without performing hand hygiene. CNA #9 was observed going to the linen closet and getting clothing protections and brining them to the unit dining room. CNA #9 was observed exiting the room without performing hand hygiene.</p> <p>During an interview on 4/16/25 at 4:06 P.M., CNA #9 said each of the signs outside of the resident's rooms indicated the type of precautions the residents were on. He said the signs indicated the directions for hand hygiene and PPE use and should be followed.</p> <p>During an interview at 8:55 A.M., the Infection Control Preventionist said when a staff enter the rooms of residents on precautions they should be performing hand hygiene when entering and exiting. For Contact Plus precautions the staff would need to don PPE if they are touching resident items, but not if they were only dropping off linen.</p> <p>50740</p> <p>2. Resident #36 was admitted to the facility in March 2025 with diagnoses including pressure ulcer of the sacral region and left calf hematoma requiring incision and drainage.</p> <p>Review of Resident #36's Care Plan indicated, but was not limited to, the following:</p> <p>Problem: EBP (Enhanced Barrier Precautions) - I am at increased risk of MDRO (multi-drug resistant organism) acquisition secondary to surgical wounds to my left lower extremity.</p> <p>Approach:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Do not wear the same gown and gloves for the care of more than one resident or reuse the gown and gloves for the same resident.</p> <p>-Post clear signage on the door or wall outside of the resident's room indicating the type of precautions and required personal protective equipment. *For enhanced barrier precautions, signage should indicate the high-contact resident care activities that require the use of gown and gloves.</p> <p>On 4/17/25 at 10:03 A.M., the surveyor observed the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precautions sign posted on the wall outside of Resident #36's room. The sign indicated that everyone must clean their hands and that providers and staff must wear gloves and a gown for high-contact resident care activities such as: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and wound care. Gowns were located in a hanging basket on the room door.</p> <p>On 4/17/25 at 10:03 A.M., Certified Nursing Assistant (CNA) #10 was observed in Resident #36's room providing incontinence care and assisting the Resident with turning and repositioning in bed. CNA #10 was wearing gloves but was not wearing a gown during care.</p> <p>On 4/17/25 at 10:15 A.M., the surveyor observed wound care provided to Resident #36. CNA #10 was present in the room and assisted in providing hygiene and positioning the Resident during wound care. CNA #10 was wearing gloves but was not wearing a gown. During wound care, the surveyor observed Nurse #4 remove her gloves and don new gloves without performing hand hygiene at 10:21 A.M., 10:23 A.M., and 10:25 A.M.</p> <p>During an interview on 4/17/25 at 10:35 A.M. Nurse #4 said Resident #36 required Enhanced Barrier Precautions and that CNA #10 should have had on a gown for high-contact care activities. Nurse #4 said that after removing gloves, hand hygiene should be performed before new gloves are put on.</p> <p>During an interview on 4/17/25 at 11:22 A.M., CNA #10 said Resident #36 required Enhanced Barrier Precautions and that she should have worn a gown when providing care, but was busy and forgot to.</p> <p>49428</p> <p>3. Review of the facility's policy titled Hand Hygiene, undated, indicated but was not limited to the following:</p> <p>Purpose - Hand hygiene continues to be the primary means of preventing the transmission of infection.</p> <p>Policy - All employees of the facility shall perform hand hygiene (such as hand washing or use of alcohol hand rubs) in accordance with the recommendations of the Center for Disease Control (CDC) Guideline for Hand Hygiene in Health Care Settings, World Health Organization (WHO), Centers for Medicare and Medicaid Services (CMS) Guidance.</p> <p>Hand washing with antimicrobial soap and water must be performed in the following situations:</p> <p>-When hands are visibly dirty or contaminated with proteinaceous materials or with blood or any body fluids;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Before and after eating or handling food.</p> <p>Alcohol based hand rubs can be used for routinely decontaminating hands if they are not visibly soiled and if the aforementioned situations do not exist.</p> <p>The following is a list of some situations that require hand hygiene:</p> <ul style="list-style-type: none"> -Before and after eating or handling food (hand washing required); -Before and after assisting a resident with meals (hand washing required); -After handling soiled equipment or utensils; -After contact with objects and environmental surfaces in a resident's room or in vicinity of resident. <p>On 4/14/25 at 12:10 P.M., the surveyor observed CNA #6 walking around the Unit 7 dining room feeding several residents. The surveyor observed CNA #6 feeding food and drinks to residents. The surveyor observed the CNA touch residents' utensils and serving ware, discard used placemats and finished meal items, and remove residents' used clothing protectors. The surveyor did not observe the CNA wash or sanitize her hands between these tasks or between assisting residents.</p> <p>On 4/16/25 at 7:17 A.M. to 7:50 A.M., the surveyor observed twelve residents sitting in the Unit 7 dining room awaiting the arrival of their meals. The surveyor observed staff preparing for breakfast by placing clothing protectors on residents and putting placemats on table. Residents were not offered hand hygiene at any time prior to being served breakfast.</p> <p>On 4/16/25 at 7:50 A.M., the surveyor observed staff serving breakfast to the Residents in the Unit 7 dining room. The surveyor observed staff did not offer Residents hand hygiene when serving the food.</p> <p>During an interview on 4/16/25 at 8:38 A.M., Nurse #1 said that hand hygiene should be offered to residents prior to them having their meal and she said she was not sure if it was offered.</p> <p>During an interview on 4/16/25 at 12:33 P.M., Resident Representative #1 said she sits with her husband almost daily in the dining room at lunch and she said she has not witnessed staff offer hand hygiene to residents prior to eating.</p> <p>On 4/16/25 at 12:05 P.M., the surveyor observed CNA #11 assisting three residents with lunch in the Unit 2A dining room. CNA #11 was observed moving from resident to resident without sanitizing her hands before assisting with their meals. CNA #11 was observed handling bread from one Resident's tray with her bare hands as she spread margarine on the bread with the Resident's utensils. CNA #11 then moved to feed another Resident without sanitizing or cleaning her hands.</p> <p>During an interview on 4/16/25 at 12:27 P.M., the Director of Nurses (DON) said her expectation is residents are being offered hand hygiene prior to every meal, and staff who are assisting/feeding residents should wash or sanitize their own hands when moving from one resident to the next.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>15214</p> <p>4. The Use of the Medication Cart policy, dated March 2021, and reviewed by the surveyor on 4/16/25, indicated but was not limited to:</p> <p>-J. The licensed personnel should maintain a clean top surface of the medication cart while passing medications and clean and replenish the medication cart after each use.</p> <p>During observation of the Med Cart, on the D-Wing, Unit 7, on 4/16/25 at 4:14 PM with Nurse #7, the following was observed:</p> <p>The 1st, 5th and 6th drawers of the medication cart were observed to be significantly dirty with black, soiled and sticky areas, with dark marks left on the bottoms of the drawers from sticky medication bottles. Nurse #7 said that the drawers in the med cart were dirty and in need of cleaning. Nurse #7 said that typically, the night shift cleans the medication carts. However, she also said that each nurse is responsible for ensuring the cleanliness of the medication carts during their shifts.</p> <p>During an interview on 4/17/25 at 11:21 A.M., the Director of Nursing (DON) said, after viewing the pictures of the dirty med cart provided by the surveyor, that is pretty gross. The DON said that the facility policy is for nurses to clean the med carts after each shift.</p> <p>5. During observation on 4/15/25 at 9:10 A.M., Nurse #8, assigned to administer medications on the 2 AB Unit, was observed preparing medications for Resident #109. During the preparation process, the nurse indicated to the surveyor which pill in the cup was the Metformin (diabetic medication) that she had placed in the medication cup. Nurse #8 was observed inserting her finger in the medication cup and physically touched the pill with her finger. When the surveyor indicated that she had placed her finger in the cup and touched the pill, she said, That's a no no. She said that she understood that touching medication with bare hands is a violation of infection control procedures.</p> <p>During an interview on 4/17/25 at 11:33 A.M., the DON said that Nurse #8 should not have touched the Resident's medication with her bare finger. The DON said that it is an infection control issue.</p>		