STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225455	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Craneville Rehabilitation and Skilled Care Center	265 Main Street Dalton, MA 01226

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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 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. 44129 Based on record review and interview, the facility failed to provide timely Physician and/or Nurse Practitioner (NP) notification of a significant change in condition for one Resident (#61) out of three sampled residents. Specifically, the facility staff failed to notify the Physician and/or NP when the Resident was assessed to have low blood pressure readings, resulting in delayed interventions and transfer to the hospital. Findings include: Review of the facility's policy titled, Change in Resident Condition, dated April 2020 indicated but was not limited to: -The facility shall promptly notify the resident, his or her attending physician and resident representative of changes in the resident's medical/mental condition and/or status. -The nurse will notify the resident's attending physician or physician on call when there has been significant change in the resident's physical/emotion/mental condition. -Unless otherwise instructed by the resident, the nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status. Review of the website: https://medlineplus.gov/ency/article/002341.htm, titled Vital Signs, review date 2/2/23 and accessed 1/19/24 indicated the following: Normal vital sign ranges for the average healthy adult while resting are as follows: -Blood pressure (BP): between 90/60 millimeters of mercury (mmHg) and 120/80 mmHg. -Pulse: 60-100 beats per minute. Review of the website: https://medlineplus.gov/lab-tests/pulse-oximeter, titled Pulse Oximetry (test that uses a finger clip-like device called a pulse oximeter to measure oxygen levels in the blood) indicated the following: (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pulse Oximetry results are often given as oxygen saturation levels (SpO2). -A normal oxygen saturation level ranges between 95 percent (%) and 100%. Resident #61 was admitted to the facility in October 2023 with the following diagnoses: Diastolic Congestive Heart Failure (CHF - condition in which the heart muscle does not pump blood as well as it should causing fluid to build up in the lungs and legs), Atrial Fibrillation (A-fib - irregular heartbeat), frequent falls, and Dementia (organic disease of the brain with impairment of memory and progressive loss of intellectual functioning). Review of the Resident's Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST - medical orders that document an individual's wishes for life-sustaining treatments) indicated: -Transfer to hospital. Review of the Resident's medical record indicated that he/she suffered a fall on 11/18/23. The facility initiated scheduled neurological assessments (assessments that included blood pressure, temperature, pulse, respirations, pupil size and response, level of consciousness, speech, and motor responses) because the Resident was on anticoagulant medications (blood thinners medication that help to prevent blood clots) and hit his/her head on 11/18/23. Review of Resident's #61 electronic health record (EHR), Weights and Vitals Summary indicated: -the lowest BP recorded for October 2023, was 110/70 mmHg on 10/21/23. -the lowest BP recorded for November 2023, was 120/52 mmHg on 11/17/23. Review of the Neurological Assessment Sheet indicated the following: -11/18/23: during the 3:00 P.M. - 11:00 P.M. shift, the Resident's BP was recorded as 95/58 mmHg. -11/19/23 -11/20/23: during the 11:00 P.M. -7:00 A.M. shift, no VSs were recorded on neurological assessment sheet. -11/20/23: during the 3:00 P.M. to the 11:00 P.M. shift, the Resident's BP was recorded as 112/62 mmHg. -11/20/23 - 11/21/23: during the 11:00 P.M. to 7:00 A.M. shift, the Resident's BP was recorded as 80/56 mmHg. -11/21/23: during the 7:00 A.M. to 3:00 P.M. shift, the Resident's BP was recorded as 80/56 mmHg. Review of a Nursing Progress Note dated 11/21/23 at 12:48 P.M., indicated that Nurse #5 was unable to arouse the Resident after several attempts. The Resident appeared to have difficulty breathing and was observed to have audible gurgling sounds. Vital signs obtained were as follows: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Blood Pressure (BP): 80/79 mmHg -Pulse/ Heart Rate (HR): 48 -oxygen saturation (SpO2): 79% Oxygen (O2) was applied at a flow rate of 5 liters per minute (LPM). The Resident's SpO2 was documented as increasing to 97% then dropped back down to 84%. The Nurse Practitioner (NP) was available and able to assess the Resident and it was decided to send the Resident to the hospital for evaluation. Review of the NP Progress Note dated 11/21/23 indicated the following: -Resident was seen today for acute visit because the Nurse reported the Resident to be in respiratory distress. The NP noted the Resident's lungs sounded congested with SpO2 of 75% on room air (not using supplemental Oxygen). The Resident was then placed on supplemental Oxygen at 5 LPM and the SpO2 was now 82%. The Resident was not able to be aroused and was noted to be in acute respiratory failure (when the lungs are unable to deliver oxygen and remove carbon dioxide from the blood) with hypoxia (low oxygen levels). During an interview on 1//18/24 at 3:47 P.M., the Director of Nurses (DON) said that given the Resident's abnormal blood pressure obtained 11/20/23 - 11/21/23, Nurse #7 should have obtained a second reading to ensure the first reading was accurate, and if the BP results were accurate, Nurse #7 should have contacted the Physician or NP for further direction. The DON further said there was no evidence that the Nurse re-checked the Resident's blood pressure or contacted the Physician or NP, as required. During a telephone interview on 1/19/24 at 12:25 P.M., the NP said she was unaware of the Resident's abnormal blood pressures obtained on 11/21/23, and that the staff should have contacted the on-call Provider, as a BP of 80/56 mmHg is too low. The NP said the Nurse alerted her to the Resident's respiratory distress as soon as she noticed it. The NP reviewed her records during the telephone interview, and said she wrote her progress note at 12:22 P.M. on 11/21/23. The NP further said she wrote her notes immediately after an encounter with a Resident. The NP said once she saw the Resident, she knew he/she needed to be sent out to the hospital immediately and ordered the transfer. During a telephone interview on 1/19/24 at 1:00 P.M., Nurse #5 said when she arrived on duty on 11/21/23 at 7:00 A.M., the overnight Nurse (Nurse #7) told her (Nurse #5) that Resident #61 was restless most of the night, the Resident's blood pressure was on the low side, that Nurse #7 had just obtained a new set of vital signs and the Resident was stable. Nurse #5 said she went to check on the Resident after obtaining report from Nurse #7 and the Resident seemed very tired, however Nurse #5 did not think that was unusual since it was reported that he/she was restless most of the night. Nurse #5 said the Certified Nurses Aides (CNAs) alerted her to the Resident's restlessness around lunchtime, and upon checking on him/her, she knew immediately that he/she was not well. Nurse #5 said she was unable to arouse the Resident and his/her skin was cool to the touch. Nurse #5 said she then immediately obtained the Resident's vital signs, but could not recall to the surveyor what the exact numbers were, only that his/her blood pressure and oxygen saturation levels were both very low. Nurse #5 further said that she immediately called the DON and the NP, and the Resident was then sent emergently to the hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/19/24 at 1:20 P.M., Nurse #7 said she could not remember exactly what time she obtained the Resident's vital signs and recorded them on the Neurological Assessment Sheet. Nurse #7 said she thought the vital signs were obtained mid-shift on the 11:00 P.M.-7:00 A.M. shift. Nurse #7 said she remembered the blood pressure was low but could not recall the exact numbers. She further said that she obtained another set of vital signs, including blood pressure at the very end of the 11:00 P.M.-7:00 A.M. shift/ beginning of the 7:00 A.M.-3:00 P.M. shift and remembered telling the oncoming Nurse that the Resident's blood pressure was on the low side. Nurse #7 said she never contacted the MD or NP when either low blood pressure readings (on 11/20/23 - 11/21/23 11:00 P.M. - 7:00 A.M shift) were obtained because the Resident's other vital signs parameters were normal.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42741 Based on interviews and record review, the facility failed to provide the required Discharge/Transfer notices to the Resident and/or his/her Representative and the Office of the Long-Term Care Ombudsman for one Resident (#10) out of a total sample of 15 residents. Findings include: Review of the facility policy titled Discharge Policies: Transfer out of the facility or by death, revised 9/23, indicated the following: -Notification of a potential transfer or discharge of the resident must be made in writing 30-days prior or as soon as practicable .The transfer/discharge notice is issued and contains all required elements by regulation. -A copy of the transfer/discharge notice must be sent to the Ombudsman . Resident #10 was admitted to the facility in September 2019 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - refers to a group of diseases that cause airflow blockage and breathing-related problems). Review of the Resident's Medical Record indicated the Resident was transferred to the hospital on the following dates: -9/5/23 -11/22/23 Further review of the Resident's Medical Record indicated no evidence that a Notice of Transfer or Discharge form was provided to the Resident and/or Resident Representative or the Office of the Long Term Care Ombudsman for either hospitalization . During an interview on 1/17/24 at 12:54 P.M., the Director of Nurses (DON) said she was unable to locate the Notice of Transfer/Discharge forms for 9/5/23 or 11/22//23 for Resident #10. The DON further said the Medical Records department should send a list of discharges every month to the Office of the Long Term Care Ombudsman, however she was unable to determine or provide evidence that this had occurred as required. During an interview on 1/17/24 at 2:59 P.M., the DON said the process of updating the Ombudsman was broken, and there was no clear indication who should be updating the Ombudsman and that the Ombudsman had not been updated for Resident #10's transfers to the hospital on 9/5/23 and 11/22/23, as required.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interviews and record review, the facility failed to provide the required Notice of Bed-Hold Policy to the Resident and/or Resident Representative for one Resident (#10) out of a total sample of 15 residents. Findings include: Review of the facility policy titled Discharge Policies: Transfer out of the facility or by death, revised 9/23, indicated the following: -Before the facility transfers the resident to a hospital or therapeutic leave, the nursing facility must provide a copy of the facility Bed-Hold policy to the resident and if known, a family member or representative. Resident #10 was admitted to the facility in September 2019 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - refers to a group of diseases that cause airflow blockage and breathing-related problems). Review of the Resident's Medical Record indicated the Resident was transferred to the hospital on 11/22/23. Further review of the Medical Record indicated no evidence the Resident and/or Resident Representative received a Notice of Bed-Hold Policy and Return when he/she was hospitalized on [DATE]. During an interview on 1/17/24 at 12:54 P.M., the Director of Nurses (DON) said she was not able to locate the Notice of Bed-Hold Policy for the Resident's transfer on 11/22/23. During a follow-up interview on 1/17/24 at 2:59 P.M., the DON said that the Notice of Bed-Hold Policy is completed by nursing, a copy should have been sent to the hospital with the Resident and a copy should have been retained in the chart, however this did not occur.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42741 Based on observation, interview and record review, the facility failed to ensure that oxygen care and services were provided per the Physician's prescribing orders for one Resident (#20) out of a total sample of 15 residents. Specifically, for Resident #20, the facility failed to ensure the Resident's Oxygen flow rate was set at the ordered three (3) liters per minute (LPM - the rate at which Oxygen flows over a period of one minute) prescribed by the Physician. Findings include: Review of the facility policy titled Use of Oxygen, reviewed 9/23, indicated the following: -Oxygen is administered only on the order of the Physician. -Physician's order shall include liters of flow and vehicle of administration. -Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Resident #20 was admitted to the facility in June 2020 with diagnoses including Congestive Heart Failure (CHF - when the heart cannot pump blood as it should resulting in fluid buildup in the lungs and extremities [hands and legs]) and cardiomyopathy (disease of the heart muscle where it is difficult for the heart to deliver blood to the body, leading to heart failure). Review of the January 2024 Physician's orders indicated: -Oxygen continuously at 3 LPM via nasal cannula (tubing that sit just within the nostrils to deliver oxygen) . every shift with a start date of 9/21/2023. Review of the Resident's Care Plan titled Altered Cardiac Status initiated 6/26/20 indicated the following intervention: -Give Oxygen as ordered by the Physician, initiated 6/26/20. On 1/16/24 at 8:36 A.M., the surveyor observed the Resident lying in bed receiving Oxygen via nasal cannula with the flow rate set at 2 LPM. On 1/16/24 at 3:06 P.M., the surveyor observed the Resident seated in his/her wheelchair receiving Oxygen via nasal cannula and portable oxygen tank with the flow rate set at 2 LPM. On 1/17/24 at 8:33 A.M., the surveyor observed the Resident in bed receiving Oxygen via nasal cannula with the flow rate set at 2 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/17/24 at 8:57 A.M., the surveyor and Nurse #1 observed the Resident lying in bed receiving Oxygen via nasal cannula with the flow rate set at 2 LPM. Nurse #1 said the Resident had an order for his/her Oxygen to be set at 3 LPM and that the Resident was not able to adjust his/her Oxygen on his/her own. Nurse #1 further said each shift should be checking that the Oxygen is set at the correct oxygen flow rate and Resident #20's was not set at the correct flow rate ordered by the Physician.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44129 Based on interview and record review, the facility failed to ensure that one Resident (#40) out of a total sample of 15 residents, received dialysis care consistent with professional standards of practice. Specifically, the facility staff failed to monitor and track the Resident's fluid intake as ordered. Findings include: Resident #40 was admitted to the facility in June 2020 with a diagnosis of End Stage Renal Disease (ESRD - condition in which a person's kidneys stop functioning on a permanent basis) and dependent on renal dialysis (treatment that removes waste products and excess fluid from the blood). Review of the facility's policy titled Intake and Output, dated September 2023 indicated but was not limited to: -Purpose: to determine residents at risk and provide early intervention for dehydration/fluid overload. -All residents placed on fluid restriction will be on intake and output for the duration of their therapy. Review of the January 2024 Physician's orders included the following: Fluid restriction to 1200 milliliters (ml) per 24 hours. Nursing allowance 480 ml per 24 hours with medications and in between meals. Dietary allowance 720 ml per 24 hours. Nursing and Dietary allowance to be broken down as follows: *7:00 A.M.-3:00 P.M. shift: Nursing 300 ml, Dietary 480 ml *3:00 P.M.-11:00 P.M. shift: Nursing 90 ml, Dietary 240 ml *11:00 P.M.-7:00 A.M. shift: Nursing 90 ml Review of the January 2024 Medication Administration Record (MAR) indicated the following: -an area for each shift to document the total fluid intake (day, evening, and night) -an area for the night shift to document the cumulative fluid intake for each day. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the January 2024 MAR indicated no evidence the Resident's total daily fluid intake was monitored and documented for 12 out of 16 days. During an interview on 1/18/24 at 9:36 A.M., the Dialysis Nurse said it is common for residents on dialysis to have their fluid intake restricted. She further said consuming too much fluids may cause problems such as weight gain, swelling of the extremities, difficulty breathing, increased blood pressure and heart damage due to the body's inability to produce urine which normally rids the body of extra fluids. During an interview on 1/18/24 at 12:50 P.M., Nurse #6 said if a resident was on fluid restriction, the Nurse is supposed to monitor and record in the MAR the fluid amount given to the resident by the Nurse. Nurse #6 also said the Nurse is supposed to check the resident's meal trays and record the amount of fluids the resident consumes with each meal. During an interview on 1/18/24 at 1:30 P.M., Unit Manager (UM) #2 said the nursing staff were responsible for monitoring Resident #40's fluid intake to ensure that the Resident stayed within his/her allotted amount. UM #2 also said the nursing staff should document all of the fluid intake each shift on the MAR including the amount the Resident consumed with meals. During an interview on 1/18/24 at 3:30 P.M., the surveyor and the Director of Nurses (DON) reviewed the January 2024 MAR. The DON said that the staff Nurses should have been monitoring and recording the Resident's fluid intake, including fluids consumed with meals each shift, as well as ensured the daily totals were also recorded in the MAR but did not, as required. The DON further said it did not appear the nursing staff were monitoring and documenting the Resident's daily fluid intake with his/her meal trays consistently, therefore there was no way to know how much fluid the Resident consumed daily.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44129 Based on interview and record review, the facility failed to ensure that nursing staff possessed the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely. Specifically, the facility failed to provide documentation and could not verify that three Licensed Nurses (#3, #4, and #5) out of a sample of three Licensed Nurses, had completed orientation training/competencies (Nurse #3), or annual competencies (Nurse #4, Nurse #5) as outlined in the Facility Assessment Tool Findings include: Review of the Facility Assessment Tool, most recent revision undated, indicated but was not limited to the following: >Section 1.4: If we have a referral that we have screened and we are not certain we are able to care for the person, we would complete research to see what the needs are and to see if we are able to care for that person. -We will determine if we have the clinical competence and resources to care for that person. -We may be able to do some inservicing (education) to be sure our staff are competent and at times staff may need training regarding equipment. If we can do that and can demonstrate competency, we would be able to admit the patient. >Section 3.4: Staff Training and Education Competencies -We do a 2-day orientation for all staff and then within their own department they are on orientation with someone for a few weeks or as long as it takes for the department head to have a comfort level with their competence. -We do annual educations for all staff and staff have competencies to show they are competent to perform their job duties. During an interview on 1/18/24 at 1:46 P.M. with the Director of Nurses (DON) and the Staff Development Coordinator (SDC), the DON said competencies for clinical staff should be completed upon orientation to the facility, then annually, thereafter. The DON also said that competencies are done as needed if a situation warrants it. The DON said there was no orientation training checklist/competency completed for Nurse #3 and no annual competencies on file for Nurse #4 and Nurse #5.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42741 Based on interviews and record review, the facility failed to ensure that Pharmacy Recommendations were reviewed and implemented as agreed to by the attending Physician for one Resident (#20) out of a total sample of five residents. Specifically, the facility failed to ensure that a Pharmacy recommendation was reviewed by the attending Physician within 30 days, and that Pharmacist recommendations agreed to by the attending Physician were implemented. Findings include: Resident #20 was admitted to the facility in June 2020 with diagnoses including Heart Failure (when the heart muscle does not pump blood as well as it should), history of Myocardial Infarction (heart attack), and Cardiomyopathy (disease of the heart muscle where it is difficult for the heart to deliver blood to the body, leading to heart failure). Review of the January 2024 Physician's orders indicated the Resident had the following order: -Amiodarone (medication used to treat irregular heart beat that can effect thyroid hormone levels) HCl Tablet 200 milligram (mg) give by mouth one day daily, with a start date of 6/19/20. Review of the Pharmacist recommendations from 10/19/23 and 11/9/23 indicated the following recommendation: -Suggest TSH lab level with Amiodarone order. Further review of the 10/19/23 and 11/9/23 Pharmacist recommendations indicated the attending Physician reviewed and agreed to the recommendations to obtain a Thyroid Stimulating Hormone (TSH) lab level (lab that shows current level of thyroid hormone). Review of Resident #20's medical record indicated on 10/23/23, an order for a TSH lab draw was put into place. Further review of the Resident's medical record indicated that Resident #20 was being administered the Amiodarone medication as ordered and no documentation that the TSH lab was ever drawn. Review of the Pharmacist recommendation on 12/7/23, indicated that the Pharmacist again recommended a TSH lab level with Amiodarone order. Further review of the Pharmacist recommendation indicated no documentation that the attending Physician had reviewed or responded to the 12/7/23 recommendation. (continued on next page)

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Craneville Rehabilitation and Skilled Care Center	265 Main Street Dalton, MA 01226

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/17/24 at 11:16 A.M., Unit Manager (UM) #1 said the TSH lab was never obtained when it was ordered in October 2023 and should have been obtained as recommended by the Pharmacist and agreed to by the attending Physician. UM #1 further said the most recent Pharmacist recommendation on 12/7/23 had not been reviewed by the Physician and it should have been reviewed within 30 days.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42741 Based on observation, interview and policy review, the facility failed to ensure that food in three unit kitchenettes (Unit 1, Unit 2, and Unit 3) out of three units observed, were labeled and dated as required, and the cleanliness of the refrigerators and freezers were maintained to prevent contamination and the spread of food borne diseases. Findings include: Review of the facility policy titled Labeling and Storage of Food, dated 9/1/16 indicated the following: -All food must be discarded 3 days after it is opened. -All food belonging to a specific resident must be labeled with their name and the date that it was put in the refrigerator. Review of the facility policy titled Nourishment Kitchen Sanitation, reviewed 9/23, indicated the following: -The following tasks and the frequency are the responsibility of the Housekeeping Department .Weekly or more frequently as needed wash all refrigerator shelves and clean toaster . -The following tasks and the frequency are the responsibility of the Nutrition and Food Service Department . remove/discard unlabeled items, remove/discard undated items, remove/discard employee items -Keep refrigerator neat On 1/17/24 at 9:01 A.M., in the Unit 1 kitchen area, the surveyor observed the following: >in the refrigerator: -a large area on the bottom shelf was covered in a white liquid and splattered throughout the refrigerator. -a plastic bag containing a glass storage container with unidentified food and a muffin that was unlabeled and undated. -an odor of sour milk was noted when the refrigerator was opened. On 1/17/24 at 9:30 A.M., in the Unit 3 kitchenette, the surveyor observed the following: -in the bottom drawer of the refrigerator, a plastic container with orange colored unidentified food that was unlabeled and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	>in the freezer: -an open bag of frozen blueberries that was unlabeled and undated. -a frozen dinner that was unlabeled and undated. -a bottle of frozen sport drink that was unlabeled and undated. On 1/17/24 at 10:24 A.M., in the Unit 2 kitchenette, the surveyor observed the following: -the toaster was laden with crumbs in the crumb drawer. -a bag of ice open to air, with loose ice and black debris scattered on the bottom shelf of the freezer. On 1/18/24 at 7:24 A.M., on Unit 1, the surveyor and Nurse #5 observed the following: -in the refrigerator a large area of dried white/yellowish material covering the bottom shelf and also splattered throughout the upper shelves. -a plastic bag containing a glass storage container with unidentified food and a muffin that was unlabeled and undated. During an interview following the observation on 1/18/24, Nurse #5 said the kitchen staff stock the Unit refrigerator in the morning and in the evening and someone should have noticed the spill yesterday and cleaned it up before it became dried throughout the refrigerator. Nurse #5 also said the plastic bag should be labeled with a resident name and date, and she could not determine who the food in the plastic bag belonged to as it was unlabeled. On 1/18/24 at 7:30 A.M., on Unit 2, the surveyor and Dietary Staff #2 observed the following: -the toaster was laden with crumbs in the crumb drawer. -a bag of ice open to air, with loose ice and black debris scattered on the bottom shelf of the freezer. During an interview following the observation on 1/18/24, Dietary Staff #2 said the housekeeping staff maintained the cleanliness of the kitchenette. Dietary Staff #2 further said the toaster should be cleaned regularly and it did not appear that the toaster had been cleaned recently. She further said the toaster with all the debris in it not only could attract pests but it was also a fire hazard. Dietary Staff #2 also said there should not be an open bag of ice in the freezer and the shelf in the freezer should be free of loose ice and debris. On 1/18/24 at 7:19 A.M., on Unit 3, the surveyor, Nurse #4, and Dietary Staff #2 observed the following: -the freezer contained an unlabeled and undated frozen meal, an unlabeled and undated bag of frozen blueberries, and an unlabeled and undated bottle of frozen sports drink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-the refrigerator contained an unlabeled and undated take-out container of food. During interviews following the observation on 1/18/24 with Nurse #4 and Dietary Staff #2, Nurse #4 said all items in the refrigerator and freezer needed to be labeled with a resident's name and a date. Nurse #4 further said that she was unsure who the frozen meal, bag of frozen blueberries, frozen sports drink, and take-out container belonged to as the items were all unlabeled. Nurse #4 also said that the kitchen staff should clean any unlabeled food out of the refrigerator and freezer every day. Dietary Staff Member #2 said the night kitchen person should be cleaning out the refrigerator and freezer of any unlabeled food. During an interview on 1/18/24 at 7:35 A.M., Housekeeper #1 said she only cleans the resident rooms and floors in the common areas. Housekeeper #1 further said that she was unaware who cleaned the Units refrigerators and freezers. During an interview on 1/18/24 at 7:37 A.M., the Housekeeping Director said she was recently hired and was unsure of whose responsibility it was to maintain the cleanliness of the kitchenettes on the units. During an interview on 1/18/24 at 9:36 A.M., the Food Service Director (FSD) said all items in the unit refrigerators and freezers needed to be labeled with a resident name and the date the item was brought in. Items brought should only remain in the refrigerator or freezer for three days and the kitchen staff should be checking daily that all items are labeled with a resident name and date and if they are not, they are to be disposed. The FSD also said it was the housekeeping staff's responsibility to clean the kitchenettes on a daily basis but any staff member who noticed a shelf in a refrigerator or freezer had a spill or debris could wipe it up and should also notify housekeeping that it needed further cleaning. The FSD said the refrigerator on Unit 1 and freezer on Unit 2 should not have been left with spilled liquid and debris, as staff were regularly in and out of the refrigerators and freezers and someone should have noticed that cleaning was required.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, interview, record and policy review, the facility failed to adhere to infection control guidelines to prevent contamination and the spread of infection for two Residents (#40 and #47) out of three sampled residents. Specifically, the facility staff failed to: 1) implement the facility infection surveillance program and conduct Covid-19 outbreak testing for Resident's #40 and #47. Findings include: Review of the facility policy titled Infection Prevention and Control Guidelines for Patients with Confirmed 2019 Novel Coronavirus (2019-nCoV) or Persons Suspected for 2019-nCoV, reviewed 9/2023 indicated the following in part: -The Center for Disease and Control (CDC) and Massachusetts Department of Public Health (MA DPH) recommended guidelines for infection control practices related to Coronavirus will be followed. Review of the DPH Memorandum dated 5/10/23, with a subject titled: Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents, including Visitation Conditions, Communal Dining, and Congregate Activities, indicated the following: -Once a new case is identified in a facility, following outbreak testing, long-term care facilities should test exposed residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case unless a DPH epidemiologist directs otherwise. During an interview on 1/16/24 at 4:48 P.M., the Director of Nurses (DON) said that the facility began outbreak testing on 12/29/23 for all residents on Unit 3, due to one employee who had worked on Unit 3 testing positive for Covid-19. 1a) Resident #40 was admitted to the facility in June 2020. Review of the Resident's medical record indicated no documented evidence that the Resident had been tested on [DATE] or 1/2/23 following an employee exposure on 12/29/23. 1b) Resident #47 was admitted to the facility in June 2021. Review of the Resident's medical record indicated no documented evidence that the Resident had been tested on [DATE] following an employee exposure on 12/29/23. During an interview on 1/16/24 at 4:48 P.M., with the DON and Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP), the DON said that the facility began outbreak testing on Unit 3 on 12/29/23, as a result of a Covid-19 positive staff exposure. The DON said that staff were testing residents on Unit 3 every other day, until seven days had passed with no new cases. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/24 at 4:48 P.M., the surveyor and the DON reviewed Resident's #40 and #47's December 2023 and January 2024 Medication Administration Records (MARs), in addition to the Covid testing and reporting sheets kept in the residents paper charts. During an interview at the time, the DON said that Resident #40 was not tested for Covid-19 on 12/31/23 and 1/2/24, during an outbreak on Unit 3. The DON said the medical record indicated that the facility staff were unable to obtain a Covid-19 test, but did not indicate a reason why they were unable to complete the test. The DON said it may have been because Resident #40 was out of the facility for a scheduled appointment, but the staff should have conducted a Covid-19 test upon his/her return to the facility and did not complete the testing. The DON further said that Resident #47 was not tested on [DATE] as required. The DON said that the December 2023 MAR indicated the facility staff were unable to obtain a Covid-19 test for Resident #47 but did not indicate a reason why the test could not be obtained. The DON said the staff should have re-attempted obtaining the Covid-19 test but did not do so as required.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 42690 Based on observation, interview and policy review, the facility failed to maintain laundry equipment in a safe operating condition. Specifically, the facility staff failed to clean the lint traps of the laundry drying machines as scheduled per manufacturer's instructions and facility policy. Findings include: Review of the manual titled American Dryer Corporation, undated, indicated the following in part: -A program and/or schedule should be established for periodic inspection, cleaning, and removal of lint .The frequency of cleaning can be determined from experience at each location. -Lint from most fabrics is highly combustible. The accumulation of lint can create a potential fire hazard. Review of the facility Laundry Aid Training tool, undated, provided by the Maintenance Director, indicated the following: -Dryer lint traps must be cleaned every 2 hours - .Clean lint traps thoroughly. During an observation and interview on 1/16/24 at 10:27 A.M., the surveyor and the Maintenance Director observed the lint traps for two out of the two operational laundry dryers. The surveyor reviewed the lint trap cleaning schedule and noted that the lint traps had been signed off as being emptied at 10:00 A.M. on 1/16/24. When the surveyor requested removal of the lint doors for lint traps and lint screens observation, a solid layer of lint was found to be covering the lint screen and piles of lint were observed on the floor of the lint trap of the first operational dryer. The Maintenance Director said that there was quite a bit of lint in the lint trap of the first operational dryer and that it needed to be cleaned. During a follow-up interview on 1/16/24 at 11:15 A.M., the Maintenance Director said that the lint trap and screen had more lint build-up in it than there should have been. She said that the lint screen was a solid layer of lint and there was a pile of lint in the corners on the floor of the lint trap that should not have been there. During a follow-up interview on 1/16/24 at 11:40 A.M., Maintenance Staff #1 said that the Laundry Aide who was working at the time of the initial observation told Maintenance Staff #1 that she did not think there was enough lint to be cleaned out of the lint traps at the time. Maintenance Staff #1 further said that the Laundry Aide checked the lint traps and checked off the 10:00 A.M. cleaning schedule as if the lint trap had been cleaned.