STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225458	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairhaven Healthcare Center	476 Varnum Avenue Lowell, MA 01854

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review and interview, the facility failed to provide a dignified existence for one Resident (#317) out of a total sample of 24 Residents. Specifically, the facility failed to utilize a privacy bag while Resident #317's urinary catheter bag was visible and in use. Findings include: Review of the facility policy titled Resident Rights Policy and Procedures, revised and dated 9/18/23, indicated the following: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence. Resident #317 was admitted to the facility in October 2024 with diagnoses including acute and chronic respiratory failure with hypoxia and type 2 diabetes mellitus. Review of Resident #317's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status score of 13 out of a possible 15 indicating intact cognition. The MDS further indicated that Resident #317 is dependent on staff for toileting hygiene. The surveyor made the following observations: - On 10/21/24 at 8:01 A.M., Resident #317 was sleeping in his/her bed. A urinary catheter bag with visible yellow urine was hanging from the bed. The urinary catheter bag could be seen from the Resident's doorway in the hallway. No privacy bag was in use. - On 10/21/24 at 12:57 A.M., Resident #317 was in his/her room eating lunch while sitting in his/her wheelchair. The Resident's urinary catheter bag was clipped to the left arm rest of the wheelchair with yellow urine visible. The urinary catheter bag was visible from the Resident's doorway in the hallway. No privacy bag was in use. - On 10/22/24 at 6:47 A.M., Resident #317 was sleeping in his/her bed. A urinary catheter bag with visible yellow urine was hanging from the bed. The urinary catheter bag could be seen from the Resident's doorway in the hallway. No privacy bag was in use. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 10/22/24 at 8:21 A.M., Resident #317 was laying in his/her bed awake, eating breakfast. A urinary catheter bag with visible yellow urine was hanging from the bed. The urinary catheter bag could be seen from the Resident's doorway in the hallway. A privacy bag was observed next to the hanging urinary catheter bag but was not in use. - On 10/22/24 at 9:47 A.M., Resident #317 was laying in his/her bed. A urinary catheter bag with visible yellow urine was hanging from the bed. The urinary catheter bag could be seen from the Resident's doorway in the hallway. A privacy bag was observed next to the hanging urinary catheter bag but was not in use. - On 10/23/24 at 6:58 A.M., Resident #317 was sleeping in his/her bed. A urinary catheter bag with visible yellow urine was hanging from the bed. The urinary catheter bag could be seen from the Resident's doorway in the hallway. No privacy bag was in use. Review of Resident #317's physician's orders dated 10/16/24 indicated the following: - Foley Catheter care every shift - Replace foley bag monthly the 16th every month - Insert foley catheter 16fr (French) with 5ml (milliliter) balloon. - Change foley catheter bag as needed During an interview on 10/23/24 at 8:56 A.M., Nurse #3 said all urinary catheter bags should have a privacy bag when in use so they cannot be seen from the hallway. Nurse #3 and the surveyor observed Resident #317's urinary catheter bag from the hallway and she said it should have a privacy bag covering it. During an interview on 10/23/24 at 9:02 A.M., the Assistant Director of Nursing said Resident #317 should have a privacy bag over his/her catheter bag when in use.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed to ensure person-centered care plans with measurable goals and individualized interventions were developed and implemented for two residents (#58 and #94), out of 24 sampled residents. Specifically: 1. For Resident #58 the facility failed to develop a plan of care related to the prevention of pressure ulcers. 2. For Resident #94, the facility failed to develop comprehensive pacemaker care plan. Findings include: 1. Resident #58 was admitted to the facility in June 2024 and has diagnoses that include adult failure to thrive, type 2 diabetes mellitus, and need for assistance with personal care. During an observation and interview on 10/21/24 at 9:41 A.M., Resident #58 was laying on his/her bed without sheets under him/her. Resident #58 said he/she was incontinent and staff stripped his/her bed. Review of the Minimum Data Set (MDS), assessment dated [DATE], indicated Resident #58 scored a 14 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having intact cognition, and requires set up/clean up assistance with toileting and is at risk of developing pressure ulcers. Review of the comprehensive MDS dated [DATE] indicated at section M that Resident #58 was at risk for developing pressure ulcers. Review of the Care Area Assessment (CAA) Pressure Ulcer/Injury indicated Resident is at risk of PI (pressure injury) r/t (related to) needing assistance with ADLs (activities of daily living) and incontinence and a pressure ulcer/injury will be addressed in a care plan. Review of the Norton Plus (an assessment that determines the level of risk for developing pressure ulcers/injuries) completed for Resident #58 indicated the following: -6/7/24 assessed score of 12 moderate risk. -6/21/24 assessed score of 11 moderate risk. -6/28/24 assessed score of 10 high risk. -7/5/24 assessed score of 11 moderate risk. Review of Resident #58's care plans failed to indicate a care plan for the risk of developing pressure ulcers/injuries was developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 9:16 A.M., Certified Nursing Assistant (CNA) #3 said Resident #58 requires assistance with daily care. CNA #3 said the Resident wears a brief and is incontinent of urine. During an interview on 10/23/24 at 9:41 A.M., Nurse #5 said Resident #58 is incontinent of bladder. Nurse #5 said incontinence is a risk for developing pressure ulcers and Resident #58 should have a risk for pressure injury care plan. During an interview on 10/23/24 at 9:45 A.M., Unit Manager #4 said incontinence puts a resident at risk for skin breakdown. Unit Manager #4 said Resident #58 is incontinent of bladder and should have a risk for skin breakdown care plan. 46339 2. Review of the facility policy titled Pacemaker Checks', dated April 2024, indicated the following: Identify type and identification number of pacemaker resident/patient has on admission and note same in medical record. Document in the medical record. Resident #94 was admitted to the facility in August 2023 with diagnoses that include presence of cardiac pacemaker. Review of Resident #94's most recent Minimum Data Set (MDS) dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15 indicating he/she had moderate impaired cognition. Review of Nursing- Admission readmission-V2 assessment dated [DATE] indicated the Resident had a pacemaker upon admission. Review of the Resident medical record failed to indicate a care plan was developed for the pacemaker. During an interview on 10/22/24 at 11:18 A.M., Unit Manager #1 said that the Resident's pacemaker was new and that a care plan should have been developed. During an Interview on 10/23/24 at 12:10 P.M., the Assistant Director of Nursing (ADON) said a care plan for pacemaker should have been developed.

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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** 46339 Based on observation, record review and interview, the facility failed to meet professional standards of quality for three Residents (#61, #40 and #78), out of a total of 24 residents. Specifically: 1. For Resident #61, the facility failed to apply wound care dressing per physician orders. 2. For Resident #40, the facility failed to apply hand rolls to both hands per physician orders. 3. For Resident #78, the facility failed to provide 15-minute checks and ensure a wanderguard was in place per physician orders. Findings include: 1. Resident #61 was admitted to the facility in October 2024 with diagnoses including need for assistance with personal care. Review of Resident #61's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 14 out of a possible 15 indicating intact cognition. The MDS further indicated that the Resident is at risk of developing pressure ulcers/injuries and is dependent on staff for activity of daily living care. On 10/23/24 at 11:17 A.M., the surveyor observed Nurse #3 prepare to perform a wound dressing change for Resident #61. Nurse #3 was observed removing a soiled silicone dressing from the Resident's buttock. The silicone dressing had no date or initials. Review of Resident #61's physician's order dated 10/21/24 indicated the following: Treatment Order (cleanse with wound cleanser and apply collagen and bordered gauze) Location: (coccyx/right buttock). During an interview on 10/23/24 at 11:36 A.M., Nurse #3 said the silicone foam dressing was the incorrect treatment applied. Nurse #3 said there was no shortage of the border gauze dressing. During an interview on 10/23/24 at 12:05 P.M., the Assistant Director of Nursing (ADON) said nursing staff should follow the orders as ordered and follow facility protocols for wound care treatment. 48671 2. Resident #40 was admitted to the facility in August 2015 with diagnoses including quadriplegia, contracture right elbow, contracture left elbow, and dementia. Review of Resident #40's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15, indicating he/she has moderate cognitive impairment. Further review indicated Resident #40 is dependent on staff for all functional tasks. (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 #40's active physician's orders indicated the following: -Hand rolls at night daily every evening shift for Contractures. Dated: 12/08/2023 -Hand rolls off every day shift for Contractures. Dated 12/28/2023 Review of Resident #40's Occupational Therapy (OT) discharge summary dated 3/11/24, included the following information: Patient will safely wear least restrictive splining /orthotic device night hours only without complaints of discomfort in order to improve ability to participate with self-feeding. Review of the OT In-Service training dated 3/6/24 indicated the following: -Topic Splint care and universal cuff use during meals. -Resident should wear comfy palm roll splints overnight. Review of Resident #40's care plans failed to indicate the use of bilateral hand rolls. On 10/21/24, at 7:29 A.M., the surveyor observed Resident #40 laying in bed sleeping. Resident #40 was not wearing bilateral hand rolls. The hand rolls were not visible in the room. A hand written sign was observed hanging behind the Residents bed that indicated Please put hand rolls in hands at night when he/she sleeps. Thanks Rehab. On 10/22/24, at 7:21 A.M., the surveyor observed Resident #40 laying in bed sleeping. Resident #40 was not wearing bilateral hand rolls. The hand rolls were not visible in the room. A hand written sign was observed hanging behind the Residents bed that indicated Please put hand rolls in hands at night when he/she sleeps. Thanks Rehab. During an interview on 10/22/24, at 1:05 P.M., Certified Nursing Assistant (CNA) #7 said the Resident cannot move his/her fingers well and said the Resident did not have on hand rolls when she came in this morning and said she has never seen Resident #40 wearing them. During an interview on 10/22/24 at 9:04 A.M., Nurse #7 said she was unaware that Resident #40 had hand rolls and said she did not see hand rolls on the Resident. During an interview on 10/22/24 at 1:21 P.M., Unit Manager #4 said she was not aware of the Resident requiring hand rolls and said staff should be placing them on in the evening and removing them in the morning as the order is written. Unit Manager #4 said she would find hand rolls for the Resident. During an interview on 10/23/24 at 9:14 P.M., the Assistant Director of Nurses (ADON) said Resident #40 was receiving occupational therapy and should be wearing bilateral hand rolls as ordered. During an interview on 10/23/24 at 11:43 P.M., the Director of Nurses (DON) said Resident #40 should have been wearing the hand rolls and said orders should be followed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #78 was admitted to the facility in February 2024 with diagnoses including major depressive disorder, traumatic brain injury, acute pain due to trauma, anxiety, alcohol abuse, suicidal ideations, cognitive communication deficit, and expressive language disorder. Review of Resident #78's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating he/she has moderate cognitive impairment. Review of Resident #78's active physician's orders indicated the following: -15 minute checks for safety every shift for Safety, for 14 Days. Start Date:10/15/2024. Review of the Nurse Practitioner progress note dated 10/17/24, indicated: Resident #78 had an unwitnessed fall and was found on the floor at bedside. The Resident was agitated and verbally aggressive towards staff. Resident refused assessment and was transported to the hospital after making SI/HI statement. Review of the Nursing Progress note dated 10/16/24 indicated: Safety precautions in place. Call light within reach. Recommendations: Continue to monitor with 15-minute checks for safety. Review of Resident #78's Falls care plan dated 2/27/24, indicated Resident #78 is at risk for falls due to history of fall with injury - s/p (status post) fall with comp fx (compound fracture) 3/3/24- unwitnessed fall in room, 4/15/24 - witnessed fall in parking lot. Dated as revised 5/23/24. The falls care plan failed to indicate the need for 15-minute checks. On 10/22/24 from 8:35 A.M. to 9:11 A.M., the surveyor observed Resident #78 in his/her room sitting in a wheelchair with a breakfast tray place on the overbed table. No staff were observed providing 15-minute checks to Resident #78 and no staff were visible in the hallway walking by or looking into Resident #78's room throughout the observation. At 9:12 A.M., a staff member walked into Resident #78's room to remove the breakfast tray. During an interview on 10/22/24 at 12:48 P.M., Behavioral Health Nurse Practitioner (NP) #2 said Resident #78 had a recent fall and was sent to the hospital and said he/she has a history of behaviors with recent suicide ideations. NP #2 said Resident #78 has been doing well and is currently on 15-minute checks for safety after the fall. During an interview on 10/22/24 at 1:39 P.M., Unit Manager (UM) #4 said Resident #78 is on 15 minute checks for safety for recent falls and history of behaviors. UM #4 said she expects staff to conduct 15-minute checks and to follow the physician orders. UM #4 said staff are to document safety checks in the binder and showed the surveyor the binder and said staff should not document checks that were not completed. During an interview on 10/23/24 at 9:37 A.M., The Assistant Director of Nursing said 15 minute safety checks were implemented due to a recent fall and said Resident #78 reported his/her call light in bathroom was not working. The ADON said Resident #78 has a history of behaviors and requires 15-minute checks for safety but is not an elopement risk. (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 10/23/24 at 12:14 P.M., the Director of Nurses (DON) said Resident #78 is behavioral and said 15 minute checks were implemented for safety. The DON said Resident #78 could be harmful to him/herself and staff must follow physician orders.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, record review, policy review and interviews, the facility failed to provide supervision with meals for one Resident, (#44) out of a total sample of 24 residents. Findings include: Review of the facility policy titled Activities of Daily Living (ADL) dated as revised April 2024, indicated A program of activities of daily living (ADL) is provided to residents to maintain or restore maximum functional independence. The ability of each resident to meet the demands of daily living is assessed by a licensed nurse and/or other members of the interdisciplinary team. A program of assistance and instruction in ADL skill is developed and implemented based on the individual evaluation to encourage the highest level of functioning. This process is reviewed minimally quarterly. Resident #44 was admitted to the facility in March 2017 with diagnoses including dysphasia, hyperlipidemia, failure to thrive and bipolar disorder. Review of the Minimum Data Set (MDS) assessment, dated 9/1/2024, indicated Resident #44 did not have a Brief Interview for Mental Status (BIMS) assessment completed. Further review of the MDS indicated Resident #44 is dependent on staff for all functional tasks. On 10/21/24 at 8:45 A.M., the surveyor observed Resident #44 in bed, breakfast was set up on the overbed table, and the Resident was attempting to eat the meal. Eggs were observed on the Residents chest, overbed table and floor. The Resident was not visible from the hallway, no staff were present in the room throughout the breakfast meal. On 10/22/24 from 8:18 A.M. to 8:59 A.M., the surveyor made the following observations: Resident #44 was sitting up sleeping in bed, the breakfast tray was placed on the overbed table. The Resident was not visible from the hallway, no staff were present in the room. At 8:55 A.M., the surveyor observed a staff member walk into the Residents room and set up breakfast items on the overbed table, pour milk into the cereal bowl and exit the room. The Resident remained sitting up sleeping. The Resident was not visible from the hallway, and no staff were present in the room. At 8:58 A.M., the surveyor observed a staff member walk into Resident #44's room and remove the breakfast items from the overbed table and exit the Residents room. The Resident remained sitting up in bed sleeping. The staff member made no attempts to arouse Resident #44 throughout the observations. Review of Resident #44's nutrition care plan indicated has a potential for impaired nutrition status due to variable po (oral) intake with the following interventions: EATING: Supervision 1:8 ratio with occasional assist (assistance) of one. Resident prefers to eat meals in his/her room. Staff assist him/her to sit upright in his/her chair, and provide set-up help and cues for all meals. [NAME] mug (thermal mug) with cover at all meals. Dated 3/24/17. Allow the resident adequate time to consume meals Dated 3/28/2017. He/she may refuse meals at times. Diet liberalized to encourage eating. Staff to offer him/her extra portions of the foods he/she may enjoy. Dated: 9/09/2024 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident # 44's CNA (Certified Nursing Assistant) Resident Care Card (form indicating level of care) indicated the following: -Eating- Independent, assist into chair and set up for all meals. -Provide mug with lid for hot liquids. During an interview on 10/22/24 at 12:57 A.M., CNA #6 said Resident #44 needs help with eating because he/she needs reminders. CNA #6 said staff use the Kardex and care cards to see what level of assistance each resident requires and said she documents care in the computer. During an interview on 12/23/24 at 11:49 A.M., the Director of Nursing said she expects staff to follow the care plan and provide supervision to residents if indicated and said Resident #44 should not be eating alone.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed to provide the necessary treatment and services for two residents (#37 and #61) with pressure ulcers, out of a total sample of 24 residents. Specifically: 1. The facility failed to implement soft booties to Resident #37's feet in accordance to the medical plan of care. 2. The facility failed to implement the treatment orders for a pressure ulcer as recommended by the wound physician for Resident #61. Findings include: Review of the facility's policy titled 'Prevention and Management of Pressure Injuries, dated 7/23 included but not limited to indicates the following: Policy: Residents with pressure injuries and those at risk for skin breakdown are identified, assessed and provided with appropriate treatment to encourage healing and/or maintenance of skin integrity. Care Plans are developed based on individual resident's goals and decisions for treatment. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. The facility follows NPUAP (National Pressure Injury Advisory Panel) guidelines when staging wounds. Wound treatments: Wound treatments are done per MD (medical doctor) order. 1. Resident #37 was admitted to the facility in May 2016 and has diagnoses that include but are not limited to chronic obstructive pulmonary disease, moderate protein calorie malnutrition, neoplasm of unspecified part of right bronchus or lung, and bipolar disorder. Review of the most current Minimum Data Set assessment, dated 9/21/24 indicated Resident #37 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating he/she as having moderately impaired cognition, is dependent on staff for bed mobility and dressing, does not display behaviors, is at risk for developing pressure ulcers and has two pressure ulcers. During an observation and interview on 10/21/24 at 8:40 A.M., Resident #37 was lying on an air mattress. Resident #37 said he/she could not walk, that he/she had a dressing on his/her feet that the nurse changes. Both of Resident #37's feet were observed with nonskid socks on a flat pillow. Resident #37's feet/heels were flat on the pillow and not offloaded. On 10/21/24 at 1:37 P.M., Resident #37's was observed in bed wearing slipper socks, his/her legs were on a flat pillow and his/her feet were directly on the air mattress. On 10/21/24 at 4:13 P.M., Resident #37 was observed in bed, wearing slipper socks on both feet, with his/her feet on a pillow and his/her heels on the air mattress. One soft pillow was loose in the bed. On 10/22/24 at 8:41 A.M., Resident #77 was in bed, with his/her left foot in a soft bootie and a nonskid slipper sock on his/her right foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #37's physician's order indicated the following: -wash right ankle with Vashe, pat dry, apply CMS fiber and cover with silicone border dressing daily and PRN (as needed) dated 8/27/24. -soft booties to both feet while in bed, every shift for redness to right ankle, dated 9/1/23. Review of Resident #37's care card failed to indicate the use of soft booties. During an interview on 10/22/24 at 12:38 P.M., Nurse #5 said Resident #37 has an open area on his/her right ankle and it has been there for a few months. Nurse #5 said the area is macerated around the wound with slough in the wound bed. Nurse #5 said they provide a treatment for the wound per the orders. During an interview on 10/23/24 at 8:21 A.M., Certified Nursing Assistant (CNA) #4 said Resident #37 requires his/her feet to be on a pillow or booties. CNA #4 said the Resident should have the booties on while in bed. CNA #4 said the booties may have been in the laundry and that is why they were not on. During an interview on 10/23/24 at 8:42 A.M., Nurse #5 said Resident #5 should have soft booties on both feet while in bed. Nurse #5 said yesterday (10/22/24) she put on one soft bootie on his/her foot with the ankle wound. Nurse #5 said the other bootie may have been in the laundry. During an interview on 10/23/24 at 12:23 P.M., the Assistant Director of Nursing said staff are to go to the laundry to get the soft booties and to make sure Resident #37 is wearing the soft booties per the orders. 45984 2. Resident #61 was admitted to the facility in October 2024 with diagnoses including heart failure and chronic respiratory failure with hypoxia. Review of Resident #61's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 14 out of a possible 15 indicating intact cognition. The MDS further indicated that the Resident is at risk of developing pressure ulcers/injuries and is dependent on staff for activity of daily living care. Review of Resident #61's wound care evaluation performed by the wound physician dated 10/21/24 indicated the following: Pressure Ulcer Coccyx, stage 3. Treatment Recommendations: Cleanse the wound with normal saline moistened gauze, apply collagen with silver, cover with silicone border foam dressing QD (once daily) and PRN (as needed). Review of a nursing progress note dated 10/21/24 created by Nurse #3 indicated the following: Dressing changed. Applied collagen and bordered gauze to R (right) buttock/coccyx. Review of Resident #61's physician's order dated 10/21/24 indicated the following: Treatment Order (cleanse with wound cleanser and apply collagen and bordered gauze) Location: (coccyx/right buttock) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #61's document titled Pressure Ulcer Evaluation dated 10/22/24 indicated that the Resident had a Stage 3 Pressure ulcer on his/her right buttock and is followed by wound care. Review of Resident #61's Treatment Administration Record for October 2024 indicated the following treatment on 10/22/24 and 10/23/24: Treatment Order (cleanse with wound cleanser and apply collagen and bordered gauze) Location: (coccyx/right buttock) On 10/23/24 at 11:15 A.M., the surveyor observed Nurse #3 perform treatment on Resident #61's right buttock/coccyx wound. The surveyor observed Nurse #3 apply collagen cream on the wound, not collagen with silver. During an interview on 10/23/24 at 11:29 A.M., Nurse #3 said the wound doctor comes in on Mondays and the Assistant Director of Nursing (ADON) shadows the wound doctor. Nurse #3 said when the wound doctor makes wound treatment recommendations, she tells the ADON so they can get implemented. The surveyor and Nurse #3 reviewed the wound doctor's recommendations for collagen with silver, the surveyor asked Nurse #3 why the active order in the electronic medical record is for collagen and not collagen with silver and Nurse #3 was not sure. Nurse #3 said she just follows the orders as they are written. When asked what the difference between collagen and collagen with silver was, Nurse #3 was not sure. During an interview on 10/23/24 at 11:38 A.M., the ADON said she will get the wound doctor recommendations by the following day at the latest. The ADON said the silver in collagen has antimicrobial benefits and helps with wound healing. The ADON said she would expect the wound doctor's recommendations to be followed. During a follow up interview on 10/23/24 at 12:07 P.M., the ADON said she spoke with the wound doctor and Resident #61 should be receiving collagen with silver and it was an oversight by the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observation, record review and interview the facility failed for one Resident (#76), out of a total sample of 24 residents, to ensure interventions to maintain his/her safety were implemented in accordance to the plan of care. Findings include: Resident #76 was admitted to the facility in July 2022 and has diagnoses that include dysthymic disorder (dysthymia is a chronic form of depression), anxiety, and diabetes. Review of the Minimum Data Set (MDS) assessment, dated 10/7/24, indicated Resident #76 had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 which indicated intact cognition. Review of MDS indicated that Resident #76 requires setup assistance with meals. Review of Resident #76's incident report dated 8/30/24 indicated that Resident #76 suffered burns from spilled hot coffee to the suprapubic area and bilateral thighs and was sent to the emergency room for evaluation. Corrective measures indicated in the incident report include the following: -Facility coffee cups with be served with lids. -The resident has an insulated coffee cup with a lid and has been educated to use this for his/her coffee. -A cup holder will be provided for his/her wheelchair to enable easier mobility. -Education has been provided for his/her wheelchair to enable easier mobility. -Education has been provided for safety rounds during meals/activities. Review of Resident #76's skin care plan dated 8/30/24, indicated Resident #76 received bilateral thigh, scrotal and suprapubic burns from a spilled coffee and included the following intervention: Resident will use a covered cup/mug or covered Styrofoam cup per patient preference with all hot liquids to avoid further burns. Review of Resident #76's ADL (Activities of Daily Living) care plan dated as revised 8/30/24, indicated the following interventions: Eating- [NAME] mug with cover at all meals. All hot liquids should be covered or a covered Styrofoam cup may be used per patient request. During observations throughout the survey Resident #76 failed to have a cup holder attached to his/her wheelchair. Review of Resident #76's diet slip did not indicate the need for lids with coffee. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/24 at 8:39 A.M., the surveyor observed Resident #76 seated in a wheelchair in the communal dining room during the breakfast meal. Resident #76 picked up a blue mug containing hot coffee and began to drink from the mug. The mug did not have a lid. There was no lid placed on the table. Staff were present in the dining room passing out hot coffee and beverages. There was no cup holder attached to the wheelchair. On 10/22/24 at 12:16 P.M., the surveyor observed Resident #76 seated in a wheelchair in the communal dining room during the lunch meal. Staff were present in the dining room passing out hot coffee and beverages. Staff placed a blue mug containing coffee in front of Resident 76. The mug did not have a lid. Resident #76 picked up a blue mug containing hot coffee and began to drink from the mug. There was no cup holder attached to the wheelchair. During an interview on 10/22/24 at 1:38 P.M., Unit Manager #4 said Resident #76 requires coffee with lids due to a burn and said he/she should not be given hot coffee without a lid. Unit Manager #4 said Resident #76 may refuse a lid, but staff should encourage the use of the lid. On 10/23/24 at 8:05 A.M., the surveyor observed Resident #76 seated in a wheelchair in the communal dining room during the breakfast meal. Staff were present in the dining room passing out hot coffee and beverages. Staff placed a blue mug containing coffee in front of Resident 76. The mug did not have a lid. Resident #76 picked up a blue mug containing hot coffee and began to drink from the mug. There was no cup holder attached to the wheelchair. During an interview on 10/23/24 at 8:39 A.M., the Food Service Director (FSD) said Residents who require a lid with coffee will have diet slips indicating that lids are required. The FSD said nursing will fill out a pink dietary communication slip and she will update it in the system. The FSD said she did not have a communication slip for Resident #76 and the diet slip should indicate lids with hot coffee. During an interview on 10/23/24 at 9:30 A.M., the Assistant Director of Nursing (ADON) said Resident #76 should be given coffee with lids due to a history of burns from coffee and said his/her diet slip should say coffee with lids. The ADON said he/she will refuse the lids, and he/she will rip it off due to no safety awareness. The ADON said Resident #76 can eat unsupervised, but he/she should be given coffee with lids. During an interview on 10/23/24 at 12:15 P.M., the Director of Nursing said Resident #76 had burns due to spilled hot coffee and said staff should not be passing out coffee without lids and said care plan interventions are to be followed. The DON said the diet slip should indicate the need for lids.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interviews, the facility failed to ensure services to maintain continence were implemented for one Resident (#58), out of a total sample of 24 residents. Specifically, for Resident #58 the facility failed to evaluate his/her incontinence and failed to develop a person-centered plan of care with individualized interventions for bladder incontinence. Findings include: Review of the facility's policy titled, Bladder and Bowel Continence Evaluation and Management Planning, dated April 2024, indicated the following: Resident/patients who are incontinent of urine or bowel will be identified, evaluated and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible and within the capability of the resident. Procedure: Upon admission or re-admission, a 3-day observation tool will be conducted to determine the resident's level of continence of both bladder and bowel. Based upon this information the next step would be to complete a Bladder and Bowel Evaluation to determine the appropriate program for the resident who is identified with bladder or bowel incontinence. The Bladder and Bowel Evaluation will additionally be completed annually, quarterly and when a significant change is identified. A 3-day Observation tool may be initiated at any time to determine a consistent level or continence or incontinence or to be utilized in the development of a Re-training program of an Individualized Toileting Program. Establish, implement, review and revise as necessary, a plan of care for any resident/patient at risk for bladder incontinence, and any resident/patient with bladder incontinence. The plan of care should be individualized, and management should be based on the resident/patient's Bladder and Bowel Evaluation and 3-day Observation Tool which direct the staff towards a program likely to be the most beneficial to the residents. Resident #58 was admitted to the facility in June 2024 and has diagnoses that include adult failure to thrive, type 2 diabetes mellitus, and need for assistance with personal care. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #58 scored a 14 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having intact cognition, and requires set up/clean up assistance with toileting. During an observation and interview on 10/21/24 at 9:41 A.M., Resident #58 was laying on his/her bed without sheets under him/her. Resident #58 said he/she was incontinent, and they stripped his/her bed. Resident #58 said he/she wears a brief and does not always know when he/she has the urge. Review of Resident #58's medical record indicated the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A 'Nur-Bladder and Bowel' evaluation dated 6/7/24 indicated Resident #58 as continent of bladder, no further evaluation needed. -The Care Area Assessment (CAA) of the MDS dated [DATE] indicated Resident #58 requires assistance with toileting and has episodes of incontinence and the urinary incontinence will be addressed in a care plan. -The MDS dated [DATE] indicated at section H, Resident #58 does not have a toileting program and is occasionally incontinent of bladder. -The MDS dated [DATE] indicated at section H, Resident #58 does not have a toileting program and is frequently incontinent of bladder. Review of the MDS's dated 6/13/24 and 9/11/24 indicate that Resident #58 experienced a decline in urinary continence going from occasionally incontinent of bladder to frequently incontinent of bladder. Further review of Resident #58's medical record failed to indicate a care plan for urinary incontinence with individualized interventions was developed. The record also failed to indicate any further 'Nur-Bladder and Bowel' evaluation was implemented and any 3-day Observation tool was completed to determine if Resident #58 could benefit from a toileting program related to the determination of the type of incontinence he/she experiences. During an interview on 10/23/24 at 9:16 A.M., Certified Nursing Assistant (CNA) #3 said Resident #58 requires assistance with daily care and often refuses assistance, so you must give him/her time and reapproach. CNA #3 said Resident #58 wears a brief and is incontinent of urine. CNA #3 said Resident #58 had urinary incontinence since he/she was admitted . CNA #3 said Resident #58 will attempt to go to the bathroom to change his/her brief. CNA #3 said she was not aware of Resident #58 having a toileting plan. During an interview on 10/23/24 at 9:35 A.M., Nurse #5 said Resident #58 is incontinent of urine all the time and believed he/she was incontinent of urine since he/she was admitted a few months back. Nurse #5 said Resident #58's bed will be wet in the morning and the Resident will remove his/her sheets. Nurse #5 said during the day Resident #58 will attempt to toilet him/herself or change his/her brief. Nurse #5 said she did not know if any evaluation was done to determine what type of incontinence, and she would need to ask the unit manager. Nurse #5 said residents with incontinence usually have a plan of care in place. During an interview on 10/23/24 at 9:45 A.M., Unit Manager #4 said at admission residents are assessed for Bladder and Bowel to determine if they are continent of bladder and bowel. Unit Manger #4 said the CNAs will document on the Activities of Daily Living sheets if a resident is incontinent of bladder and are to report if a resident has a change in continence. Unit Manager #4 said Resident #58 tries to be independent and he/she uses incontinence briefs and will go to the bathroom to change his/her briefs. Unit Manager #4 said she was not aware if Resident #58 was assessed with a 3-day observation tool to assist in determining a plan for Resident #58. Unit Manager #4 said Resident #58 should have a care plan for urinary incontinence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 10:50 A.M., the Director of Nursing said Resident #58's admission Bowel and Bladder evaluation indicated he/she as continent of bladder on admission. The DON said a new assessment should have been triggered after admission. The DON said a quarterly Bladder and Bowel evaluation should have been completed at the time of the quarterly MDS. The DON said a 3-day bladder voiding trial should have been completed to determine the type of bladder incontinence Resident #58 has and to determine if he/she would benefit from a toileting plan. The DON said a care plan for bladder incontinence should have been developed.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure staff implemented interventions related to weight loss for one Resident (#13) out of a total of 24 sampled residents. Findings include: Review of the facility's weight policy, dated August 2023, indicated: Policy: the facility residents are weighted weekly, monthly, or as needed following MD orders. - All weight loss/gain of three or more pounds or more on a resident weighing 100 pounds or less and weight loss/gain of five pounds or more on a resident weighing 100 pounds or more requires a reweigh for verification. - Weights are documented in the resident's/patient's medical record and/or weight book. - If a significant weight loss/gain is identified (greater than 5% in 30 days or greater than 10% in 6 months), the IDT (interdisciplinary team), Dietitian, Physician and Family are notified. - All residents with a significant weight loss are reviewed by the Interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly. Resident #13 was admitted to the facility in July 2022 with diagnoses including dementia and lactose intolerance. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she was severely cognitively impaired evidenced by a score of six out of a possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated Resident #13 required supervision/touching assistance for meals. On 10/21/24 at 8:39 A.M., the surveyor observed Resident #13 resting in bed. Resident #13 was unable to participate in the interview process due to his/her cognitive status. Resident #13 presented as thin and frail. Review of Resident #13's weights indicated the following: 4/2/24: 145.7 lbs (pounds) 5/2/24: 142.7 lbs 6/2/24: 136 lbs 7/2/24: 132.6 lbs (a total loss of 8.99% of his/her body weight in three months) 7/25/24: 128.2 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/1/24: 130 lbs lbs 8/8/24: 126.8 lbs (a total loss of 12.97% of his/her body weight in four months) 8/28/24: 127 lbs 9/2/24: 123.2 lbs (a total loss of 15.4% of his/her body weight in five months) 10/2/24: 124.4 lbs 10/10/24: 123.6 lbs 10/18/24: 121.5 lbs (a total loss of 16.61% of his/her body weight in six months) Additional review of the clinical record indicated that the Dietitian recommended interventions related to Resident #13's weight loss which included limiting/avoiding lactose (implemented in July 2024) and fortified foods (implemented in August 2024). Review of the Dietitian Evaluation dated 9/4/24, indicated: Wt (weight) loss continues despite addition of fortified foods. Recommend Mighty Shakes BID (twice daily) d/t (due to) sig (significant) wt loss. Will continue to monitor wt and [intake] for indications for further intervention. Review of Resident #13's physicians orders, and Treatment Administration Record dated September 2024 indicated the Dietitians recommendation for Mighty Shakes twice daily was not implemented. Review of the Dietitian Note dated 10/10/24, indicated: His/Her appetite is decreased, possibly r/t (related to) pain . He/She receives fortified foods r/t (related to) sig wt loss. Recommend Mighty Shake TID (three times daily) d/t continued sig wt loss and decreased appetite. Review of Resident #13's physicians orders indicated an order for Mighty Shakes three times daily was initiated on 10/11/24. During an interview on 10/22/24 at 11:39 A.M., Certified Nursing Assistant (CNA) #1 said Resident #13's appetite is variable. During an interview on 10/22/24 at 1:44 P.M., Physician #1 said that recommendations made by the Dietitian for supplements should be initiated immediately after being reviewed by the physician or Nurse Practitioner (NP). On 10/23/24 at 8:30 A.M., the surveyor observed Resident #13 eating breakfast in the dining room eating small bites of his/her meal. During an interview on 10/23/24 at 9:05 A.M., Family Member #1 said that Resident #13 had been losing weight and staff have been in touch with her to keep her updated on changes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 10:21 A.M., the Dietitian said when he makes recommendations for the use of supplements he puts the order in the electronic record which is then reviewed before being initiated. The Dietitian said he was not aware that the recommendations for Mighty Shakes twice daily were not implemented in September 2024. During an interview on 10/23/24 at 11:38 A.M., Unit Manager #1 said that when residents are having weight loss, the team discusses their status at Risk Meetings and the Dietitian will make recommendations. Unit Manager #1 said that the Dietitian puts the orders in the electronic record which is then reviewed by the Physician or Nurse Practitioner. During an interview on 10/23/24 at 1:05 P.M., the Director of Nursing (DON) said that when a resident loses weight, the team meets and discusses interventions like fortified food and supplements. The DON said that either the Dietitian or Nursing inputs the orders into the electronic record which is then approved by the Physician or Nurse Practitioner. The DON said that interventions should be implemented right away and was not aware that the Dietitians recommendations for twice daily Mighty Shakes were not implemented in September 2024.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, record review and interview, the facility failed to provide respiratory care services in accordance with professional standards of practice for three Residents (#317, #77, #42) out of a total sample of 24 Residents. Specifically, the facility failed to: 1. Ensure oxygen filters were in use while Resident #317 was receiving oxygen via nasal cannula 2. Ensure oxygen filter was clean, oxygen tubing was dated and labeled and CPAP (continuous positive airway pressure) machine was clean and stored in a sanitary way. 3. Ensure oxygen filter was clean, oxygen tubing was dated and labeled, distilled water was changed and dated, and BIPAP (bilevel positive airway pressure) machine was clean and stored in a sanitary way. Findings include: Review of facility policy titled 'Oxygen Administration Nasal Cannula' dated April 2024, indicated the following but not limited: -To deliver low flow oxygen per physician's order. -Oxygen source. Review of facility policy titled 'CPAP/BiPAP Management' dated April 2024, indicated the following but not limited to: -Masks and nasal pillows wash daily with mild detergent (rinse thoroughly with warm water to remove all detergent and residue air dry. 1. Resident #317 was admitted to the facility in October 2024 with diagnoses including acute and chronic respiratory failure with hypoxia and type 2 diabetes mellitus. Review of Resident #317's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status score of 13 out of a possible 15 indicating intact cognition. The MDS further indicated that Resident #317 requires oxygen therapy. The surveyor made the following observations: - On 10/21/24 at 8:01 A.M. and 8:43 A.M., Resident #317 was sleeping in his/her bed receiving oxygen via nasal cannula. The oxygen machine did not have any external filters in place. - On 10/21/24 at 12:57 A.M., Resident #317 was in his/her bedroom sitting in his/her wheelchair receiving oxygen via nasal cannula. The oxygen machine did not have any external filters in place. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 10/22/24 at 7:10 A.M.,, Resident #317 was sleeping in his/her bed receiving oxygen via nasal cannula. The oxygen machine did not have any external filters in place. Review of Resident #317's physician's order dated 10/8/24 indicated the following: Oxygen at 4-10 LPM (liters per minute) via NC (nasal cannula) continuously every shift Review of Resident #317's oxygen therapy care plan dated 10/8/24 indicated the following intervention: Oxygen Settings: O2 (oxygen) via nasal prongs @ 4-10 liters continuously. During an interview on 10/22/24 at 12:45 P.M., Unit Manager #3 and the surveyor observed Resident #317's oxygen concentrator machine. Unit Manager #3 and the surveyor observed the oxygen machine to not have any external filters on either side. The surveyor asked Unit Manager #3 if the machine was supposed to have filters on it and she was unable to answer the question and said she would go ask the Assistant Director of Nursing (ADON). During an interview on 10/22/24 at 1:03 A.M., the ADON observed the oxygen machine and said there were no external filters. The ADON said she was not sure if it should have filters since it is a high flow oxygen machine. At 1:16 P.M., the ADON said she would expect the oxygen machine to be ready for use once delivered but will need to review the oxygen machine's operator's manual. Review of the oxygen concentrator's operator's manual indicated there was a spot for cabinet filters on the sides of the machine. Further review of the manual indicated instructions for routine cleaning of the oxygen filters indicating they should be in use while the machine is operating. During an interview on 10/22/24 at 1:28 P.M., the surveyor and ADON reviewed the manual and she said filters should be in place on Resident #317's oxygen concentrator machine. On 10/23/24 at 11:14 A.M., a representative from the company that provided Resident #317's oxygen concentrator arrived at the facility with external filters. He said the machine should have filters on it. 46339 2. Resident #77 was admitted to the facility in January 2024 with diagnoses including dependence on other enabling machines and devices (CPAP). Review of Resident #77's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 10 out of possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she was moderately cognitively impaired. On 10/22/24 at 8:15 A.M., the surveyor observed the oxygen concentration in Resident #77's room with a thick layer of dust on the filter. The CPAP machine was visibly dirty and laying on the bedside table. On 10/22/24 at 11:13 A.M., the surveyor and Nurse #1 observed the oxygen concentrator with a thick dust covered filter, the tubing was undated, the CPAP mask was laying on the bedside table. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician order dated 1/10/2024 indicated the following: CPAP to be worn at bedtime. Settings set between 8-20 with 2 liters per minute oxygen every evening shift for insomnia. Review of the Treatment Administration Record (TAR) for October 2024, indicated the Resident had been wearing the CPAP at night for the past 17 consecutive nights. There was no documented refusal to wear the CPAP. During an interview on 10/22/24 at 11:22 A.M., Nurse #1 said he did not know how often the oxygen filter was changed and how often the CPAP cleaning was one. During an interview on 10/22/24 at 11:24 A.M., Unit Manager #1 said the oxygen tubing and filters are changed weekly, and the CPAP mask should be cleaned daily. During an interview on 10/23/24 at 9:24 A.M., the Assistant Director of Nursing (ADON) said the oxygen tubing, filters are changed weekly on 11-7 shift and are stored in a bag with name and room number and the CPAP mask is cleaned daily and air dried. 48671 2. Resident #42 was admitted to the facility in February 2024 with diagnoses including dependence on other enabling machines and devices BIPAP, (bilevel positive airway pressure machine that delivers air through a mask on your face), chronic obstructive pulmonary disease, obstructive sleep apnea, dependency on supplemental oxygen, chronic respiratory failure with hypoxia, and morbid obesity. Review of Resident #42's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she was cognitively intact. On 10/21/24 at 8:15 A.M., the surveyor observed Resident #42 sleeping in bed wearing oxygen. The oxygen tubing was dated 3/10/24. The concentrator had one 540 ml (milliliter) bottle of sterile water connected and was dated 6/7/24. There was one clear bag hanging off the side of the concentrator with a label which indicated: Date issued 9/23/24. Time: 0645. Equipment in use; BIPAP connecting tubing. The concentrator had a thick layer of dust covering the entire filter. The BIPAP machine was located on the bedside table and contained no water. The facemask was visibly dirty with discolored yellow and tan flakes and stains covering the entire facemask. On 10/22/24 at 7:56 A.M., the surveyor observed Resident #42 sleeping in bed. The oxygen tubing was dated 3/10/24. The concentrator had one 540 ml bottle of sterile water connected and was dated 6/7/24. There was one clear bag hanging off the side of the concentrator with a label which indicated: Date issued 9/23/24. Time: 0645. Equipment in use; BIPAP connecting tubing. The concentrator had a thick layer of dust covering the entire filter. The BIPAP machine was located on the bedside table and contained no water. The facemask was visibly dirty with discolored yellow and tan flakes and stains covering the entire facemask. Review of Resident #42's active physician orders indicated the following: -Oxygen as needed via nc (nasal cannula) at 2 LPM (liters per minute) as needed as needed [SIC] for keep sas [SIC] >90% Start Date: 08/29/2023. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Change O2 tubing every Sunday on the 7 am to 3 pm shift. In the morning every Sunday. Dated 6/5/22. -Change BIPAP tubing every Sunday 7 AM - 3 PM one time a day every Sun. Dated 2/12/23. -Change distilled water at bedtime every evening shift. Dated 12/28/21. -Clean filter weekly with soap and water rinse and dry on Friday. Dated 12/31/21. -Tubing wash bi-monthly with mild detergent soap and rinse with water air dry wipe BIPAP machine with damp cloth on the 1st and 15th every month for BIPAP maintenance. Dated 3/15/22. -Wash mask everyday with soap and water air dry on 7-3 shift every day shift. Dated 12/29/21. -BIPAP on at all time while resident is sleeping/taking a nap. Every shift. Dated 1/4/23. -BIPAP setting auto BIPAP 15 max IPAP 5 min EPAP bleed in 2L/min oxygen every shift. Dated 10/11/23. Review of the Treatment Administration Record (TAR) for October 2024, indicated the Resident had been wearing the BIPAP at night for the past 20 consecutive nights. There was no documented refusal to wear the BIPAP. Further review of the TAR indicated the following: -O2 tubing was documented as changed on 10/20/24 -BIPAP tubing was documented as changed on 10/20/24. -Distilled water was documented as changed 12 of the 20 documented days during the month of October. The last documented change was 10/20/24. -The filter was documented as cleaned with soap and water on 10/18/24. -The BPAP tubing was documented as changed on 10/20/24. -The mask was documented as last washed on 10/21/24. During an interview on 10/22/24 at 1:02 P.M., Certified Nursing Assistant (CNA) #7 said the Nurses clean the oxygen and BIPAP equipment and put it on the resident when he/she needs it. On 10/22/24 at 12:34 P.M., the surveyor observed the oxygen tubing changed dated 10/22/24. The concentrator had a new one 540 ml (milliliter) bottle of sterile water connected and was dated 10/22/24. There was one clear bag hanging off the front of the concentrator labeled Date 10/22/24. The concentrator still had a thick layer of dust covering the entire filter. The BIPAP machine was located on the bedside table and contained no water. The facemask was cleaned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 1:25 P.M., Unit Manager #4 said she went into Resident #42's room while he/she was outside and changed out the respiratory and BIPAP equipment, washed the facemask and equipment and removed the old water and dated the tubing because sometimes the Resident will refuse and it is easier to change it when he/she is not in the room. UM #4 said the oxygen tubing and filters are changed every Sunday and said the BIPAP equipment needs to be cleaned daily and air dried. UM #4 said tubing needs to be dated weekly and stored in a bag with name and room number. UM #4 said physician orders must be followed and if the Resident is refusing care it needs to be documented by the nurses in the TAR and not documented as administered. During an interview on 10/23/24 at 9:24 A.M., the Assistant Director of Nursing (ADON) said the oxygen tubing and filters are changed weekly, and the BIPAP mask should be cleaned daily. During an interview on 10/23/24 at 11:47 A.M., the Director of Nursing (DON) said staff must follow physician orders for respiratory care and cleaning and said the tubing must be dated appropriately and changed according to the order. The DON said the filters and masks must be checked and cleaned weekly. The DON said Resident #42 should not have distilled water attached to the concentrator that is outdated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interviews, the facility failed for one Resident (#11), out of a total sample of 24 residents, to ensure professional standards of care and treatment for hemodialysis (a treatment where a machine removes blood from your body, filters it through a dialyzer (artificial kidney) and returns the cleaned blood to your body). Specifically, the facility failed to adhere to emergency care practices for the use of a venous catheter, failed to have a person-centered care plan with individualized interventions and failed to ensure communication between the facility and dialysis treatment center was consistent according to the medical plan of care. Findings include: Review of the facility's policy titled, 'Hemodialysis dated April 2024, included but was not limited to the following: To provide comprehensive care to residents/patients that receive hemodialysis treatments. Procedure Admission Assessment: Determine the type of hemodialysis access device. Care of Venous Catheter: -Hemodialysis catheters are not to be accessed by any nurse at the facility. -Perform hand hygiene before and after the assessment of venous catheter. -Assess the insertion site every shift for the following and document: a. Pain, b. Infection. C. Fever/chills, d. Bleeding, e. Dislodgement. -Keep dressing clean and dry. -Keep catheter taped to skin to prevent pulling -Showers/Baths should not be given. -A non-serrated clamp is to be kept bedside for emergencies. Communication -Communication between the facility and the hemodialysis center will occur using a communication book/sheet that consist of: a. vital signs, b. Cope of MAR, c. Any change of condition from last dialysis treatment i.e., i. Changes in weight, ii. Falls -Documentation will be completed prior to dialysis treatment, -The communication book/sheet will be reviewed upon return from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #11 was admitted to the facility in October 2022 with diagnoses of end stage renal disease, and dependence on renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #11 scored a 12 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately impaired cognition, is dependent on staff for bathing and dressing and is on dialysis. During an interview and observation on 10/21/24 at 7:51 A.M., Resident #11 said he/she has a chest port for dialysis because the fistula in his/her arm did not work. Resident #11 pulled the top of his/her shirt down, revealing a catheter with a dressing, and a double lumen extending down from the dressing. Resident #11 said the dialysis staff take care of the chest port. No emergency items including a clamp were in the Resident's immediate area. During an interview on 10/22/24 at 3:16 P.M., Resident #11 said he/she always had the chest port even when he/she had a left arm fistula. Resident #11 said he/she was not aware of any supplies used for emergency care of the chest catheter. Further, Resident #11 said he/she returned from dialysis a few hours ago and his/her communication book was in his/her dialysis bag. Review of Resident #11's physician's orders indicated the following: -An order dated 10/6/22 Dialysis Days: Times: Tuesday, Thursday and Saturday at 7:20 A.M. -Monitor Dialysis Port every shift related to end stage renal disease for s/s (signs and symptoms) of infection/bleeding/dressing status, dated 10/22/22. -VS (vital signs every Tuesday, Thursday and Saturday for dialysis, document in the dialysis book. One time a day every Tue, Thu, Sat for documentation for dialysis. Review of the physician's orders failed to have non-serrated clamps for emergencies related to the venous catheter access site for dialysis. Review of Resident #11 care plans indicated a care plan dated as revised 9/10/24, Resident needs hemodialysis r/t (related to) renal failure. Review of the dialysis care plan failed to indicate the location of Resident #11's dialysis access site, nor have interventions related to the access site, or the intervention to have non-serrated clamps bedside for emergencies. Review of Resident #11's communication book indicated the following: -October 2024, Hemodialysis Communication documents were missing for the dates of 10/8/24, 10/15/24 and 10/22/24. -September 2024, the Hemodialysis Communication document was missing for the date 9/24/24. -August 2024, the Hemodialysis Communication documents were missing for the dates of 8/1/24, 8/17/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 4:10 P.M., Nurse #6 said he works on the 3 to 11 shift and that Resident #11 is already back from dialysis. Nurse #6 said Resident #11 goes to dialysis Tuesday, Thursdays and Saturdays. Nurse #6 said the Resident has a chest port access for the dialysis treatment. At 4:16 P.M., Nurse #6 and the surveyor went to Resident #11's room. Nurse #6 said staff monitor the dialysis access site each shift. Nurse #6 said he was not aware of an emergency plan or need for emergency supplies at bedside and would send Resident #11 to the ED (emergency department) if he/she had an emergency with the dialysis access site. During an interview on 10/22/24 at approximately 4:20 P.M., Unit Manager #4 said they expect the nurses to check the dialysis access site each shift, to make sure the dressing is intact. Unit Manager #4 said she was not aware of the need for a clamp in the event of an emergency with the chest catheter dialysis access site. Unit Manager said nursing staff should complete the communication sheet and review the communication sheet upon return on each dialysis day for Resident #11. During an interview on 10/22/24 at 4:32 P.M., the Assistant Director of Nursing (ADON) said staff are to send Resident #11 with a completed communication document for each dialysis treatment. The ADON said the dialysis staff change the dressing to the chest port and facility staff are to monitor the dialysis access site each shift. The ADON said the dialysis care plan should have the location of Resident #11's dialysis access site with the intervention to monitor the site. The ADON said Resident #11 does not have a non-serrated clamp in his/her room and that clamps are available to the nursing staff in the IV kit or foley catheter kit. During an interview on 10/23/24 at 7:36 A.M., the ADON said the non-serrated clamp should be on Resident #11's bedside for emergencies. During an interview on 10/23/24 at 10:44 A.M., the Director of Nursing said a non-serrated clamp should be with the Resident in the event of an emergency. The DON said the dialysis care plan should be resident specific with the location of the dialysis access site, and the physician's order to monitor the chest port should have the specific location of the chest port.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observation, record review, and interview, the facility failed to ensure it was free from a medication error rate of five percent or greater. Two out of four nurses observed made three errors in 28 opportunities on two of the three units resulting in a medication error rate of greater than 5%. These errors impacted two Resident (#317 and #44), out of nine residents observed. Findings include: Review of the facility policy titled 'Administering of Medications' dated April 2019, indicated the following but not limited to: -Medications are administered in accordance with prescriber orders, including any required time frame. -The individual administering the medications checks the label three times to verify the right resident, right medications, right dosage, right time and method (route) of administration before giving the medication. 1. During a medication pass on 10/23/24 at 8:19 A.M., on the [NAME] unit, the surveyor observed Nurse #3 prepare and administer including the following medications to Resident #317: -Albuterol nebulizer 0.083% via nebulizer -Lidocaine 4% patches to chest and back -Celexa 20 milligram (mg) one tablet by mouth -Plavix 75 mg one tablet by mouth -Protonix 40 mg enteric coated one tablet by mouth Nurse #3 said she was not going to administer the following medications due to being outside of the parameters. -Amlodipine (medication for high blood pressure) 10 mg -Lasix 40 mg (a medication to remove excessive fluids from the body) Review of the current physician orders indicated the following orders. -Amlodipine 10 mg give one tablet for primary pulmonary hypertension. -Lasix 40 mg give one tablet for primary pulmonary hypertension. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 11:00 A.M., Nurse #3 said she did not administer the two medications because of the low blood pressure of 98/68. Nurse #3 further said she did not have physician orders with parameters to follow and should not have held the medications without a physician order. 2. During a medication pass on 10/23/24 at 8:49 A.M., on Highlands one unit, the surveyor observed Nurse #4 prepare and administer the following medications to Resident #44: -Vitamin B12 1000 micrograms one tablet by mouth -Aripiprazole (an antipsychotic medication for treatment of mood disorders) 30 milligram one tablet (Directions on the medication card said, do not crush, do not chew, swallow whole) Nurse #4 prepared and crushed the medications and administered to Resident #44. During an interview on 10/23/24 at 11:41 A.M., Nurse #4 said the Resident requested the medication to be crushed. When asked if a physician order was required to crush medications especially ones with specific directions of not to crush, Nurse #4 said an order is required. During an interview on 10/23/24 at 11:46 A.M., Unit Manager #2 said nursing would follow the pharmacy guidelines for medication administration. She further said if a Resident required their medications to be crushed an alternative would be requested from the physician. During an interview on 10/23/24 at 1:51 P.M., the Assistant Director of Nursing (ADON) said medication administration should follow physician orders. The ADON further said even with a nurse's clinical judgment, the physician's order should be followed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observation and interview, the facility failed to ensure medications were labeled with open dates and failed to ensure outdated medications were not available for administration on two of four resident care units. Findings include: Review of the facility policy titled Medication Storage, undated, indicated the following: - The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. - Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. - If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. During an observation of the [NAME] Unit medication Cart One on 10/23/24 at 2:30 P.M., the following medications were observed without open dates: -One 30 fluid ounce bottle of ProSource Liquid Protein, opened and undated, therefore unable to determine an expiration date. -One bottle of fluticasone nasal spray (nasal spray contain steroid used to treat allergies) 50 mcg (micrograms) opened and undated, therefore unable to determine the expiration date. Manufacturer instructions indicated to discard after using 120 sprays. - One bottle of saline nasal spray, opened and undated, therefore unable to determine an expiration date. Manufacturer instruction indicated to discard the bottle after 30 days of opening. -One Budesonide 80 mcg (micrograms)/formoterol fumarate dihytdrate 4.5 mcg., Inhaler, opened and undated, therefore unable to determine an expiration date. Manufacturer instructions indicated to discard 3 months after the foil pouch is opened. - Fluticasone Propionate (an inhaled medication to treat breathing conditions) 110 mcg (micrograms) opened and undated, therefore unable to determine an expiration date. Manufacturer instruction indicated to discard the bottle after 60 days of opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fluticasone-salmeterol (an inhaled medication to treat breathing conditions) 100 mcg/ 50 mcg., opened and undated, therefore unable to determine an expiration date. Manufacturer instructions indicated to discard 30 days after the foil pouch is opened. -Albuterol Sulfate (an inhaled medication to treat breathing conditions) 90 mcg., opened and undated, therefore unable to determine an expiration date. Manufacturer instructions indicated to discard 30 days after the foil pouch is opened. During an observation of the Centerville Unit medication Cart One on 10/23/24 at 2:55 P.M., the following medications were observed without open dates: -One Budesonide 160 mcg (micrograms)/formoterol fumarate dihytdrate 4.5 mcg., Inhaler, opened and undated, therefore unable to determine an expiration date. Manufacturer instructions indicated to discard 3 months after the foil pouch is opened. -One package of ipratropium Bromide and albuterol sulfate (an inhaled medication to treat breathing conditions) 0.5 mg/ 3 mg/ml (milligrams/milliliter) opened and undated, therefore unable to determine an expiration date. Manufacturer instructions indicated once removed from foil pouch individual vials should be used within one week. -One Dorzolamide 2 % eye solution bottle open and undated, bottle was placed in a plastic bag and clear liquid was spilled in the bag. The bottle, label and inside of bag was wet. Dispense date printed on the bag was 4/20/24. - One 1 ml Vial Tuberculin Purified Protein Derivative (Mantoux) Tubersol Multi-dose vial (10 Tests), opened and undated, therefore unable to determine expiration date. Manufacturer instructions indicated to discard 30 days after opening. During an interview on 10/23/24 at 2:34 P.M., Nurse #4 said medications must be labeled and dated when opened. During an interview on 10/23/24 at 2:54 P.M., Unit Manager #1 said medications must be dated when opened and expired medications should not be in the medication cart. During an interview on 10/23/24 at 3.45 P.M., the Director of Nursing said medications requiring dates when opened should be labeled and dated.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review and interview, the facility failed to provide the prescribed, therapeutic diet for one Resident (#317) out of a total sample of 24 Residents. Specifically, Resident #317 was prescribed a therapeutic Mechanical soft (Dental) Ground texture diet and did not receive ground textures during meals. Findings include: Resident #317 was admitted to the facility in October 2024 with diagnoses including acute and chronic respiratory failure with hypoxia and type 2 diabetes mellitus. Review of Resident #317's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status score of 13 out of a possible 15 indicating intact cognition. The MDS further indicated under Section L Oral/Dental Status that Resident #317 has obvious or likely cavity or broken natural teeth. During an interview on 10/21/24 at 8:43 A.M., Resident #317 told the surveyor he/she has a hard time eating bread because he/she is missing a lot of teeth. The surveyor observed Resident #317 to be missing many upper and lower teeth with blackened color on the visible teeth. Resident #317 showed the surveyor his/her breakfast plate with 3 pieces of toast cut in half left on the plate, he/she said he/she cannot eat because of his/her teeth. During an interview on 10/21/24 at 12:57 A.M., Resident #317 was sitting in his/her room in his/her wheelchair eating lunch with family members. Resident #317's family member said Resident #317 has trouble eating bread products and meats because of his/her teeth. Review of Resident #317's physician's order dated 10/10/24 indicated the following: - Controlled Carb (carbohydrate) diet, Mechanical Soft (Dental) Ground Texture, no bread, fortified foods Review of Resident #317's nutrition care plan dated 10/17/24 indicated the following intervention: - Provide, serve diet as ordered. - Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals Review of Resident #317's Nutritional Risk assessment dated [DATE], completed by the Registered Dietitian (RD) indicated the following: - Resident #317 prefers softer foods d/t (due to) missing some teeth, recommend mech (mechanical) soft diet. Will continue to monitor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairhaven Healthcare Center	476 Varnum Avenue Lowell, MA 01854

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/22/24 at 12:23 P.M., Resident #317 was in his/her room in his/her wheelchair eating his/her lunch. The Resident opened his/her meal to show the surveyor an uncut, grilled cheese sandwich with the crust on it. At 12:27 P.M., a certified nursing assistant entered the room and left at 12:29 P. M., she did not check his lunch meal. During an interview on 10/22/24 at 12:33 P.M., Unit Manager #3 observed Resident #317's lunch with the surveyor. She said she was not sure if he/she can eat that and left to get the Food Service Director (FSD). At 12:39 P.M., the FSD and RD entered Resident #317's room and observed the uncut grilled cheese. The surveyor, FSD and RD reviewed the Resident's diet order for a ground textured diet, and they said it was not a ground texture. During an interview on 10/22/24 at 12:58 P.M., Unit Manager #3, the Assistant Director of Nursing and Administrator said Resident #317 will get assessed by Speech Therapy to see what diet is appropriate. During a telephone interview on 10/22/24 at 1:18 P.M., the Speech Therapist said a Resident on a ground textured diet should not have any bread products due to risk of choking. During an interview on 10/22/24 at 1:30 P.M., the FSD and surveyor reviewed the facility's therapeutic diets, none of which mentioned ground textures. The FSD said if Resident #317's diet order says ground texture then he/she should be on the Mechanically Altered diet, not the Mechanically Dental Soft diet. The FSD continued to say bread products would be puree texture on the Mechanically altered diet. During an interview on 10/22/24 at 1:43 P.M., the Administrator said all physician's orders should be followed as written. The Administrator continued to say she was not sure why Resident #317 was on a ground diet when the facility's therapeutic diets do not use ground diets. The Administrator then said she spoke with Resident #317, and he/she told her that he/she has a hard time with the crust and only can eat the center since it is easier to chew with his/her teeth. During a follow up interview with the Administrator on 10/22/24 at 2:19 P.M., she said she spoke with the nursing facility where Resident #317 was previously at and was assessed by Speech Therapy there but was not screened by Speech Therapy at this facility, she said he/she should have been screened upon admission to this facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, record review and interviews, the facility failed to maintain an accurate medical record for one Resident (#94) out of a total sample of 24 Residents. Findings include: Resident #94 was admitted to the facility in July 2023 and has diagnoses that include pressure ulcer of sacral region. Review of Resident #94's most recent Minimum Data Set (MDS) dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15 indicating he/she had moderate impaired cognition. The MDS further indicated the Resident had a pressure ulcer. Review of Resident 94's physician orders indicated the following order initiated on 12/27/23: Specialty air mattress set at 165 check setting and function every shift to help with wound healing. On 10/22/24 at 10:53 A.M., the surveyor observed the air mattress set at 180 lbs (pounds). On 10/23/24 at 7:09 A.M,. the surveyor observed the air mattress set at 180 lbs. Review of the Treatment Administration Record (TAR) for October 2024, indicated the nurses signed off that the air mattress was set at 165 lbs. During an interview on 10/23/24 at 11:50 A.M., Unit Manager #1 said the air mattress goes by the Resident's weight, and said the Resident weighed 178 pounds, and that the physician's orders and the TAR orders should reflect the correct setting. During an interview on 10/23/24 at 12:09 P.M., the Assistant Director of Nursing (ADON) said the nurses should not be documenting inaccurately in the TAR. She further said the air mattress is set by the Resident's weight.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review and interview, the facility failed to follow infection control practices to prevent possible spread of infection by: 1. Failing to perform proper hand hygiene and failing to use Personal Protective Equipment (PPE) for an Enhanced Barrier Precaution room. 2. Failing to sanitize shared medical equipment between residents, specifically a glucometer (a machine used to test blood sugar). 3. Failing to follow infection control practices during a wound dressing change, specifically not performing hand hygiene after glove removal and storage of wound treatment supplies. Findings include: Review of the facility's policy titled Personal Protective Equipment, undated, indicated the following: - Personnel who perform tasks that may involve exposure to blood/body fluids are provided appropriate personal protective equipment (PPE). - PPE is required for transmission-based precautions is maintained outside and inside the resident's room, as needed - Training on proper donning, use of PPE is provided upon orientation and at regular intervals. 1. The surveyor observed signage indicating Enhanced Barrier Precautions hanging outside of rooms [ROOM NUMBERS] on the Belvidere Unit. The signage indicated the following: - Everyone must: clean their hands, including before entering and when leaving the room. - Providers and staff must also wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, wound care. `On 10/21/24 the surveyor made the following observations: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 12:43 P.M., a housekeeper entered room [ROOM NUMBER], identified as occupying a resident requiring enhanced barrier precautions, without performing hand hygiene. The housekeeper then exited room [ROOM NUMBER] without performing hand hygiene. The housekeeper then proceeded to enter room [ROOM NUMBER], occupied by a resident requiring enhanced barrier precautions, without performing hand hygiene. The housekeeper changed the trash with her bare hands. Then outside of room [ROOM NUMBER] the housekeeper put gloves on both hands without performing hand hygiene, re-entered room [ROOM NUMBER] and then proceeded to exit. At 12:59 P.M., the housekeeper entered room [ROOM NUMBER] wearing the same gloves and exited the room to remove her gloves. At 1:02 P.M., she put on a new pair of gloves without performing hand hygiene and was observed changing the trash and sweeping. On 10/22/24 the surveyor made the following observations: - At 11:49 A.M., two certified nursing assistants (CNA) were observed in room [ROOM NUMBER], identified by a sign that the room was occupied by a resident requiring enhanced barrier precautions, one CNA (#2) was making the Resident's bed while the other CNA was wheeling out the Hoyer lift. The resident was observed to be sitting in his/her [NAME] chair in his/her room while the CNAs were in his/her room. The CNAs were observed wearing masks, no gloves or gowns in the room. During an interview on 10/22/24, CNA #2 said the Resident in room [ROOM NUMBER] is totally dependent on staff for all ADL care and requires two staff members for transfer. CNA #2 continued to say she was just providing ADL care to that resident and needed another CNA to help her. During an interview on 10/23/24 at 9:10 A.M., the Assistant Director of Nursing (ADON), who is also the Infection Preventionist, said she would expect staff to be following the instructions for each precaution sign outside of a resident's room. The ADON said housekeepers should be performing hand hygiene before entering rooms and when exiting rooms. The ADON further said all staff including CNAs should be following the enhanced barrier instructions for PPE while providing care to the residents. 46339 2 Review of the facility's policy, Glucose monitoring equipment, revised August 2024, included but not was limited to the following: Blood glucose monitoring equipment will be checked for accuracy, including a quality control test performance. Blood glucose monitoring equipment will be cleaned with a bleach wipe before and after use and/or as per manufacturer guidelines. On 10/23/24 at 7:45 A.M., the surveyor observed Nurse #1 gather supplies to check a resident's blood sugar. The surveyor observed Nurse #2 exit the resident's room and place the glucometer back in the basket on his medication cart that contained other blood sugar testing items. On 10/23/24 at 7:49 A.M., the surveyor observed Nurse #1 checking another resident's blood sugar without cleaning the glucometer. During an interview on 10/23/24 at 7:54 A.M., Nurse #1 said the glucometer should be sanitized after each use. During an interview on 10/23/24 at 12:13 P.M., the Assistant Director of Nursing (ADON) said glucometers should be sanitized after each use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility's policy titled, 'Prevention and management of Pressure injuries' dated July 2023 included but was not limited to the following: Infection control: -Clean technique is utilized in performing dressing changes. Sterile technique may be ordered by the physician as indicated. -Standard precautions are utilized per policy unless otherwise indicated. On 10/23/24 at 11:17 A.M., the surveyor observed Nurse #3 perform wound care on Resident #61. During the wound care treatment, the following were observed: -Nurse #3 was observed placing the dressing treatment supplies on the Resident's bed, then proceeded with removing the old, soiled dressing from Resident #61's right buttock, Nurse #3 did not perform hand hygiene after removing her gloves. -Nurse #3 applied new gloves without performing hand hygiene, applied a new dressing to the Resident's wound. Nurse #3 proceeded to remove her gloves without hand hygiene, removed a sharpie from her pocket and dated the Resident's dressing while on the Resident's body. -Nurse #3 then removed the unused portion of the dressing treatment supplies and placed them in the Resident's personal drawer which contained personal clothing in the drawer. During an interview on 10/23/24 at 11:36 A.M., Nurse #3 said she should perform hand hygiene after removing gloves, use a sterile field to place dressing treatment supplies, and to store the dressing supplies appropriately. Nurse #3 further said she should not be writing on the Resident and should have dated the dressing prior to applying to the Resident. During an interview on 10/23/24 at 12:05 P.M., the Assistant Director of Nursing (ADON) said nurses are to follow the facility wound care protocol and hand hygiene should be performed before putting on gloves, in between changes and after completing the treatment.