STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225461	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Gardens	130 Chestnut Street Franklin, MA 02038

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48084 Based on the Beneficiary Protection Notification Review, interview, and policy review the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Form CMS-10055 and the Notice of Medicare Non-Coverage (NOMNC), Form CMS 10123, were provided timely and explained to the resident/resident representative for two Residents (#19 and #49), out of three sampled residents. Specifically, the facility failed to issue the SNF ABN and failed to issue and explain the NOMNC timely ensuring the Resident/Resident representative understood the appeal process. Findings include: Review of the facility's policy titled Advance Beneficiary Notices, dated as last revised 3/4/24, indicated but was not limited to the following: -It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. -The current Center for Medicare and Medicaid Services (CMS) approved version of the forms shall be used. a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Form CMS-10055. b. For Part B items and services, the facility shall use the Advanced Beneficiary Notice of Non-Coverage (ABN), Form CMS-R131. c. A Notice of Medicare Non-Coverage (NOMNC), Form CMS 10123, shall be issued to the resident/resident representative when Medicare covered service(s) are ending, no matter if a resident is leaving the facility or remaining at the facility. This informs the resident on how to request an appeal to expedite determination from their Quality Improvement Organization (QIO). -Delivery requirements: a. The notice shall be written legibly in a language and/or format that the resident/representative understands. Verbal explanations detailing the reasons for the determination of possible non-coverage shall be provided. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The notice shall be hand delivered, if possible, to obtain beneficiary or resident representative signature. c. The notice shall be prepared with an original and at least two copies. The facility shall retain the original and give a copy to the resident/representative. d. If the notice cannot be hand delivered, a telephone call shall be made, followed up immediately with a mailed, emailed, faxed, or hand delivered notice. Documentation shall comply with form instructions regarding telephone notices. e. Mail, secure fax machine and internet email may also be utilized for delivery of the notice if in-person issuance is not able to be performed. -The original notice shall be placed into the resident's financial file. The notice shall be retained at least five years. -A notice must be completed before delivery, and a copy must be provided to the resident/representative immediately after signing it. Review of the NOMNC, Form CMS 10123, indicated but was not limited to the following: -Request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated. A. Resident #21 received Medicare Part A skilled services. Review of the medical record indicated Resident #21 was a long-term care (LTC) Resident and his/her Health Care Proxy (HCP) had been invoked. The facility failed to provide the surveyor with a copy of the SNF ABN, Form CMS-10055. The facility provided the surveyor with the ABN, Form CMS-R131. Review of the ABN failed to indicate a physical copy was provided to the HCP, a discussion took place with the HCP, the HCP signed any document or was aware of the services expected to not be covered or options available regarding services and billing options. The Resident was receiving Medicare Part A services and the SNF ABN (Form CMS-10055) should have been issued, not the ABN (Form CMS-R131). Review of the NOMNC indicated the notice was provided to Resident #21's HCP via a telephone call on 2/7/24 at 1:30 P.M., with a voicemail message left for effective date for last covered day (LCD) of 2/9/24. The NOMNC failed to indicate the document was mailed to the HCP. Further review of the NOMNC failed to indicate a physical copy was provided to the HCP, a discussion took place beyond a voicemail message or that the HCP signed any document or was aware of the appeal rights related to ending of the skilled benefit. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes from January and February 2024 failed to indicate a conversation took place or the documents were mailed. During an interview on 5/3/24 at 12:39 P.M., Resident #21's HCP said she was notified and told she needed to sign the form to show Resident #21 would not be getting therapy because he/she reached their max level, but she was not provided with any other information on her right to appeal the decision. She said she would have liked to appeal against the decision as the Resident was previously walking and eating a regular diet and feels he/she would benefit from more rehab services. She said she was not provided with the information on the appeal process and wished she was. During an interview on 5/3/24 at 1:53 P.M., Minimum Data Set (MDS) Nurse #1 said she found proof that Resident #21's HCP received the forms via certified mail on 2/23/24. Review of the secondary documents provided indicated the HCP signed for a certified mail letter delivery on 2/23/24 (16 days after the initial notice date and after the appeal window had closed). The documents were signed/dated 2/24/24. B. Resident #49 received Medicare Part A skilled services. Review of the medical record indicated Resident #49 was a LTC resident and his/her HCP had been invoked. The facility failed to provide the surveyor with a copy of the SNF ABN, Form CMS-10055. The facility provided the surveyor with the ABN, Form CMS-R131. Review of the ABN failed to indicate a physical copy was provided to the HCP, a discussion took place with the HCP, the HCP signed any document or was aware of the services expected to not be covered or options available regarding services and billing options. The resident was receiving Medicare Part A services and the SNF ABN (Form CMS-10055) should have been issued, not the ABN (Form CMS-R131). Review of the NOMNC indicated the notice was provided to Resident #49's HCP via a telephone call on 4/15/24 at 1:00 P.M., for effective date for last covered (LCD) of 4/17/24. The NOMNC failed to indicate the document was mailed to the HCP. During an interview on 5/3/24 at 12:27 P.M., Resident #49's HCP said she was not notified that the Resident was coming off skilled services or that she had any options to appeal. She said she had not received any paperwork in the mail that provided this information to her. She said the Resident may benefit from more therapy and asked if she could still appeal and was informed, she was outside of the window and would need to alert the facility of her desire and initiate a screening process, from there she said she will likely not bother. During an interview on 5/3/24 at 12:42 P.M., MDS Nurse #1 said the forms are sent via mail to the HCP and although they are not in the medical record, they are probably in the financial files. Additionally, she said the documents are not mailed in a way that can be tracked. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/3/24 at 12:53 P.M., MDS Nurse #1 said there was no further information available for Resident #49 and she did not have signed copies of the forms. She said there was no documentation in the medical record that the HCP was aware of the information or appeal rights. She said she didn't have the second page of Resident #49's NOMNC and thinks the original was mailed without a copy being made. Additionally, she said it appears from the documentation for both Residents #21 and #49 the process was not followed. During an interview on 5/3/24 at 1:53 P.M., MDS Nurse #1 said for Resident #49 she found evidence the second page was completed on the NOMNC but could not find evidence the documents were mailed or returned. She said they did not follow up and was unaware of the HCP's desire or awareness of the appeal rights.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on observation, interview, and policy review, the facility failed to ensure the residents' environment was clean, comfortable, and homelike. Specifically, the facility failed to ensure the residents' rooms and environment were maintained in good repair and homelike on 2 of 2 resident care units. Findings include: Review of the facility's policy titled Safe and Homelike Environment, dated as last revised 10/10/24 (sic) indicated but was not limited to the following: -The facility will provide a safe, clean, comfortable, and homelike environment. -Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas. -Orderly is defined as an uncluttered physical environment that is neat and well-kept. -Sanitary includes, but is not limited to, preventing the spread of disease causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living. -Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. -General Considerations: Report any furniture in disrepair to Maintenance promptly. -Report any unresolved environmental concerns to the Administrator. The facility failed to provide a preventative maintenance policy. Between 5/2/24-5/3/24, the surveyor observed the following: -room [ROOM NUMBER]: Baseboard heater broken/separated; window curtain dirty with rust color stains; nightstand door broken/hanging off; bathroom sink with rust around faucet and hot water knob; ceiling above/in the closet was stained a rust color which looked like water damage and the wallpaper border was falling off the wall. -room [ROOM NUMBER]: Window blinds broken, missing multiple slats leaving large gap of uncovered window. room [ROOM NUMBER]A wheelchair filthy with caked on food/debris. -room [ROOM NUMBER]: Window cracked/broken and taped with bright red tape; baseboard/wall with scuffed up paint. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER]: Entry wall scuffed up with paint chipped off the wall; window curtain filthy with rust-colored stains; Bathroom wall and ceiling in disrepair with what looked like water damage to plaster/sheet rock with staining and old patch work repairs. -room [ROOM NUMBER]: Window curtain filthy with rusty colored stains; multiple holes in the wall next to the window; Bathroom sink with rust stains around faucet into sink and around hot water handle. -room [ROOM NUMBER]: Window curtain with yellow/rust-colored stains. -Unit One Day Room: Multiple window blinds broken with missing and/or broken slats, some windows with no blinds at all; Baseboard heater panels broken/hanging off the wall. -Second Floor Kitchenette: Wall grate dented and in disrepair, not fully secured to the wall. -room [ROOM NUMBER]: Window in disrepair, frame appeared to be missing parts and was taped with silver tape. -room [ROOM NUMBER]: Window blinds broken with multiple missing slats and exposed window. room [ROOM NUMBER]A left side bed rail covered with dried dirt/debris on grab handle. -room [ROOM NUMBER]: Large crack down the corner of the wall. room [ROOM NUMBER]B wheelchair armrest torn with rough material to grasp and exposed foam. -room [ROOM NUMBER]: Window broken with multiple cracks taped together with duct tape. -room [ROOM NUMBER]: Window falling off the rail/track and no screen on the window. -Unit Two Day Room: Window blinds with broken slats, baseboard heater panels broken/hanging off the wall. During an interview on 5/7/24 at 11:50 A.M., the Administrator and Consulting Staff #1 said they did not believe there was a policy for routine facility maintenance. During an interview on 5/8/24 at 9:38 A.M., the Maintenance Director said they do rounds on the units, but he did not have a schedule for rounding the floors. He said each floor has a maintenance book and he checks that twice a day but was unaware of the damage to the rooms when shown by the surveyor. During a follow-up interview on 5/8/24 at 1:18 P.M., the Maintenance Director said before a new admission comes in, they check the beds, but he does not walk around the room or look up at the ceiling. He said these concerns would be his responsibility to repair but he was unaware of them. Additionally, he said it is not very homelike with broken blinds and baseboard heaters and the broken windows that are taped are a safety concern. He said several of the rooms were in disrepair and he would have to walk around the entire building to see what else needed to be repaired. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/24 at 1:32 P.M., the Administrator said his expectation is that rounds are completed to identify issues and expect that the residents have a homelike environment and these concerns with stains on curtains, holes in the walls, and broken windows etc. should have been identified and a solution in process but they were not. During a follow-up interview on 5/8/24 at 4:16 P.M., the Administrator said they have a rounding process in place, but it needs improvement. He said the Maintenance Director is not part of it and he should be. Additionally, he said each department head is assigned a room/area and they are supposed to complete a checklist to identify concerns, however he said there is no tracking process for the forms, and he only had one returned to him with no concerns identified. He said he was unaware of the concerns the surveyor showed him and those areas would need to be addressed. The Administrator said those rooms are not very homelike with the damage and the broken windows are dangerous and should not be duct taped together.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 48362 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the Resident's status for three Residents (#4, #1, #160), out of a sample of 15 residents. Specifically, the facility failed: 1. For Resident #4, to accurately reflect falls sustained in the facility; 2. For Resident #1, to accurately reflect hospice services; and 3. For Resident #160, to accurately reflect the use of a Foley catheter. Findings include: 1. Resident #4 was admitted to the facility in April 2016 with diagnoses including history of falling and muscle weakness. Review of Resident #4's medical record indicated he/she sustained three falls in the facility on 4/11/24, 4/16/24 and 4/25/24. Review of Section J on the MDS assessment, dated 4/29/24, indicated Resident #4 had not sustained any falls since the prior MDS assessment on 3/2/24. During an interview on 5/8/24 at 12:00 P.M., MDS Nurse #1 said she reviews the medical record for each resident since the previous MDS assessment to determine items to be coded on the new assessment. MDS Nurse #1 and the surveyor reviewed the falls Resident #4 sustained in the facility over the past several months. MDS Nurse #1 reviewed the MDS assessment completed 4/29/24, including Section J. MDS Nurse #1 said the falls Resident #4 sustained should have been documented on the most recent MDS assessment. MDS Nurse #1 said the assessment would need to be modified to correctly reflect Resident #4's fall history. 48084 2. Resident #1 was admitted to the facility in June 2019 with diagnoses including abnormal weight loss, cognitive communication deficit, dementia, and epilepsy. Review of the medical record indicated Resident #1 was admitted to Hospice services on 4/8/24. Review of the MDS assessment, dated 4/24/24, Section O110 indicated Resident #1 was not on Hospice Services and Section J1400 indicated there was not a less than 6-month prognosis. During an interview on 5/3/24 at 10:28 A.M., MDS Nurse #1 said she did not correctly document on the MDS, and the Resident was receiving Hospice Services with a less than 6-month prognosis and the MDS required a modification for accuracy. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	3. Resident #160 was admitted to the facility in April 2024 with diagnoses including urinary tract infection (UTI) and retention of urine. Review of the Admission/Re-Admission Nursing Assessment, dated 4/17/24, indicated Resident #160 was admitted with an indwelling Foley catheter. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Alteration/Risk for alteration in Bowel/Bladder continence as evidenced by/related to has indwelling catheter diagnosis urinary retention (4/18/24) Review of the MDS assessment, dated 4/24/24, Section H100 failed to indicate Resident #160 had an indwelling catheter. During an interview on 5/3/24 at 12:41 P.M., MDS Nurse #1 said Resident #160 had an indwelling catheter and it should have been coded on the MDS. She said the MDS would need to be modified for accuracy.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49424 Based on record review, policy review, and interview, the facility failed to ensure staff developed and implemented a baseline care plan within 48 hours of the resident's admission, which included the instructions needed to provide effective and person-centered care to the resident and provide the resident and/or their representative with a summary of the baseline care plan for two Residents (#52 and #109), out of a total sample of 15 residents. Specifically, the facility failed: 1. For Resident #52, to provide him/her a written summary of the baseline care plan by completion of the comprehensive care plan and document receipt of the information within the Resident's clinical record; and 2. For Resident #109, to develop a baseline care plan for Post-Traumatic Stress Disorder (PTSD- mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). Findings include: Review of the facility's policy titled The Baseline Care Plan, last reviewed December 2022, indicated but was not limited to the following: -The facility will develop and implement a Baseline Care Plan for each resident within 48 hours of admission. -The resident and representative, if applicable, will be informed of the initial plan for delivery of care and services by receiving a written summary of the Baseline Care Plan. 1. Resident #52 was admitted to the facility in January 2024 and had diagnoses including respiratory failure with dependence on supplemental Oxygen. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/17/24, indicated Resident #52 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. During an interview on 5/6/24 at 10:50 A.M., Resident #52 said he/she did not have a meeting within 48 hours of their admission and did not receive any written summary of the baseline care plan since admission. The Resident said he/she keeps all records the facility provides including meal tickets and he/she would have kept a copy of the baseline care plan so he/she would know what his/her care needs were. During an interview on 5/7/24 at 2:01 P.M., the Social Worker (SW) said the MDS Coordinator is responsible for coordination of the baseline care plan meetings and ensuring completion. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24 at 8:25 A.M., the MDS Coordinator said she begins the baseline care plan and provides the copy to the rest of the interdisciplinary team to complete, and it is signed at the clinical morning meeting and uploaded into the resident's chart. She said she didn't know why this Resident's baseline care plan was not completed and she said that the interdisciplinary team should have signed the care plan. She said that she does not provide a copy to the resident or resident representative and was unaware she should be providing a copy of the baseline care plan. During an interview on 5/8/24 at 8:36 A.M., the Director of Nursing (DON) said the MDS Coordinator oversees the care plan process including the paper process for baseline care plans. She said the baseline care plan for Resident #52 was incomplete and failed to indicate clinical information, contributing staff signatures, and failed to indicate if the resident was offered or received a written summary of the baseline care plan. She said the expectation is that the resident or resident representative receive a copy of the baseline care plan since their care is collaborative and person-centered. 48084 2. Review of the facility's policy titled Trauma Informed Care, dated as last revised 3/4/24, indicated but was not limited to the following: -It is the policy of this facility to provide care and services which address the needs of trauma survivors by minimizing triggers and/or re-traumatization. -DEFINITIONS: Trauma results from an event or series of events, or circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. -The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals to develop and implement individualized care plan interventions. -The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. Resident #109 was admitted to the facility in April 2024 with diagnoses including PTSD and depression. Review of the Nursing Admission Assessment failed to indicate a diagnosis of PTSD. Review of the MDS assessment, dated 4/30/24, Section I6100 indicated Resident #109 had a diagnosis of PTSD. Review of the Social Services Assessment, dated 5/3/24, indicated the assessment was incomplete. Review of the medical record failed to indicate a PTSD Assessment had been completed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the paper Baseline Care Plan in the Resident Record/Chart with Nurse #1 failed to indicate the care plan had been developed. The document was blank. During an interview on 5/3/24 at 1:35 P.M., Nurse #1 said the facility no longer uses paper forms and the Baseline Care Plan would be in the computer and initiated within 48 hours of admission. Additionally, he said Resident #109 did not have a current care plan for PTSD. Review of the Care Plan failed to indicate a care plan had been developed for PTSD. Review of the Care Kardex (summary of resident's care and preferences) failed to indicate any trauma associated triggers to guide resident care. During an interview on 5/3/24 at 1:39 P.M., Resident #109 said he/she does have a diagnosis of PTSD, and no one had asked about it, how the trauma occurred, or what things may re-trigger the trauma. Resident #109 shared with the surveyor the physical and emotional trauma they had endured and said they have been incapable of being in a closed space with a male and could never think of having a male being nearby during care or providing personal care and speaking of it now is causing anxiety. Additionally, Resident #109 said no one at the facility had discussed this or said they could put barriers in place to ensure events like this would not come up. The surveyor encouraged Resident #109 to speak with the SW and share the triggers to ensure comfort and safety at the facility. During an interview on 5/3/24 at 11:12 A.M., SW #1 said she had not completed a PTSD Assessment on Resident #109 and had not seen one at this facility. Additionally, she said there was no Baseline Care Plan for PTSD and there should be one to identify the resident's triggers and therefore ensure the staff can do their best to avoid them or work around the process for the Resident as best as possible. SW #1 said she was unsure of the facility policy but said the regulatory guidelines in this instance were not followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48084 Based on observation, interview, record review, and policy review, the facility failed to implement interventions on the Falls Care Plan for one Resident (#21), out of a total sample of 15 residents to meet the resident's physical, psychosocial and functional needs. Findings include: Review of the facility's policy titled Comprehensive Care Plans, dated as last revised 3/4/24, indicated but was not limited to the following: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. -The comprehensive care plan will describe, at minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. -Qualified staff responsible for carrying out interventions specified in the care plan. Review of the facility's policy titled Fall Reduction, dated as last revised 6/22/22, indicated but was not limited to the following: -The facility will implement interventions to minimize and/or eliminate contributing factors for falls for residents at risk based in the individual resident's needs. -Implement intervention(s) as appropriate to prevent reoccurrence. Resident #21 was admitted to the facility in January 2024 with diagnoses including dementia, muscle weakness, unsteadiness on feet, and history of right hip traumatic fracture. Review of the Minimum Data Set (MDS) assessment, dated 4/10/24, indicated Resident #21 had severe cognitive impairment as evidenced by a score of 6 out of 15 on the Brief Interview for Mental Status (BIMS), required assistance with activities of daily living (ADLs), and had a history of recent falls. Review of the Physician's Orders indicated but were not limited to the following: -Place Dycem on top of the cushion prior to seating patient in the wheelchair (4/23/24). Review of the Comprehensive Care Plans indicated but was not limited to the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FOCUS: Risk for injury related to falls as evidenced by/related to history of falls, impaired mobility. GOAL: Free from fall related injury through next review. INTERVENTIONS: -Non-skid strips to side of bed and in front of the closet (1/25/24) -Place Dycem (non-slip pad) on top of cushion prior to seating patient in wheelchair (4/24/24) The surveyor made the following observations: -5/2/24 at 10:18 A.M., no non-skid strips on floor next to bed or in front of closet and no Dycem on wheelchair cushion. -5/3/24 at 8:30 A.M., no non-skid strips on floor next to bed or in front of closet; Resident was sitting in wheelchair with no Dycem on the wheelchair cushion. -5/3/24 at 9:56 A.M., no non-skid strips on floor next to bed or in front of closet and no Dycem on wheelchair cushion. (Dycem was under wheelchair cushion). -5/7/24 at 8:41 A.M., no non-skid strips on floor next to bed or in front of closet and no Dycem on wheelchair cushion. During an interview on 5/7/24 at 11:20 A.M., Nurse #3 said there were not any non-skid floor strips in Resident #21's room and the wheelchair cushion did not have a Dycem on top of it per the care plan. During an interview on 5/7/24 at 12:04 P.M., the Director of Nurses (DON) said there were no non-skid strips next to bed or closet and there was no Dycem on top of the cushion. She said she would expect the staff to be following the care plan and Resident #21 likely had a room change after the intervention was initially added for the floor strips, but she would expect the interventions to follow the Resident with a room change. During an interview on 5/7/24 at 12:04 P.M, Consulting Staff #1 said she did not realize the order/care plan said the Dycem should be on top of the cushion, and it was only beneath the cushion. Additionally, she said the floor strips were not there and they should have been placed in this room when he/she had a room change. She said she would expect the interventions to go with them when they move rooms.

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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. 48362 Based on observations, interviews, record review, and policy review, the facility failed to ensure activity of daily living (ADL) care was provided to maintain good personal grooming for one Resident (#46), out of a total sample of 15 residents. Specifically, the facility failed to ensure nail care was performed for Resident #46. Findings include: Review of the facility's policy titled Nail Care, last revised 3/4/24, indicated but not limited to: - The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. - Routine cleaning and inspection of nails will be provided during activities of daily living (ADL) care on an ongoing basis. - Routine nail care, to include trimming and filing, will be provided/offered on a regular schedule and as needed based on resident need and preference. - Principles of nail care: nails should be kept smooth to avoid skin injury; each resident will have his/her own nail care equipment (e.g., clippers, emery boards, files, etc.); equipment will not be shared between residents. - Procedure: document completion of task, any complications, or if resident refuses. Resident #46 was admitted to the facility in May 2021 with diagnoses including need for assistance with personal care and muscle weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/21/24, indicated the Resident was dependent on staff for ADLs and personal hygiene. The MDS assessment also indicated Resident #46 was cognitively intact as evidenced by a score of 14 out of 15 on the Brief Interview for Mental Status (BIMS). During an observation with interview on 5/2/24 at 9:05 A.M., the surveyor observed Resident #46 to have long fingernails. Resident #46 said he/she had long fingernails because staff do not cut them routinely. Resident #46 said he/she had a shower three days prior and no one attempted to cut his/her nails. Resident #46 said he/she was embarrassed by how long and dirty their fingernails were and he/she would not typically like them to be long but could not manage them on his/her own. On 5/3/24 at 7:19 A.M., the surveyor observed the Resident in bed and noted his/her fingernails to be long, yellowed and have a brown substance underneath some of the nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 5/6/24 at 8:43 A.M., the surveyor observed the Resident to be resting in bed and noted his/her fingernails to be long, yellowed and have a brown substance underneath four fingers on the right hand. Resident #46 said he/she had a shower three days prior but his/her nails were not cut or trimmed by staff. Resident #46 said he/she was embarrassed by their nails being so long and untrimmed. Review of the Certified Nurse Assistant (CNA) flow sheets indicated Resident #46 was dependent for grooming and personal care. Review of the documentation in the medical record failed to indicate the last time Resident #46 had their fingernails cut, filed, or cleaned. Furthermore, the documentation in the medical record failed to indicate Resident #46 had refused fingernail care. During an interview on 5/3/24 at 8:13 A.M., CNA #2 said Resident #46 usually gets showered once a week and nail care would typically be done at that time. CNA #2 said while nail care is typically completed after a shower, it can be done any day during any shift if the Resident needs or wants their nails trimmed. CNA #2 said residents are accommodated for nail care when they ask. During an interview on 5/3/24 at 9:03 A.M., CNA #3 said Resident #46 should have his/her nails trimmed and filed on shower days but it can be done at any time nail care is needed. CNA #3 said if a resident refuses or is reluctant to nail care they would notify the nurse to document attempts that were made and resident response. CNA #3 said at times Resident #46 can be resistive to nail care but if you talk to him/her and re-approach he/she is reasonable. CNA #3 said if Resident #46 continued to refuse care, staff could have the nurse or Director of Nursing (DON) talk with him/her about why nail care was necessary. CNA #3 said he thought Resident #46 last had nail care about two to three weeks ago, but the Resident was not currently on their assignment. During an interview on 5/7/24 at 9:58 A.M., Nurse #6 said CNA staff would be noting the length of nails when completing morning care daily. Nurse #6 said if fingernails were assessed to be long or dirty during morning care, CNAs would complete nail care. Nurse #6 said there was no specific day or time when nail care was performed, but rather to be completed when fingernails were noted to be long or dirty. Nurse #6 said CNAs would report to the nurse if a resident refused nail care. Nurse #6 said they would re-approach the resident and educate them on the importance of nail care. Nurse #6 said if a resident continued to refuse nail care it should be documented in a nursing note. During an interview on 5/7/24 at 11:53 A.M., the DON said staff are expected to assess fingernails for cleanliness and length during daily care. The DON said she would also expect staff to assess fingernail length on shower days. The DON said if a resident needed nail care, she would expect staff to be trimming, filing and cleaning fingernails. The DON said nursing documentation should reflect refusal of nail care. The DON and the surveyor reviewed the observations and interviews with Resident #46 related to nail care. The DON said Resident #46 often refuses care, but refusal of nail care should be documented in the record as well as any re-approach and education provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48362 Based on observation, record review, policy review and interview, the facility failed to provide adequate supervision and an environment free from accidents and/or hazards for three Residents (#4, #19, and #26), out of a total sample of 15 residents. Specifically, the facility failed: 1. For Resident #4, to follow their fall Reduction policy for investigating falls and initiating fall prevention interventions; 2. For Resident #19, to follow their fall Reduction policy for investigating falls and initiating fall prevention interventions; and 3. For Resident #26, to follow their Elopements and wandering residents policy for assessing risk factors and implementing interventions to prevent further elopements. Findings Include: 1. Review of the facility's policy titled Fall Reduction, dated as last revised [DATE], indicated but was not limited to the following: - Goal: To identify residents at risk for falls and to decrease the incidence of resident falls. - The facility will identify residents at risk for falls through use of a Fall Assessment Tool. - The facility will implement interventions to minimize and/or eliminate contributing factors for falls for residents at risk based on the individual resident's needs. - The facility will provide education on fall prevention to caregivers, residents, and family. - In the event that a fall occurs, the facility will investigate the factors contributing to the fall and develop a plan of action to minimize further falls. - Upon admission, readmission, quarterly, annually and with change in condition and/or after a fall has occurred, residents will be evaluated for risk of potential falls by completing a Fall Risk Assessment. - Residents at risk, in addition to the Universal Safety Standards; will be reviewed for resident specific intervention(s) as deemed appropriate. - In the event a resident falls, the following measures will be instituted: e. Evaluate why the resident may have fallen, clarify the details of the fall. f. Implement intervention(s) as appropriate to prevent recurrence. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Document in the medical record. h. Complete an Incident Report. - Resident falls will be reviewed in the Standard of Care Meeting and may include, but not be limited to, the following: identification of trends, evaluation of effectiveness of interventions and development of additional measures as indicated. Resident #4 was admitted to the facility in [DATE] with diagnoses including schizoaffective disorder, history of falling, and muscle weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #4 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Further review of the MDS assessment indicated Resident #4 required assistance of one staff member for transfers, ambulation, toileting, and dressing activities. Review of the medical record indicated Resident #4 had a total four falls between [DATE] and [DATE]. Review of Resident #4's Incident Report, dated [DATE], indicated: - On [DATE] at 5:30 A.M., the nurse heard Resident #4 calling for help from their room and responded. The nurse found Resident #4 on the floor, unclothed, just beside his/her bed with his/her body facing the door. - Resident #4 stated they had slipped and fallen on the floor landing on his/her right hip. Resident #4 had complaints of right hip and neck pain. Review of the medical record failed to indicate a Fall Risk Assessment was completed for the incident on [DATE]. Review of the medical record failed to indicate any interventions were developed or implemented post fall. Review of Resident #4's interdisciplinary care plan for falls failed to indicate any interventions were developed or implemented post fall. Review of Resident #4's Incident Report, dated [DATE], indicated: - On [DATE] at 3:50 P.M., another resident reported to the nurse that Resident #4 was on the floor. The nurse and two other nurses went into Resident #4's room and observed him/her to be seated on the floor next to his/her bed with both feet slightly bent. Resident #4 was observed to have one foot slightly stuck underneath his/her buttock. - Resident #4 said he/she was trying to get out of bed. Review of the medical record failed to indicate a Fall Risk Assessment was completed for the incident on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record failed to indicate any interventions were developed or implemented post fall. Review of Resident #4's interdisciplinary care plan for falls failed to indicate any interventions were developed or implemented post fall. Review of Resident #4's Incident Report, dated [DATE], indicated: - On [DATE] at 3:30 P.M., the nurse was called into Resident #4's room by the Certified Nursing Assistant (CNA). The nurse discovered Resident #4 on the ground lying on their back at the foot of the bed. No visible injury was noted. - Resident #4 said he/she went to the bathroom in the wheelchair and it moved from them causing him/her to fall. - The incident report indicated Resident #4 had a numerical pain scale rating of 3 out of 10 related to the head/neck and he/she was ambulatory with assistance. - The incident report indicated Resident #4 had removed gripper socks and donned their own socks prior to the incident occurring. The facility's Fall Risk Assessment completed on [DATE] indicated Resident #4's last known fall was during the current stay/within the last month, he/she had dizziness/generalized weakness related to mobility, he/she was oriented to person and place, he/she had no communication/sensory deficits, he/she was behavioral/non-compliant with instructions and takes medication for the cardiovascular or central nervous system. The Fall Risk Assessment failed to indicate a fall risk score for Resident #4. Review of Resident #4's interdisciplinary care plan for falls indicated an intervention of Physical Therapy (PT) referral for screen and treatment as needed. Review of the PT therapy documentation indicates Resident #4 had been receiving skilled services since [DATE] after returning to the facility from a hospitalization for a previous fall. Review of Resident #4's Incident Report, dated [DATE], indicated: - On [DATE] at 10:30 A.M., the nurse was told by a Certified Nursing Assistant (CNA) that the Resident was on the floor in the dining room. The nurse and another nurse on the unit responded to Resident #4 in the dining room. Resident #4 was observed to be lying on his/her back with his/her head between a chair and the piano in the dining room. - Resident #4 said he/she was trying to transfer from the wheelchair to a standard chair when they lost their balance and fell to the floor hitting their head on the chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Risk Assessment completed on [DATE] indicated Resident #4's last known fall was within the last three months, he/she requires assist of one person for mobility, he/she is oriented to person and place, he/she has no communication/sensory deficits, Resident #4 exhibits impulsive behavior, he/she takes medication for cardiovascular or central nervous system, and he/she has no problem with volume/electrolyte status. The Fall Risk Assessment failed to indicate a fall risk score for Resident #4 indicating level of fall risk. Review of the medical record failed to indicate any interventions were developed or implemented post fall. Review of Resident #4's interdisciplinary care plan for falls failed to indicate any interventions were developed or implemented post fall. During an interview on [DATE] at 2:32 P.M., Resident #4's Health Care Proxy (HCP) said he was concerned regarding Resident #4's falls which have increased over the last year. The HCP said he is notified by the facility after Resident #4 has a fall. The HCP said Resident #4 has had no major injuries from the falls. The HCP said he did not feel like the facility informed him of what they were doing to prevent further falls or incidents for Resident #4. The HCP said he was not informed if the facility determined the cause of the fall or any plans to prevent future falls. The HCP said he was unaware of any interventions put in place after a fall occurs. The HCP said there was no communication on how the facility plans to prevent futures issues and it would be a great improvement to ensure quality care is being provided. During an interview on [DATE] at 12:04 P.M., the Director of Nursing (DON) said when a fall occurs in the facility the nursing staff would complete an incident report. The DON said the interdisciplinary team would update the resident's care plan with interventions within a day or so. The DON said all falls are reviewed weekly on Friday at the facility's Risk Meeting. The DON said interdisciplinary care plan interventions should be followed. During an interview on [DATE] at 8:36 A.M., Nurse #5 said after a resident sustains a fall in the facility, the nurse would complete a fall risk assessment and fall incident report. Nurse #5 said any orders would be updated. Nurse #5 said the interdisciplinary care plan would be updated to reflect any fall interventions implemented. During an interview on [DATE] at 11:55 A.M., the Director of Rehabilitation (DOR) said they are notified of a resident's fall through a screen form. The DOR said the screen is either given to her directly or left in her office depending on when a resident falls. The DOR said the form is reviewed and additional information is gathered the following morning in the clinical meeting. The DOR said the rehabilitation department would complete a screen and/or an evaluation to determine the need for skilled therapy services after a fall occurs. During an interview on [DATE] at 1:35 P.M., the DON said the interdisciplinary care plan should be updated after each fall that occurs in the facility. The surveyor and the DON reviewed the medical record for Resident #4. The DON said interventions should be updated on the fall care plan after each incident and were not. 49425 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #19 was admitted to the facility in [DATE] with diagnoses including neuropathy (group of diseases resulting from damaged or malfunctioning of nerves that causes weakness, numbness and pain in hands and feet), repeated falls, and muscle weakness. Review of the most recent MDS assessment, dated [DATE], indicated Resident #19 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Review of the medical record indicated Resident #19 had a total of two falls between [DATE] and [DATE]. Review of Resident #19's Incident Report, dated [DATE], indicated but was not limited to the following: - On [DATE] at 3:30 P.M., the nurse heard a loud noise coming from the dining room and noted Resident #19 lying on his/her back. Resident #19 said he/she was trying to pick up lucky coins, fell and hit his/her head. Review of the medical record and interdisciplinary care plan for falls failed to indicate any interventions were developed or implemented after the fall to prevent recurrence. Review of Resident #19's Incident Report, dated [DATE], indicated but was not limited to the following: - On [DATE] at 4:10 A.M., Certified Nursing Assistant (CNA) heard the resident calling out for help, entered the room and called for the nurse to come into the room. The nurse observed Resident #19 sitting up on the floor. Resident #19 said he/she was going to the bathroom, slipped and fell . - Resident #19 complained of soreness in their right side of his/her face and right knee. Review of the medical record indicated a Fall Risk Assessment was started but incomplete with errors after the fall on [DATE]. Further review of the medical record and review of the interdisciplinary care plan for falls failed to indicate any interventions were developed or implemented after the fall to prevent recurrence. During an interview on [DATE] at 12:44 P.M., Nurse #1 said when a resident has a fall, he completes an incident report in the computer and obtains witness statements. He said the fall is reviewed and the resident's care plan is updated with interventions to decrease the resident's risk of falling again. During an interview on [DATE] at 12:48 P.M, the DON said her expectation is for Resident #19's care plan to be updated with a new intervention that is relevant to how the fall occurred to reduce the risk of falling again. She said all falls are supposed to be reviewed with the risk management team to ensure new interventions, and care plans are put into place for the resident's safety. She said Resident #19's medical record and care plan has not been updated with any new interventions as it should have been after his/her falls, per facility policy. 49424 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility's policy titled Elopements and Wandering Residents, dated [DATE], indicated but was not limited to: -Elopement is defined as when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. -The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. -Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. -Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Resident #26 was admitted to the facility in [DATE] with diagnoses including unspecified intellectual disabilities, dementia with behavioral disturbances, and unspecified psychosis. Review of the MDS assessment, dated [DATE], indicated Resident #26 scored a 13 out of 15 on the BIMS assessment. Resident's Healthcare Proxy (HCP) was activated due to impaired judgement and intellectual disabilities. During an interview on [DATE] at 12:39 P.M., Resident #26 said they had walked to the grocery store about one year ago and when they came back, the staff put the wanderguard (device to sound an alarm to prevent elopement/wandering) on him/her and then he/she kept it in their pocket. Resident #26 said he/she did not have the wanderguard device anymore and did not know when he/she stopped needing it. Review of the medical record indicated the facility failed to complete an elopement risk screen upon Resident #26's return to the facility on [DATE]. Additionally, the nursing progress notes indicated staff applied a wanderguard to right wrist on [DATE]. The medical record indicated a physician's order was received for a wanderguard to be placed on [DATE]. Review of the Care plans for Resident #26 failed to indicate a comprehensive care plan with interventions to prevent or identify risks for elopement/wandering was developed or implemented. Review of the nursing progress notes indicated on [DATE] the hand/arm of Resident #26 was swollen, the wanderguard was removed and the Resident was told to always keep the wanderguard in his/her pocket. Review of the current and active task progress notes indicated the following: -Resident has a wanderguard and carries it in his/her pocket (with serial number and expiration of [DATE]) (continued on next page)

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Cedarwood Gardens	130 Chestnut Street Franklin, MA 02038

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Elopement risk identification sheet completed and placed in elopement book -Monitor resident when going towards the elevator, for tailgating of other residents or family members Review of the Physician's Orders indicated the order for the wanderguard was updated on [DATE] to include in the description: - Wanderguard in place, check function every shift; with serial number and an expiration date of [DATE] (the device expiration date had already occured when this ordered was updated.) Review of the Physician's Orders indicated the order for wanderguard was discontinued on [DATE]. Review of the assessments for Resident #26 indicated an Elopement Risk Screen was created on [DATE] and was not completed, no additional Elopement Risk Screens were completed for Resident #26. Review of the Quarterly Care Plan review, dated [DATE], indicated Resident #26 was an elopement risk and had a wanderguard. During an interview on [DATE] at 2:40 P.M., the MDS Coordinator said she opened an elopement focused care plan for Resident #26 but did not create any interventions. She also said the risk assessment should have been completed to determine if Resident #26 continued to be an elopement risk, but it was not completed. She said in the intervention section of the care plan is where the wanderguard information should be such as placement and expiration date. She said that the wanderguard device should have been replaced when the order was updated in January since the wanderguard device had expired. During an interview on [DATE] at 7:45 A.M., the DON said she would expect to find the location of the wanderguard placed on the body, the serial number of the device, and an expiration date that had not passed to be in the care plan and orders for Resident #26 after his/her elopement. She said that she would expect that an elopement assessment was completed. She said there was a nursing note that indicated the Resident kept the wander guard device in his/her pocket, but she said she feels this does not prevent elopement since the device was not secure on the Resident's body. She said she would expect that there were personalized interventions in place to identify and reduce risks of the Resident having another elopement, but there were not. She said Resident #26 should still have the wanderguard device in place unless an assessment was completed and the assessment determined the Resident was not a risk for elopement. She said there was no assessment indicating the Resident was no longer at risk for elopement.

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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. 48362 Based on observation, interview, record review and policy review, the facility failed to provide indwelling catheter (a flexible tube inserted into the bladder to drain urine outside of the body) care and management consistent with professional standards for three Residents (#34, #160, and #16), out of a total sample of 15 residents. Specifically, the facility failed: 1. For Resident #34, to ensure the Foley catheter was assessed for removal as soon as possible or determine a clinical condition related to Foley catheter placement on admission to the facility; 2. For Resident #160, to ensure orders were in place for the Foley catheter and Foley catheter care, and to ensure the Foley catheter bag was hung at an appropriate level, below the bladder to discourage backflow of urine which helps prevent urinary tract infections (UTIs); and 3. For Resident #15, to ensure the catheter bag was hung at an appropriate level, below the bladder, to discourage backflow of urine which helps to prevent UTIs. Findings include: Review of the facility's policy titled Appropriate Use Indwelling Catheters, last revised 3/4/24, indicated but was not limited to the following: - It is the policy of this facility to ensure that a resident who is continent of bladder on admission receives services and assistance to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain. - An indwelling urinary catheter will be utilized only when a resident's clinical condition demonstrates that catheterization was necessary. - It is the policy of this facility to ensure each resident with urinary incontinence: b. Who is admitted with an indwelling urinary catheter, or each resident who subsequently receives an indwelling catheter, will be assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. - Any decision regarding the use of an indwelling urinary catheter will be based on the resident's condition and goals for treatment. - The resident and/or representative will be included in discussions about the indications, use, potential benefits and risks of urinary catheters, and alternatives to help support the resident's rights to make an informed decision. - The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of catheter necessary, size of the catheter, frequency of change (if applicable). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Documentation to support decision making will be included in the medical record, including but not limited to: a. Clinical or medical conditions demonstrating the need for an indwelling urinary catheter. b. Assessment of incontinence, including the type, frequency, duration, and complicating factors associated with the incontinence. c. Assessment of psychosocial and functional factors affecting urinary continence status. d. Services provided to restore normal bladder function to the extent possible. e. Response to interventions prior to the decision to use an indwelling catheter. f. Resident's wishes and prognosis. - Indwelling urinary catheters will be used on a short-term basis, unless the resident's clinical condition warrants otherwise. - The interdisciplinary team, with the support and guidance form the physician, will assure the ongoing review, evaluation, and decision-making regarding the insertion, continuation, or removal of an indwelling catheter. - The plan of care will address the use of an indwelling catheter, including strategies to prevent complications. Review of the facility's policy titled Catheter Care, dated as last revised 3/4/24, indicated but was not limited to the following: -It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. -Catheter care will be performed every shift and as needed. -Privacy bags will be available and catheter drainage bags will be covered at all times while in use. -Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. 1. Resident #34 was admitted to the facility in March 2024 with diagnoses including retention of urine, history of UTI, benign prostatic hyperplasia (BPH - a condition in which the flow of urine is blocked due to the enlargement of the prostate gland). Review of the Minimum Data Set (MDS) assessment, dated 3/8/24, indicated Resident #34 was cognitively intact with a score of 14 out of 15 on the Brief Interview for Mental Status (BIMS) evaluation. The MDS assessment further indicated Resident #34 had an indwelling catheter placed and was dependent for activities of daily living (ADL), bed mobility and transfers. The MDS assessment indicated Resident #34 had a Genitourinary (reproductive/urinary system) diagnosis of BPH only. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24 at 8:53 A.M., the surveyor observed Resident #34 resting in bed with his/her Foley catheter hanging from the side of the bed. Resident #34 said he/she does not need the Foley catheter. Resident #34 said it was put in during a hospitalization and has not been removed. Resident #34 said he/she has asked the nursing staff in the facility to remove the Foley catheter and has been given no explanation as to why he/she has it. On 5/7/24 at 12:24 P.M., the surveyor observed Resident #34 resting in bed with his/her Foley catheter hanging from the side of the bed. Resident #34 said he/she has never been given the opportunity of having the Foley catheter removed. Resident #34 said he/she would like to try to have the Foley catheter removed. Review of Resident #34's active Physician's Orders indicated but were not limited to: - 3/1/24: Provide Foley catheter care every shift and as needed - 3/2/24: Foley catheter order - Size 16 French (Fr) with 10 cubic centimeter (cc) balloon Review of Resident #34's Admission/Re-Admission Nursing Assessment, dated 3/1/24, indicated the following under Section 34 - Bladder: - Resident #34 had been incontinent or had a catheter for an unknown period. - Resident #34 was incontinent 1-2 times a week. - Resident #34 was taking diuretic (medication that help reduce fluid buildup in the body) medications. - Resident #34's catheter size and type were not indicated on the assessment. Further review of the electronic record indicated the Admission/Re-Admission Nursing Assessment, dated 3/1/24, was noted to be in progress and incomplete. Review of Resident #34's medical record failed to indicate a voiding trial had been attempted upon admission to the facility. Further review of the medical record failed to indicate the facility had contacted Resident #34's Urologist in the community to gather information related to the Foley catheter placement. Additionally, the medical record failed to indicate Resident #34 had been seen by a Urologist since admission to the facility. Review of the Hospital Summary documentation indicated Resident #34 had a chronic Foley catheter and diagnoses including BPH and history of UTIs. The documentation failed to indicate how long the Foley catheter had been inserted and if/when a voiding trial for removal had been attempted. Review of the Physician (MD) and Nurse Practitioner (NP) progress notes indicated Resident #34 had a chronic indwelling Foley catheter. MD/NP progress notes failed to indicate medical reasoning for current placement of Foley catheter, voiding trial and/or follow up with Urology regarding Foley catheter placement. (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 5/7/24 at 2:18 P.M., Nurse #1 said when a resident with a Foley catheter is admitted to the facility, we check to make sure there is a reasoning or clinical diagnosis. Nurse #1 said staff would reach out to the MD to discuss the continued use or discontinuation of use related to the Foley catheter. Nurse #1 said if it was appropriate orders would be obtained from the MD to start a voiding trial. Nurse #1 said if a resident was seeing a Urologist in the community, they would contact them to gather more information regarding the Foley catheter placement. Nurse #1 said he was uncertain if Resident #34 had any voiding trials since admission or his diagnosis related to the Foley catheter placement. During an interview on 5/7/24 at 2:40 P.M., the Director of Nursing (DON) said she believed the hospital documentation indicated Resident #34 had a voiding trial during his/her stay which he/she failed. The DON said she would have to review the clinical hospital documentation to verify the information related to the voiding trial. During an interview on 5/8/24 at 11:41 A.M., Consulting Staff #1 said she would expect documentation in the record related to diagnoses and reasoning for Foley catheter placement. Consulting Staff #1 said she would expect documentation related to rationale for follow up with urology and/or voiding trials. On 5/7/24 at 2:40 P.M., the surveyor requested any additional information related to Resident #34 and a voiding trial or other clinical reasoning related to Foley catheter placement. No additional information was provided to the surveyor by the facility prior to exit. 48084 2. Resident #160 was admitted to the facility in April 2024 with diagnoses including UTI, kidney transplant, and retention of urine. Review of the MDS assessment, dated 4/23/24, indicated Resident #160 had moderate cognitive impairment as evidenced by a score of 12 out of 15 on the BIMS and failed to indicate the Resident had an indwelling catheter. Review of the Admission/Re-Admission Nursing Assessment, dated 4/17/24, Section J indicated Resident #160 had a catheter. Review of the Physician's Orders failed to indicate orders for the catheter or catheter care. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Alteration/Risk for alteration in Bowel/Bladder continence as evidenced by/related to indwelling catheter and diagnosis of urinary retention. GOAL: Free from complications of catheter. INTERVENTIONS: -Dependent on staff for Foley care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Foley catheter care every shift and as needed. -Ensure anchoring bag to promote adequate drainage/prevent backflow. -Change catheter and drainage bag per facility protocol/orders. -Ensure drainage bag is covered for dignity at all times. -Empty and record urine from foley every shift and as needed. Review of the Care Card/Kardex indicated but was not limited to the following: -Foley catheter care every shift and as needed. -Ensure anchoring bag to promote adequate drainage/prevent backflow. -Change catheter and drainage bag per facility protocol/orders. -Ensure drainage bag is covered for dignity at all times. The surveyor made the following observations: -5/2/24 at 10:45 A.M., Resident sitting in wheelchair at nurses' station with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). -5/3/24 at 8:30 A.M., Resident sitting in wheelchair at nurses' station with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). -5/3/24 at 8:33 A.M., Resident sitting in wheelchair at nurses' station with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). Nurse #3 stopped and spoke to Resident and failed to move the drainage bag below the bladder. -5/3/24 at 8:45 A.M., Resident sitting in wheelchair at nurses' station with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). Nurse #3 stopped and gave Resident a drink, failed to move the drainage bag below the bladder and then assisted to put Resident back to bed. During an interview on 5/7/24 at 11:20 A.M., Nurse #3 said there should be orders for the catheter and catheter care and there were not any. During an interview on 5/7/24 at 12:04 P.M., the DON said Resident #160 should have a physician's order for the catheter and catheter care. She said there is a batch set of orders that should have been implemented and they were not. Additionally, she said the catheter drainage bag should not be hung on the armrest, it should be below the bladder on the wheelchair frame. 3. Resident #16 was admitted to the facility in December 2023 with diagnoses including urinary retention and history of urogenital implants. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment, dated 2/29/24, indicated Resident #16 was cognitively intact as evidenced by a score of 14 out of 15 on the BIMS and he/she had an indwelling catheter. Review of the Physician's Orders indicated but was not limited to the following: -Foley catheter care every shift and as needed (5/3/24). Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Indwelling Foley catheter: neurogenic bladder/urine retention. GOAL: Will be/remain free from catheter-related trauma through review date INTERVENTIONS: -Has a chronic Foley. Position catheter bag and tubing below the level of the bladder. -Change catheter once a month per doctor orders. -Catheter privacy bag is covered every shift when out of bed. Review of the Care Card/Kardex indicated but was not limited to the following: -Has a chronic Foley. Position catheter bag and tubing below the level of the bladder. -Monitor/Document for pain/discomfort due to catheter. The surveyor made the following observations: -5/2/24 at 10:45 A.M., Resident sitting in wheelchair at nurses' station with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). -5/2/24 at 1:15 P.M., Resident in hallway returned from appointment with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). -5/6/24 at 12:48 P.M., Resident in hallway with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). -5/6/24 at 4:23 P.M., Resident in hallway with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). -5/7/24 at 8:40 A.M., Resident sitting in wheelchair at nurses' station with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). Multiple staff members stopped and spoke to Resident between 8:40 A.M. and 9:00 A.M., none of the staff members moved the catheter drainage bag from the armrest of the wheelchair. -5/8/24 at 7:37 A.M., Resident self-propelling from dining room in wheelchair with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/8/24 at 7:41 A.M., Resident sitting in front of nurses' station with the DON and Nurse #7. -5/8/24 at 8:19 A.M., Staff Development Coordinator/Infection Control Nurse (SDC/IP) was interacting with Resident (cleaning the white board), Foley catheter drainage bag was attached to armrest of wheelchair (above the bladder), SDC/IP did not adjust catheter bag. Resident self-propelled down hallway in wheelchair past the SDC/IP after the above interaction and again the SDC/IP did not adjust the Foley catheter bag. -5/8/24 at 8:28 A.M., Resident sitting in front of nurses' station, SDC/IP sitting at nurses' station, acknowledged Resident, however, did not adjust catheter bag. Nurse #3 observed walking by Resident and did not adjust catheter bag. -5/8/24 at 11:08 A.M., Resident sitting in front of nurses' station with Foley catheter drainage bag attached to armrest of wheelchair (above the bladder). SDC/IP and Nurse #3 sitting at desk, neither adjusted catheter bag. During an interview on 5/8/24 at 7:39 A.M., Certified Nursing Assistant #4 said Resident #16 transfers him/herself into wheelchair and puts the catheter bag there (pointing to armrest). During an interview on 5/8/24 at 7:42 A.M., Resident #16 shook his/her head and said they do not get up independently to get into the wheelchair and staff put the catheter bag on the armrest of the wheelchair. During an interview on 5/7/24 at 12:04 P.M., the DON said the catheter drainage bag should not be hung on the armrest, it should be below the bladder on the wheelchair frame. During an interview on 5/8/24 at 11:36 A.M., Consulting Staff #1 said she was just on the unit and saw Resident #16's catheter drainage bag hanging on the arm rest of the wheelchair. She said she tried to move it and the Resident declined. Additionally, she said if he/she likes it up there and wants it there it should have been care planned that way and it was not. She said the care plan would need to be updated for Resident preference if that was the case.

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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. 48084 Based on observations, interviews, record review, and policy review, the facility failed for four Residents (#53, #54, #34, and #1), out of a sample of 15 residents, to ensure staff provided respiratory care and services consistent with professional standards of practice. Specifically, the facility failed: 1. For Resident #53, to ensure orders were in place for Oxygen and the equipment/tubing was changed per policy; 2. For Resident #54, to ensure a Respiratory care plan was developed and the nebulizer equipment/tubing/mask were stored and changed per policy; 3. For Resident #34, to ensure nebulizer equipment was clean and mask/tubing were stored per policy; and 4. For Resident #1, to ensure the oxygen equipment/tubing was changed per policy. Findings include: Review of the facility's policy titled Oxygen Administration Policy and Procedure, dated as last reviewed 12/6/22, indicated but was not limited to the following: -Oxygen is administered by Licensed Nurses with a physician's order. Orders should specify the oxygen equipment and flow rate, or concentration required as routine or as needed. -Oxygen equipment will be checked daily for correct flow and concentration, properly filled humidification system if in use, and correct set up of equipment. -Check the physician's order. If it is unclear, clarification must be obtained. -All tubing will be changed at least weekly, more often if soiling with secretions occurs. Review of the facility's policy titled Nebulizer Therapy, dated as last revised 3/4/24, indicated but was not limited to the following: -Verify practitioner's order. -Correctly assemble the tubing, nebulizer cup, and mouthpiece or mask per manufacturer's specifications and ensure connections are secured tightly. -Clean after each use. -Store nebulizer cup and the mouthpiece in a zip lock bag. -Change nebulizer tubing weekly or as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Periodically disinfect unit per manufacturer recommendations. 1. Resident #53 was admitted to the facility in March 2024 with diagnoses including acute respiratory failure, acute on chronic heart failure, obesity, and cerebral infarction (stroke). Review of the Minimum Data Set (MDS) assessment, dated 4/2/24, indicated Resident #53 was cognitively intact as evidenced by a score of 14 out of 15 on the Brief Interview for Mental Status (BIMS) and was not receiving oxygen therapy. Review of the Physician's Orders failed to indicate an order for oxygen therapy or equipment care/management. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: At risk for and has impaired gas exchange and shortness of breath related to diagnosis of respiratory failure and use of oxygen. GOAL: Will have no complications related to shortness of breath; Will maintain normal breathing pattern. INTERVENTIONS: -Oxygen as needed per order. Review of the progress notes indicated Resident #53 was receiving oxygen therapy. The surveyor made the following observations: -5/2/24 at 11:06 A.M., Resident lying in bed with Oxygen via nasal cannula on at 2 liters per minute (LPM); tubing dated 4/21/24. -5/3/24 at 11:15 A.M., Resident lying in bed with Oxygen via nasal cannula on; tubing dated 4/21/24. -5/7/24 at 8:41 A.M., Resident lying in bed with Oxygen via nasal cannula off; tubing dated 5/2/24. The facility failed to ensure orders were in place for Oxygen and the equipment was changed per policy. During an interview on 5/2/24 at 11:06 A.M., Resident #53 said they had been on Oxygen since admission to the facility. During an interview on 5/3/24 at 11:20 A.M., Nurse #3 said there should be an order for Oxygen and there is not. During an interview on 5/3/24 at 11:31 A.M., Consulting Staff #2 said there should be an order for the Oxygen and there was not. (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 5/7/24 at 12:04 P.M., the Director of Nurses (DON) said there should be a physician's order for the use of Oxygen. 2. Resident #54 was admitted to the facility in April 2024 with diagnoses including diseases of the circulatory system, encounter for surgical aftercare following surgery on the circulatory system, and dissection of ascending aorta (tear in the body's main artery). Review of the MDS assessment, dated 4/9/24, indicated Resident #54 was cognitively intact as evidenced by a score of 13 out of 15 on the BIMS. Review of the Physician's Orders indicated but were not limited to the following: -Albuterol Sulfate Inhalation Nebulizer Solution 0.083% one vial inhale orally via nebulizer every four hours as needed for wheezing (4/3/24). (medication to open airway) -Ipratropium Bromide Inhalation Solution 0.02% one vial inhale orally via nebulizer every four hours as needed for wheezing (4/3/24). (medication to open airway) The physician's orders failed to indicate an order for nebulizer equipment care/management. Review of the Medication Administration Record (MAR) indicated Resident #54 received the medication via nebulizer three times in April 2024. Review of the Comprehensive Care Plans for Resident #54 failed to indicate a Respiratory Care Plan had been developed. The surveyor made the following observations: -5/2/24 at 11:06 A.M., Resident sitting on edge of bed, nebulizer face mask hanging off the nightstand onto the floor, unbagged (to protect from germs/debris), tubing dated 4/4/24. -5/7/24 at 8:41 A.M., Resident sitting on edge of bed, nebulizer face mask in nightstand drawer attached to nebulizer, mask unbagged, (to protect from germs/debris), lying in drawer full of personal belongings including unfolded gray non-skid slipper socks, tubing dated 4/4/24. The facility failed to ensure a Respiratory care plan was developed and the nebulizer equipment was stored and changed per policy. During an interview on 5/7/24 at 8:41 A.M., Resident #54 said they use the breathing treatment frequently and it helps. Resident #54 demonstrated how the nurse fills the machine and placed the mask on his/her face to show the surveyor how it worked. Additionally, he/she said they were unsure how often the tubing was changed because they had only been here (at facility) for about a month and didn't think it had been changed since admission. 3. Resident #34 was admitted to the facility in March 2024 with diagnoses which included chronic obstructive pulmonary disease (COPD-lung disease that blocks airflow), respiratory failure, and dependence on supplemental Oxygen. (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 the MDS assessment, dated 3/8/24, indicated Resident #34 was cognitively intact as evidenced by a score of 14 out of 15 on the BIMS and received Oxygen therapy. Review of the Physician's Orders indicated but were not limited to the following: -Oxygen at 4 LPM via nasal cannula for diagnosis of respiratory failure and COPD every shift (3/2/24). -Clean oxygen filter weekly on Thursdays 11 P.M. - 7 A.M. shift (3/1/24). -Change oxygen tubing weekly on Thursday 11 P.M. - 7 A.M. shift (3/4/24). -Albuterol Sulfate Inhalation Nebulizer Solution inhale orally via nebulizer every four hours as needed for shortness of breath (3/1/24). -Change nebulizer tubing weekly on Thursday 11 P.M. - 7 A.M. shift (3/4/24). Review of the April and May 2024 MAR and Treatment Administration Records (TAR) indicated the Resident received Oxygen and Albuterol medication via nebulizer daily and the tubing was signed off as changed last on 5/2/24. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Diagnosis of COPD and obstructive sleep apnea and requires oxygen, inhaler, nebulizer treatments and BiPAP. GOAL: Will display optimal breathing pattern daily. INTERVENTIONS: -Oxygen therapy as ordered by the physician. -Give aerosol or bronchodilators as ordered (Albuterol Nebulizer) The surveyor made the following observations: -5/2/24 at 9:07 A.M., Resident wearing nebulizer mask actively receiving a breathing treatment, Nebulizer machine in use laden with dust, crumbs/debris of orange color, small pieces of hair, and three twist off caps to from unit dose packaging. -5/3/24 at 7:20 A.M., Resident in bed with Oxygen in place, nebulizer mask and tubing on top of nebulizer machine, unbagged (to protect from germs/debris), an empty bag under the machine. The facility failed to ensure nebulizer equipment was clean and mask/tubing were stored per policy. During an interview on 5/3/24 at 7:24 A.M., Nurse #1 said the nebulizer mask and tubing should be cleaned and stored in the storage bag after use and it was not currently stored the way it should be. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #1 was admitted to the facility in June 2019 with diagnoses including dementia, cerebrovascular disease, and palliative care. Review of the MDS assessment, dated 2/7/24, indicated Resident #1 had severe cognitive impairment as evidenced by a score of 2 out of 15 on the BIMS. Review of the Physician's Orders indicated but were not limited to the following: -Continue Oxygen for comfort only every shift for comfort (4/8/24). -Oxygen at 2 LPM for oxygen saturation less than 90% for comfort (10/26/23) -Change oxygen tubing every seven days on night shift and as needed (10/27/23). Review of the May 2024 MAR and TAR indicated the Resident received Oxygen daily and the tubing was signed off as changed last on 5/1/24. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Potential for altered respiratory status/difficulty breathing and needs oxygen therapy. GOAL: Will have no signs and symptoms of poor oxygen absorption; Will maintain normal breathing pattern. INTERVENTIONS: -Provide oxygen as ordered. The surveyor made the following observations: -5/2/24 at 9:25 A.M., Resident sitting in dining room in wheelchair with Oxygen in place. Tubing appeared old, was yellow from area below the chin up around both ears and up to the prongs that enter the Resident's nose. The tubing was yellow and opaque (cloudy-not clear and see through) and dated 4/10/24, the humidifier bottle attached to the concentrator was unlabeled/undated and the bottle was empty, and the concentrator was set to 2 LPM. -5/2/24 at 9:27 A.M., Nurse #1 entered the dining room, he opened a new disposable humidifier bottle and re-attached the Oxygen tubing dated 4/10/24. -5/3/24 at 7:06 A.M., Resident sitting in the dining room with no Oxygen in place or available in the room, appeared comfortable and not in distress. 5/3/24 at 9:48 A.M., Resident in the dining room, Oxygen in place via nasal canula at 2 LPM, tubing and humidifier bottle dated 5/2/24. The facility failed to ensure the oxygen equipment was changed per policy. (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 5/2/24 at 9:27 A.M., the surveyor asked Nurse #1 about the tubing, and he said it was old and dirty looking and was supposed to be changed weekly. Nurse #1 checked the label and said the tubing was from 4/10/24 and should not be in use, and it was an infection control risk for germs. Additionally, he said the tubing needed to be changed and the procedure for changing it weekly was not completed as it should have been. During an interview on 5/3/24 at 11:31 A.M., Consulting Staff #2 said there should be physician's orders in place for Oxygen and the tubing for all nebulizers and oxygen should be changed weekly on Sundays and should populate on the TAR. During an interview on 5/7/24 at 12:04 P.M., the DON said there should be orders in place for Oxygen which include rate and delivery method. She said the tubing should be changed weekly on Sundays and dated accordingly, and the nebulizer equipment/mask should be cleaned and stored in a bag when not in use. She said they don't have orders that populate. Her expectation is that it is nursing practice, and the nurse should get in report who is on nebulizers or oxygen and this facility changes the equipment on Sunday nights. Additionally, she said an individualized respiratory care plan should be in place. The DON said herself or the Staff Development Coordinator/Infection Control Nurse (SDC/IP) walk the units on Mondays to ensure tubing was changed. When asked how she knows who is on Oxygen, she said she uses her clinical squares (personal worksheet of clinical information specific for each resident which she creates/updates), but not all of these residents are on her squares so she will need to look at the process to ensure things are not missed.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 48084 Based on record review, interview, and policy review, the facility failed to ensure one Resident (#109), out of a sample of 15 residents, received culturally competent, trauma-informed care accounting for resident experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. Specifically, the facility failed to assess Resident #109 and identify triggers of trauma to prevent potential re-traumatization. Findings include: Review of the facility's policy titled Trauma Informed Care, dated as last revised 3/4/24, indicated but was not limited to the following: -It is the policy of this facility to provide care and services which address the needs of trauma survivors by minimizing triggers and/or re-traumatization. -DEFINITIONS: Trauma results from an event or series of events, or circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. -The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals to develop and implement individualized care plan interventions. -The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. Review of the facility's policy titled Behavioral Health Services, dated as last revised 12/6/21, indicated but was not limited to the following: -The facility will ensure that a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services. -The resident will receive, and the facility will provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #109 was admitted to the facility in April 2024 with diagnoses including post-traumatic stress disorder (PTSD- mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) and depression. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Admission Assessment failed to indicate a diagnosis of PTSD. Review of the Minimum Data Set (MDS) assessment, dated 4/30/24, Section I6100 indicated Resident #109 had a diagnosis of PTSD. Review of the Social Services Assessment, dated 5/3/24, indicated the assessment was incomplete. The medical record failed to indicate a PTSD Assessment had been completed. Review of the care plans failed to indicate a baseline or comprehensive care plan for PTSD had been developed to note any potential triggers to try and mitigate the effects and decrease the likelihood of re-traumatization. Review of the care kardex (summary of resident's care and preferences) failed to indicate any trauma associated triggers to guide resident care. During an interview on 5/3/24 at 1:39 P.M., Resident #109 said he/she does have a diagnosis of PTSD, and no one had asked about it, how the trauma occurred, or what things may re-trigger the trauma. Resident #109 shared with the surveyor the physical and emotional trauma they had endured and said they have been incapable of being in a closed space with a male and could never think of having a male being nearby or providing personal care and speaking of it now is causing anxiety. Additionally, Resident #109 said no one at the facility had discussed this or said they could put barriers in place to ensure events like this would not come up. The surveyor encouraged Resident #109 to speak with the SW and share the triggers to ensure comfort and safety at the facility. During an interview on 5/3/24 at 11:12 A.M., Social Worker (SW) #1 said she had not completed a PTSD assessment on Resident #109 and had not seen one at this facility. Additionally, she said there was no care plan for PTSD and there should be one to identify the Resident's triggers and therefore ensure the staff can do their best to avoid them or work around the process for the Resident as best as possible. SW #1 said she was unsure of the facility policy but said the regulatory guidelines in this instance were not followed. During an interview on 5/3/24 at 1:35 P.M., Nurse #1 said there was not a care plan for PTSD in the Resident's medical record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on interviews, record review, and policy review, the facility failed to ensure monthly Medication Regimen Review (MRR) recommendations made by the pharmacy consultant were addressed timely and maintained as part of the permanent medical record for three Residents (#21, #9, and #19), out of 5 residents selected for an unnecessary medication review. Specifically, the facility failed: 1. To ensure facility wide recommendations were addressed timely and maintained as part of the medical record; 2. For Resident #21, to ensure the January, February, and March 2024 consultant pharmacist recommendations were acted upon timely and to ensure the January, February, March, and April 2024 consultant pharmacist recommendations were maintained as part of the permanent medical record; 3. For Resident #9, to ensure the April 2024 consultant pharmacist recommendations were maintained as part of the permanent medical record and acted upon timely for Abnormal Involuntary Movement Scale (AIMS) testing to be completed; and 4. For Resident #19, to ensure January 2024, February 2024, March 2024, and April 2024 consultant pharmacist recommendations were maintained as part of the permanent medical record and acted upon timely to decrease dosage of Escitaloram (an antidepressant) medication. To ensure March 2024 consultant pharmacist recommendations were maintained as part of the permanent medical record and acted upon timely to re-evaluate need for Benadryl (anti-itch), Cepacol (throat lozenge), and Mucinex (an expectorant) medications. Findings include: Review of the facility's policy titled Medication Regimen Review, dated as effective January 2024, indicated but was not limited to the following: -The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. -The findings for the offsite MRR are phoned, faxed, or emailed timely to the Director Nursing (DON) or designee and are documented and stored with the other Consultant Pharmacist recommendations in the resident's active record. -The prescriber is notified of the consultant findings applicable to the prescriber by the facility in a timely manner to allow the prescriber sufficient time to respond prior to the next monthly consultant visit. -Recommendations are acted upon and documented by the facility staff and/or the prescriber. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Prescriber accepts and acts upon suggestion or rejects and provides an explanation including medical rationale for disagreeing. 1. During an interview on 5/7/24 at 12:04 P.M., the Director of Nurses (DON) said she did not have copies of previous monthly MRRs (December 2023-March 2024). She said she did not know where they were and said they were not kept as part of the resident's medical record once addressed. Additionally, she said only the admission review is scanned into the record. The DON said she had to call the pharmacy to get copies of the previous MRR reviews to make a binder for 2024 even though many of them were not done. Review of the MRR binder provided indicated but was not limited to the following: -January and February 2024 review reports were all unsigned. -March 2024 reviews were signed 5/3/24. -April 2024 reviews were signed 5/3/24. Review of the Executive Summary of the Consultant Pharmacists Monthly Visits indicated but were not limited to the following: -12/21/23: Residents Reviewed 43; Recommendations forwarded to the Physician were 23 and Nursing 4; The three most prevalent areas of focus were Psychotropic Management, Deprescribing Initiative, and Unused as needed (PRN) medication. The care center's follow up of last visit's recommendations was determined to be 44.4%. -1/19/24: Residents Reviewed 48; Recommendations forwarded to the Physician were 33 and Nursing 4; The three most prevalent areas of focus were Psychotropic Management, Deprescribing Initiative, and Risk/benefit documentation. The care center's follow up of last visit's recommendations was determined to be 11.5%. -2/14/24: Residents Reviewed 52; Recommendations forwarded to the Physician were 24 and Nursing 3; The three most prevalent areas of focus were Psychotropic Management, Unused as needed (PRN) Medications, and Risk/benefit documentation. The care center's follow up of last visit's recommendations was determined to be 53.3%. -3/20/24: Residents Reviewed 50; Recommendations forwarded to the Physician were 34 and Nursing 2; The three most prevalent areas of focus were Psychotropic Management, Unused PRN Medications, and Deprescribing Initiative. The care center's follow up of last visit's recommendations was determined to be 12. 5%. -4/16/24: Residents Reviewed 55; Recommendations forwarded to the Physician were 37 and Nursing 6; The three most prevalent areas of focus were Psychotropic Management, Deprescribing Initiative, and Unused PRN Medications. The care center's follow up of last visit's recommendations was determined to be 32.3%. In summary 11.5% - 53.3% of recommendations were addressed by the facility in the five monthly summaries reviewed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/24 at 12:04 P.M., the DON said the MRR recommendations should be given to the provider and addressed timely, scanned into medical record after they have been completed, and a progress note should be written. She said her expectation for all recommendations to be addressed within a week or so but certainly before the next review. Additionally, she said right now there is no tracking method in place to ensure all the recommendations have been addressed. 2. Resident #21 was admitted to the facility in January 2024 with diagnoses including unspecified dementia with agitation, adjustment disorder with mixed anxiety and depressed mood, and insomnia. Review of the Minimum Data Set (MDS) assessment, dated 4/10/24, indicated Resident #21 had severe cognitive impairment as evidenced by a score of 6 out 15 on the Brief Interview for Mental Status (BIMS) and took antipsychotic and antidepressant medications. Review of the Pharmacist's progress notes indicated recommendations were made 1/19/24, 2/13/24, 3/20/24, and 4/16/24. Review of the medical record (paper chart and electronic medical record) failed to indicate any of the recommendations had been completed and failed to indicate copies of signed/completed recommendations were filed or scanned into the record. The surveyor requested copies of the MRR from the DON for 1/19/24, 2/13/24, 3/20/24, and 4/16/24 for Resident #21 on 5/7/24 at 3:53 P.M. During an interview on 5/7/24 at 3:53 P.M., the DON said she had the March and April recommendations as she just had those addressed. She said she did not have the ones previous and would call the pharmacy to have them sent over. The MRRs provided by the DON indicated but were not limited to the following: -1/19/24- This Resident is receiving an antipsychotic agent Seroquel. Please update the diagnosis for this medication in PCC (the electronic medical record). A list of appropriate diagnosis/conditions was part of the recommendation including Dementia with behavioral symptoms. The document was unsigned by the Physician. -2/13/24- This Resident is receiving an antipsychotic agent Seroquel. Please update the diagnosis for this medication in PCC. A list of appropriate diagnosis/conditions was part of the recommendation including Dementia with behavioral symptoms. The document was unsigned by the Physician. (SAME RECOMMENDATION FROM JANUARY 2024) -2/13/24- This Resident has an order for a psychoactive PRN Trazodone which has been in place without a stop date recorded. After 14 days, the use of this psychoactive PRN may be continued if it is determined that the benefit of treatment outweighs the potential/actual risk of the continued PRN therapy. Please consider discontinuing this medication or scheduling this medication if necessary. If this medication is continued as a PRN, a stop date or evaluation date must be added to the PRN order. The document was unsigned by the Physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/20/24- This Resident is receiving an antipsychotic agent Seroquel. Please update the diagnosis for this medication in PCC. A list of appropriate diagnosis/conditions was part of the recommendation including Dementia with behavioral symptoms. (SAME RECOMMENDATION FROM JANUARY and FEBRUARY 2024). The document was signed by the Physician and dated 5/3/24 indicating a diagnosis of Dementia with Behavioral Symptoms. -3/20/24-This Resident has an order for a psychoactive PRN Trazodone which has been in place without a stop date recorded. After 14 days, the use of this psychoactive PRN may be continued if it is determined that the benefit of treatment outweighs the potential/actual risk of the continued PRN therapy. Please consider discontinuing this medication or scheduling this medication if necessary. If this medication is continued as a PRN, a stop date or evaluation date must be added to the PRN order. The document was signed by the Physician and dated 5/3/24 indicating the Resident was no longer on the PRN Trazodone. -4/16/24- Recommendation to discontinue an unused PRN and or lab work was addressed and signed by the Physician 4/17/24. In summary, the Consultant Pharmacist recommended adding an appropriate diagnosis for the use of an antipsychotic (Seroquel) in January, February, and March which was not addressed until 5/3/24 to add a diagnosis of Dementia with Behavioral Symptoms. During an interview on 5/7/24 at 12:04 P.M., the DON said the MRR recommendations should be given to the provider and addressed timely, scanned into medical record after they have been completed, and a progress note should be written. She said her expectation for all recommendations to be addressed within a week or so but certainly before the next review. Additionally, she said this diagnosis was not added to the Resident profile in PCC until 5/3/24 and it should have been addressed sooner. 49425 3. Resident #9 was admitted to the facility in April 2024 with diagnoses which included personality disorder and chronic pain syndrome. Review of the medical record indicated Resident #9 was prescribed the following: -Olanzapine 5 milligrams (mg) give 2.5 mg by mouth in the evening for mood disorder Review of the progress notes indicated the Pharmacy Consultant made recommendations on 4/16/24 for an AIMS assessment to be completed. Review of the electronic and paper medical records failed to include the Consultant Pharmacist Recommendation from April 2024. At 8:45 A.M., the surveyor requested the Pharmacy Consultant Recommendation from the DON. During an interview on 5/8/24 at 10:01 A.M., the DON provided the surveyor with a Summary of Recommendations for DNS/Medical Director. The DON said she was unable to locate the Consultant Pharmacist Recommendation for April 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Summary of Recommendations for DNS/Medical Director dated for recommendations created between 4/1/24 and 4/16/24 indicated Resident #9 was taking an antipsychotic, and AIMS testing was to be performed now and every 6 months to monitor for tardive dyskinesia (involuntary movement disorder). Review of the electronic and paper medical record failed to indicate the Pharmacy Consultant recommendation was reviewed or addressed by the facility. During an interview on 5/8/24 at 10:53 A.M., Social Worker (SW) #1 said AIMS assessments are completed by their psychology consultant services. SW #1 reviewed Resident #9's medical record with the surveyor and said Resident #9 has not been seen by their psychology services yet, and an AIMS assessment had not been completed. 4. Resident #19 was admitted to the facility in December 2019 with diagnoses which included major depressive and bipolar disorders. Review of the medical record indicated Resident #19 was prescribed the following medications: -Escitalopram 30 mg by mouth every morning -Benadryl 25 mg by mouth as needed -Cepacol Sore throat lozenge one lozenge by mouth as needed -Mucinex extended release 400 mg by mouth as needed Review of the progress notes indicated the following: -Pharmacy Consultant made recommendations on 1/19/24 to review the Escitalopram dosage. -Pharmacy Consultant made recommendations on 2/14/24 to review the Escitalopram dosage. -Pharmacy Consultant made recommendations on 3/20/24 to review the Escitalopram dosage and unused as needed medications; Benadryl, Cepacol, and Mucinex. -Pharmacy Consultant made recommendations on 4/16/24 to review the Escitalopram dosage and unused as needed medication, Benadryl. During an interview on 5/8/24 at 8:45 A.M., the surveyor requested the pharmacy recommendations from the DON for Resident #19. She said she is only able to provide March 2024 Note to Attending Physician/Prescriber, and the Summary of Recommendations for DNS/Medical Director for the month of April 2024. She said she is unable to locate any pharmacy recommendations for the months of January and February 2024 for Resident #19. She said the pharmacy recommendations were not kept in the Resident's permanent medical record as they should have been. Review of the Note to Attending physician/Prescriber, dated 3/20/24, indicated Resident #19 was receiving Escitalopram 30 mg daily, and the recommended dose should not exceed 10 mg per day in residents over [AGE] years old. Physician/Prescriber response was blank and incomplete. (continued on next page)

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Cedarwood Gardens	130 Chestnut Street Franklin, MA 02038

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Note to Attending Physician/Prescriber, dated 3/20/24, indicated Resident #19 was prescribed as needed Benadryl, Cepacol, and Mucinex that have not been used in over 90 days and can lead to medication errors and potentially using expired medications. Physician/Prescriber response was blank and incomplete. Review of the Summary of Recommendations for DNS/Medical Director, dated for recommendations created between 4/1/24 and 4/16/24, indicated Resident #19 was taking Escitalopram 30 mg daily, and the recommended dosage should not exceed 10 mg per day in residents over [AGE] years of age. Further review indicated Resident #19 was prescribed as needed Benadryl that has not been used in over 90 days and can lead to medication errors potentially using expired medication. Review of the electronic and paper medical record failed to indicate the Pharmacy Consultant recommendation was reviewed or addressed by the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48084 Based on record review, policy review, and interview, the facility failed to ensure for one Resident (#15), out of a sample of 15 residents, that their as needed (PRN) psychotropic medication, Lorazepam (antianxiety), was re-evaluated 14 days after the medication was prescribed to ensure it was beneficial and necessary for the Resident in accordance with the standard of practice. Findings include: Review of the facility's policy titled Psychotropic Medication Treatment in Long Term Care (LTC), dated January 2021, indicated but was not limited to the following: -It is the policy to abide by state and federal regulations when requesting consent and administering medications. -Pharmacy Consultant will perform monthly medication regimen reviews. These reviews will identify existing irregularities regarding indications for use, dose, duration, and the potential for, or existence of adverse consequences or other irregularities. Any identified concerns must be reported to the attending physician and the Director of Nurses (DON). Resident #1 was admitted to the facility in June 2019 with diagnoses including dementia, mood disorder, anxiety, and epilepsy (seizure disorder). Review of the Minimum Data Set (MDS) assessment, dated 2/7/24, indicated Resident #1 had severe cognitive impairment as evidenced by a score of 2 out of 15 on the Brief Interview for Mental Status (BIMS) and had anxiety. Review of the Physician's Orders indicated but was not limited to the following: -Lorazepam Oral Concentrate milligrams/milliliter (ml) give 0.5 ml by mouth every four hours as needed for anxiety/agitation. (4/14/24) Further review of the Lorazepam order failed to indicate a stop date or re-evaluation date as required. Review of the Consultant Pharmacist's Note, dated 4/16/24, indicated to evaluate PRN Lorazepam. The facility failed to provide the surveyor with a copy of the full pharmacist recommendation. During an interview on 5/7/24 at 12:04 P.M., the DON said all psychotropic PRN medications, including Lorazepam, should be written for 14 days only and then re-evaluated. She said the order should not be written with no stop date and would have to be clarified as it had been over 14 days since the order was written. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/24 at 12:04 P.M., Consulting Staff #1 confirmed that all psychotropic PRN orders should be written for 14 days and then re-evaluated and extended if needed. She said they should not be left open ended unless being used for seizures and this is not the case as the order is written for anxiety/agitation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48084 Based on observation, interview, and policy review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed: 1. For Resident #50, to ensure the medications were administered under direct supervision and not left at the bedside; 2. To ensure medication and treatment carts on Unit One were locked when not in direct supervision of the licensed nurse; and 3. Ensure safe storage of medications and biologicals according to current standards of practice in 2 of 2 observed medication carts. Findings include: Review of the facility's policy titled Medication Administration-General Guidelines, dated as effective January 2024, indicated but was not limited to the following: -Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications. -Medications are administered in accordance with written/electronic orders of the prescriber. -When medications are administered by mobile cart taken to the resident's location, medications are administered at the time they are prepared. -Residents can self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. -The resident is always observed after administration to ensure that the dose was completely ingested. -Medications are not pre-poured either in advance of the med pass or for more than one resident at a time. -No medications are kept on top of the cart. Review of the facility's policy titled Storage of Medications, dated as effective January 2024, indicated but was not limited to the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -Medication rooms, carts, and medication supplies are locked when not attended to by persons with authorized access. 1. Resident #50 was admitted to the facility in December 2023 with diagnoses including depression, alcohol dependence in remission, and alcoholic cirrhosis of the liver (severe liver disease causing the inability for the liver to function properly). Review of the Minimum Data Set (MDS) assessment for Resident #50 indicated he/she had moderate cognitive impairment as evidenced by a score of 12 out 15 on the Brief Interview for Mental Status (BIMS). The surveyor made the following observations: -5/2/24 at 11:44 A.M., Resident in his/her room, two plastic medication cups containing a slightly pale-yellow thick liquid. Each cup had approximately 30 milliliters (ml) in it. -5/2/24 at 1:58 P.M., Resident in his/her room, two plastic medication cups containing a slightly pale-yellow thick liquid. Each cup had approximately 30ml in it. -5/2/24 at 4:05 P.M., Resident in his/her room, two plastic medication cups containing a slightly pale-yellow thick liquid. Each cup had approximately 30ml in it. Review of the Physician's Orders for Resident #50 indicated but were not limited to the following: -Lactulose Oral Solution 10 grams/15 ml, give 60 ml by mouth three times a day related to Hepatic Failure, unspecified without coma (liver failure). Nursing to Monitor Resident taking medication. (1/22/24) Review of the Medication Administration Record (MAR) indicated but was not limited to the following: -Lactulose Oral Solution 10 grams/15 ml, give 60 ml by mouth three times a day related to Hepatic Failure, unspecified without coma (liver failure). -Nursing to Monitor Resident taking medication, had been signed off as administered 5/2/24 at 9:00 A.M. and 1:00 P.M. Review of the comprehensive care plan failed to indicate Resident #50 self-administered medications. Review of the medical record failed to indicate a Self-Administration Assessment Form had been completed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the physician's orders failed to indicate Resident #50 had an order to self-administer medications. Further review of the medical record indicated Resident #50 had recently (April 2024) been hospitalized for an elevated ammonia level resulting from hepatic encephalopathy (loss of brain function when a damaged liver does not remove the toxins from the blood). The lactulose helps to reduce ammonia levels in the body. The discharge summary indicated to ensure he/she is receiving the lactulose as prescribed. During an interview on 5/3/24 at 11:40 A.M., Nurse #3 said Resident #50 can self-administer and has an order. Additionally, she said she left the lactulose at the bedside yesterday. During an interview on 5/3/24 at 11:44 A.M., Nurse #2 said no residents on this unit self-administers medications. She said if they did, they would have an assessment and an order to self-administer. During an interview on 5/7/24 at 12:04 P.M., the Director of Nurses (DON) said Resident #50 should not have medication left at the bedside. Additionally, she said if a resident were to self-administer medications, they would need an assessment and an order to do so, and Resident #50 does not have those things. She said the nurses should be staying and observing him/her take the medication and if they refuse the medication the nurse should be documenting accordingly. 2. The surveyor made the following observations: -5/2/24 at 10:47 A.M., Unit One, Treatment Cart observed in the hallway, with drawers facing outward, unlocked, staff not in the vicinity of the cart, residents roaming the halls. -5/2/24 at 10:47 A.M., Unit One-High Side, Medication Cart observed in the hallway near room [ROOM NUMBER], with drawers facing outward, unlocked, staff not in the vicinity of the cart, residents roaming the halls. Additionally, Resident from room [ROOM NUMBER] was standing next to the medication cart, agitated, and pacing around the cart. -5/2/24 at 12:00 P.M., Unit One, Treatment Cart observed in the hallway, with drawers facing outward, unlocked, staff not in the vicinity of the cart, residents roaming the halls. -5/3/24 at 8:30 A.M., Unit One, Treatment Cart observed in the resident day room, with drawers facing outward, unlocked, staff not in the vicinity of the cart, residents roaming the halls with access to the day room. At 8:36 A.M. and 9:00 A.M., the treatment cart remained unlocked in the resident day room. -5/3/24 at 11:00 A.M., Unit One-Low Side, Medication Cart observed in the hallway near nurses' station, with drawers facing outward, unlocked, nurse was sitting behind the desk unable to see the drawers of the medication cart, residents were roaming the halls. The nurse got up several times and failed to lock the medication cart until it was moved down the hallway at 11:33 A.M. During an interview on 5/3/24 at 11:40 A.M., Nurse #3 said the medication and treatment carts should be locked when the nurse is not with the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/24 at 12:04 P.M., the DON said the medication and treatment carts should be locked when not in use and never left unattended where residents have access to them. 49425 3. On 5/6/24 at 10:20 A.M., the surveyor observed Nurse #4 place a package of SalonPas patches (medication used to treat pain) on top of Unit Two high side medication cart along with a clear plastic container, uncovered, unlabeled with two loose pills inside. Nurse #4 then locked her cart, and walked down the hallway, leaving the medication on top of the cart, out of view, unsecured and unattended. During an observation with interview on 5/6/24 at 10:21 A.M., Nurse #4 returned to the medication cart. Nurse #4 said the two loose pills were blood pressure medications for a resident that she could not administer because the resident's blood pressure was too low, and she needed to destroy them. She said the SalonPas patches were placed on top of the cart, because she needs to apply them to a resident. Nurse #4 said she is not supposed to leave medications unlocked and unattended and should have placed them inside the medication cart before she walked away. During an observation and interview on 5/6/24 at 3:14 P.M., the surveyor observed the medication cart on Unit two high side with Nurse #9 and made the following observations: -In the fourth drawer on the left-hand side: a small, clear plastic medication cup, uncovered and not labeled, which included: four loose pills. Nurse #9 said she does not know what medications are in the clear plastic cup, and medications are not supposed to be stored unlabeled and uncovered in the medication cart. During an interview on 5/6/24 at 3:19 P.M., Nurse #4 said she put the pills in the cup and stored them in the medication cart. She said the resident was not in their room when she attempted to administer them and forgot to destroy them prior to giving report to Nurse #9. During an observation and interview on 5/7/24 at 8:12 A.M., the surveyor observed the medication cart on Unit one high side with Nurse #3 and made the following observations: -In the top drawer: a small, clear plastic medication cup, uncovered, and not labeled which included: 5 loose pills. Nurse #3 said she does not know what the medication is, she just took count and report from the 11:00 P.M.-7:00 A.M. nurse and has not opened the top drawer yet. During an interview on 5/7/24 at 8:18 A.M., Nurse #8 said she had worked the 11:00 P.M.-7:00 A.M. shift and prepared a resident's medication, got called into another resident's room, and placed the container with the pills in the top drawer. She said she was going to administer the medications before she went home for the day. During an interview on 5/7/24 at 8:33 A.M., the DON said medications should be administered once prepared. She said her expectation is for the nurse to destroy the medications, document in the resident's record the medications were not given, notify the physician, and document the physician's response in a progress note. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/24 at 12:04 P.M., the DON said the medication and treatment carts should be locked when not in use, never left unattended, and medications should not be left on top of the medication cart.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48084 Based on observation, record review, and interview, the facility failed to maintain medical records securely and accurately in accordance with accepted professional standards for one Resident (#3), out of 15 sampled residents. Specifically, the facility failed to ensure Resident #3's electronic medical record contained scanned documents pertaining only to Resident #3. Findings include: Resident #3 was admitted to the facility in August 2022. Review of the electronic medical record documents tab indicated but was not limited to the following: -Informed Consent for Psychotropic document had been scanned into the record 14 times. Review of the document titled Informed Consent for Psychotropics, scanned in on 3/22/24 with effective dates ranging from 8/22/18 through 12/4/23 indicated the document was not an Informed Consent for Psychotropics. Further review of the document scanned into Resident #3's medical record titled Informed Consent for Psychotropics indicated it was a Consent to Treat for Resident #50. During an interview on 5/8/24 at 11:30 A.M., the Director of Nurses (DON) said those documents were scanned into the wrong medical record and should not be there. She said her expectation is for the medical records to be accurate and only contain documents for the individual Resident. During an interview on 5/8/24 at 11:37 A.M., Medical Records Staff #1 said those documents should not be in Resident #3's medical record.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48084 Based on record review and interview, the facility failed to electronically submit direct care staffing data to Centers for Medicare and Medicaid Services (CMS) for the entire reporting period, Fiscal Year (FY) Quarter 1 2024 (October 1 - December 31) in accordance with the schedule specified by CMS. Findings include: Review of the CMS Payroll Based Journal (PBJ) Staffing Data Report, CASPER Report 1705D, indicated the facility failed to submit data for the quarter. During an interview on 5/8/24 at 7:44 A.M., the Nursing Staff Scheduler said she did not know who did the PBJ reporting. During an interview on 5/8/24 at 12:38 P.M., Consulting Staff #5 said in reviewing the data sent to him from the facility it appears the data from October 1-15 was missing. He said the first 15 days of data were missing from the previous owners and that is probably why it got kicked back. Additionally, he said he was going to look into it further. During an interview on 5/8/24 at 1:18 P.M, Consulting Staff #5 said the previous owners did not file the data for October 1-15 as they should have and therefore that data submission was incomplete. During an interview on 5/8/24 at 3:00 P.M., the Administrator said he was unaware of the reporting status prior to his employment start date and deferred questions to Consulting Staff #4. During an interview on 5/8/24 at 3:00 P.M., Consulting Staff #4 said the previous owners should have submitted the data and he was unsure why it was not done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49425 Based on observation, document review, policy review, and interviews, the facility failed to: 1. Maintain an infection prevention and control program with a complete system of surveillance to identify any trends of actual or potential infections within the facility; 2. For Resident #36, ensure staff wore personal protective equipment (PPE) as required for Enhanced Barrier Precautions (EBP); 3. For Resident #160, ensure EBP were implemented, and PPE was utilized when providing high contact resident care; and 4. Ensure policy and procedures for EBP were developed and implemented, effective 4/1/24 as required. Findings include: Review of the facility's policy titled Infection Prevention and Control Program, undated, indicated but was not limited to the following: - The facility maintains an organized, effective facility-wide program to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors, volunteers and healthcare workers. The program is interdisciplinary in design and works in collaboration with other programs and services within the facility. - Ongoing surveillance is recognized as a fundamental component of a strong effective infection control and prevention program. The Infection Preventionist will perform ongoing surveillance to identify opportunities to prevent and/or reduce the rate of infections within residents, employees, and visitors. - The McGeer criteria will be used to standardize the definition and criteria for infection. - Standardized logs will be used for line listing infections throughout the month. These will be reviewed regularly by the facility Infection Control Preventionist for any trends that need to be addressed before the monthly infection control report. - Surveillance activities will be ongoing and documented for the purpose of tracking, trending and identifying needs. - Surveillance will include information collected by either concurrent or retrospective review of resident records, review of microbial reports, reports from resident care providers, families, and review of other documents as appropriate. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Surveillance activities will include employee, visitor, and resident practices as they relate to unprotected exposure to communicable diseases including but not limited to Influenza, gastrointestinal virus, and COVID-19. Review of the facility's policy titled Enhanced Barrier precautions, dated 5/3/24, indicated but was not limited to the following: - It is the policy of this facility to implement enhanced barrier precautions - Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs gown and gloves use during high contact resident care activities. - An order for EBP will be obtained for residents with any of the following: Wounds, and/or indwelling medical device, even if the resident is not known to be infected or colonized with a Multidrug-resistant organism - PPE for EBP is only necessary when performing high-contact care activities - Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. - High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care (any skin opening requiring a dressing) - EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 1. Review of the facility's surveillance sheets titled Antibiotic Use Tracking Sheet for the months of February 2024, March 2024, and April 2024 indicated the following: -The February 2024 tracking sheet 3 out of 6 residents met McGeer criteria for infection and 6 out of 6 residents were started on antibiotics -The March 2024 tracking sheet 4 out of 5 residents met McGeer criteria for infection and 5 out of 5 residents were started on antibiotics -The April 2024 tracking sheet 6 out of 6 residents met McGeer criteria for infection and all were started on antibiotics The surveillance data sheets failed to indicate any tracking or trending of illness, not prescribed antibiotics, for surveillance of the potential spread of illnesses. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/7/24 at 12:17 P.M., the Infection Preventionist (IP) said she completes surveillance for COVID-19 and Influenza outbreaks but does not keep a line listing of illness on a day-to-day basis that do not require the use of antibiotics. During an interview on 5/7/24 at 3:10 P.M., the IP said she reviews the resident progress notes every day for signs or symptoms of an infection, but she does not document the information anywhere. She said there is no system of surveillance to identify any potential spread of illnesses. 2. Resident #36 was admitted to the facility in December 2021 with diagnoses including Type 2 diabetes and chronic osteomyelitis (infection of bone tissue). Review of the active Physician's Orders, dated 5/4/24, indicated: - Enhanced Barrier Precautions, please use enhanced barrier precautions (gloves, gown) during all close contact resident care every shift for infection control. On 5/6/24 at 8:02 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 don (put on) gloves and enter Resident #36's room; the CNA was not observed to don a gown. A sign posted outside of the door indicated but was not limited to the following: Stop; Enhanced Barrier Precautions; Providers and staff must wear a gown and gloves for high contact care activities. Outside of the door was a clear plastic bin containing PPE (gloves and gowns). On 5/6/24 at 8:17 A.M., the surveyor observed CNA #1, open Resident #36's room door, doff his gloves in the trash located inside the Residents' room at the doorway, and exit the room. The surveyor then observed the trash in Resident #36's room by the doorway, inside the trash only used gloves were observed. During an interview on 5/6/24 at 8:22 A.M., CNA #1 said he just gave Resident #36 a bed bath and set him/her up for breakfast. He said he did not wear a gown only gloves to provide care because he/she is not on precautions. CNA #1 and the surveyor then reviewed the sign posted outside of the room together that indicated Enhanced Barrier Precautions; Providers and staff must wear a gown and gloves for high contact care activities. CNA #1 said no one told him Resident #36 was on precautions, and he did not notice the sign upon entering the room. During an interview on 5/6/24 at 10:32 A.M., Nurse #4 said Resident #36 is on EBP precautions for open wounds on his/her abdomen and requires a gown and gloves for all high contact care activities. During an interview on 5/6/24 at 10:48 A.M., Consulting Staff #3 said when residents are on precautions it is communicated to the CNAs in shift to shift report and written on the CNA care cards. She said precautions signs and PPE bins are placed outside of the rooms to alert staff of the precautions needed for that specific resident. Review of the CNA care card failed to indicate Resident #36 was on precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225461	A. Building B. Wing	05/08/2024

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Cedarwood Gardens	130 Chestnut Street Franklin, MA 02038

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/7/24 at 2:03 P.M., the Director of Nursing (DON) said CNA #1 did not wear the required PPE while providing care for Resident #36. She said assisting a resident with bathing is considered a high contact care activity and requires the use of a gown with gloves when Enhanced Barrier Precautions are in place. She said they just began utilizing EBP a couple of days ago and the staff development coordinator has not completed the education with all of the staff yet. 48084 3. Resident #160 was admitted to the facility in April 2024 with diagnoses including retention of urine and gastrostomy status. Review of the Minimum Data Set (MDS) assessment, dated 4/23/24, indicated Resident #160 had a gastrostomy tube (feeding tube), and failed to indicate the Resident had a urinary catheter. The surveyor made the following observations: - 5/3/24 at 9:20 A.M., a therapist and CNA transferred Resident #160 from his/her bed into the wheelchair. Neither staff member had a gown on during the transfer. There was no EBP sign, nor any PPE aside from gloves available in the direct proximity of the Resident's room. After the transfer, the therapist wheeled the Resident off the unit. Review of the Physician's Orders failed to indicate an order for EBP. Review of the comprehensive care plan failed to indicate Resident #160 was on EBP. During an interview on 5/3/24 at 8:45 A.M., Nurse #2 said no one on this unit (Unit 1) is on EBP. During an interview on 5/3/24 at 9:10 A.M., Nurse #3 said EBP has something to do with residents having a catheter or feeding tube but said we don't do anything differently for them. She said she did not really understand it and requested Consulting Staff #2 speak with the surveyor. During an interview on 5/3/24 at 9:12 A.M., Consulting Staff #2 said the facility had not implemented EBP yet. During an interview on 5/3/24 at 12:31 P.M., the DON said they have not rolled out EBP yet. 4. Review of the Centers for Medicare and Medicaid Services (CMS), Quality, Safety, and Oversight (QSO) Reference #QSO-24-08-NH memo dated 3/20/24, indicated but was not limited to the following: -SUBJECT: EBP in Nursing Homes to prevent spread of multi-drug resistant organisms (MDROs). -In July 2022, the Centers for Disease Control (CDC) released recommendations for implementation of PPE use in nursing homes to prevent spread of MDROs, and therefore CMS is updating its infection prevention and control guidance accordingly. The recommendations now include the use of EBP during high contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status. -EBP are indicated for residents with wounds and/or indwelling medical devices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. -EBP should be used for any resident who meets the above criteria, wherever they reside in the facility. -EBP is employed when performing the following high contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. -Effective Date: 4/1/2024 The surveyor made the following observations on Unit 1: -No EBP signs or PPE carts/set ups were on the unit, except for one set, for a resident on Contact Precautions for an active infection. -During initial screening on the unit on 5/2/24, several residents were observed to have wounds and/or indwelling medical devices (pressure ulcer, Foley catheters and feeding tubes specifically). During an interview on 5/3/24 at 8:45 A.M., Nurse #2 said no one on this unit is on EBP. During an interview on 5/3/24 at 9:12 A.M., Consulting Staff #2 said the facility had not implemented EBP yet. During an interview on 5/3/24 at 12:31 P.M., the DON said they have not rolled out EBP yet. She said they got the memo, and it was supposed to be effective April 1, 2024. She said they have ordered more supplies, are getting the signs ready, and then they will do education. She said she did not have a policy at this time and Consulting Staff #1 was working on it. The facility policy titled Enhanced Barrier Precautions, dated 5/3/24, was provided by Consulting Staff #1 at the end of the business day on 5/3/24.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on record review, policy review, and interview, the facility failed to provide education, assess for eligibility, and offer pneumococcal vaccinations per facility policy and the Centers for Disease Control and Prevention (CDC) recommendations for three Residents (#9, #13, and #34), out of a total sample of five residents reviewed for immunizations. Findings include: Review of the facility's policy titled Pneumococcal Vaccine, updated May 2023, indicated but was not limited to the following: -It is the policy of this facility to offer and administer pneumococcal Vaccine to eligible individuals who consent for vaccination. -Vaccination for adults ages 19 through [AGE] years old with certain chronic medical conditions or risk factors. The CDC [Centers for Disease Control and Prevention] recommends vaccination for those with any of these conditions and risk factors: -Chronic lung disease, including chronic obstructive pulmonary disease, emphysema, and asthma. -Residents will be screened for needing vaccine, and if deemed appropriate will be offered the vaccine. -Vaccine information sheets will be provided to those who accept or decline vaccination. -Resident/Responsible party must sign or give verbal consent for vaccine prior to administration. -MD order for vaccine administration will be obtained. Review of the CDC website titled Pneumococcal Vaccine Timing for Adults (cdc.gov), dated 3/15/23, indicated but was not limited to the following: -For adults 65 and over who have not had any prior pneumococcal vaccines, then the patient and provider may choose Pneumococcal conjugate vaccine (PCV) 20 or PCV15 followed by Pneumococcal polysaccharide vaccine (PPSV) 23 one year later. -For adults 65 and over who has had Pneumococcal Conjugate Vaccine 13 (PCV13) and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) and it has been 5 years or greater since the last Pneumococcal Vaccination, then the patient and the vaccine provider may choose to administer the 20-Valent Pneumococcal Conjugate Vaccine (PCV20). 1. Resident #9 was admitted to the facility in April 2024 and was [AGE] years old. Review of the immunization record failed to indicate Resident #9 had previously received any pneumococcal vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated a consent form for the Pneumococcal Vaccine, that was blank and incomplete. Further review of the record failed to indicate documentation of screening, assessment for eligibility to receive the pneumococcal vaccine, the provision of education related to the vaccine, and administration of the vaccine in accordance with facility policy and CDC recommendations. 2. Resident #13 was admitted to the facility in August 2022 and was [AGE] years old. Review of the immunization record indicated Resident #13 received the Pneumococcal Vaccine 23 in May 2012, and was eligible to receive the Pneumococcal Conjugate Vaccine PCV20 per CDC recommendations. Review of the medical record indicated a consent form for the Pneumococcal Vaccine, that was blank and incomplete. Further review of the record failed to indicate any documentation of screening, assessment for eligibility to receive the pneumococcal vaccine, the provision of education related to the vaccine, and administration of the vaccine in accordance with facility policy and CDC recommendations. 3. Resident #34 was admitted to the facility in March 2024 and was [AGE] years old with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of the immunization record failed to indicate Resident #34 had previously received any pneumococcal vaccinations. Review of the medical record indicated a consent form for the Pneumococcal Vaccine, that was blank and incomplete. Further review of the record failed to indicate any documentation of screening, assessment for eligibility to receive the pneumococcal vaccine, the provision of education related to the vaccine, and administration of the vaccine in accordance with facility policy and CDC recommendations. During an interview on 5/7/24 at 2:50 P.M, the Infection Preventionist Nurse (IPN) said the admitting nurse has the residents sign the consent for vaccination upon admission, once signed they are placed in the medical record. She said she follows up with the residents within one to two days after admission, enters the order for the vaccine, and completes a progress note. The surveyor and IPN reviewed Residents #9, #13, and #34's medical records together. IPN said Residents #9, #13, and #34 consents for vaccination were blank and incomplete. She said all three residents were missing documentation of screening, assessment for eligibility, and education on the risks versus the benefits of receiving the vaccination. She said all three residents are not up to date with their Pneumococcal vaccine as they should be per facility policy.