| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225459 | A. Building<br>B. Wing | 09/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Royal Nursing Center, LLC | 359 Jones Rd<br>Falmouth, MA 02540 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>49424<br><br>Based on record review, policy review, and interview, the facility failed to accurately execute Advance Directives (written documents that tells your health care providers who should speak for you and what medical decisions should be made if you become unable to speak for yourself) for one Resident (#44), out of a total sample of 22 residents. Specifically, for Resident #44 the facility failed to ensure the MOLST (Massachusetts Medical Order for Life-Sustaining Treatment) form was valid and reflected the signature of Resident #44's invoked (made active by a Physician) Health Care Proxy (HCP- a legal document that allows you to appoint someone you trust to make medical decisions on your behalf if you are unable to do so).<br><br>Findings include:<br><br>Resident #44 was admitted to the facility in November 2019 with diagnoses including Alzheimer's disease.<br><br>Review of the facility's policy titled Advanced Directives, undated, indicated but was not limited to the following:<br><br>-If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative.<br><br>-The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.<br><br>-The interdisciplinary team will conduct ongoing review of the resident's decision-making capacity and communicate significant changes to resident's legal representative. Such changes will be documented in the care plan and medical record.<br><br>Review of Resident #44's medical record indicated:<br><br>-a HCP, dated 7/23/19, appointing Resident Representative #1 as the primary HCP, if that person is unwilling or unavailable to serve there is a Resident Representative #2 named, if that person is unwilling or unavailable to serve as HCP there is a Resident Representative #3 named.<br><br>(continued on next page) |

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

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

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -a HCP activation form, dated 5/17/19, indicating that the Resident's dementia is so severe that the Resident lacks capacity to make or to communicate health care decisions.<br><br>-a MOLST completed by Resident Representative #3 on 4/7/19.<br><br>Review of Resident #44's Advance Directive care plan, initiated on 10/11/21, and revised on 4/1/24 indicated:<br><br>Focus: I am unable to make health care decisions due to dementia. A MD has documented my incapacity. Primary HCP: Resident Representative #1, Alt HCP: Resident Representative #2, MOLST in place DNR, DNI, no dialysis, no artificial nutrition.<br><br>Goal: Healthcare decisions made by my designated HCP will be honored and followed.<br><br>Interventions: MOLST/Advanced Directives will be discussed with my HCP at quarterly care plan meetings to ensure decisions are accurately documented.<br><br>-My Health care agent will be informed of their right to formulate advanced healthcare to guide facility staff and their attending physician in the provision of my care.<br><br>During an interview on 9/12/24 at 11:18 A.M., Social Worker #1 said the MOLST was initiated at the hospital but should be reviewed quarterly at the facility. She said it should have been reviewed multiple times since Resident #44's admission in 2019 and most recently reviewed on 7/25/24. She said it was not identified that the primary or the first alternative HCP did not complete the MOLST. She said the Resident's HCP is available and willing to serve as the primary HCP.<br><br>During an interview on 9/12/24 at 2:50 P.M., Social Worker #1 said she spoke with the primary HCP and that she was unsure why she wasn't asked to complete the MOLST and the person who completed it was Resident Representative #3. She said the Resident Representative would be in to initiate a new valid MOLST and this should have been identified sooner.<br><br>During an interview on 9/16/24 at 12:33 P.M., the Assistant Director of Nursing (ADON) said the only time they would obtain a signature different than the primary HCP is if they were not available. She said Resident Representative #1 signs all the Resident's consents and the MOLST should have been reviewed multiple times and revised to have Resident Representative #1 complete the MOLST. She said that she is aware that Resident Representative #1 is available and willing to serve as the primary HCP. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106<br><br>Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive care plan for one Resident (#11), out of a total sample of 18 residents. Specifically, the facility failed to:<br><br>a. Implement a care plan to ensure Resident #11 was transferred with the assistance of two people; and<br><br>b. Develop and implement a care plan for pressure injury prevention for Resident #11, who was assessed to be at risk for skin breakdown, resulting in a facility acquired unstageable (actual depth of ulcer is completely obscured by slough and/or eschar in the wound bed) right heel ulcer.<br><br>Findings include:<br><br>Resident #11 was admitted to the facility in June 2024 with diagnoses which included: cellulitis right lower extremity (LE), muscle weakness, unsteadiness on feet, delirium, and metabolic encephalopathy (brain dysfunction due to chemical imbalance).<br><br>Review of the Minimum Data Set (MDS) assessment, dated 6/19/24, indicated Resident #11 scored 10 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment.<br><br>a. Review of the facility's policy titled Safe Lifting and Movement of Residents, undated, indicated but was not limited to the following:<br><br>-In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.<br><br>-Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe transfer and moving of residents.<br><br>-Manual lifting of residents shall be eliminated when feasible.<br><br>-Nursing staff, in conjunction with the rehabilitation staff, shall assess individual resident needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan.<br><br>-Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.<br><br>-Mechanical lifting devices shall be used for heavy lifting including lifting and moving residents when necessary.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the MDS assessment, dated 6/19/24, indicated Section GG indicated sit to lying down and lying down to sit was substantial/maximal assistance, sit to stand was not applicable, chair to bed transfer was dependent.<br><br>Review of Resident #11's Care Plan indicated but was not limited to the following:<br><br>-I require assistance with activities of daily living care related to metabolic encephalopathy, acute delirium, shortness of breath, and weakness.<br><br>-Transfers: dependent on two people with mechanical lift; date initiated 6/21/24. Revised to current transfer: Provide sub maximal/maximum assist of two people, left ankle foot orthosis to be worn for all transfers.<br><br>During an interview on 9/11/24 at 12:20 P.M., Resident #11 said a Certified Nursing Assistant (CNA) was trying to transfer him/her out of a shower chair to a wheelchair which was blocked behind the bathroom door. Resident #11 said the CNA picked him/her up (demonstrated the motion of the CNA picking him/her up for the surveyor) and he/she told the CNA to put him/her down on the bed because he/she was never going to make it to the wheelchair; he/she didn't want to be dropped on the floor. Resident #11 said, The CNA put me on the bed and the CNA told me that she noticed I was bleeding, and she went out and got the nurse. Resident #11 said he/she was told he/she had to go to the hospital.<br><br>Review of a Physical Therapy progress note, dated 7/2/24, indicated but was not limited to the following:<br><br>-Resident #11 was dependent for functional transfers with partial to moderate assist, patient unable to ambulate, weight bearing is tolerated, transfer sit to stand not attempted due to medical condition and safety concerns chair to bed transfers, dependent toilet transfer others dependent, interventions bilateral lower extremities and supine.<br><br>-Transfers to edge of bed Max assist times 2, remains fearful and complains of pain with gentle range of motion to bilateral knees.<br><br>-Can resident sit unsupported times 30 seconds with feet flat on the floor with no back support?: No.<br><br>During an interview on 9/17/24 at 8:40 A.M., Rehabilitation (Rehab) Staff #1 said Resident #11 was maximal (max) assist times 2 person to get to the edge of bed because he/she has retropulsion (leaning backwards). She said Resident #11 has been a mechanical lift since his/her re-admission in June 2024, and has never been upgraded, and remains a mechanical lift. Rehab Staff #1 said she has not assessed the Resident for showers, but if Resident #11 was to have a shower even now, Resident #11 would be a mechanical lift in/out of the shower chair. Rehab Staff #1 said the nurses have never been trained in any other transfer mode, including stand/pivot or squat/pivot, and the Resident remains a mechanical lift.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/17/24 at 9:23 A.M., Rehab Staff #2 said Resident #11 is a max assist and still is max assist for transfers. He said back in July, at the time of injury, Rehab was still working on bed mobility and transferring to edge of bed because of his/her strong severe retropulsion. Rehab Staff #2 said Resident #11 was a mechanical lift back in July and remains a mechanical lift now. Rehab Staff #2 said he was aware of the leg injury in July 2024 and his recollection was that Resident #11 hit his/her leg on something during a shower transfer. Rehab Staff #2 said the Resident has fragile skin, and it was a pretty significant injury of which he has never seen from a transfer. Rehab Staff #2 said Resident #11's only safe transfer out or into bed is a mechanical lift; a one person transfer with Resident #11 would not be safe even today.<br><br>Review of the Facility Investigation Packet, dated 7/9/24, indicated but was not limited to the following:<br><br>-Incident description: This writer responded to a call to help from CNA in the above resident's room. Upon entry, CNA stated that the resident had just gotten out of the shower and pointed out that he/she had a cut on his/her right lateral lower leg. Resident was assisted onto bed. Upon assessment, a large skin tear like wound was noted to the right lateral lower shin approximately 7 x 8 x 0.4 centimeters. This area was noted to be an existing large bruise (present on admission). On call physician was notified. Health care proxy was called and left a voicemail. Resident was sent to the emergency room for further evaluation and treatment per physician orders.<br><br>-Resident unable to give description.<br><br>Immediate Action Taken:<br><br>-Resident was assisted back into bed. First aid applied.<br><br>-Shower chair was inspected for any cracks, broken pieces, or sharp edges. None were found. Residents' nails were assessed and found to be longer in length with sharp edges. Nail care was provided to ensure not sharp edges.<br><br>-Resident taken to hospital: N<br><br>-Injuries Observed at Time of Incident: No injuries observed at time of incident.<br><br>-Level of Pain: 0<br><br>-Mobility: Ambulatory with assistance<br><br>-Mental status: Oriented person and place.<br><br>-Injuries Reported Post Incident: Skin tear right lower leg (front)<br><br>Other information:<br><br>-Post shower. Skin very fragile and thin at baseline. Increase edema. Bruising to area (present on admission).<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Residents fingernails noted to have sharpened edges with presumed blood under them.<br><br>Witnesses:<br><br>1. CNA #1, dated 7/8/24, indicated but not limited to:<br><br>- I turned to the dresser to grab the johnny and returned to the Resident to place the johnny on the person. Resident then stated, be careful my leg has a cut on it put and to put me in the bed It just needs a Band-Aid. At that time, I looked at his/her leg and noticed the skin was broken open. I immediately called out for the nurse. I assisted the resident onto the bed in a seated position. The nurse and I then assisted in getting both legs into bed. The nurse proceeded to complete first aid. Resident #11 was sent to the emergency room (ER). Resident #11 did not complain of any pain or discomfort in the area.<br><br>2. Nurse #2, dated 7/5/24 indicated but was not limited to:<br><br>- I went to assist the CNA. Upon arrival to the room, the Resident was sitting upright on his/her bed. I quickly wrapped the wound with a clean towel and ran to get wound supplies. Upon return, the assigned nurse was also present in the room. I assisted with transferring Resident #11's legs into the bed.<br><br>During an interview on 9/12/24 at 11:45 A.M., with the surveyor, Director of Nurses (DON), and Corporate Nurse #1 present, Resident #11 said he/she completed the shower, and the CNA wheeled him/her out of the bathroom in the shower chair, pushing the bathroom door open with the chair as they exited the bathroom. Resident #11 said the black wheelchair was behind the bathroom door, and the CNA lifted him/her up out of the chair (Resident demonstrated extending both arms in front of him/her making a lifting motion). Resident said he/she told the CNA, he/she was not going to make it to the wheelchair, and he/she needed to put him/her down before she dropped him/her. Resident #11 said the CNA threw/dropped him/her onto the bed and he/she rolled over to his/her left side. Resident #11 said that is when he/she hit the right leg because that is when it hurt. Resident #11 said CNA told her Oh my God you're bleeding and the CNA went to get help. Resident #11 said he/she never saw the blood because he/she was lying back to his/her left side on the bed.<br><br>During an interview on 9/12/24 at 3:30 P.M., Nurse #2 said she was getting food out of the nourishment kitchenette across the hallway from Resident #11's room when she heard the call for help from CNA #1. Nurse #2 said she was the first one in the room and Resident #11 was sitting on the edge of the bed.<br><br>During a telephonic interview on 9/12/24 at 3:45 P.M., CNA #1 said she had given Resident #11 a shower and wheeled him/her out of the shower room and positioned the shower chair by the bed. CNA #1 said she dried off Resident #11 and he/she said he/she was cold. CNA #1 said she turned to get a johnny off the dresser and Resident #11 complained his/her leg was burning and that he/she had a small cut on the leg. CNA #1 said she looked at Resident #11's leg and saw a large cut on the leg and went and notified the nurse. CNA #1 said she knew Resident #11 was a two person transfer and waited for Nurse #2 to assist her transferring Resident #11 from the shower chair to the bed. CNA #1 stated again, she did not transfer Resident #11 back to bed alone, she would never have attempted that because Resident #11 was not dressed, and she said she never hit Resident #11's legs on anything.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/17/24 at 12:25 P.M., the DON said they re-enacted the incident with the involved staff, and they found CNA #1 did not understand what a two-person transfer meant. She said CNA #1 thought a two-person transfer meant only two people had to be in the room. Corporate Nurse #1 said the CNA told them she only transferred Resident #11 into bed after she saw the wound on the leg to help the nurses.<br><br>b. Review of [NAME](R) NURSING PROCEDURES -11th Ed. (2019), indicated but was not limited to the following:<br><br>Review Factors in the Development of Pressure ulcers.<br><br>-Edema, anemia, hypoxia, or hypotension.<br><br>-Neurologic impairment or immobility.<br><br>-Altered mental status, including delirium or dementia.<br><br>-Areas susceptible to pressure ulcers: Heel<br><br>-Nursing Assessment<br><br>-Assess for risk factors for pressure ulcer development and alter those factors, if possible.<br><br>-Assess skin of the older adult frequently for the development of pressure ulcer. The Braden Scale for Predicting Pressure Sore Risk is one of the most commonly used instruments for predicting the development of pressure ulcers.<br><br>-Stage the ulcer so appropriate treatment can be started. The National Pressure Ulcer Advisory Panel advocates the following staging system.<br><br>-Unstageable-full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed.<br><br>- Prevent Pressure Ulcer Development<br><br>-Provide meticulous care and positioning for immobile patients.<br><br>-Inspect skin several times daily.<br><br>Relieve the Pressure<br><br>-Avoid elevation of head of bed greater than 30 degrees.<br><br>-Reposition every 2 hours.<br><br>-Use special devices to cushion specific areas (especially bony areas), such as flotation rings, lamb's wool or fleece pads, convoluted foam mattresses, booties, or elbow pads. Lift heels off the bed in bedbound patients. Do not use donut devices.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's policy titled Prevention of Pressure Ulcers/Injuries, undated, indicated but was not limited to the following:<br><br>-The purpose of this procedure is to provide information regarding identification of pressure ulcer injury risk factors and interventions for specific risk factors.<br><br>Preparation:<br><br>-Review of the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.<br><br>Risk Assessment:<br><br>-Assess the resident on admission (within 8 hours) for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition.<br><br>-Choose a frequency for repositioning based on resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences.<br><br>-Reposition residents who are chair bound or bed bound.<br><br>-Reposition resident regularly based on the condition of the skin and the resident's comfort<br><br>Monitoring:<br><br>-Evaluate report and document potential changes in skin<br><br>-Review the intervention strategies for effectiveness on an ongoing basis.<br><br>Review of the facility's policy titled Skin Integrity Management, undated, indicated but was not limited to the following:<br><br>-Residents with pressure ulcer risk factors are identified, assessed, and provided treatment according to standard practice.<br><br>-To provide safe and effective care to prevent the occurrence of pressure ulcers, manage the treatment and promote healing of all wounds.<br><br>Procedure:<br><br>-Following admission, the [NAME] plus pressure ulcer or Braden scale is completed quarterly, changing condition, or changing skin integrity.<br><br>-Resident skin integrity status and need for prevention interventions or treatment modalities is identified through review of assessment information.<br><br>a. Identify resident's risk level.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. Care plan for residents at high risk for skin breakdown<br><br>c. Perform skin inspections at admission and weekly. Document in resident record.<br><br>Comprehensive care plan developed to include prevention and wound treatments, as indicated:<br><br>a. Implement pressure ulcer prevention for identified risk factors.<br><br>b. Evaluate the need for support services.<br><br>Review of Resident #11's admission progress note, dated 6/2024, indicated but was not limited to the following:<br><br>-Right toes blackened toes throughout all toes.<br><br>-Right lower leg discoloration: length 12 cm, width 18 cm<br><br>-Skin is ashen (pale gray or white color). Skin is dry/cracked. Decrease skin turgor (elasticity).<br><br>-Resident has bilateral edema with excessive dry thick scaly skin covering the lower extremities.<br><br>Review of the MDS assessment, dated 6/19/24, indicated:<br><br>-Section M0150 Risk for pressure ulcers: Yes.<br><br>-Section M0300 Unhealed pressure ulcers: No.<br><br>-Section M1200 Skin and ulcer treatments: Pressure reducing bed.<br><br>-Section GG0170 Mobility: roll left and right substantial/maximal assistance.<br><br>Review of a progress note, dated 6/19/24 at 2:44 P.M., indicated Braden scale for predicting pressure ulcer risk evaluation score of 15, indicating a mild risk for pressure ulcer. Further review indicated Resident was chairfast (ability to walk is limited) and is very limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Friction and shear: potential problems.<br><br>Review of the medical record indicated that on 7/5/24, Resident #11 sustained a large trauma wound to the right lower leg requiring emergency room treatment and weekly wound care by a consultant wound physician.<br><br>Review of the Wound Care Clinic progress note, dated 7/15/24, indicated but was not limited to the following:<br><br>-Traumatic open wound of right lower leg, initial encounter<br><br>-No heel pressure wound at this visit.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Wound Care Clinic progress note, dated 7/22/24, indicated but was not limited to the following:<br><br>-Pressure injury right posterior lateral heel.<br><br>-Peri-wound assessment: Intact<br><br>-Exposed structure: Other (Comment)<br><br>-Wound length: 3.5 centimeters (cm)<br><br>-Wound width: 2.5 cm<br><br>-Wound Depth: 0.1 cm<br><br>-Wound surface area: 8.75 cm2<br><br>-Drainage amount: Moderate<br><br>-Drainage description: serosanguineous<br><br>Pressure ulcer of right heel, unstageable:<br><br>-Continue skin prep daily, intensify offloading with offloading boot.<br><br>-Showering-no showering right heel; unstable pressure wound cannot get wet<br><br>Review of wound doctor appointments referral form, dated 7/22/24, indicated the following:<br><br>-Wound follow-up<br><br>-* note unstageable pressure wound right, posterior lateral heel. Must offload heel boot NOW.<br><br>Further review of the medical record indicated no additional Braden risk assessments were performed after Resident #11 returned from the emergency room with a traumatic soft tissue injury to the right lower extremity 7/5/24.<br><br>Further review of the care plan indicated there was no care plan developed or implemented for a resident at risk for skin breakdown or pressure ulcers upon admission or post traumatic soft tissue injury to right leg.<br><br>During an interview on 9/12/24 at 12:00 P.M., the DON said Resident #11 had a facility acquired pressure ulcer that started out as a blister and is seen by the outside wound doctor for management.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225459 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Royal Nursing Center, LLC | 359 Jones Rd<br>Falmouth, MA 02540 |

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

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/17/24 at 11:42 A.M., the Assistant Director of Nurses (ADON) said the nurses should be doing a weekly skin assessment of the whole body, looking to identify areas of potential skin breakdown, fragile skin areas and areas that may need attention or preventative treatment. She said she reviewed Resident #11's medical record and said the skin assessment, dated 7/17/24, indicated bilateral legs and feet have thick, dry skin that has been previously documented. The ADON said there was no additional documentation of skin concerns until the outside Consultant Wound Doctor identified the right heel pressure on 7/22/24. The ADON said she has not found any interventions for pressure relief to the right lower extremity at admission or after the Resident sustained the injury on 7/5/24.<br><br>During an interview on 9/17/24 at 12:58 P.M., the ADON said the only pressure relief/prevention for Resident #11's right lower extremity was CNA repositioning logs which are standard for all residents. The ADON said there is no new orders for pressure relief interventions after the injury to the right leg. The ADON provided the surveyor with the CNA repositioning documentation.<br><br>Review of the CNA documentation for Positioning Q (every) shift: Was the resident repositioned every two hours? Y-yes, N-No, indicated between 7/17/2024 through 7/22/2024, Resident #11 was not repositioned every two hours on the following shifts:<br><br>-7/19/2024-11:00 P.M. through 7:00 A.M.<br><br>-7/20/2024- 3:00 P.M. through 11:00 P.M.<br><br>-7/21/2024- 3:00 P.M. through 11:00 P.M. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225459 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
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| NAME OF PROVIDER OR SUPPLIER Royal Nursing Center, LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 359 Jones Rd Falmouth, MA 02540 | |

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

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>15214<br><br>Based on observation, interview, and policy review, the facility failed to ensure that infection control and prevention measures were followed during preparation of medication for administration.<br><br>Findings include:<br><br>Review of the facility's Policy Statement for Administering Medications, undated, indicated that medications are administered in a safe and timely manner, and as prescribed. The policy statement included but was not limited to the following:<br><br>-Staff follows established facility infection control procedures (e.g., handwashing, antiseptic (sic) technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.<br><br>On 9/13/24 at 10:10 AM, on the Nantucket Unit, the surveyor observed Nurse #1 preparing Resident #22's morning medications. Nurse #1 touched multiple medication cards and the medication cart drawer handle with her bare hands. The Resident had an order for mirtazapine 7.5 milligrams (mg) by mouth every morning. Nurse #1 obtained a card of mirtazapine 30 mg from the medication cart, and in error, popped the pill into the med (medication) cup. After realizing she had poured the incorrect dose of mirtazapine, Nurse #1 inserted her bare finger into the med cup to remove the 30 mg tablet of mirtazapine. Nurse #1 did not sanitize her hands or apply a protective barrier to her hand to prevent contaminating the rest of the nine medications she had already poured for the Resident.<br><br>During an interview with observation on 9/13/24 at 10:11 AM, the surveyor said to Nurse #1 that she had potentially contaminated the medications that were in the med cup, by scooping the mirtazapine 30 mg out of the med cup with her bare finger. She acknowledged that she did not adhere to accepted practices for infection control by her actions. Nurse #1 commented, That's bad. She then discarded the mirtazapine 30 mg tablet, poured mirtazapine 7.5 mg into the med cup, and administered all the Resident's morning medications.<br><br>During an interview on 9/17/24 at 7:33 AM, the Director of Nursing (DON) said that Nurse #1 should not have inserted her finger into the med cup to scoop out the mirtazapine 30 mg tablet. The DON said that it was an infection control issue. |