STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225453	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carvalho Grove Health and Rehabilitation Center	273 Oak Grove Avenue Fall River, MA 02723

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48695 Based on observation, record review, and interview, the facility failed to ensure medications were not self-administered without a physician's order and an assessment for self-administration was completed for two Residents (#58 and #73), out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to: - 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 capacity to do so safely. Review of the facility's policy titled Self-Administration of Medications, undated, indicated but was not limited to: - Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for residents to do so. - As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. - The staff and practitioner will document their findings and the choices of the residents who are able to self-administer medications. - Self-administered medications must be stored in a safe and secure place which is not accessible by other residents. 1. Resident #58 was admitted to the facility in September 2024 with diagnoses including Herpes viral keratitis (an infection of the cornea, the clear front part of the eye, caused by the herpes simplex virus). (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 12/12/24, indicated Resident #58 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review of the MDS indicated the Resident was independently able to perform activities of daily living. During an observation with interview on 2/12/25 at 9:36 A.M., the surveyor observed Resident #58 lying in bed; a bottle of Prednisolone Ophthalmic Suspension (a steroid medicine that is used to relieve the redness, itching, and swelling caused by eye infections and other conditions) was on Resident #58's overbed table. Resident #58 said he/she uses the Prednisolone Ophthalmic Suspension daily in the evening in his/her left eye. On 2/12/25 at 1:49 P.M., the surveyor observed Resident #58 sitting on the edge of his/her bed with the Prednisolone Ophthalmic Suspension on his/her overbed table. On 2/13/25 at 9:01 A.M., the surveyor observed Resident #58 sitting on the edge of his/her bed eating breakfast with the Prednisolone Ophthalmic Suspension on his/her overbed table. During an interview on 2/13/25 at 11:48 A.M., Resident #58 said he/she used the Prednisolone Ophthalmic Suspension nightly. Resident #58 said he/she had been diagnosed with herpes viral keratitis in the past and the Prednisolone Ophthalmic Suspension was prescribed to decrease swelling in his/her left eye. Resident #58 said they (facility staff) took his/her eye drops away because the surveyor asked him/her what he/she used them for, but he/she would like them because he/she wanted to administer them himself/herself. Resident #58 said the nurses knew he/she administered the Prednisolone Ophthalmic Suspension. Review of Resident #58's current Physician's Orders included but was not limited to: - Prednisolone Ophthalmic Suspension 1%, Instill 1 drop in the left eye, dated 12/16/24 Review of Resident #58's January and February Medication Administration Record (MAR) indicated Resident #58 received the Prednisolone Ophthalmic Suspension daily. Review of Resident #58's medical record failed to indicate the facility completed any additional Self-Administration of Medication Assessments. During an interview on 2/18/25 at 12:15 P.M., Nurse #9 said if a resident wanted to administer their own medications, then the Physician would have to give an order for them to self-administer the medication and the Resident should have been evaluated to ensure he/she was able to safely administer the medication. Nurse #9 reviewed Resident #58's medical record and said Resident #58 did not have an order to self-administer Prednisolone Ophthalmic Suspension and an evaluation had not been completed and documented. Nurse #9 said for residents who were able to self-administer, they should have a locked and secure place to store the medications. (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 2/18/25 at 2:30 P.M., Unit Manager (UM) #1 said an assessment for self-administration, teaching with return demonstration, and an order should have been obtained from the Physician for Resident #58 to self-administer his/her Prednisolone Ophthalmic Suspension, but it had not been done. Medications stored at the beside should have been stored in a secure way. UM #1 said Resident #58 should have an assessment and orders to self-administer the Prednisolone Ophthalmic Suspension but did not. During an interview on 2/19/25 at 12:35 P.M., the Director of Nursing (DON) said the expectation was for all residents who expressed a desire to self-administer medication(s) to have an assessment completed, teaching and return demonstration completed, and a physician's order must be obtained. The DON said without an order medications should not be left in a resident's room. The DON said for those residents that were able to have medications at their bedside, they should be stored in a secure place. 2. Resident #73 was admitted to the facility in May 2023 with diagnoses including post-polio syndrome. Review of the MDS assessment, dated 11/15/24, indicated Resident #73 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS indicated the Resident was dependent on staff to perform activities of daily living. On 2/13/25 at 9:27 A.M., the surveyor observed Nurse #2 administer Fluticasone Nasal Spray to Resident #73. Resident #73 told Nurse #2 that he/she had a bottle of the Fluticasone Nasal Spray on his/her overbed table. Nurse #2 said she had brought the Fluticasone Nasal Spray with her and administered the Fluticasone Nasal Spray to Resident #73. During an interview on 2/13/25 at 9:32 A.M., Resident #73 said he/she utilized the Fluticasone Nasal Spray as needed when he/she had a dry nose. Resident #73 said he/she did not notify the nursing staff when he/she self-administered the Fluticasone Nasal Spray. Resident #73 said he/she wanted to be able to administer his/her Fluticasone Nasal Spray and not have the nurses do it. During an interview on 2/13/25 at 11:32 A.M., Nurse #2 said Resident #73 had not had an evaluation and did not have an order to self-administer Fluticasone Nasal Spray. Nurse #2 said if a resident voiced that they wanted to self-administer medications then they should have had teaching done, were able to do a return demonstration, had a medication-self administration assessment with documentation and a physician's order but Resident #73 did not have these documents completed. During an interview on 2/19/25 at 8:56 A.M., UM #2 said Resident #73 did not have an order to self-administer Fluticasone Nasal Spray and had not been evaluated to administer his/her Fluticasone Nasal Spray but should have had. During an interview on 2/19/25 at 12:35 P.M., the DON said the expectation was for all residents who expressed a desire to self-administer medication(s) to have an assessment completed, teaching and return demonstration completed, and a physician's order must be obtained. The DON said without an order medications should not be left in a resident's room. The DON said for those residents that were able to have medications at their bedside, they should have stored them in a secure place.

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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. 48362 Based on observation, record review, and interviews, the facility failed to ensure one Resident (#11), out of a total sample of 21 residents, had their call light accessible and within reach in order to utilize to call for assistance. Findings include: Review of the facility's policy titled Resident Call System, undated, indicated but was not limited to the following: - The facility will be equipped with a communication to ensure residents have the ability to contact a staff member for assistance from their bedside and from toilet and bathing areas. - When in their rooms and toilet and bathing areas, residents will have a means of directly contacting caregivers. Resident #11 was admitted to the facility in July 2014 with diagnoses including Alzheimer's disease, history of falling, and anxiety. Review of Resident #11's Minimum Data Set (MDS) assessment, dated 11/17/24, indicated he/she had a severe cognitive deficit and required extensive assistance for activities of daily living. During the following days and times, the surveyor made the following observations: - On 2/12/25 at 8:05 A.M., the Resident was in bed and his/her call light was positioned on the wall near the shut off button. The call light was not within reach of the Resident. - On 2/12/25 at 8:29 A.M., the Resident was in bed and his/her call light was not within reach. - On 2/18/25 at 2:10 P.M., the Resident was in a reclining wheelchair positioned in front of his/her television. The call light was resting on his/her bed and out of reach of the Resident. - On 2/18/25 at 3:37 P.M., the Resident was in a reclining wheelchair positioned in front of his/her television. The call light was resting on his/her bed and out of reach of the Resident. - On 2/19/25 at 8:32 A.M., the Resident was in bed and his/her call light was positioned on the wall near the shut off button. The call light was not within reach of the Resident. Review of Resident #11's comprehensive care plan for ADL (activities of daily living) indicated but was not limited to the following interventions: - Call bell within reach while in room/bathroom/shower room and remind to use (last revised 4/4/23). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's comprehensive care plan for falls indicated but was not limited to the following interventions: - Be sure that the call bell and personal items are in reach before leaving the room (last revised 3/16/22). During an interview on 2/13/25 at 10:14 A.M., Certified Nursing Assistant (CNA) #1 said call lights should be in reach at all times for all residents, regardless of their ability to use them. During an interview on 2/13/25 at 10:20 A.M., CNA #4 said residents are required to have their call lights in reach at all times in their room. During an interview on 2/19/25 at 7:39 A.M., Nurse #7 said all residents should have their call lights within reach whether they are in or out of bed in order to call for assistance of staff. During an interview on 2/19/25 at 8:35 A.M., the Assistant Director of Nursing (ADON) said call lights should be within arm's reach of residents at all times. The ADON said call lights in the facility can be clipped to residents or placed next to them. The ADON said call lights should always be left near a resident regardless of cognitive ability.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 34145 Based on observation and interview, the facility failed to ensure the availability of statements of deficiencies and plans of correction from complaint investigations conducted since the previous recertification survey were prominent and readily accessible to residents, family members, and legal representatives of residents without having to ask to see them, as required. Findings include: On 2/13/25 at 1:30 P.M., the surveyor held a resident group meeting with nine residents in attendance representing each of the facility's three units. Nine of nine residents said they were not aware of the availability of survey results, and that they could examine the survey results without asking to see them. On 2/13/25 at 2:05 P.M., the surveyor toured the second-floor units and was unable to find postings of the availability of survey results. On 2/13/25 at 2:12 P.M., the surveyor searched the lobby area and observed a large, three-ringed binder labeled survey results resting on a shelf behind the reception desk. The binder was inaccessible to residents, family members, and legal representatives of residents as the shelf was blocked by the reception desk and a table positioned perpendicular to the reception desk. During an interview on 2/13/25 at 2:20 P.M., the Administrator said he was not aware that the survey results binder was kept on a shelf behind the reception desk and was not readily accessible to residents and their representatives, and they would have to ask to see them.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observation, interview, and record review, the facility failed to notify the Physician and/or responsible party of recommendations or changes in condition for two Residents (#43 and #1), out of a total sample of 21 residents. Specifically, the facility failed: 1. For Resident #43, to notify the physician/physician extender of STAT x-ray (a medical imaging technique that uses electromagnetic radiation to create images of internal structures in the body) results in order to make a treatment decision; and 2. For Resident #1, to notify the attending physician group of Resident #1 exceeding their daily fluid restriction of 1200 milliliters (ml) a day. Findings include: Review of the facility's policy, Change in a Resident's Condition or Status, last revised November 2015, indicated but was not limited to: -The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: -A need to alter the resident's treatment significantly -Refusal of treatment or medications (i.e. two (2) or more consecutive times) 1. Resident #43 was admitted to the facility in November 2020 and had diagnoses including gastroparesis and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 1/20/25, indicated Resident #43 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15, and required maximum assistance for activities of daily living. Review of the medical record indicated on 1/12/25, Nurse Practitioner (NP) #1 ordered Augmentin (antibiotic) 500-125 milligrams (mg) twice daily for seven days for a possible urinary tract infection (UTI). On 1/13/25, Resident #43 developed a fever of 101.2, and Physician #1 ordered a STAT chest x-ray and Bactrim DS (antibiotic) 800-160 mg twice daily for three days for possible pneumonia. Further review of the medical record indicated the order for the STAT chest X-ray was entered/written in the medical record on 1/13/25. The radiology report indicated the chest X-ray was completed, and the results (lungs are clear) were sent electronically to the facility on [DATE] at 4:13 P.M. Review of the Radiology Results Report, dated as sent to the facility on [DATE] at 4:16 P.M., indicated it was reviewed by facility staff on 1/15/25 at 8:03 P.M., two days after the results were sent to the facility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record failed to indicate facility staff communicated the STAT chest x-ray results to the physician/physician extender in order to make a decision to alter treatment. During an interview on 2/14/25 at 7:42 A.M., Physician #1 said he was not aware Resident #43 had already been started on an antibiotic for a UTI on 1/12/25. He said he ordered the chest x-ray and prescribed Bactrim on 1/13/25 because he thought the Resident may have pneumonia and did not know the x-ray results were negative. During an interview on 2/19/25 at 10:48 A.M. and 11:34 A.M., Nurse #8 reviewed Resident #43's medical record and said there was no documentation to indicate the Physician or NP was notified of the results of the STAT chest x-ray. During an interview on 2/19/25 at 1:59 P.M., the Director of Nursing (DON) reviewed Resident #43's medical record and said there were no notes to indicate the Physician or NP were notified of the STAT x-ray results. She said the nurse should have reviewed the results when it was sent on 1/13/25 and notified the Physician or NP right away. 43935 2. Review of the facility's policy titled Fluid Restriction Policy, revised January 2025, indicated but was not limited to the following: - It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders. - Water will not be provided at the bedside unless calculated into the daily total fluid restriction. - The resident has the right to refuse the fluid restriction, and if refused, documentation should support the reason for the refusal, the education of the risks and benefits, and any supporting documentation of the resident's continued refusal, assessment for any changes in condition related to the refusal, and the notification of the physician about the resident's refusal. Review of the facility's policy titled: Intake, Measuring and Recording, dated as revised October 2010, indicated but was not limited to the following: - The purpose of the procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period - verify the physician order is in place; review the resident's care plan - record fluid intake as soon as possible after the resident has consumed the fluids - at the end of your shift total the amounts of all liquids consumed by the resident and record on the intake side of the intake and output record in milliliters (ml) Review of the [NAME] Concise Medical Dictionary, 8th Edition, 2010 indicated that one cubic centimeter (cc) is equal to one ml and one ounce is equal to 30 ml. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was admitted to the facility in October 2024 with diagnoses including: chronic kidney disease stage 5, end stage renal disease (ESRD), bipolar disorder, and generalized anxiety. Review of the BIMS, dated 2/9/25, indicated the Resident was cognitively intact with a score of 15 out of 15. During an interview on 2/13/25 at 8:29 A.M., the surveyor observed Resident #1 consuming their breakfast. There was a 160 ml cup of coffee, a 5-ounce (oz.) (150 ml) plastic cup with water, an empty (used) plastic juice cup that the Resident said contained apple juice and a large 16-oz. (480 ml) styrofoam cup of a light orange-brown liquid in it that was 3/4 of the way empty and smelled like tea. The Resident said they did not have any food or fluid concerns and did not have any fluid restrictions that they recalled and could drink whatever they wanted. He/She said after breakfast they usually headed downstairs for a cigarette and then would get a snack or drink on the way up and requested it from the staff who provide him/her with anything he/she asked for. Review of the current Physician's Orders from 2/13/25 for Resident #1 indicated but were not limited to the following: - Diet: Regular textures, thin liquids, comment: Renal (10/31/24) - 1200 cc fluid restriction- Dietary to give 900 cc; nursing to give up to 300 cc in 24 hours. 7:00 A.M. - 3:00 P.M. shift 120 cc; 3:00 P.M. - 11:00 P.M., shift 120 cc; 11:00 P.M., to 7:00 A.M., shift 60 cc. every shift fluids to be given with medications, no water to be left at bedside (2/5/25) - Resident to have dialysis on days: Monday, Wednesday, Friday. (11/27/24) Throughout the survey the surveyor made the following observations on the following days and times: - 2/13/25 at 8:29 A.M., a 16 oz. (480 ml) styrofoam cup at the bedside containing what appeared to be tea that was 3/4 of the way empty - 2/13/25 at 2:19 P.M., a 5 oz. cup of water was at the bedside with approximately 1-2 sips remaining in it - 2/13/25 at 3:38 P.M., a 480 ml cup of ginger ale and ice was at the bedside with approximately a 1/2 inch of fluid remaining in the bottom - 2/18/25 at 9:22 A.M., Resident walking to his/her room drinking a 480 ml full cup of ginger ale - 2/18/25 at 1:42 P.M., a 480 ml cup that had a few drops of fluid in the bottom and a 480 ml cup filled with ginger ale and ice Review of the nursing progress notes from 2/5/25 through 2/13/25 indicated but were not limited to the following: - 2/5/25 at 10:50 A.M., Fluid restriction initiated by dialysis center 1200 ml per 24 hours (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/9/25 at 12:37 P.M., patient noted non-compliant with fluid restriction, nurse entered the Residents' room to find two 16 oz. styrofoam cups and an 8 oz. cup of tea on the bedside table, patient educated to importance of fluid restriction, but denies having too much fluid since the start of shift The nurses note on 2/9/25 failed to indicate the nurse notified the Attending Physician group to make them aware of the Resident exceeding their ordered fluid restriction. During an interview on 2/13/25 at 1:11 P.M., Nurse #2 (who documented the non-compliance on 2/9/25) said Resident #1 is on a prescribed fluid restriction but is not very compliant with it and that she often finds the Resident with extra drinks. She said she didn't think the Resident understood the fluid restriction and even though they tried to limit the Resident it was hard to do. She said she previously wrote a note on the Resident not being compliant with the restriction and provided education to the Resident at that time. She said she had never notified the Physician group that Resident #1 was not compliant with their ordered fluid restriction but should have. During an interview on 2/18/25 at 8:17 A.M., Nurse #5 said Resident #1 had an ordered fluid restriction of 1200 ml a day and nursing was only allowed to provide 120 ml on the day and evening shift with medications and 60 ml on the night shift. The order also indicated no additional fluids should be left at the bedside. She said if staff were providing extra fluids to the Resident or they were observed at the bedside, then the Physician group should have been notified that the Resident was not compliant with their fluid restriction. During an interview on 2/18/25 at 2:03 P.M., Unit Manager #2 said any day that the Resident had exceeded their prescribed fluid restriction the Attending Physician group should have been notified. She was informed of the surveyor's observations and upon review of the medical record said there were no indications that the Attending Physician group was made aware of the fluid restriction order not being followed. Review of the Physician notes for Resident #1's in the medical record, following the initiation of the fluid restriction on 2/5/25 indicated the Resident had been seen by the physician on 2/17/25, but the note did not indicate the physician was aware of Resident #1's non-compliance with their fluid restriction. During an interview on 2/18/25 at 5:12 P.M., NP #2 said Resident #1 was on dialysis for ESRD and, following a request from dialysis for a 1200 ml per day fluid restriction, orders were provided to the facility on [DATE]. She said she was not aware that the Resident had not been following the fluid restriction and upon review of the available notes in the medical record it did not appear that any member of the Attending Physician group was notified of the fluid restriction order not being followed. During an interview on 2/19/25 at 10:51 A.M., the DON said it appeared Resident #1 was choosing not to follow their fluid restriction as ordered and he/she was non-compliant. She said the expectation is that when orders are received, they are to be followed as written and if they are not followed or there is an unexplained abrupt change in the plan of care or non-compliance the Attending Physician group should have been notified. She said there was no documentation that the Attending physician group was notified as they should have been in accordance with the policy and regulatory standard.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 48695 Based on observation and interviews, the facility failed to ensure residents' rights to personal privacy and confidentiality was promoted and protected for one Resident (#337), from a total sample of 21 residents, and unopened mail and other letters, packages and other materials delivered to the facility were promptly received by residents. Specifically, the facility failed to ensure: 1. Staff did not communicate Resident #337's private health information with his/her Nurse Practitioner (NP) via a text messaging application utilizing an unsecured mobile phone platform; and 2. United States Postal Service (USPS) mail and/or packages was promptly delivered to residents within 24 hours of delivery by the postal service. Findings include: Review of the facility's policy titled Security of Portable Electronic Devices, last revised January 2025, indicated but was not limited to: - To aid in the prevention of disclosure of confidential information, our company has adopted procedures for the safety and security of confidential business and protected health information. The purpose of this policy is to define requirements to safeguard sensitive data contained on portable devices and portable electronic storage media on or off company premises and procedures to follow. This policy applies to all company employees and business associates that create, store, and access sensitive data. Review of the facility's policy titled Personal Cell Phone Policy, last revised January 2025, indicated but was not limited to: - This facility prohibits employees from using personal cell phones for any reason on the nursing units or in working areas of the facility. - This includes calls, texts, social media or any other use of cell phones. Review of the facility's policy titled Confidentiality/HIPPA, undated, indicated but was not limited to: - All employees are responsible for protecting the privacy, both medical and personal, of all the residents of our facilities. - Residents' records whether medical or social in nature will be safeguarded to protect the confidentiality of the information. Review of the National Library of Medicine (NLM), dated 3/15/20, indicated but was not limited to: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The main problem of these commercial messaging apps is that they are owned by companies whose main aim is to collect data from their users. For this reason, it is difficult to imagine a future where these applications can satisfy the requests concerning the processing of personal health data both at European and US level. - What healthcare systems need are Secure Messaging Apps (SMA) specifically dedicated to keep confidentiality of patient data. Beyond encrypting data within a private communication network, SMA must prevent data being sent outside the healthcare organization's network. Saving of sensitive data to external hard-drives or outside the organization's network must be avoided and administrative control must be available, deleting messages if the smartphone is stolen or lost (remote wipe) or after a predetermined period of time. (https://pubmed.ncbi.nlm.nih.gov/32062746/) Resident #337 was admitted to the facility in February 2025 with diagnoses including dementia. During an interview on 2/13/25 at 1:17 P.M., Unit Manager (UM) #1 said she notified Resident #337's NP of his/her change in condition and transfer to hospital via text message. UM #1 showed the surveyor the text message to the NP. UM #1 said some Physicians and NPs used a secure messaging network but to contact Resident #337's NP she utilized his/her phone's text messaging platform. Review of the text message on UM #1's cell phone to Resident #337's NP included but was not limited to: - Resident #337's First and Last Name; - Resident #337's change in medical condition; and - Plan for Resident #337's treatment. During an interview on 2/18/25 at 2:09 P.M., UM #1 said she thought the text messaging platform she had utilized to contact Resident #337's NP was encrypted. During an interview on 2/19/25 at 12:35 P.M., the Director of Nursing (DON) said Resident #337's Physician and NP did not utilize a secure messaging platform and a text which included Resident #337's private health information should not have been sent to his/her NP. The DON said a phone call should have been placed to Resident #337's NP. The DON said personal cell phone messaging platforms are not secured unless a secure messaging platform was used or an encrypted company cell phone was used. The messaging platform and cell phone were not secure. 34145 2. During the Resident Group Meeting on 2/13/25 at 1:30 P.M., nine out of nine residents reported that USPS mail and packages are not delivered to them on Saturdays. The residents said that the receptionist sorts the mail and gives it to the activity staff to deliver to them during the week, but not on the weekends because the receptionist does not work on the weekends. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/25 at 2:12 P.M., the receptionist said she is responsible for sorting the residents' mail and packages when she works Monday through Friday and gives it to activity staff for distribution. She said mail is not distributed on Saturdays and she takes care of mail and packages delivered on Saturday when she returns to work on Monday.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 34145 Based on observation, interviews, and document review, the facility failed to ensure that residents were fully aware of the grievance process. Specifically, for nine of nine residents who attended the resident group meeting, the facility failed to ensure residents were aware of and had access to grievance forms, and were aware they could formulate grievances anonymously, should they choose not to alert a staff member of their concern(s). Findings include: Review of the facility's policy titled Complaint/Grievance Policy Procedure, dated September 2023, indicated but was not limited to: - Voiced grievances (e.g. those about treatment, care, management of funds, lost clothing, or violation of rights) are not limited to a formal, written process and may include a resident's verbalized complaint to facility staff. - Grievance/Complaint forms will be available at the nurse's station or other designated area. - Residents and/or their responsible representative shall complete the form. - If a resident is unable to complete the form, a staff member shall assist them. - Staff shall complete a grievance form when residents or responsible representatives make verbal complaints, if not completed by the complainant. - Resident and/or responsible representative have the right to file a grievance anonymously. - Completed forms should be forwarded to the Grievance Official and notify the Executive Director. On 2/13/25 at 1:30 P.M., the surveyor held a resident group meeting with nine residents in attendance representing each of the facility's three units. Nine of nine residents said that they had not seen any postings about the grievance process and did not know how to file a grievance except for telling a staff member about a problem. The residents said they were not aware of the availability of grievance forms or that they could file a grievance anonymously. On 2/13/25 at 2:05 P.M., the surveyor toured the second-floor unit and was unable to locate any posting about the grievance process and no grievance forms. On 2/13/25 at 2:19 P.M., down a hallway across from the admissions office on the first-floor unit, the surveyor observed a wall mounted file holder with blank grievance forms. The forms were not easily visible as the file holder was black wire mesh. A sign was posted above the file holder and indicated the following: - Grievance Officer: Administrator (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If you have any issues that you would like to file a grievance, please contact the following departments: Administrator, Director of Nursing, Social Services. The sign failed to indicate grievance forms were available in the wall mounted file holder and residents could file a complaint or grievance anonymously. During an interview on 2/13/25 at 2:20 P.M., the Administrator said he was the Grievance Officer and grievance forms were available on each of the units. He and the surveyor toured the second-floor unit and he found a black mesh file holder mounted to the wall in the hallway near a restroom. The file holder had papers in it, but it was not labeled and the papers were not easily visible through the black mesh. He said there should be a posting near the folder to inform residents how to file a grievance and that forms were available, but there were not. He said he was not aware that residents did not know they could file a grievance anonymously.

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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** 43935 Based on observation, interviews, and record review, the facility failed to develop, implement and individualize comprehensive care plans for seven Residents (#1, #16, #78, #43, #14, #50 and #72), out of a total sample of 21 residents. Specifically, the facility failed: 1. For Resident #1, to implement the Resident's end stage renal disease (ESRD) care plan for fluid restriction; 2. For Resident #16 to ensure the Resident's urinary catheter care plan was Resident specific and included accurate information on the manner in which catheter care was provided and monitored; 3. For Residents #78, #43, and #14, to ensure a comprehensive care plan was developed to address the use of psychotropic medication that identified target behaviors and individualized, measurable non-pharmacological interventions and measurable goals of treatment; 4. For Resident #50, to implement the Resident's nutritional care plan related to a fluid restriction; and 5. For Resident #72, to develop and implement a care plan for the resident's gastrostomy tube (G-tube-a surgically inserted tube that provides access to the stomach to deliver nutrition, medicine, and fluids). Findings include: Review of the facility's policy titled Comprehensive Person-Centered Care Plan, dated May 2023, indicated but was not limited to the following: - The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident - the care plan interventions are derived from thorough analysis of the information gathered as part of the comprehensive assessment - the comprehensive care plan will include: measurable objectives and timeframes, describe services that are to be furnished, describe services that are not provided due to the resident exercising their rights, describe specialized services as a result of PASARR, include stated goals and desired outcomes, include preferences, incorporate identified problems and risk factors associated with those problems, build on resident strengths, reflect treatment goals, identify the professional services responsible for each element of care, aid in preventing decline, enhance optimal functioning, and reflect current recognized standards of practice for problem areas and conditions - areas of concern identified will be evaluated before interventions are added to the care plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident - care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making 1. Resident #1 was admitted to the facility in October 2024 with diagnoses including: chronic kidney disease stage 5, ESRD, Bipolar disorder, and generalized anxiety. Review of the Brief Interview for Mental Status (BIMS), dated 2/9/25, indicated the Resident was cognitively intact with a score of 15 out of 15. Review of the [NAME] Concise Medical Dictionary, 8th Edition, 2010: one cubic centimeter (cc) is equal to one milliliter (ml) and one ounce is equal to 30 ml. During an interview on 2/13/25 at 8:29 A.M., the surveyor observed Resident #1 eating their breakfast. There was a 160 ml cup of coffee, a 5-ounce (150ml) plastic cup with water, an empty (used) plastic juice cup that the Resident said contained apple juice and a large 16-ounce (480 ml) styrofoam cup of a light orange-brown liquid in it that was 3/4 of the way empty and smelled like tea. The Resident said he/she did not have any food or fluid concerns and does not have any fluid restrictions that he/she recalled and could drink whatever he/she wanted. Resident #1 said after breakfast he/she usually headed downstairs for a cigarette and then got a snack or drink on the way up and requested it from the staff who provide him/her with anything he/she asks for. Review of the current Physician's Orders from 2/13/25 for Resident #1 indicated but were not limited to the following: - Diet: Regular textures, thin liquids, comment: Renal (10/31/24) - 1200 cc fluid restriction- Dietary to give 900cc; nursing to give up to 300cc in 24 hours. 7:00 A.M. - 3:00 P.M. shift 120cc; 3:00 P.M. - 11:00 P.M., shift 120cc; 11:00 P.M., to 7:00 A.M., shift 60cc. every shift fluids to be given with medications, no water to be left at bedside (2/5/25) - Resident to have dialysis on days: Monday, Wednesday, Friday. (11/27/24) Review of the current care plans for Resident #1 from 2/13/25, indicated but were not limited to the following: PROBLEM: I have acute on chronic Stage 5 renal failure related to end stage disease; I need hemodialysis three times per week; I am on a 1200 ml fluid restriction (revised: 2/5/25) INTERVENTIONS: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1200cc fluid restriction - dietary to give 900cc nursing to give 300cc in 24 hours. (2/6/25); Fluids as ordered - restrict or give as ordered (10/31/24) - (Nursing and Certified nurse assistant (CNA) were the responsible positions for both interventions) PROBLEM: I have a nutritional problem or potential nutritional problem related to obesity, therapeutic diet, weight gain Neither care plan indicated Resident #1 had a history of non-compliance with their fluid restriction. During an interview on 2/13/25 at 10:14 A.M., CNA #1 said she was not aware that Resident #1 was on a fluid restriction and that the Resident requests, receives, and keeps drinks on their bedside table frequently. During an interview on 2/13/25 at 1:05 P.M., CNA #2 said she was not aware that Resident #1 was on a fluid restriction. During an interview on 2/13/25 at 1:11 P.M., Nurse #2 said Resident #1 is on a prescribed fluid restriction, but is not very compliant with it and that she often finds the Resident with extra drinks. She said she doesn't think the Resident understands the fluid restriction and even though they try to limit the Resident it is hard to do. She said she previously wrote a note on the Resident not being compliant with the restriction and provided education to the Resident at that time. During an interview on 2/18/25 at 8:26 A.M., the Food Service Director (FSD) provided the surveyor with Resident #1's daily meal tickets. He said he does not have any knowledge of Resident #1 being on an ordered fluid restriction. He said the kitchen provides the Resident with a coffee at breakfast only that contains 160 ml and a cup of juice containing 240 ml. He said at the other two meals the Resident only receives 240 ml of juice from the kitchen, which is a large cup 3/4 of the way full. Throughout the survey the surveyor made the following observations on the following days and times: 2/13/25 at 8:29 A.M., the Resident had 1,030 ml of fluid available at the bedside including their medication water and dietary beverages (details above) 2/13/25 at 2:19 P.M., a 5-ounce (oz.) cup of water was at the bedside with approximately 1-2 sips remaining in it 2/13/25 at 3:38 P.M., a 480 ml cup of ginger ale and ice was at the bedside with approximately 1/2 inch of fluid remaining in the bottom 2/18/25 at 8:08 A.M., 160 ml of coffee and 240 ml of apple juice 2/18/25 at 9:22 A.M., Resident walking to his/her room drinking a 480 ml full cup of ginger ale (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/18/25 at 1:42 P.M., a 480 ml cup that has a few drops of fluid in the bottom and a 480 ml cup filled with ginger ale and ice During an interview on 2/18/25 at 8:17 A.M., Nurse #5 said Resident #1 has an ordered fluid restriction of 1200 ml a day and nursing was only allowed to provide 120 ml on the day and evening shift with meds and 60 ml on the night shift. She said the order also indicated no additional fluids should be left at the bedside. She said the Resident should not be having additional drinks throughout the day and the staff should not be providing them. She said the unit kitchenette is locked and not accessible to the residents without staff assistance. During an interview on 2/18/25 at 8:21 A.M., CNA #3 said Resident #1 pretty much drinks whatever they want and requests ginger ale all day every day. She said CNAs are supposed to complete I & O sheets and the Nurses total them daily. She said the I & O sheets for this Resident are incomplete and don't provide any information on a fluid restriction. She said the Resident does not have access to get their own drinks. During an interview on 2/18/25 at 9:22 A.M., the surveyor observed Resident #1 walking towards his/her room drinking from a 16-oz. cup. He/She said they requested a drink while downstairs and were given the large cup of ginger ale by the game playing people. The Resident said he/she does recall being told something about a fluid restriction in the past but doesn't think it's a problem anymore since the staff always give him/her the drinks when he/she asks for them. During an interview on 2/18/25 at 9:35 A.M., the Activity Director said she provided Resident #1 with a beverage as requested. She said she was not aware that Resident #1 was on a fluid restriction and follows a list of diets, fluids, and allergies from the kitchen daily. On review of the list, last printed 2/17/25 in the afternoon, the list did not indicate Resident #1 was on a fluid restriction. During an interview on 2/18/25 at 2:03 P.M., Unit Manager #2 reviewed Resident #1's documents and the concerns with the surveyor. She said the Resident has an ordered fluid restriction and a care plan that indicates they are on a fluid restriction and it is clear the staff have not followed the fluid restriction or implemented the care plan as they should have. During an interview on 2/19/25 at 10:42 A.M., the Director of Nurses (DON) said Resident #1 has a prescribed fluid restriction and a care plan for that fluid restriction. She said fluid restrictions and the manner in which they are documented and monitored is a work in progress and the facility needs to work on a better process to implement this part of the care plan. She said the care plan has not been implemented as it should have been. 2. Review of the facility's policy titled Catheter Care, Urinary, undated, indicated but was not limited to the following: - the purpose is to prevent catheter-associated urinary tract infections - maintain clean technique when handling or manipulating the catheter, tubing or drainage bag - do not clean the periurethral area with antiseptics to prevent catheter-associated UTIs while the catheter is in place, routine hygiene is appropriate (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- use a clean washcloth with warm soap to cleanse and rinse the catheter from insertion site to approximately four inches outward Resident #16 was admitted to the facility in August 2023 with diagnoses including: cerebral infarct (stroke), infection and inflammation due to an indwelling catheter, obstructive and reflux uropathy, and retention of urine. Review of the BIMS indicated the Resident was cognitively intact with a score of 14 out of 15. During an interview on 2/12/25 at 8:19 A.M., Resident #16 said he/she is pretty independent with their care. The Resident said he/she has had the urinary catheter since prior to admission and was told he/she would need it for the rest of their lives. The Resident said the CNAs empty the drainage bags and the Nurses change the catheter monthly but no one comes to clean the tubing. The Resident said he/she wasn't aware that it was something that should be done routinely. Review of the Resident activity for daily living (ADL) self-performance care plan indicated, but was not limited to the following: The Resident is independent with: ambulation, bed mobility, eating, bathing (assist with showers only), dressing, and grooming. Resident has a urinary catheter for urine output and is continent of bowel and independent with toileting; staff measure Foley output each shift. During an interview on 2/13/25 at 9:47 A.M., CNA #1 said Resident #16 has a catheter and the CNAs are required to empty the drainage bag at least once a shift and report the output to the Nurse. She said in general catheter care includes emptying the drainage bag and cleaning the catheter tubing around the insertion site every shift with warm soapy water and drying it to prevent germs on the tube. She said she does not provide any care like that for Resident #16 because catheter care is provided during ADL care and the Resident is independent with their ADLs. On 2/13/25, review of the CNA documentation for catheter care for the last 31 days for Resident #16 indicated out of 93 potential opportunities for catheter care the CNAs documented catheter care a total of 14 times. During an interview on 2/13/25 at 10:23 A.M., CNA #4 said Resident #16 is pretty independent with their ADLs and rarely requests any type of assistance. She said she has not provided any catheter care beyond emptying the drainage bag at the end of the shift. CNA #4 reviewed the CNA documentation for the last 31 days for catheter care and she said she would sign that off if she emptied the drainage bag since that is part of catheter care. She said she is unsure if the cleaning of the catheter tubing is done by the Nurses or the Resident but doesn't think any CNA has done that for this Resident. During an interview on 2/13/25 at 1:01 P.M., CNA #2 said Resident #16 really takes care of themselves and as far as she knows the CNAs are not providing any catheter care beyond emptying the drainage bag. She said she herself has never cleansed the catheter tubing for the Resident as part of catheter care and didn't realize that might be the indication when they sign off catheter care on the CNA documentation. She said she doesn't know if the Resident cleans their catheter tubing. (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 current care plan for Resident #16's Indwelling Foley catheter indicated but was not limited to the following: Interventions: - 9/30/23: Assess for cloudy foul smelling urine, hematuria, elevated temperature, abdominal or flank discomfort - (Nurse (N) is responsible position) - 7/18/24: change Foley every month and as needed for blockage (no responsible position identified) - 9/30/23: Drain and empty catheter every shift and as needed (N and CNA) - 9/30/23: Foley catheter care every shift and as needed - assess (CNA and N) During an interview on 2/13/25 at 1:13 P.M., Nurse #2 said the CNAs provide catheter care to Resident #16 by emptying the catheter bag and ensuring the drainage bag is properly placed to prevent infection. She said the Licensed Nurses will flush, irrigate or change the catheter when it is due or as needed. She said the Resident is very independent and doesn't require much assistance and can be resistive to assistance, even changing from a standard drainage bag to a leg bag during the day independently. She said she does not believe anyone assists the Resident with cleaning the catheter tubing around the insertion site to prevent infections and said it is possible the Resident completes that themselves but does not know for a fact. On review of the care plan, she said she was not aware the care plan indicated the staff were to provide catheter care every shift and as needed and it does not accurately reflect the Resident since they are independent. During an interview on 2/13/25 at 3:44 P.M., Resident #16 said he/she changes between their catheter drainage bag and leg bag independently and uses alcohol wipes to clean the tip of each device prior to connecting the new one. He/She said on occasion there will be some build up on the catheter tubing near the insertion point and he/she will use those same wipes (alcohol wipes) to clean the tubing all around the insertion site when they notice that. The Resident said after cleaning the tubing with the alcohol wipe it does cause some discomfort at the insertion site but it is brief and he/she knows the tube shouldn't be dirty to prevent infection. The Resident said when he/she lived at home (over a year ago) the home care Nurse did tell him/her how to clean the tubing and keep it that way with soap wipes but he/she does not have those here so when he/she cleans the tubing he/she uses alcohol wipes that he/she stores in their drawer. The Resident said he/she was not aware that alcohol or any harsh chemical like that should not be used to clean the tubing or that doing so could actually contribute to an infection by irritating the urethra, but when he/she thinks of it that makes sense. The Resident said he/she has had a few urinary tract infections (UTIs), including one about a month ago, but assumed with a catheter it was pretty much unavoidable. The Resident said the staff do not assist with catheter care or help keep the tubing clean and he/she did not know that using just soap and water was an option for cleaning the catheter tubing or that it should be done routinely, not just when he/she notices it is visibly soiled. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/18/25 at 12:37 P.M., the Infection Preventionist said catheter care is provided each shift and as needed by the CNAs and includes cleaning the catheter tubing from the insertion site approximately four inches down with warm soapy water to ensure there are no germs on the catheter tubing and to assist in preventing UTIs. She said Resident #16 is very independent with their care and is likely performing their own catheter care. She reviewed the care plan for Resident #16 and said the care plan is not resident-specific and should not indicate the staff are assisting with catheter care, since the Resident is independent with their ADLs. During an interview on 2/18/25 at 2:28 P.M., Unit Manager #2 reviewed Resident #16's care plan and said if the Resident is providing their own catheter care, then the care plan should reflect that they were educated on catheter care and can demonstrate the care appropriately and that the staff are not providing the care. She said the care plan for Resident #16's indwelling urinary catheter was not individualized or resident-specific and required updating to reflect the actual care the Resident was receiving. During an interview on 2/19/25 at 11:36 A.M., the DON said her expectation is that care plans are individualized and reflect the current care and services the residents are receiving. The DON said the Resident should not be using alcohol wipes to perform catheter care and the care plan for indwelling urinary catheter was not person-centered and did not reflect Resident #16 or their urinary catheter care accurately. 34145 3A. Resident #78 was admitted to the facility in July 2024 and had diagnoses including major depressive disorder and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 12/8/24, indicated Resident #78 was cognitively intact as evidenced by a BIMS score of 13 out of 15, and received antianxiety and antidepressant medication daily. Review of the medical record indicated but was not limited to the following Physician's orders: - Fluoxetine HCl (antidepressant) 40 milligrams (mg) one time a day (8/7/24) - Remeron (antidepressant) 7.5 mg one time a day (10/27/24) - Buspirone HCl (antianxiety) 10 mg two times a day (10/27/24) - Trazodone (antidepressant) 50 mg three times a day (10/27/24) Review of November through February 2025 Medication Administration Records (MAR) indicated Fluoxetine, Remeron, Buspirone and Trazodone were administered as ordered by the physician. Review of comprehensive care plans failed to indicate any care plan had been developed for the use of psychotropic medications. B. Resident #43 was admitted to the facility in November 2020 and had diagnoses including major depressive disorder, anxiety and dementia. (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 MDS assessment, dated 1/20/25, indicated Resident #43 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15, and received antidepressant medication daily. Review of the medical record indicated but was not limited to the following Physician's orders: -Lexapro (used to treat anxiety) 20 mg one time a day (5/5/23) -Trazodone 50 mg in the evening (7/12/22) Review of November 2024 through February 2025 MAR indicated Lexapro and Trazodone were administered as ordered by the physician. Review of comprehensive care plans included but was not limited to: - Focus: I use antidepressant medication related to depression, antipsychotic medication (last revised 1/30/25) - Interventions: Administer antidepressant medication as ordered by the physician. Monitor/document side effects and effectiveness every shift (3/23/23); Monitor/document/report as needed (prn) adverse reactions to antidepressant therapy (3/23/23) - Goal: I will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (last revised 11/17/24) Review of comprehensive care plans failed to identify specific targeted signs/symptoms, Resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of antianxiety and antidepressant medications to meet the Resident's needs. C. Resident #14 was admitted to the facility in August 2016 and had diagnoses including bipolar disorder. Review of the MDS assessment, dated 12/26/24, indicated Resident #14 had moderately impaired skills for daily decision making and received antidepressant medication daily. Review of the medical record indicated but was not limited to the following Physician's orders: - Trazodone 100 mg at bedtime (9/25/23) - Trazodone 25 mg two times a day (9/25/23) - Escitalopram (used for anxiety) 5 mg one time a day (4/19/24) - Topamax (used for depression) 25 mg, give 50 mg one time a day (5/28/24) Review of November 2024 through February 2025 MARs indicated Trazodone, Escitalopram, and Topamax were administered as ordered by the physician. Review of comprehensive care plans included but was not limited to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Focus: Resident is on psychotropic medications related to behavior management, disease process, bipolar, panic attacks, insomnia. - Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness (8/12/16); Educate Resident's family/caregivers about risks, benefits and the side effects and/or toxic symptoms (last revised 2/23/23) - Goal: Resident will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the review date (last revised 7/3/24) Review of comprehensive care plans failed to identify specific targeted signs/symptoms, Resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of antianxiety and antidepressant medications to meet the Resident's needs. During an interview on 2/19/25 at 12:33 P.M., Unit Manager #2 reviewed Residents #78, #43 and #14's medical records and said Resident #78 did not have a care plan to address his/her use of psychotropic medication. She said for Residents #43 and #14, the comprehensive care plans for the use of psychotropic medications do not identify what the target behaviors, signs/symptoms are for their use and do not include non-pharmacological interventions, and had no measurable goals of treatment, but should. 42742 4. Resident #50 was admitted to the facility in January 2025 and had diagnoses including nontraumatic intracerebral hemorrhage, end stage renal disease, hypertensive emergency, type 2 diabetes mellitus with diabetic chronic kidney disease, and dependence on renal dialysis. Review of the MDS assessment, dated 1/28/25, indicated Resident #50 was cognitively intact as evidenced by a BIMS score of 13 out of 15 and was receiving dialysis. Review of current Physician's Orders indicated the following: -1500 ml fluid restriction, no water to be left at bedside, 2/5/25 Review of Resident #50's comprehensive care plans indicated a care plan for: -Nutrition, initiated 1/30/25, with interventions including a 1500 milliliter (ml) fluid restriction per MD (physician), initiated 2/6/25. -Hemodialysis related to End Stage Renal Disease (ESRD), initiated 1/25/25, with interventions including 1500 cc fluid restriction, dietary to give 1200 cc ,nursing to give up to 300 cc/24 hour, 7-3 (120 cc), 3-11 (120 cc), 11-7 (60 cc), initiated 2/5/25 Further review of the care plans failed to indicate an intervention to not leave water at the Resident's bedside as indicated by the physician. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation with interview of 2/18/25 at 8:21 A.M., the surveyor observed Resident #50 in his/her room eating breakfast. A separate 8-ounce (oz.) (118 ml) plastic cup of water was observed on top of the Resident's overbed tray table with approximately 15 ml remaining. It was unclear how much water the Resident had originally been given. Resident #50 said he/she was on a fluid restriction but sometimes they give him/her too much. Review of the medical record and Intake and Output document failed to indicate documentation of the amount of fluid per 24 hours that was distributed to the Resident between the food and nutrition department and the nursing department to ensure the fluid restriction was being followed per care planned intervention. During an interview on 2/19/25 at 10:25 A.M., the FSD said he wasn't aware the Resident was on a fluid restriction until yesterday. During an interview on 2/19/25 at 12:28 P.M., the surveyor reviewed the medical record with Nurse #3 and Unit Manager (UM) #2 who said a supplemental order was not entered which would have prompted staff to enter fluid amounts and totals. When asked how staff know that they're following a fluid restriction without fluid amounts documented, UM #2 said they can't. During an observation with interview on 2/19/25 at 12:30 P.M., the surveyor observed Resident #50 sitting in his/her room. A large Styrofoam cup, approximately 20 ounces (591 ml) (exceeds care plan intervention for dietary/nursing fluids), was filled with water and left at the bedside on the Resident's overbed tray table. Approximately 1/4 had been consumed at the time of the observation. Resident #50 said staff give him/her too much, but he/she doesn't drink it all. During an interview on 2/19/25 at 12:32 P.M., CNA #5 said she gave the Resident the water but was not aware that he/she was on a fluid restriction until Nurse #3 told her. During an interview on 2/19/25 at 1:35 P.M., the DON said Resident #50 had a current order for a 1500 cc fluid restriction, dietary to give 1200cc, nursing to give up to 300cc/24hr- 7a-3p (120cc), 3p-11p (120cc), and 11p-7a (60cc) with a start date of 2/5/25. She said staff document by checkmark only on the MAR and she didn't think there would be any other I+O sheets for Resident #50, just the one dated 2/12/25 through 2/18/25 since it was just implemented. The DON said because staff just document with a checkmark on the MARs, there's no way to find out what the fluid amounts or totals were. She said Resident #50 was on a fluid restriction due to dialysis and could potentially have an extended dialysis session because of accumulating fluid. The DON further said fluid restrictions should be communicated to dietary staff via a diet request form for each resident and the nurse who takes the order is the one who should complete it. She said if the kitchen is not aware of fluid restriction orders, then they wouldn't know to abide by it when preparing meal trays. She said staff are expected to implement the care planned intervention for a fluid restriction. 5. Resident #72 was admitted to the facility in June 2024 and had diagnoses including cerebral infarction and dysphagia (difficulty swallowing) with a G-tube. Review of the MDS assessment, dated 12/24/24, indicated Resident #72 had severe cognitive impairment as evidenced by a BIMS score of 7 out of 15 and had a feeding tube. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/25 at 2:13 P.M., the surveyor observed Resident #72's G-tube site with Nurse #4. The tube was capped, indicating it was not in use. Review of Resident #72's care plans failed to indicate a care plan was developed and implemented for the Resident's G-tube that included measurable goals, timeframes, and interventions to meet the Resident's needs. During an interview on 2/18/25 at 2:31 P.M., the surveyor reviewed Resident #72's medical record with Nurse #4 who said there wasn't a care plan for the G-tube but there should have been. Nurse #4 said the Resident had a stroke and had the G-tube put in. During an interview on 2/18/25 at 4:17 P.M., the DON said the Resident had a care plan for the G-tube, but it was canceled on 12/31/24. She said as long as he/she still has the G-tube there should be a care plan in place for it that includes goals of treatment and interventions. During an interview on 2/19/25 at 1:08 P.M., the DON said the Dietitian accidentally cancelled the whole G-tube care plan on 12/31/24 when attempting to cancel one specific intervention. During an interview on 2/19/25 at 1:59 P.M., the Dietitian said she accidentally cancelled the G-tube care plan when she meant to just cancel the tube feeding intervention because the Resident was no longer receiving tube feedings. See F658

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and record review, the facility failed to provide services that met professional standards of practice for five Residents (#72, #50, #1, #43, and #78), out of a total sample of 21 residents. Specifically, the facility failed: 1. For Resident #72, to ensure Clonidine (antihypertensive drug) was administered within the parameter as prescribed by the physician to help prevent low blood pressure and heart rate; 2A. For Resident #50, who had end stage renal disease, to ensure the food service department was notified of the Resident's 1500 milliliter (ml) fluid restriction, fluids were not left at the bedside without being calculated into the daily fluid restriction, and fluid restriction for each shift was consistently followed per physician's orders; B. For Resident #1, to ensure that staff consistently implemented the prescribed fluid restriction of 1200 ml a day for the Resident who was on hemodialysis; 3. For Resident #43, to ensure injection sites for subcutaneous (SC-insertion of medications beneath the skin) insulin medication were rotated to prevent potential adverse effects; and 4. For Resident #78, to ensure a right upper extremity (RUE) resting hand roll splint (device designed to help with finger extension, prevent pressure, and reduce finger flexion contractures) was donned/doffed (put on/ taken off) in accordance with physician's orders. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Review of Lippincott Nursing Procedures, Eighth Edition, [Philadelphia: Wolters Kluwer, [2019], indicated but was not limited to the following: Safe Medication Administration Practices, General: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-To promote a culture of safety and to prevent medication errors, nurses must avoid distractions and interruptions when preparing and administering medications and adhere to the five rights of medication administration: identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route. Recent literature identifies nine rights of medication administration, which in addition to the five rights includes the right documentation, the right action (or appropriate reason for prescribing the medication), the right form, and the right response. Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to the following: -Medications are administered in accordance with prescriber orders, including any required time frame. -The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Resident #72 was admitted to the facility in June 2024 and had diagnoses including essential hypertension, chronic kidney disease stage 5, and was dependent on renal dialysis. Review of the Minimum Data Set (MDS) assessment, dated 12/24/24, indicated Resident #72 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. Review of current Physician's Orders indicated the following: -Clonidine HCL oral tablet 0.1 milligrams (mg), give 1 tablet by mouth three times a day for HTN (hypertension), for SBP >180 only **For SBP >180 only**, 12/15/24 Review of the January 2025 Medication Administration Record (MAR) indicated Clonidine was administered on the following dates/times with the systolic blood pressure (SBP - top number of your blood pressure, the pressure in your arteries when your heart contracts and ejects blood) readings as follows: January 2025 12:00 P.M.: 1/7/25 - 150 1/15/25 - 138 1/17/25 - 150 1/28/25 - 148 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6:00 P.M.: 1/1/25 - 138 1/3/25 - 177 1/4/25 - 173 1/6/25 - 167 1/7/25 - 168 1/11/25 - 153 1/14/25 - 131 1/15/25 - 146 1/22/25 - 156 1/23/25 - 177 1/25/25 - 136 1/27/25 - 153 10:00 PM 1/3/25 - 171 1/4/25 - 141 1/7/25 - 168 1/14/25 - 143 1/19/25 - 164 1/20/25 - 155 1/21/25 - 175 1/22/25 - 156 1/23/25 - 177 1/25/25 - 140 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/27/25 - 153 Further review of the January 2025 MAR indicated Clonidine was administered below the parameter (SBP was < 180) and not >180 per physician's orders for 27 out of 93 total opportunities. Review of the February 2025 MAR indicated Clonidine was administered on the following dates/times with the SBP readings as follows: February 2025 12:00 P.M.: 2/3/25 - 156 2/4/24 - 148 2/11/25 - 176 6:00 P.M.: 2/6/25 - 160 2/9/25 - 136 2/10/25 - 174 2/11/25 - 149 10:00 P.M.: 2/3/25 - 149 2/5/25 - 180 2/10/25 - 164 Further review of the February 2025 MAR indicated Clonidine was administered below the parameter (SBP was < =180 and not >180) per physician's orders for 10 out of 52 total opportunities. During an interview on 2/18/25 at 2:42 P.M., Nurse #4 reviewed Resident #72's medical record and said, that's a problem, the parameters for Clonidine are there for a reason. She said the Resident could bottom out as he/she was also taking valsartan (antihypertensive drug) and amlodipine (calcium channel blocker, treats high blood pressure) and was on dialysis. She said nursing initials and a checkmark on the MAR indicate that the medication was administered on the specific dates/times but should have been held with a code number 5 documented for not being within the parameter of an SBP >180. Nurse #4 said she wasn't sure if nurses are just clicking the medication was administered when it really wasn't, but if it has the initials and a checkmark it means it was given. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/19/25 at 1:16 P.M., the Director of Nurses (DON) reviewed the medical record and said the physician's order is for Clonidine HCl Oral Tablet 0.1 MG, give 1 tablet by mouth three times a day for HTN, for SBP >180 ONLY with an order date of 12/15/24. She said the Resident is on Clonidine for hypertension and also takes Amlodipine, Metoprolol (beta blocker, treats high blood pressure), and Valsartan. The DON said the Resident has a history of hypertension and hypertensive chronic kidney disease, stage 5, and is on dialysis. She said if the medication was not given because it didn't meet the parameter there would be a code 5 for a hold and said if the medication was administered, there would just be the nurse's initials and a checkmark on the MAR. The surveyor reviewed the January and February 2025 MARs with the DON who said Clonidine was documented as being given for all the above dates and times when the SBP was below the parameter and should not have been documented as given. She said there is the danger of hypotension if given below range. The DON said nursing staff are expected to administer medications per physician's orders and if nursing is checking it off as given when it wasn't, that is not good practice, it's a safety issue. She said if it's documented as being given, then it was given. 2. Review of the facility's policy titled Fluid Restriction Policy, revised January 2025, indicated but was not limited to the following: -It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders. -Fluid restrictions are basically the restriction of fluid intake. This may be due to underlying medical conditions that may cause fluid build up such as congestive heart failure or end stage renal disease (ESRD), in addition to electrolyte imbalance disorders such as hyponatremia. Fluid restriction amounts can vary according to the resident's condition and the physician's judgement. -The nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department and will be recorded on the medication record or other format as per facility protocol. -The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. -The food and nutrition department will be notified by facility communication methods of the fluid restriction. -Water will not be provided at the bedside unless calculated into the daily total fluid restriction. -The resident has the right to refuse the fluid restriction, and if refused, documentation should support the reason for the refusal, the education of the risks and benefits, and any supporting documentation of the resident's continued refusal, assessment for any changes in condition related to the refusal, and the notification of the physician about the resident's refusal. Review of the facility's policy titled Intake, Measuring and Recording, dated as revised October 2010, indicated but was not limited to the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The purpose of the procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period - verify the physician order is in place; review the resident's care plan - record fluid intake as soon as possible after the resident has consumed the fluids - at the end of your shift total the amounts of all liquids consumed by the resident and record on the intake side of the intake and output record in milliliters (ml) A. Resident #50 was admitted to the facility in January 2025 and had diagnoses including non-traumatic intracerebral hemorrhage, ESRD, hypertensive emergency, type 2 diabetes mellitus with diabetic chronic kidney disease, and dependence on renal dialysis. Review of the MDS assessment, dated 1/28/25, indicated Resident #50 was cognitively intact as evidenced by a BIMS score of 13 out of 15 and was receiving dialysis. Review of current Physician's Orders indicated the following: -1500 ml fluid restriction, dietary to give 1200 cc (also called ml), nursing to give up to 300 cc/24 hour - 7-3 (120 cc), 3-11 (120 cc), 11-7 (60 cc) every shift. Fluids to be given with medications, no water to be left at bedside, 2/5/25 During an observation with interview on 2/18/25 at 8:21 A.M., the surveyor observed Resident #50 sitting in his/her room eating breakfast. Fluids provided on the breakfast tray consisted of a small bowl of corn flakes cereal with milk (90% consumed), one hard plastic cup of milk (75% consumed), and one 4-ounce (oz.) (118 ml) container of apple juice (75% consumed). One separate small thin plastic cup of water was observed on top of the overbed tray table with approximately 15 ml remaining. Resident #50 said he/she was on a fluid restriction but sometimes they give him/her too much. On 2/18/25 at 11:55 A.M., the surveyor observed Resident #50 sitting in his/her room eating lunch. Fluids provided on the tray included one 4 oz. (118 ml) container of apple juice and a cup of coffee that were being consumed. Review of the February 2025 MAR indicated documentation of the 1500 cc fluid restriction consisted of a checkmark and nursing initials for the day, evening, and night shifts. The MAR did not indicate amounts of fluid intake for each shift. On 2/19/25 at 9:37 A.M., the surveyor reviewed Resident #50's Intake and Output (I+O) document located in the I+O binder at the [NAME] Unit nurses' station. The document was dated 2/12/25 through 2/18/25 and indicated the following: -only one documented entry of fluid intake out of 21 opportunities from all three shifts (11:00 A.M.-7:00 P.M., 7:00 A.M.-3:00 P.M., and 3:00 P.M.-11:00 P.M.) Further review of the medical record and I+O document failed to indicate documentation of the amount of fluid per 24 hours that was distributed to the Resident between the Food and Nutrition Department and the Nursing Department. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/19/25 at 9:25 A.M., Nurse #8 said Certified Nursing Assistants (CNAs) document I+O in the electronic record only. During an interview on 2/19/25 at 9:33 A.M., Nurse #3 said the facility had just started using the I+O documents in the I+O binder which are specific to each resident who is on a fluid restriction. The surveyor reviewed the I+O binder with Nurse #3 who said it's a new thing and said Resident #50's I+O sheet was dated 2/12/25 through 2/18/25 but it didn't look like it was being documented on. She said this was the only place she knew of where fluid intake was being documented for the Resident. She said if it's not documented anywhere then she wouldn't know what the fluid intake totals were. Nurse #3 said the Resident was on a fluid restriction due to dialysis. During an interview on 2/19/25 at 9:40 A.M., CNA #5 said the I+O sheets are new, but CNAs don't document on them, they just tell the nurse how much fluid intake there was after each meal, and the nurses document it in the record. She said there is nowhere in the record where CNAs document fluid intake and output. During an interview on 2/19/25 at 9:44 A.M., Nurse #3 said nurses used to document fluid totals on the MAR per verbal communication by the CNAs, but they stopped doing that recently and now are expected to document on the I+O sheets as of 2/12/25. She said she worked the 7:00 A.M.-3:00 P.M. shift on 2/14/25 and 2/17/25, but didn't document fluid intake on the sheet as required. She said a new I+O sheet had not been started yet for today for Resident #50. During an interview on 2/19/25 at 10:25 A.M., the Food Service Director (FSD) said the Resident's fluid restriction was ordered on 2/5/25 but he didn't know about it; no one told him until yesterday. He said he had printed out a list of all residents yesterday but there weren't any residents that were on a fluid restriction. The FSD said the Resident's meal trays should have reflected the fluid restriction order, but he didn't know about it. He said a coffee mug is 160 ml, a hard plastic cup of milk or apple juice is 240 ml and believes the small thin plastic cups are 8 ounces (118 ml). During an interview on 2/19/25 at 12:28 P.M., the surveyor reviewed the medical record with Nurse #3 and Unit Manager (UM) #2 who said a checkmark and nurses initials on the MAR just means that the nurse is following the fluid restriction, but a supplemental order was not entered which would have prompted staff to enter fluid amounts and totals. When asked how staff know that they're following a fluid restriction without fluid amounts documented, UM #2 said they can't. During an observation with interview on 2/19/25 at 12:30 P.M., the surveyor observed Resident #50 sitting on a chair in his/her room. A large Styrofoam cup, approximately 20 ounces (591 ml), was filled with water and left at the bedside on the Resident's overbed tray table. Approximately 1/4 had been consumed. Resident #50 said staff give him/her too much, but he/she doesn't drink it all. During an interview on 2/19/25 at 12:32 P.M., CNA #5 said she gave the Resident the water but was not aware that he/she was on a fluid restriction until Nurse #3 told her. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/19/25 at 1:35 P.M., the DON said Resident #50 had a current order for a 1500 cc fluid restriction, dietary to give 1200 cc, nursing to give up to 300 cc/24 hr- 7a-3p (120 cc), 3p-11p (120 cc), and 11p-7a (60 cc) with a start date of 2/5/25. She said staff document by checkmark only on the MAR and the I+O sheets were just implemented last week so she didn't think there would be any other I+O sheets for Resident #50, just the one dated 2/12/25 through 2/18/25. The DON said because staff just document with a checkmark on the MARs, there's no way to find out what the fluid amounts or totals were. She said staff are now expected to complete the I+O sheets for each shift daily. Said she Resident #50 was on a fluid restriction due to dialysis and could potentially have an extended dialysis session because of accumulating fluid. The DON further said fluid restrictions should be communicated to dietary staff via a diet request form for each resident and the nurse who takes the order is the one who should complete it. She said if the kitchen is not aware of fluid restriction orders, then they wouldn't know to abide by it when preparing meal trays. During an interview on 2/19/25 at 1:54 P.M., the Dietitian said she was aware the Resident was on a fluid restriction and said the Resident is on dialysis. She said although she wouldn't necessarily look at I+O totals, she would need to know if the Resident was being provided with large amounts of water due to a concern of increased fluid volume and weight gain. 43935 B. Review of the [NAME] Concise Medical Dictionary, 8th Edition, 2010: one cubic centimeter (cc) is equal to one milliliter (ml) and one ounce is equal to 30ml Resident #1 was admitted to the facility in October 2024 with diagnoses including chronic kidney disease stage 5 and ESRD. Review of the BIMS, dated 2/9/25, indicated the Resident was cognitively intact with a score of 15 out of 15. During an interview on 2/13/25 at 8:29 A.M., the surveyor observed Resident #1 consuming their breakfast. There was a 160ml cup of coffee, a 5 ounce (oz.)(150ml) plastic cup with water, an empty (used) plastic juice cup that the Resident said contained apple juice and a large 16 oz. (480 ml) styrofoam cup of a light orange-brown liquid in it that was 3/4 of the way empty and smelled like tea. The Resident said he/she does not have any food or fluid concerns and does not have any fluid restrictions that he/she recalls and can drink whatever he/she wants. The Resident said after breakfast he/she usually heads downstairs for a cigarette and then gets a snack or drink on the way up and requests it from the staff who provides him/her with anything he/she asks for. Review of the current Physician's Orders from 2/13/25 for Resident #1 indicated but were not limited to the following: - Diet: Regular textures, thin liquids, comment: Renal (10/31/24) - 1200cc fluid restriction- Dietary to give 900cc; nursing to give up to 300cc in 24 hours. 7:00 A.M. - 3:00 P. M. shift 120cc; 3:00 P.M. - 11:00 P.M., shift 120cc; 11:00 P.M., to 7:00 A.M., shift 60cc. every shift fluids to be given with medications, no water to be left at bedside (2/5/25) - Resident to have dialysis on days: Monday, Wednesday, Friday. (11/27/24) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/25 at 1:11 P.M., Nurse #2 said Resident #1 is on a prescribed fluid restriction, but is not very compliant with it and that she often finds the Resident with extra drinks. She said she doesn't think the Resident understands the fluid restriction and even though they try to limit the Resident it is hard to do. She said she previously wrote a note on the Resident not being compliant with the restriction and provided education to the Resident at that time. Review of Resident #1's current care plans on 2/13/25 with focus areas of: Acute on chronic stage 5 renal failure and nutritional problems failed to indicate the Resident was non-compliant with their prescribed fluid restriction. During the survey, the surveyor made the following observations: 2/13/25 at 8:29 A.M., the Resident had 1,030ml of fluid available at the bedside including their medication water and dietary beverages 2/13/25 at 2:19 P.M., a 5oz. cup of water was at the bedside with approximately 1-2 sips remaining in it 2/13/25 at 3:38 P.M., a 480ml cup of ginger ale and ice was at the bedside with only approximately a 1/2 inch of fluid remaining in the bottom 2/18/25 at 8:08 A.M., 160ml of coffee and 240ml of apple juice 2/18/25 at 9:22 A.M., Resident walking to his/her room drinking a 480ml full cup of ginger ale 2/18/25 at 1:42 P.M., a 480ml cup that has a few drops of fluid in the bottom and a 480ml cup filled with ginger ale and ice Review of the I+O sheets for Resident #1 from 2/5/25 through 2/18/25 indicated but were not limited to the following intakes: 2/5: 3:00 - 11:00 P.M. (evening) shift - 300cc, all other shifts and total were blank 2/7 and 2/8: 360cc on both the day and evening shift - no documentation on the night shift or total (with documentation total would have been 720cc) 2/9: 320cc on evening shift, all other shifts and total were blank 2/11: 360cc on the evening shift, all other shifts and total were blank 2/12: all shifts and total were blank 2/13 and 2/14: 120cc on the night shift, all other shifts and total were blank 2/15: 120cc plus unknown, all other shifts and total were blank The I+O sheets did not have any documentation available on 2/6, 2/10, 2/16, 2/17 or 2/18/25 and were incomplete for all other days since the fluid restriction was started on 2/5/25 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/18/25 at 8:17 A.M., Nurse #5 said Resident #1 had an ordered fluid restriction of 1200ml a day and nursing was only allowed to provide 120ml on the day and evening shift with meds and 60ml on the night shift, she said the order also indicated no additional fluids should be left at the bedside. She said the Resident should not be having additional drinks throughout the day and the staff should not be providing them. She said the unit kitchenette is locked and not accessible to the residents without staff assistance. She said the fluid restriction was not part of a diet order and is signed off by a check mark indicating the Nurse only provided 120ml of water and did not observe or leave any fluids at the bedside. On review of the I+O sheets she said they were incomplete and did not indicate Resident #1 was on a fluid restriction. During an interview on 2/18/25 at 8:21 A.M., CNA #3 said the CNAs are supposed to complete I+O sheets and the Nurses total them daily. She said the I+O sheets for this Resident are incomplete and don't provide any information on a fluid restriction. During an interview on 2/18/25 at 9:22 A.M., the surveyor observed Resident #1 walking towards his/her room drinking from a 16-oz. cup. The Resident said he/she requested a drink while downstairs and was given the large cup of ginger ale. The Resident said he/she does recall being told something about a fluid restriction in the past but doesn't think it's a problem anymore since the staff always give him/her the drinks when he/she asks for them. During an interview on 2/18/25 at 2:03 P.M., Unit Manager #2 reviewed Resident #1's I+O sheets, MAR, orders and nursing notes and said the facility is not documenting or following the Resident's prescribed fluid restriction as they should be. She said there is no evidence that the unit had ever provided the dietary department with a communication notifying them of the fluid restriction and it was not part of the Resident's diet order and was put in as a regular order. She said the MAR sign off by the Nurses should indicate a total that was provided by nursing each shift for clarity since the I+O sheets are incomplete and the sign off that the Resident is on a restriction is not enough to prove the restriction is being followed. She said there is no place she could locate the total amount of fluids the Resident was consuming by nursing each day and it did not appear the facility was tracking or monitoring the Resident's intake to ensure he/she did not exceed the 1200ml restriction as ordered. She was made aware of the surveyor's observations of Resident #1 with 16 oz. cups of fluid and said the staff were clearly not following the fluid restriction as ordered. She said the process for monitoring and documenting a fluid restriction and fluid intake seemed to be problematic and required more attention. During an interview on 2/19/25 at 10:42 A.M., the DON said Resident #1 has a prescribed fluid restriction of 1200ml a day that was ordered by the physician on 2/5/25. She said the expectation is that physician's orders are followed as written. On review of the documentation and observations the surveyor had made she said the fluid restriction order appears to not be being followed as it should be. She said fluid restrictions and the manner in which they are documented and monitored is a work in progress and the facility needs to work on a better process to implement and document them. 34145 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. According to the National Institute of Health, July 2019 and February 2022, it is crucial to rotate injection sites when administering medications to prevent the development of lumps or hardened tissue under the skin, known as lipohypertrophy, which can interfere with proper medication absorption; this means moving the injection site to a different area of the body with each injection, such as between the abdomen, thigh, and upper arm, while ensuring to space injections at least one finger width apart within each area. These cutaneous complications could be one of the causes of unexplained blood glucose fluctuation as insulin absorption is impaired under these pathological conditions. Review of the facility's policy, Administering Medications, undated, included but was not limited to: -As required or indicated for a medication, the individual administering the medication records in the resident's medical record: The injection site (if applicable). Resident #43 was admitted to the facility in November 2020 and had diagnoses including diabetes mellitus, type 2 (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). Review of the MDS assessment, dated 1/20/25, indicated Resident #43 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15, and received insulin injections daily. Review of the medical record indicated but was limited to the following physician's orders: -Novolog Solution (insulin) inject as per sliding scale: If 200 - 249=4 units 250 - 299= 6 units 300 - 349=8 units 350 - 400=10 units 401 - 450=12 units 451 - 500=14 units call MD for Capillary Blood Glucose (CBG) >500, SC with meals (2/19/23) -Novolog Solution 100 unit/ml, inject 16 units SC two times a day with breakfast and dinner; hold <50% meal (9/25/23) -Novolog Solution 100 unit/ml, inject 8 units SC one time a day with lunch (9/25/23) Review of December 2024 through February 2025 Medication/Treatment Administration Records (MAR/TAR) indicated but was not limited to: December 2024 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Novolog Solution 100 unit/ml, inject 8 units SC one time a day with lunch was administered as ordered by the physician; no injection sites were recorded. -Novolog Solution 100 unit/ml, inject 16 units SC twice a day with breakfast and dinner; hold for <50% meal was administered as ordered by the physician; no injection sites were recorded. -Novolog Solution (insulin) inject as per sliding scale with meals was administered on 29 occasions; no injection sites were recorded. January 2025 -Novolog Solution 100 unit/ml, inject 8 units SC one time a day with lunch was administered as ordered by the physician; no injection sites were recorded. -Novolog Solution 100 unit/ml, inject 16 units SC twice a day with breakfast and dinner; hold for <50% meal was administered as ordered by the physician; no injection sites were recorded. -Novolog Solution (insulin), inject as per sliding scale with meals was administered on 37 occasions; no injection sites were recorded. February 2025 -Novolog Solution 100 unit/ml, inject 8 units SC one time a day with lunch was administered as ordered by the physician; no injection sites were recorded. -Novolog Solution 100 unit/ml, inject 16 units SC twice a day with breakfast and dinner; hold for <50% meal was administered as ordered by the physician; no injection sites were recorded. -Novolog Solution (insulin) inject as per sliding scale with meals was administered on 15 occasions; no injection sites were recorded. Further review of the medical record failed to indicate staff identified and documented injections sites for the subcutaneous injection of Novolog insulin to prevent potential complications which can interfere with proper medication absorption. During an interview on 2/13/25 at 1:15 P.M., Nurse Practitioner #1 said insulin administration and rotation of injection sites should be rotated according to professional standards of practice. During an interview with Physician #1 and the DON on 2/14/25 at 7:42 A.M., Physician #1 said nurses should be administering insulin according to standards of practice which include rotation of injection sites. The DON agreed that insulin injection sites should be rotated. The DON reviewed Resident #43's medical record and confirmed that injection sites for Novolin were not documented, and they should be to ensure injection sites are rotated to prevent complications. 4. Resident #78 was admitted to the facility in July 2024 and had diagnoses including hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness or loss of muscle function) following a stroke affecting the right dominant side. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 12/8/24, indicated Resident #78 was cognitively intact BIMS score of 13 out of 15, had right upper extremity range of motion (ROM) impairment and required maximum assistance for activities of daily living. Review of Physician's Orders indicated but was not limited to the following: -Please don patient's RUE resting hand roll splint with A.M. care. Patient to wear as tolerated throughout the day. Doff with P.M. care. Provide skin checks prior to donning and after doffing. Adjust as needed throughout the day, every day and evening shift (1/23/25) Review of a white, 3-ringed binder labeled [NAME] Splint Binder on a shelf at the nursing station indicated that it contained instructions for splints for three residents on the unit including Resident #78's RUE resting hand splint as follows: -Please don patient's right hand roll splint with morning care -Patient to wear as tolerated throughout the day. -Re-adjust splint as needed throughout the day. -Provide skin checks every 2 hours. -Doff splint with evening care. The surveyor observed Resident #78 with no RUE resting hand roll splint in his/her hand as follows: - On 2/12/25 at 9:11 A.M. - On 2/12/25 at 10:40 A.M. - On 2/12/25 at 1:08 P.M. During an interview on 2/12/25 at 1:08 P.M., the surveyor observed Resident #78 reclining in bed awake with his/her hands folded across his/her chest with no RUE resting hand roll splint in place. The hand splint was noted on a chair in the Resident's room underneath two wheelchair foot pedal assemblies. The Resident said he/she cannot remember the last time staff put the splint on his/her hand. The surveyor observed Resident #78 with no RUE resting hand roll splint in his/her hand as follows: - On 2/13/25 at 11:49 AM - On 2/13/25 at 12:55 P.M. - On 2/13/25 at 2:01 P.M. - On 2/14/25 at 11:40 A.M. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #78's TAR for January and February 2025 indicated Resident #78's RUE resting hand roll splint was donned and doffed with A.M./P.M. care since 1/23/25 twice daily. Review of Resident #78's medical record failed to indicate refusal to wear the RUE resting hand roll splint and/or inability to tolerate wearing the RUE splint. The medical record also failed to indicate any attempts by the Resident to self-remove the RUE splint. During an interview with Unit Manager #2 and Resident #78 on 2/14/25 at 12:25 P.M., Unit Manager #2 said she donned the RUE resting hand roll splint to Resident #78's hand this morning documented it on the TAR. The surveyor and Unit Manager #2 entered Resident #78's room and noted the RUE splint on the Resident's bedside [TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observation and interview, the facility failed to maintain an environment that was free of accidents and hazards on one ([NAME] Unit) out of three units. Specifically, the Nurse failed to secure an insulin vial in her medication cart while not in her sight leaving it accessible to residents in the immediate vicinity. Findings include: Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to: -During administration of medications, the medication cart is kept locked and closed when out of sight of the medication nurse or aide. -No medications are kept on top of the cart. -The cart must be inaccessible to residents or others passing by. Review of the facility's policy titled Storage of Medications, undated, indicated but was not limited to: -Drugs and biologics used in the facility are stored in locked compartments. -Only persons authorized to prepare and administer medications have access to locked medications. On 2/13/25 at 8:56 A.M., the surveyor observed Nurse #1: - Prepare Lispro Insulin (a fast-acting insulin used to treat diabetes mellitus) for Resident #30. - Place the vial of Lispro Insulin on the top of the medication cart. - Enter Resident #30's rooms leaving the vial of Lispro Insulin on top of the medication cart unattended and out of her sight with four residents in the immediate vicinity unsupervised. - Return to the medication cart, unlock it, and place the vial of Lispro Insulin inside. During an interview on 2/13/25 at 1:29 P.M., Nurse #1 said she left the vial of Insulin on the medication cart unattended and unsupervised with residents in the immediate vicinity. Nurse #1 said she should have locked the vial of Insulin in the medication cart. During an interview on 2/13/25 at 1:35 P.M., Unit Manager (UM) #1 said medications must be secured in a locked medication cart when not in direct supervision of the nurse and not accessible to residents.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48695 Based on observations, interviews, and records reviewed for two Residents (#30 and #57) of 21 sampled residents, the facility failed to ensure that pain management was provided to the Resident consistent with professional standards of practice, the comprehensive person-centered care plan, and the Resident's goals and preferences. Specifically, the facility failed: 1) For Resident #30, to administer his/her prescribed, as needed, opioid (pain medication) medication in accordance with physician's orders and implement a comprehensive person-centered care plan addressing his/her pharmacological and non-pharmacological needs; and 2) For Resident #57, to administer his/her prescribed, as needed, opioid medication in accordance with physician's orders. Findings include: Review of the facility's policy titled Pain Assessment and Management, undated, indicated but was not limited to the following: - Purpose: the purposes of this procedure are to help staff identify pain in the resident, and to develop interventions that are consistent with resident's goals and needs and that address the underlying causes of pain. - Pain Management includes: assess the potential for pain; effectively recognizing the presence of pain; identifying the characteristics of pain; address the underlying causes of pain; developing and implementing approaches to pain management; identifying and using specific strategies for different levels and sources of pain; monitor for effectiveness of interventions; and modifying approaches as necessary. - Review the medication administration record to determine how often the individual requests and receives pain medication, and to what extent the administered medications relieve the resident's pain. - The pain management interventions shall be consistent with the resident's goals for treatment. - Pain management interventions shall reflect the sources, type and severity of pain and address the underlying causes of the resident's pain. - Non-pharmacological interventions may be appropriate alone or in conjunction with medications. - Pharmacological interventions may be prescribed to manage pain, however they do not usually address the cause of the pain and can have adverse effects on the resident. - The physician and staff will establish a treatment regimen based on consideration of the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident's medical condition; current medication regimen; nature, severity and cause of the pain; course of the illness and treatment goals. - Implement the medication regimen as ordered. - Document the resident's reported level of pain with adequate detail as necessary and in accordance with the pain management program. Review of the facility's policy titled Administering Medications, undated, indicated but was not limited to: - Medications are administered in a safe and timely manner, and as prescribed. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Review of Medline Plus, last revised 3/15/24, indicated but was not limited to: - Take Ultram (opioid used to relieve moderate to moderately severe pain) exactly as directed. - Do not take more of it, take it more often, or take it in a different way than directed by your doctor. - While taking Ultram, discuss with your health care provider your pain treatment goals, length of treatment, and other ways to manage your pain. Resident #30 was admitted to the facility in January 2025 with diagnoses including chronic pain syndrome (a condition characterized by persistent pain that lasts for at least 3-6 months and significantly impacts a person's life) and rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing inflammation, pain, and stiffness). Review of the Minimum Data Set (MDS) assessment, dated 1/26/25, indicated Resident #30 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of Resident #30's MDS indicated he/she had occasional pain, was receiving scheduled and as needed pain medication, and an opioid medication. During an interview on 2/13/25 at 8:24 A.M., Resident #30 said he/she had frequent pain related to his/her diagnosis of rheumatoid arthritis. Resident #30 said he/she would request Ultram as needed for pain. Review of Resident #30's current Physician's Orders indicated but was not limited to: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Ultram 50 milligram (mg) tab, give 1 tablet by mouth every 8 hours as needed for severe pain (7-10), dated 1/22/2025 - Tylenol 650 mg, by mouth every 6 hours as needed for pain, dated 1/27/25 - Gabapentin 100 mg, by mouth two times daily for pain, dated 2/13/25 - Prednisone (steroid medication used to decrease inflammation) 5 mg one time daily, dated 1/22/25 Review of the January 2025 Medication Administration Record (MAR) for Resident #30 indicated Ultram had been administered five times. Further Review of Resident #30's January MAR indicated the Ultram was administered twice for pain below prescribed parameters: - 1/24/25, pain level 4 - 1/30/25, pain level 5 Review of the February 2025 MAR for Resident #30 indicated Ultram had been administered 10 times. Further Review of Resident #30's February MAR indicated the Ultram was administered five times for pain below prescribed parameters: - 2/1/25, pain level 2 - 2/6/25, pain level 6 - 2/7/25, pain level 5 - 2/13/25, pain level 3 - 2/15/25, pain level 3 During an interview on 2/18/25 at 8:41 P.M., Resident #30 said his/her acceptable pain level was a five. Resident #30 said when he/she would experience pain at home he/she would take a warm shower, apply heat, massage the area where the pain was, call the doctor to adjust Prednisone dose, or adjust the time of day he/she would get out of bed and perform activities of daily living just to name a few things. Resident #30 said he/she would request Ultram when nursing staff would offer him/her pain medication. Review of Resident #30's care plans failed to indicate a comprehensive person-center individualized care plan had been developed and implemented to address Resident #30's pain management needs. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/18/25 at 12:15 P.M., Nurse #9 said Resident #30 had orders for Ultram and Tylenol for pain. Nurse #9 said pain medications should be given per physician's orders, including parameters, and Resident #30 should have a care plan for his/her pain related to their diagnosis of rheumatoid arthritis. Nurse #9 reviewed Resident #30's January and February MARs and care plans and said Resident #30 had received Ultram for pain, below his/her prescribed parameters for the medication and did not have a care plan addressing his/her pain management needs but should. Nurse #9 said Resident #30 should not have been administered pain medication outside of the physician prescribed parameters. During an interview on 2/18/25 at 2:09 P.M., Unit Manager (UM) #1 said Resident #30 was prescribed Ultram as needed every eight hours for pain between 7-10 on a 0-10 scale (with 10 being the worst pain). UM #1 said Resident #30 had been administered Ultram outside of the prescribed pain level parameters. UM #1 said pain medications should only be administered as prescribed by the physician and within the prescribed pain level range. UM #1 said care plans are implemented and developed on admission, change of conditions, or as needed; she said all residents should have a care plan to address pain management, but this Resident did not have a pain management care plan to guide the manner in which their pain would be managed with their individual needs and input. During a telephonic interview on 2/18/25 at 2:09 P.M., Nurse Practitioner (NP) #2 said the expectation was for all residents to be administered medications per physician's orders and within the prescribed parameters for pain medications. NP #2 said Resident #30 should not have been administered Ultram for a pain level below the prescribed range of 7-10. During an interview on 2/19/25 at 12:35 P.M., the Director of Nursing (DON) said Resident #30 was administered Ultram outside of the physician prescribed pain level parameters and should not have been. The DON said the expectation was for all residents to have a comprehensive person-centered care plan addressing acceptable pain level, pain level goals, and interventions that are both pharmacological and non-pharmacological, but Resident #30 did not have a plan to address their pain at this time. 2. Review of Medline Plus, last revised 5/15/23, indicated but was not limited to: - Take hydromorphone (opioid analgesic used to treat moderate to severe pain when the use of an opioid is indicated) exactly as directed. - Do not take more of it, take it more often, or take it in a different way than directed by your doctor. Resident #57 was administered to the facility in December 2024 with diagnoses including surgery on the digestive system and constipation. Review of the MDS assessment, dated 12/31/25, indicated Resident #57 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of Resident #57's MDS indicated he/she had frequent pain and had received pain medication as needed. Review of Resident #57's current Physician's Orders indicated but was not limited to: - Tylenol 650 mg, every 6 hours as needed for pain, dated 12/27/24 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hydromorphone 2 mg, by mouth every eight hours as needed for pain 6-10, dated 12/27/24 Review of the January 2025 MAR for Resident #57 indicated Hydromorphone had been administered eight times. Further Review of Resident #57's January MAR indicated the Hydromorphone was administered six times for pain levels below the prescribed parameters of a 6-10 pain level: - 1/1/25, pain level 5 - 1/3/25, pain level 5 - 1/6/25, pain level 5 - 1/10/25, pain level 3 - 1/16/25, pain level 2 - 1/19/25, pain level 0 During an interview on 2/19/25 at 10:57 A.M., UM #1 said Resident #57 was prescribed Hydromorphone as needed every eight hours for pain between 6-10 on a 0-10 scale. UM #1 reviewed Resident #57's January MAR and said Resident #57 had been administered Hydromorphone outside of the prescribed pain parameters. UM #1 said pain medications should only be administered as prescribed by the physician and within the prescribed pain level range. During an interview on 2/19/25 at 12:35 P.M., the DON said Resident #57 was administered Hydromorphone 2 mg outside of the physician prescribed pain level parameters and should not have been.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 34145 Based on record review and interview, the facility failed to ensure the Physician signed and dated all orders for one Resident (#14), out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Medication Orders, undated, indicated but was not limited to: -Supervision by a Physician: -Physician orders/Progress notes must be signed and dated every thirty (30) days. (Note: this may be changed to every sixty (60) days after the first ninety (90) days of the resident's admission) Resident #14 was admitted to the facility in August 2016 and has diagnoses including diabetes mellitus, chronic kidney disease, major depression with severe psychotic symptoms, and bipolar disorder. Review of the medical record, Electronic Medical Record (EMR), and the Order Review History report, indicated the Resident's Physician last signed the Resident's orders on 11/8/24. There were no additional orders signed by the Physician. During an interview on 2/19/25 at 1:59 P.M., the Director of Nursing (DON) reviewed Resident #14's medical record and said the last signed physician's orders in the medical record were for November 2024. She said physician's orders are to be signed every 30 or 60 days.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 43935 Based on document review and interview, the facility failed to ensure residents were provided Physician/Nurse Practitioner (NP) visits every 30 days within the first 90 days of admission and then every 60 days thereafter for three Residents (#1, #43, and #14), out of a total sample of 21 residents. Specifically, the facility failed: 1. For Resident #1, to ensure the Resident was seen at least every 30 days for the first 90 days of his/her admission to the facility; 2. For Resident #43, to have visits completed by the Physician or NP every 60 days; and 3. For Resident #14, to ensure the Resident was provided oversight of their care and visits by a clinician. Findings include: Review of the facility's policy titled Physician Visits and Physician Delegation Policy, dated as revised January 2025, indicated but was not limited to the following: - It is the policy of this facility to ensure the physician takes an active role in supervising the care of residents - the physician should see the residents within 30 days of admission, and the resident must be seen at least once every 30 calendar days for the first 90 days by the physician or physician's delegate - after the first 90 days the resident must be seen at least every 60 calendar days by the physician or physician delegate - the physician should date, write and sign a progress note for each visit and review the resident's total program of care 1. Resident #1 was admitted to the facility in October 2024 with diagnoses including chronic kidney disease stage 5, end stage renal disease, Bipolar disorder, and generalized anxiety. During an interview on 2/13/25 at 1:10 P.M., Nurse #3 said all Physician and NP progress notes are scanned into the electronic medical record under the tab labeled Miscellaneous. Review of the Miscellaneous section of Resident #1's medical record on 2/13/25 indicated only one progress note was available since the Resident's admission, completed by NP #2 and dated 11/27/24. Review of the census section of Resident #1's medical record indicated that he/she had a paid hospital leave since their admission in October 2024 but has remained an active Resident since that admission. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/18/25 at 10:32 A.M., the Medical Records Clerk said the Physician's and NP's send their progress notes to the facility receptionist by email and then the receptionist places them in the correct resident records. She said although she is responsible for medical records she does not receive any physician or clinician progress notes and to check for potentially missing notes with the receptionist. During an interview on 2/18/25 at 12:54 P.M., the Receptionist said all the Physician and NP progress notes are sent to her by email and she then scans them into the correct resident record under the miscellaneous section immediately. She said on review that she did not have any other notes in her email for Resident #1 at this time and everything she had was in the Resident's medical record. During an interview on 2/18/25 at 5:12 P.M., NP #2 reviewed the medical record for Resident #1 and said she is surprised that her note from 11/27/24 is the only progress note in the medical record and wonders if anyone at the facility has records they may not have uploaded yet, since this couldn't be possible. She was informed the person who receives the emails confirmed they did not have any additional documents for Resident #1's record and she said she would speak with the team. Review of the medical record on 2/19/25 indicated additional Physician and NP notes were placed in Resident #1's medical record and the Resident had visits on the following dates: 11/4/24, 11/7/24, 11/18/24, 11/27/24 No visits were documented in the month of December 2024 1/27/25 (61 days after the last visit in November 2024) 2/17/25 The physician/NP visits indicated a gap of 61 days in visits from 11/27/24 through 1/27/25 During an interview on 2/19/25 at 10:12 A.M., the Director of Nurses (DON) said the Resident should have been seen at least once every 30 days in his/her first 90 days since admission and it appears that did not occur and the regulatory requirements were not met. 34145 2. Resident #43 was admitted to the facility in November 2020. During an interview on 2/13/25 at 1:10 P.M., Nurse #3 said all Physician and NP progress notes are scanned into the electronic medical record under the tab labeled Miscellaneous. Review of the Physician's Progress Notes indicated Resident #43 was seen by the Physician on 12/17/23. The next visit from the MD occurred on 12/23/24, 372 days since the previous MD visit. Resident #43 was only seen by the NP between 12/27/23 and 12/23/24. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON and Physician #1 on 2/14/25 at 7:34 A.M., the DON and Physician reviewed Resident #43's medical record with the surveyor. The DON said all Physician progress notes are scanned and filed in the Miscellaneous tab in the electronic medical record. The DON pulled up Resident #43's medical record on her computer and reviewed Physician progress notes. She was unable to find any other Physician progress notes between the dates of 12/17/23 and 12/23/24. The DON said she contacted Resident #43's Physician's office last evening to request all progress notes be sent to the facility right away. She said she received a fax with two additional Physician progress notes dated 12/26/24 and 1/20/25. Physician #1 said he is aware that residents needed to be seen at least every 60 days and can alternate with the NP. During an interview on 2/19/25 at 1:59 P.M., the DON said she had not received any additional Physician progress notes from Physician #1. 3. Resident #14 was admitted to the facility in August 2016. Review of the medical record indicated Resident #14 was last seen by the Physician on 11/1/24. Further review of the medical record failed to indicate Resident #43 had been seen by either the Physician or NP since 11/1/24, a lapse of 110 days. During an interview on 2/19/25 at 1:59 P.M., the DON reviewed Resident #14's medical record and said there were no Physician visit notes to indicate Resident #14 had been seen by the Physician since 11/1/24. No further documentation was provided to the survey team by the time of the exit conference.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48695 Based on record review and interview, the facility's Consultant Pharmacist failed to identify irregularities in medications during the monthly Medication Regimen Review (MRR) for two Residents (#30 and #1), out of a total sample of 21 residents. Specifically, the facility failed to ensure: 1. For Resident #30, the Pharmacist reviewed and reported irregularities related to the administration of a pain medication; and 2. For Resident #1, the Pharmacy consultant identified a lack of rationale documentation for the ongoing use of an as needed (PRN) psychotropic benzodiazepine/anti-anxiety medication. Findings include: Review of the facility's policy titled Consultant Pharmacist Services Provider Requirements, effective date January 2024, indicated but was not limited to: - The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. In collaboration with facility staff, the consultant pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services. This includes, but is not limited to: - Assisting in the identification and evaluation of medication related issues including the prevention, and reporting of medication errors and the provision and monitoring the use of medication related devices. - Identifying one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and or adverse effects dosage levels and other pertinent information. - Providing oversight and instruction on regulatory compliance issues. - Specific activities that the consultant pharmacist performs includes, but is not limited to: - Reviewing the medication regimen (medication regimen review) of each resident at least monthly, and or more frequently under certain conditions, incorporating federally mandated standards of care in addition to other applicable professional standards was outlined in the procedure for medication regimen review, and documenting the review and findings in the resident's medical record or in a readily retrievable format if utilizing electronic documentation. - Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues at least monthly. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Reviewing medication administration records (MARs), treatment administration records (TARs) and physician orders at least monthly to ensure proper documentation of medication orders and administration of medications to residents. 1. Resident #30 was admitted to the facility in January 2025 with diagnoses including chronic pain syndrome (a condition characterized by persistent pain that lasts for at least 3-6 months and significantly impacts a person's life) and rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing inflammation, pain, and stiffness). Review of Resident #30's current Physician's Orders indicated but was not limited to: - Ultram (opioid used to relieve moderate to moderately severe pain) 50 milligram (mg) tab, give 1 tablet by mouth every 8 hours as needed for severe pain (7-10), dated 1/22/2025 - Tylenol 650 mg, by mouth every 6 hours as needed for pain, dated 1/27/25 Review of the January 2025 MAR for Resident #30 indicated Ultram had been administered five times. Further review of Resident #30's January MAR indicated Ultram was administered two times for pain below parameters: - 1/24/25, pain level 4 - 1/30/25, pain level 5 Review of the February 2025 MAR for Resident #30 indicated Ultram had been administered 10 times. Further review of Resident #30's February MAR indicated Ultram was administered five times for pain below parameters: - 2/1/25, pain level 2 - 2/6/25, pain level 6 - 2/7/25, pain level 5 - 2/13/25, pain level 3 - 2/15/25, pain level 3 Review of Resident #30's MRR, dated 2/5/25, indicated but was not limited to: - Ultram utilized - No new recommendation (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephonic interview on 2/19/25 at 9:45 A.M., Consultant Pharmacist #1 said he electronically reviewed each residents' medication orders monthly. Consultant Pharmacist #1 said he would review residents' orders for things such as the indication for use, appropriate dose, and utilized per physician orders. Pharmacist #1 said he would review residents' MARs and TARs monthly as part of the MRR. Consultant Pharmacist #1 said he reviewed Resident #30's MAR during the MRR, on 2/5/25, but had not made reference to Ultram administration below the prescribed pain level but should have. During an interview on 2/19/25 at 12:35 P.M., the Director of Nursing (DON) said Resident #30 was administered Ultram outside of the Physician prescribed pain level parameters and should not have been. The DON said the expectation was for the Consultant Pharmacist to double check the MAR for medication administration as ordered and should communicate discrepancies to the facility but he had not. 43935 2. Resident #1 was admitted to the facility in October 2024 with diagnoses including chronic kidney disease stage 5, End Stage Renal Disease, bipolar disorder, and generalized anxiety. Review of the last completed Minimum Data Set (MDS) assessment, dated 11/18/24, indicated the Resident did not suffer from any behaviors (Section E). Review of the current Physician's Orders, as of 2/13/25, for Resident #1 indicated but were not limited to the following: Alprazolam (Xanax) (an anti-anxiety/benzodiazepine psychotropic medication) 0.5 mg by mouth every 12 hours as needed (PRN) for anxiety until 2/26/25 (12/26/24) Review of the history of Xanax orders for Resident #1 from November 2024 to February 2025 indicated the following: November 2024: Ordered: 11/1/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety (no stop date) - discontinued 11/2/24 Ordered: 11/2/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety for 13 days - held from 11/9-11/13 for medical leave - then discontinued 11/15/24 Ordered: 11/15/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety (no stop date) - discontinued 11/20/24 Ordered: 11/20/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety for 10 days - discontinued 11/27/24 Ordered: 11/27/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety until 12/26/24 - discontinued 12/26/24 Ordered: 12/26/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety until 2/26/25 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Attending Physician and Nurse Practitioner (NP) progress notes from 11/4/24 through 2/17/25 indicated the following: 11/4/24: New Admit: Alert and oriented, forgetful; psych stable, alert oriented and cooperative with exam. There was no documentation regarding Resident #1's anxiety or need for PRN Xanax. 11/7/24: Follow up- short term rehab (STR): Pleasant, in no acute distress. There was no documentation regarding Resident #1's anxiety or need for PRN Xanax 11/7/24: Hospital follow up note: Xanax 0.5mg twice a day as needed: temporary supply until seen by NP; pleasant in no acute distress 11/18/24: Re-admission History and Physical: In no acute distress, mildly confused. There was no documentation regarding Resident #1's anxiety or need for PRN Xanax. 11/27/24: STR follow-up: Anxiety, increase restlessness at dialysis, they are requesting they receive a dose of Xanax prior to coming to dialysis. Refill Xanax 0.5 mg twice a day PRN for 30 days for treatment of anxiety. 1/27/25: 30 day evaluation #2: There was no documentation regarding Resident #1's anxiety or need for PRN Xanax; an Addendum on 2/18/25 for this note indicated the resident needs a benzodiazepine (Xanax), the benefits are more than the risk. 2/17/25: Follow-up: Alert, pleasant, smiling, good eye contact, good speech. Bipolar affect disorder notes: continue Xanax. Review of the Psychiatric progress notes for Resident #1 from 11/19/24 through 1/22/25 indicated the Resident took Xanax on a PRN basis for anxiety but failed to indicate a risk versus benefit rationale or any indication if the medication was still necessary or effective for the Resident. Review of the Consultant Pharmacist monthly MRR for Resident #1 from November 2024 to February 2025 indicated but were not limited to the following: 11/5/24: 11/2/24 re-authorized Xanax 0.5 mg every 12 hours PRN x 14 days; Nursing recommendation for rinse of mouth 12/3/24: 11/27/24 re-authorized Xanax 0.5 mg every 12 hours PRN x 30 days, 11/2 Xanax 0.5 mg every 12 hours PRN x 14 days; No new recommendations today 1/6/25: 12/26/24 re-authorized Xanax 0.5 mg every 12 hours PRN x 60 days, 11/27/24 re-authorized Xanax 0.5 mg every 12 hours PRN x 30 days, 11/2 Xanax 0.5 mg every 12 hours PRN x 14 days; MD recommendation today to review continued need for Heparin 2/5/25: 12/26/24 re-authorized Xanax 0.5 mg every 12 hours PRN x 60 days, 11/27/24 re-authorized Xanax 0.5 mg every 12 hours PRN x 30 days, 11/2 Xanax 0.5 mg every 12 hours PRN x 14 days; No new recommendations today (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Pharmacy consultant failed to identify that there was no documented rationale for the extension of the PRN Xanax. During an interview on 2/19/25 at 9:23 A.M., the Pharmacy consultant said he completes MRRs monthly and the psychiatric and psychotropic medication review and profile is looked at holistically with a goal of getting rid of medications for the residents that may not be necessary or have had a change in their needs. He reviewed the PRN Xanax use specifically for Resident #1. He said he does not always look for the rationale documentation for a PRN psychotropic medication extension and would only look if he thought the usage seemed excessive or very minimal for a period of three months or more. He said he assumes the Physicians and Nurse practitioners (NP) know that documenting a clinical rationale for the ongoing use of a PRN psychotropic medication is required and he just ensures a stop date is in place on those PRN orders. He said he does not have time to review and check that the prescriber is completing an extension of a psychotropic PRN medication in line with the regulation and he has not documented any recommendations for this to be done for Resident #1. He said it is the Physician or NP's responsibility to provide all the necessary supporting documentation for extending PRN psychotropics to be in line with the regulatory requirements and he does not review that or any documentation potentially supporting the ongoing need for the medication by the licensed nurses. During an interview on 2/19/25 at 10:27 A.M., the DON reviewed the medical record for Resident #1 and said the Physician or NP is supposed to document a thorough clinical rationale for the extended and ongoing use of a PRN psychotropic medication, such as Xanax, each time the order is extended and it does not appear that has occurred. She said she would expect the Pharmacy consultant to pick up on the lack of documented rationale and leave a recommendation to address it, but on review that did not occur. She said she was not aware the Pharmacy consultant had any time constraints and was not ensuring all the regulatory pieces of documentation were in place to ensure any PRN psychotropics were being extended within the guidance. She thinks of the Pharmacy consultant as a second set of eyes for the facility to ensure all pieces are in place and cannot explain how this issue was missed. She said this issue should have been identified by the Pharmacy consultant and placed on a recommendation but was not.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on record review and interviews, the facility failed to ensure that one Resident (#43), out of a total sample of 21 residents, was free from unnecessary medication administration. Specifically, the facility failed to ensure the Resident was not treated with two different antibiotics (Augmentin and Bactrim) by two different clinicians concurrently without adequate indications for their use. Findings include: Review of the USAntibiotics website indicated that to reduce the development of drug-resistant bacteria and maintain the effectiveness of AUGMENTIN and other antibacterial drugs, AUGMENTIN should be used only to treat infections that are proven or strongly suspected to be caused by bacteria. Review of the [NAME] Pharmaceuticals website indicated that to reduce the development of drug-resistant bacteria and maintain the effectiveness of BACTRIM and other antibacterial drugs, BACTRIM tablets should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. According to the National Institute of Health, June 2021, elderly people confined to chronic care facilities face an increased risk of acquiring infections by multidrug-resistant organisms (MDROs). Polypharmacy and inappropriate prescriptions are well-known risk factors for adverse drug reactions, which commonly cause poor clinical outcomes in older people. Antimicrobial resistance is a major negative event resulting from inappropriate prescriptions of antimicrobials. Resident #43 was admitted to the facility in November 2020 and had diagnoses including gastroparesis (a condition where the stomach muscles do not work properly, leading to delayed emptying of food into the small intestine; symptoms include nausea and vomiting) and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 1/20/25, indicated Resident #43 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 5 out of 15, and received antibiotic medication during the assessment period. Review of the medical record indicated but was not limited to the following clinical nurse's notes: -1/12/25 -Resident vomited X 1 this evening, afebrile (free from fever), accepted approximately 25% of a thinned glucose-control nutritional supplement. Daughter is aware and continues to express her concern regarding recent general decline, poor appetite and diminished intake, and increased sleepiness. Daughter would like the physician/nurse practitioner (NP) to be notified of her concerns and feels that the Resident may have an infection such as a urinary tract infection (UTI) and would like for the Resident to be started on a broad-spectrum antibiotic. Message forwarded to NP regarding above information, awaiting response. -1/12/25- Per NP, start Augmentin 500-125 milligram (mg) one tab twice daily for seven days; new order to obtain urine for urinalysis (UA), culture and sensitivity (C&S). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Urinalysis/Urine Culture Lab report result, reported to the facility on [DATE] at 9:11 A.M., indicated Resident #43 was positive for a UTI. Review of the January 2025 Medication Administration Record (MAR) indicated that Resident #43 was administered five doses of Augmentin starting on 1/13/25 (prior to receiving the lab results) at 8:00 A.M. without a clinical rationale for its use. Further review of the medical record indicated, but was not limited to the following clinical nurse's notes: -1/13/25-Resident started on antibiotics. Spiked a temperature of 101.2 Fahrenheit, acetaminophen (pain reliever/fever reducer) 650 given with good effect. This was reported to the MD who ordered a chest x-ray (a photographic or digital image of the internal composition of something, especially a part of the body) and Bactrim DS (double strength) twice daily for three days. Review of the 1/13/25 physician's order for the chest x-ray indicated it was a STAT (urgent) order. During an interview on 2/19/25 at 10:48 A.M., Nurse #8 reviewed Resident #43's medical record and said the results of the STAT x-ray are date and time stamped as sent to the facility on [DATE] at 4:13 P.M., and date and time stamped as reviewed by facility staff on 1/15/25 at 8:03 P.M., more than two days after the STAT results were sent to the facility. He said the results indicated that the Resident's lungs were clear with no abnormality. Review of the January 2025 MAR indicated Resident #43 was administered six doses of Bactrim DS 800-160 mg starting on 1/13/25 at 5:00 P.M., without a clinical rationale for its use while concurrently receiving Augmentin. During an interview on 2/13/25 at 1:15 P.M., NP #1 reviewed Resident #43's medical record. When asked what clinical criteria are used for antibiotic use, the NP did not answer. She said the Resident shouldn't have been on two antibiotics at the same time, and it is likely that staff did not let the MD know the Resident was already on Augmentin when he ordered Bactrim. During an interview on 2/14/25 at 7:42 A.M., MD #1 said he was not aware that Resident #43 was already receiving Augmentin starting on 1/13/25 when he prescribed Bactrim DS on 1/13/25. When asked what clinical criteria are used for antibiotic use, he said he thought the Resident may have aspiration pneumonia because he/she vomited a few days earlier and was not made aware of the x-ray results. During an interview on 2/18/25 at 11:03 A.M., the Infection Preventionist (IP) reviewed Resident #43's medical record including incontinence documentation, nursing notes, urinalysis and C&S report, and physician and NP notes. She said the facility uses McGeer criteria and even with the addition of a fever, the Resident did not have enough criteria to indicate their illness met criteria for a UTI. She said the documentation indicated the urine was collected for testing on 1/12/25 at 11:45 P.M., and the first dose of Augmentin was received on 1/13/25 at approximately 8:00 A.M. She said vomiting would not be a factor for UTI for the Resident as this is a common symptom for the Resident related to his/her diagnosis of gastroparesis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/25 at 1:59 P.M., the Director of Nursing (DON) said the nurse should have reviewed and notified the MD right away of the chest x-ray results when it was sent to the facility on [DATE]. She said the Resident should not have been administered two antibiotic medications without clinical indications for their use.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34145 Based on record review and interview, the facility failed to ensure for two Residents (#78 and #1), out of a total sample of 21 residents, that each Resident's drug regimen was free from unnecessary psychotropic medications. Specifically, the facility failed: 1. For Resident #78, to monitor the Resident for potential adverse consequences for the use of antianxiety medication; and 2. For Resident #1, to ensure a documented rationale was in place for the ongoing extended use of an as needed (PRN) psychotropic benzodiazepine/anti-anxiety medication. Findings include: Review of the facility's policy titled Use of Psychotropic Medication, dated December 2024, indicated: - Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). 1. Resident #78 was admitted to the facility in July 2024 and had diagnoses including major depressive disorder and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 12/8/24, indicated Resident #78 received antianxiety and antidepressant medication daily. Review of the medical record indicated but was not limited to the following Physician's Order: -Buspirone HCl (antianxiety) 10 milligrams (mg) two times a day (10/27/24) Further review of physician's orders failed to indicate monitoring for side effects for the use of Buspirone. Review of November 2024 through February 2025 Medication Administration Records (MAR) indicated Buspirone was administered as ordered by the physician. During an interview on 2/19/25 at 12:33 P.M., Unit Manager #2 reviewed Resident #78's medical record and said they should be monitoring the Resident for potential side effects of Buspirone but are not. 2. Review of the facility's policy titled Informed Consent for Psychotropic Medications, undated, indicated but was not limited to the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- PRN psychotropics: Initial 14-day limitation on all PRN orders, orders may be extended beyond 14-days if the prescriber practitioner: a. believes it is appropriate to extend the order b. provides a specific duration for use c. documents a clinical rationale for the extension - all above items may be documented upon initiation of the PRN psychotropic order, allowing profile use of the PRN order beyond the 14-day limit Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, dated May 2023, indicated but was not limited to the following: - The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes - behavioral symptoms will be identified using facility approved tools and the comprehensive assessment - non-pharmacological approaches will be utilized to the extent possible to avoid or reduce the use of medications to manage behavioral symptoms - interventions will be adjusted based on the impact on the behavior and other symptoms Resident #1 was admitted to the facility in October 2024 with diagnoses including chronic kidney disease stage 5, end stage renal disease, bipolar disorder, and generalized anxiety. Review of the last completed MDS assessment, dated 11/18/24, indicated Resident #1 did not suffer from any behaviors (Section E). Review of the current Physician's Orders, as of 2/13/25, for Resident #1 indicated but were not limited to the following: Alprazolam (Xanax) (an anti-anxiety/benzodiazepine psychotropic medication) 0.5 mg by mouth every 12 hours as needed (PRN) for anxiety until 2/26/25 (12/26/24) Review of the history of Xanax orders for Resident #1 from November 2024 to February 2025 indicated the following: November 2024: Ordered: 11/1/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety (no stop date) - discontinued 11/2/24 Ordered: 11/2/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety for 13 days - held from 11/9-11/13 for medical leave - then discontinued 11/15/24 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ordered: 11/15/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety (no stop date) - discontinued 11/20/24 Ordered: 11/20/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety for 10 days - discontinued 11/27/24 Ordered: 11/27/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety until 12/26/24 - discontinued 12/26/24 Ordered: 12/26/24 Xanax 0.5 mg one tab by mouth every 12 hours PRN for anxiety until 2/26/25 Review of Attending Physician and Nurse Practitioner (NP) progress notes from 11/4/24 through 2/17/25 indicated the following: 11/4/24: New Admit: Alert and oriented, forgetful; psych stable, alert oriented and cooperative with exam. There was no documentation regarding Resident #1's anxiety or need for PRN Xanax. 11/7/24: Follow up- short term rehab (STR): Pleasant, in no acute distress. There was no documentation regarding Resident #1's anxiety or need for PRN Xanax. 11/7/24, Hospital follow up note: Xanax 0.5 mg twice a day as needed: temporary supply until seen by NP; pleasant in no acute distress. 11/18/24: Re-admission History and Physical: In no acute distress, mildly confused. There was no documentation regarding Resident #1's anxiety or need for PRN Xanax. 11/27/24: STR follow-up: Anxiety, increase restlessness at dialysis, they are requesting they receive a dose of Xanax prior to coming to dialysis. Refill Xanax 0.5 mg twice a day PRN for 30 days for treatment of anxiety. 1/27/25: 30 day evaluation #2: There was no documentation regarding Resident #1's anxiety or need for PRN Xanax; an Addendum on 2/18/25 for this note indicated the resident needs a benzodiazepine (Xanax), the benefits are more than the risk. 2/17/25: Follow-up: Alert, pleasant, smiling, good eye contact, good speech. Bipolar affect disorder notes: continue Xanax. Review of the MAR for Resident #1 from November 2024 - February 2025 indicated the following use of PRN Xanax: November 2024: administered one time only on 11/26/24 (25 days after the PRN was initially ordered) December 2024: administered six times total, three of those times being prior to dialysis (out of 13 opportunities to receive prior to dialysis) January 2025: administered 7 times total, two of those times being prior to dialysis (out of 14 opportunities to receive prior to dialysis) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	February 1 through 13, 2025: administered one time only Review of the Certified Nurse Assistant documentation for Resident #1's behaviors for the last 31 days indicated the Resident did not have behaviors. Review of the Psychiatric progress notes for Resident #1 from 11/19/24 through 1/22/25 indicated the Resident took Xanax on a PRN basis for anxiety, but failed to indicate a risk versus benefit rationale or any indication if the medication was still necessary or effective for the Resident. Throughout the survey, the surveyor made the following observations of the Resident: 2/12/25 at 9:33 A.M., In bed calm, denied anxiety said he/she was getting ready to go to dialysis 2/13/25 at 8:29 A.M., In his/her room, calm pleasant and engaged easily. He/She said they were told at the dialysis center they were doing well and that made them happy. 2/18/25 at 1:42 P.M., In bed, pleasant and calm with T.V. on 2/19/25 at 8:23 A.M., In his/her room, calm pleasant and easily engages in conversation, said the plan was to have a cigarette prior to heading to dialysis today During an interview on 2/18/25 at 2:14 P.M., Unit Manager #2 reviewed the medical record of Resident #1 and said it appeared that there was no documented rationale for the continued use of the PRN Xanax and the Resident was using the medication minimally and likely did not need it any longer. She said her understanding is that the Resident was anxious regarding being new to dialysis when he/she first came in and felt unsure about potential discharge plans but has since settled into a good routine and is calm and does not exhibit any behaviors. She said it appears the PRN Xanax should not have been extended initially since it was unused. She said the psych notes do not provide any information on the Resident's anxiety medication or their benefits. She said the documentation in the medical record does not reflect that the process and guideline for PRN psychotropic medication use was followed as it should have been since the medication is rarely used and missing a rationale for use with each extension of the medication. During an interview on 2/18/25 at 5:12 P.M., NP #2 said she saw the Resident in late November and the staff had informed her of the dialysis request for the Resident to receive Xanax prior to dialysis. She said this is the reason she continued the PRN Xanax for 30 days. She said she was not aware that the Resident had not received the PRN Xanax prior to dialysis each day as she had intended when extending the PRN order. She reviewed all the available Physician and NP progress notes in the medical record at this time and said she does not see that any other rationale was documented for any continued PRN use for the Xanax. She said the Resident appears to have settled into a routine and may no longer need the medication and she would request someone see and evaluate the Resident on 2/19/25 for this reason. During an interview on 2/19/25 at 9:05 A.M., the Dialysis Nurse said the Resident was having a hard time adjusting to his/her dialysis routine back a few months ago but has since settled into a good routine, is calm and inquisitive while receiving dialysis and seems to really want to understand the process and has progressed really well with his/her treatments. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/25 at 10:14 A.M., the Director of Nurses said the clinician is supposed to follow the regulation and document a complete rationale for the continued use of a PRN psychotropic medication including why the medication continues to be necessary and how it is benefiting the resident and whether or not those benefits outweigh the risks to the resident. She reviewed the medical record of Resident #1 and said simply documenting that the staff spoke with the Physician or NP or extending the order is not sufficient to prove the medication is necessary and documenting benefit outweighs risk is not sufficient to meet the facility policy or regulatory guideline; the rationale must be resident specific. She said it appears Resident #1 has not used the medication much since it's initiation and has settled into the facility well and is not likely to require any medication on a PRN basis at this time for their anxiety. She said when the medication is administered the Nurses should be documenting in a nurse's note why, if there was a behavior what it was and what the effects of the medication were and that documentation is also missing. She said the medical record for Resident #1 lacks rationale for a continual extension of the PRN Xanax or supporting documentation that is specific to the Resident's needs, behaviors, and mood and the facility had fallen short on meeting the standard for extending the psychotropic PRN for this Resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and document review, the facility failed to follow professional standards of practice for food safety to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Properly label and date food products stored in the free-standing refrigerators in the main kitchen and discard food when past their use by date; 2. Ensure food was properly stored in the walk-in freezer in the main kitchen; and 3. Ensure food was discarded when past their manufacturer's expiration date in one of two resident nourishment kitchen refrigerators reviewed. Findings include: Review of a facility document titled Labeling and Dating Inservice, undated, indicated but was not limited to the following: Guidelines for Labeling and Dating: -All foods should be dated upon receipt before being stored. Food labels must include: -The food item name -The date of preparation/receipt/removal from freezer -The use by date as outlined in the attached guidelines -Leftovers must be labeled and dated with the date they are prepared and the use by date Use By Dating Guidelines: -All Ready-to-Eat, Time/Temperature Control for Safety (TCS) foods that are to be held for more than 24 hours at a temperature of 40 degrees or less, will be labeled and dated with a prepared date (Day 1) and a use by date (Day 7) Review of a facility document affixed to the front of the refrigerator in the main kitchen indicated the following: Put a Label on the Tray With the Name of the Product/Day Produced/Use by Date: -Prepped trays of poured juice and milks, Example: Lunch drinks [DATE], UB (Use By) [DATE] (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Prepped trays of desserts, Example: Fruit cocktail [DATE], UB [DATE] 1a. On [DATE] at 7:40 A.M., the surveyor reviewed the free-standing double door refrigerator in the main kitchen and observed the following inside: Left door, top shelf: -one tray of poured beverages including orange juice (OJ) (7) and milk (1) in plastic cups with lids, and two 4-ounce (oz.) vanilla shake cartons, tray not labeled with name of product, day prepared, or use by date Left door, second shelf: -one tray of poured juices (25) and milk (3) in plastic cups with lids, tray not labeled with name of product, day prepared, or use by date Right Door, top shelf: -one container of thick & easy 32 oz. thickened dairy beverage, opened, approximately ,d+[DATE] full, not labeled with the date when opened or the use by date -one plastic container of thick & easy 46 oz. thickened OJ, opened, approximately ,d+[DATE] full, not labeled with the date when opened or the use by date -one container of imperial 46 oz. thickened lemon flavor water, opened, approximately ,d+[DATE] full, opened, not labeled with the date when opened or the use by date b. On [DATE] at 8:03 A.M., the surveyor reviewed the free-standing triple door refrigerator in the main kitchen and observed the following inside: Left door: -one tray of 11 prepared dessert bowls with lids, tray not labeled with name of product, day prepared, or use by date -one large plastic container of cranberry sauce labeled ,d+[DATE], not labeled with name of product, use by date 2. On [DATE] at 7:55 A.M., the surveyor reviewed the walk-in freezer and observed one large cardboard box opened with frozen omelets stored inside a plastic bag. The bag was not sealed and open to air, potentially exposing the contents to environmental contaminants. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:45 P.M., the surveyor reviewed the findings with the Food Service Director (FSD) and Consulting Staff #2. The FSD said when staff prepare liquid beverage trays, they pour the liquids in cups and are supposed to place a sticker on the tray that says the product name and the expiration date. He said beverage containers, once opened, also have to be labeled when opened and the use by date. The FSD said the use by date for pre-poured beverages and prepared desserts is three days. He said, once opened, containers of milk are only good for four days and containers of juices are only good for seven days. He said if it's not labeled then staff cannot determine when it was opened or the use by date. The FSD said the cardboard box of frozen omelets in the walk-in freezer should have been sealed and was no longer good. The FSD and Consulting Staff #2 said the cranberry sauce was beyond the use by date so needed to be discarded. 3. On [DATE] at 9:08 A.M., the surveyor reviewed the First Floor Unit nourishment kitchenette and observed the following stored inside the refrigerator: -one Yoplait yogurt, unopened, manufacturer's expiration [DATE], yogurt not disposed of -four Oikos yogurts, unopened, three of four labeled as prepared on [DATE], no use by date, manufacturer's expiration date for all four yogurts [DATE], yogurts not disposed of During an interview on [DATE] at 9:16 A.M., the surveyor reviewed the findings with Nurse #6 who said the yogurts were all expired and should have been disposed of. She said dietary staff label the foods, but if a family member brings in food and dietary staff aren't there, then unit staff will label. She said anything that's open is only good for three days, otherwise they go by the manufacturer's expiration. During an interview on [DATE] at 11:00 A.M., the FSD said dietary staff are responsible for checking for food expirations in the nourishment kitchenettes and said the yogurts should have been disposed of.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 48695 Based on document review and interview, the facility failed to conduct and implement a comprehensive facility wide assessment that was inclusive of resources necessary to provide both emergency and day to day care of the population the facility currently serves. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) memo titled Revised Guidance for Long-Term Care Facility Assessment Requirements, dated 6/18/24, indicated but was not limited to: -In conducting the facility assessment, the facility must ensure active involvement of the following participants in the process: - The facility's resident population, including, but not limited to: - The care required by the resident population; - The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and - Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. - The facility's resources, including but not limited to the following: - All buildings and/or other physical structures and vehicles; a. Equipment (medical and non-medical); b. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. - A facility-based and community-based risk assessment, utilizing an all-hazards approach Review of the Facility Assessment, last updated 1/28/25, failed to indicate: - The facility's resident population including but not limited to: - Resident specific care needs - The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. - The facility's resources, including but not limited to the following: - All buildings and/or other physical structures and vehicles; - Equipment (medical and non-medical); - Contracts or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. - A facility-based and community-based risk assessment. During an interview on 2/19/25 at 8:31 A.M., the Administrator said the facility assessment provided to surveyors on 2/19/25 at 7:00 A.M. was the most updated facility assessment. The Administrator said the Facility Assessment was missing key elements and was not specific to the facility. The Administrator said the facility assessment should have included the facility's resident population including care, resources, and facility needs, list of contracts and other agreements, and a facility-based and community-based risk assessment but did not. The Administrator said the facility assessment should have been more specific to the facility's population and needs.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43935 Based on record review and interview, the facility failed to maintain an accurate up to date medical record for one Resident (#1), out of a total sample of 21 residents. Findings include: Resident #1 was admitted to the facility in October 2024. During an interview on 2/13/25 at 1:10 P.M., Nurse #3 said all Physician and Nurse Practitioner (NP) progress notes are scanned into the electronic medical record under the tab labeled Miscellaneous. Review of the Miscellaneous section of Resident #1's medical record on 2/13/25 indicated only one progress note was available since the Resident's admission, completed by NP #2 and dated 11/27/24. Review of the census section of Resident #1's medical record indicated they had a paid hospital leave since their admission in October 2024 but has remained an active Resident since that admission. During an interview on 2/18/25 at 10:32 A.M., the Medical Records Clerk said the Physicians and NPs send their progress notes to the facility receptionist by email and then the receptionist places them in the correct resident records. She said although she is responsible for medical records she does not receive any physician or clinician progress notes and to check for potentially missing notes with the receptionist. During an interview on 2/18/25 at 12:54 P.M., the Receptionist said all the Physician and NP progress notes are sent to her by email and she then scans them into the correct resident record under the miscellaneous section immediately. She said, on review, that she did not have any other notes in her email for Resident #1 at this time and everything she had was in the Resident's medical record. During an interview on 2/18/25 at 5:12 P.M., NP #2 reviewed the medical record for Resident #1 and said she is surprised that her note from 11/27/24 is the only progress note in the medical record and wonders if anyone at the facility has records, they may not have uploaded yet, since this couldn't be possible. She was informed the person who receives the emails confirmed they did not have any additional documents for Resident #1's record and she said she would speak with the team. Review of the medical record on 2/19/25 indicated additional Physician and NP notes were placed in Resident #1's medical record for November 2024, January 2025 and February 2025. During an interview on 2/19/25 at 10:12 A.M., the Director of Nurses said the Resident should have had all their documents from their physician visits in the medical record at the time they occurred and she believes there may have been an issue with the physician's computer system and contacted him for additional information. She agreed the documents were from before and after the 11/27/24 visit and the documents should have been part of the medical record to reflect an accurate portrayal of the Resident.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Some	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 48695 Based on interviews and review of the Health Care Facility Reporting System (HCFRS- State agency reporting system), the facility failed to provide written notice to the State agency when a change in the facility's Administrator occurred. Findings include: During an interview on 2/12/25 at 8:43 A.M., the Administrator said that he started working at the facility on 12/27/23 as the Administrator. Review of HCFRS indicated the last time the State was notified of an Administrator change for the facility was 10/30/23. Further review of HCFRS failed to indicate the State Agency was notified when the change took place for the current Administrator. During an interview on 2/16/25 at 1:04 P.M., the Director of Operations reviewed HCFRS and said the last time the Administrator information was updated for the facility was on 10/30/23. The Director of Operations said the Administrator had started at the facility on 12/27/23. The Director of Operations said he thought the information had been updated by the previous Director of Nursing, but it had not.

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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. 48695 Based on record review and interview, the facility failed to ensure that the Quality Assurance Committee identified quality deficient areas and implemented an appropriate corrective action plan, to ensure satisfactory outcomes. Specifically, the facility failed to develop and implement a Quality Assurance Performance Improvement (QAPI) plan and a Performance Improvement Project (PIP) that focused on a high risk or problem-prone area identified through data collection and analysis. Findings include: Review of the facility's policy titled QAPI Facility Plan, dated 3/4/2024, indicated but was not limited to: - The QAPI Plan is designed to establish and maintain an organized facility wide program that is data-driven and utilizes a proactive approach to improving quality of care and services throughout the facility. This is a living document that will continue to be refined and revised. - The QAA (Quality Assurance and Assessment) Committee's overall responsibility is to develop and modify the plan, analyze information, and set priorities for PIPs. Priority will be given to issues identified as high risk, high volume and those that fall within problem prone areas. - The facility uses a systemic approach to determine when an in-depth analysis is needed to fully understand the problem, its causes, and the complications of change. The facility uses a thorough and highly organized/structured approach to determine the root cause of the identified problems. The facility will utilize a variety of tools to describe the current process we use. - Each Performance Improvement Project (PIP) subcommittee will identify areas of improvement. Data will be collected during this process and then analyzed to determine the effectiveness of change. The PIP sub-committee will provide the QAA Committee with a summary report, analysis of activities, and recommendations. - The Committee shall maintain written meeting agendas, minutes, attendance records, and QAPI program progress reports. - The Committee will complete an annual review of the QAPI program. - The facility seeks to prioritize projects in high risk, high frequency and/or problem prone areas that impact quality of care and quality of life for our residents and conducts one improvement project annually based on these areas. - PIPs are reported by the project lead to the monthly QAA Committee meeting and documented in the meeting minutes. - The QAA Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The QAA Committee will review the key elements of the program to ensure they are occurring, that the program is efficient, and the results are being communicated to the appropriate audience. During an interview on 2/19/25 at 2:19 P.M., the Administrator said the QAPI committee meets and discusses concerns monthly and quarterly but there was not a tracking method, written goals, and quarterly or annual comparison on a project. The Administrator said there are QAPI projects that have been completed but they are not tracked month after month and are just done and completed within one month. The Administrator said there was not a way to track if QAPI projects were effective or needed to be re-evaluated because they are not monitored. The Administrator said up until January's QAPI meeting he did not keep meeting notes or keep track of past QAPI projects. The Administer said he did not have a current PIP, nor did he have one last year. The Administrator said he should have documented and tracked things better. At the end of the survey, the facility failed to provide the survey team with any additional documentation or evidence of QAPI minutes or PIPs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42742 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed for one Resident (#72), out of a total sample of 21 residents, to ensure that staff performed hand hygiene after doffing (removing) gloves and prior to donning (putting on) new gloves during a wound dressing change to help prevent the potential for healthcare-associated infections. Findings include: Review of Lippincott Nursing Procedures, Eighth Edition. [Philadelphia; Wolters Kluwer, [2019], indicated, but was not limited to the following: - Hand Hygiene is a general term used by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) to refer to hand washing, antiseptic hand washing, and antiseptic hand rubbing. Hand hygiene is the single most important procedure in preventing infection. Using an alcohol-based hand sanitizer is appropriate for decontaminating the hands before putting on gloves, after removing gloves, and wound dressings (if hands aren't visibly soiled). Always perform hand hygiene before putting on gloves to avoid contaminating the gloves with microorganisms from your hands. Review of the facility's policy titled Handwashing/Hand Hygiene, undated, indicated but was not limited to the following: -This facility considers hand hygiene the primary means to prevent the spread of infection. -Use of an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: m. after removing gloves -Hand hygiene is the final step after removing and disposing of personal protective equipment. -The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Resident #72 was admitted to the facility in June 2024 and had diagnoses including a pressure ulcer of the sacral region, stage 4 (full-thickness loss of skin and tissue) and dysphagia (difficulty swallowing) with gastrostomy tube (G-tube-a surgically inserted tube that provides access to the stomach to deliver nutrition, medicine, and fluids) placement. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 2/18/25 at 2:13 P.M., the surveyor observed Resident #72's G-tube site with Nurse #4 who cleansed it with saline wash and gauze, then disposed of the gauze and her gloves in a plastic trash bag. Nurse #4 donned a new pair of gloves to perform a sacral wound dressing change. Nurse #4 did not perform hand hygiene after removing her gloves and prior to donning a new pair of gloves. Nurse #4 cleansed the sacral wound with wound wash and gauze then disposed of the gauze and her gloves in the trash. Nurse #4 donned a new pair of gloves to apply the calcium alginate, collagen sheet, and bordered gauze to the wound. Nurse #4 did not perform hand hygiene after removing her gloves and prior to donning a new pair of gloves. Nurse #4 completed the dressing change and doffed her gloves in the trash. Nurse #4 donned a new pair of gloves to fasten the Resident's brief and cover him/her with linens without performing hand hygiene first. The surveyor reviewed the observations with Nurse #4 who said she should have performed hand hygiene in between changing her gloves but got nervous and said she didn't have any hand sanitizer in the room with her, but should have brought some in. During an interview on 02/18/25 at 4:19 P.M., the Director of Nursing said staff are expected to perform hand hygiene in between each glove change.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 43935 Based on interview, record review, and document review, the facility failed to implement their antibiotic stewardship program by failing to monitor the use of dual antibiotics for one Resident (#43), who did not meet criteria for a urinary tract infection (UTI) using the facility's pre-defined McGeer criteria, out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Infection Prevention and Control Program, undated, indicated but was not limited to the following: - The elements of the infection prevention and control program consist of oversight, coordination, policies/procedures, surveillance, data analysis antibiotic stewardship, outbreak management and prevention of infection and employee health and safety. Antibiotic Stewardship: - culture reports, sensitivity data and antibiotic usage reviews are included in surveillance activities - medical criteria and standardized definitions of infections are used to help recognize and manage infections - antibiotic usage is evaluated and practitioners are provided feedback on reviews Review of the facility's policy titled Antibiotic Stewardship, dated as revised 9/25/23, indicated but was not limited to the following: - The purpose of the antibiotic stewardship is to improve the use of antibiotics in the facility to protect and reduce the threat of antibiotic resistance and to monitor the use of antibiotics in the residents. - when a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued - the clinical team will review infections to ensure the antibiotic stewardship program is being followed. During an interview on 2/12/25 at 9:25 A.M., the Infection Preventionist (IP) said the facility uses McGeer criteria to determine if illnesses and symptoms of illnesses rise to the standardized definition of infections. Review of McGeer criteria in use by the facility indicated the following criteria for a UTI: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Syndrome: Urinary Tract Infection (UTI) without indwelling catheter Criteria: Must fulfill both 1 and 2 1. At least one of the following sign or symptom Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate Fever or leukocytosis, AND greater than 1 of the following: Acute costovertebral angle pain or tenderness, Suprapubic pain Gross hematuria, New or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency * If no fever or leukocytosis, then greater than 2 of the following: Suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency 2. At least one of the following microbiologic criteria 50,000 cfu/mL of no more than 2 species of organisms in a voided urine sample 20,000 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter Review of the January 2025 facility surveillance and antibiotic tracking form indicated, but was not limited to the following: Resident #43 was categorized as a UTI with onset of symptoms as of 1/12/25 that included change in mental status/confusion and a positive urine C&S with E-Coli as the germ and a treatment of Augmentin (an antibiotic); Comment: started Bactrim DS - changed to Augmentin, dates: 1/13-1/20 The facility surveillance and antibiotic tracking form indicated the Resident only had one symptom and a positive C&S and therefore did not meet criteria for a UTI but was treated with antibiotics. Review of the Minimum Data Set (MDS) assessment, dated 1/20/25, indicated Resident #43 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 5 out of 15, and received antibiotic medication. Review of the progress notes for Resident #43 from 1/12/25 through 1/20/25, indicated but were not limited to the following: - 1/12/25 at 7:15 P.M., vomited once a tan substance - question meds, family aware, expresses concerns for general decline, feels Resident may have an infection such as UTI, would like Resident started on a broad spectrum antibiotic, wants physician (MD/DO) or Nurse Practitioner (NP) notified, NP messaged (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/12/25 at 7:41 P.M., per NP start Augmentin (an antibiotic) 500-125 milligrams (mg) one tab by mouth twice daily for 7 days and obtain urine for urinalysis (UA) and C&S - 1/13/25 at 2:05 P.M., Resident started on antibiotics, spike a temp of 101.2, received acetaminophen with good effect, reported to doctor and order for chest x-ray (CXR) and Bactrim DS (an antibiotic) by mouth twice daily for three days - 1/13/25 at 10:46 P.M., continues on antibiotic treatment for UTI, afebrile (without a fever) - 1/15/25 at 6:28 A.M., continues on Augmentin and Bactrim DS for infection - 1/16/25 at 6:34 A.M., continues on Augmentin and Bactrim DS for infection - 1/16/25 at 3:26 P.M., continues on Augmentin, Bactrim DS last dose given occasional dry cough, results of C&S reported to NP, no new orders continue Augmentin - 1/17/25 at 2:59 P.M., continues on Augmentin for UTI - 1/20/25 at 3:41 P.M., vomited twice, cough present, appears fatigued, MD in facility to assess, chest x-ray ordered The notes failed to indicate that the physician was made aware that the Resident was already receiving Augmentin when an order was received to start Bactrim DS Review of the January 2025 Medication Administration Record (MAR) indicated but was not limited to the following for Resident #43: - Augmentin 500-125 mg one tablet by mouth two times a day from 1/13/25 through 1/19/25 was received as ordered for infection. - Bactrim DS 800-160 mg one tablet by mouth twice a day from 1/13/25 through 1/16/25 was received as ordered for infection. The MAR indicated the Resident was receiving two separate antibiotics at the same time for an illness that did not meet the facility's infection criteria. During an interview on 2/13/25 at 1:15 P.M., NP #1, who was the NP that prescribed the Augmentin antibiotic, would not say what criteria she used to determine if an antibiotic was necessary or not. She said the family is very difficult and they can only be educated for so long and then she just gives them what they want. She said she ordered the antibiotic as was requested by the family. On review of the Resident's progress notes, she said the Resident should not have been placed on a second antibiotic and the staff likely did not inform the MD the Resident was already being treated with Augmentin at the time that he ordered the Bactrim DS. During an interview on 2/14/25 at 7:42 A.M., the Attending Physician for Resident #43 said he was unaware the Resident was on Augmentin at the time he had ordered the Bactrim DS. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225453	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carvalho Grove Health and Rehabilitation Center	273 Oak Grove Avenue Fall River, MA 02723

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/18/25 at 11:03 A.M., the IP said the facility monitors antibiotic use in conjunction with the surveillance for illnesses that may meet McGeer criteria and rise to the level of infections. She said she typically tracks new orders for antibiotics and then reviews the McGeer criteria for the questioned illness to determine if the illness rises to the level of infection when completing the surveillance sheets. The IP reviewed the surveillance for Resident #43 and the medical record documentation for the Resident including incontinence documentation, nursing notes, urinalysis and C&S report, and physician and NP notes. The IP said the documentation indicated the urine was collected for testing on 1/12/25 at 11:45 P.M., and the first dose of Augmentin was received on 1/13/25 at approximately 8:00 A.M., and continued until the 7 days were complete. She said vomiting would not be a factor for UTI for the Resident as this is a common symptom for the Resident related to a diagnosis of gastroparesis and unless it is excessive she does not track it. She said even with the addition of the fever the Resident did not have enough criteria to indicate their illness met criteria for a UTI, using the facility defined McGeer criteria and the antibiotics should have gone through review to ensure the facility's antibiotic stewardship was not being violated. She said she was unaware that the Resident was receiving both the Augmentin and Bactrim DS and she should have completed a review and notified the physician or NP but she missed that in error and no review was completed in accordance with the facility antibiotic stewardship. She said Resident #43 receiving two antibiotics at the same time without verification of an infection or a review of the criteria with the clinicians was a violation of the facility antibiotic stewardship initiative.