STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225472	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jeffrey & Susan Brudnick Center for Living	240 Lynnfield Street Peabody, MA 01960

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49880 Based on observation, chart review and interview the facility failed to provide a dignified existence for one Resident (#23) out of a total sample of 30 Residents. Specifically, for Resident #23 the facility staff stood over the Resident while providing meal assistance. Findings include: Review of facility policy titled Quality of Life- Dignity, undated, indicated the following: -Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Resident #23 was admitted to the facility in October 2023 with diagnoses that include Parkinson's disease, dementia and age-related physical debility. Review of Resident #23's most recent Minimum Data Set (MDS) Assessment, dated 1/23/25, indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating that the Resident had moderate cognitive impairment. The MDS further indicated that the Resident requires supervision or touching assistance with eating. Review of Resident #23's active ADL (activities of daily living) care plan, initiated on 2/28/24, indicated that the Resident is unable to perform ADLs independently due to visual deficit, gait instability and poor balance. -On 1/28/25 at 8:38 A.M., the surveyor observed Resident #23 in bed. The Resident was being assisted with the breakfast meal by a staff member who was standing next to the bed over the resident. -On 1/29/24 at 8:29 A.M., the surveyor observed Resident #23 in bed. The Resident was being assisted with the breakfast meal by a staff member who was standing next to the bed over the resident. During an interview and observation on 1/28/25 at 8:33 A.M., Nurse #2 observed the Certified Nursing Assistant (CNA) assisting the Resident while standing. Nurse #2 said that staff assisting a resident with a meal should be at their level and face to face with the resident, but the staff member was not. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 1:33 P.M., CNA #1 said when assisting a resident with a meal, it is preferred that they stand because it is more professional and if you sit down while you assist, you might get too comfortable and not pay attention to the resident. During an interview on 1/30/25 at 8:15 A.M., the Assistant Director of Nurses said that staff should be seated while assisting a resident with a meal. She said standing while assisting with a meal would be a dignity concern.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49880 Based on record review and interview, the facility failed to accurately reflect the status of one Resident (#27) out of a total sample of 30 residents, when the Minimum Data Set (MDS) assessment indicated that the Resident was receiving an anticoagulant Resident #27 was admitted to the facility in October 2023 with diagnoses that include diabetes, anemia and hematuria. Review of Resident # 27's most recent Minimum Data Set (MDS) Assessment, dated 11/16/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. The MDS further indicates that the Resident is taking an anticoagulant medication. Review of Physician's orders failed to indicate any orders for anticoagulant medications. Review of the October 2024 and November 2024 Medication Administration Records failed to indicate any anticoagulant medications were administered. During an Interview on 1/30/25 at 10:21 A.M., the MDS Nurse said that aspirin is an antiplatelet medication, not an anticoagulant medication. The MDS Nurse reviewed Resident #27's medical record and said that he/she has not been on anticoagulant medication, and the MDS assessment was coded incorrectly. During an interview on 1/30/25 at 10:29 A.M., the Assistant Director of Nursing said that she would expect accurate coding on an MDS assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, record review and interview, the facility failed to develop and implement a person-centered comprehensive care plan for three Residents (#335, #29 and #18) out of a total sample of 30 residents. Specifically, 1. For Resident #335, the facility failed to develop orders or a care plan for the use of ACE wrap bandages. 2. For Resident #29, the facility failed to devlop a care plan for alcohol use disorder when a resident, with known history of alcohol use disorder was found with alcohol bottles in his/her room. 3. For Resident #18, the facility failed to develop a pain management care plan. Findings include: Review of facility policy titled Care Plans- Comprehensive, undated, indicated the following: -An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. -Residents will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. [sic] -The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS (Minimum Data Set) -Each resident's comprehensive care plan is designed to: -a. incorporate identified problem areas based on assessments; -b. incorporate risk factors associated with identified problems; -c. build on resident's strengths; -d. reflect the resident's expressed wishes regarding care and treatment goals; -e. reflect treatment goals, timetables and objectives in measurable outcomes; -f. Identify the professional services that are responsible for each element of care; -g. aid in preventing or reducing declines in the resident's functional status and/or functional levels; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-h. reflect currently recognized standards of practice for problem areas and conditions. 1. Resident #335 was admitted in January 2025 with diagnoses including gout. Review of the Minimum Data Set (MDS) failed to indicate the Brief Interview for Mental Status had been completed. Review of the certified nursing aide activities of daily living documentation indicated Resident #335 requires substantial to maximal assist with upper body dressing. During an observation on 1/28/25 at 8:14 A.M., Resident #335 was observed lying in bed with his/her left hand wrapped in an ACE bandage (a stretchable band used to wrap around skin). During an observation on 1/29/25 at 9:39 A.M., Resident #335 was observed in the dining room with his/her left hand and wrist wrapped with an ACE bandage. Resident #335 said that he/she has had the bandage on to manage his/her gout. Review of the physician's orders or care plan failed to indicate that Resident #335 had an order or care plan for ACE bandage wraps. During an interview on 1/30/25 at 8:07 A.M., the Assistant Director of Nursing said that if a Resident has ACE bandages on, then she would expect an order and care plan to be developed for the ACE bandages. 43807 A review of the facility policy titled 'Substance Use Disorder' with no revision date indicated the following: -For the sake of this policy, substance use includes use of alcohol, legally prescribed narcotics and illegally procured narcotics. -Only legally prescribed substances will be allowed for residents to use and only if clinically indicated and ordered by the physician. All substances will need MD (Medical Director) orders. -Long term care residents with a history of substance abuse will be monitored for any substance use not ordered by a physician. If found, the substance will be removed immediately with consent from the resident. -For residents with activated HCP (Health Care Proxy) the facility will coordinate with the HCP all matters pertaining to substance use or risk of use. 2. Resident #29 was admitted to the facility in January 2023 with diagnoses including anxiety and depression. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 indicating intact cognition. A review of a behavior progress note dated 9/24/24 indicated but was not limited to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- This writer also found alcohol in resident's room. This was removed and resident informed he/she could not have alcohol in his/her room and he/she responded yes, I know that and informed him/her it was removed. This writer spoke with the HCP this morning and informed her about the alcohol She did not know he/she had alcohol in his/her room. He/she does have a hx of alcoholism. She has a hired aid to take resident out weekly for lunch and she is given a gift certificate for this so there is no cash given for the meals. She does not think the hired aid whom the resident refers to as his/her girlfriend would supply him/her with alcohol. [sic] A review of the Nurse Practitioner #2 progress notes dated 12/12/24 indicated but was not limited to: -Interim history: He/she was also found to be hoarding bottles of liquor that were hidden in his/her room. He/she continues to go out weekly with a companion which he/she very much enjoys. His/her hygiene is much improved and is urinating in appropriate places. Currently is on Depakote which has been helpful in improving behavioral control along with Trazodone at night for sleep. [sic] Visit Diagnoses: Dementia associated with alcoholism with behavioral disturbance A review of the cognitive problems care plan revised on 1/9/25 indicated the following: - Resident has alteration in cognition due to diagnosis of dementia due to alcohol use. A review of the mood care plan revised on 1/9/25 indicated the following: -Resident has alteration in mood state due to dementia associated with alcoholism with behavioral disturbance. Further review of both the cognitive problems and mood care plans failed to indicate person centered care plan with interventions and goals related to the Resident being found with alcohol bottles in his/her room. During an interview on 1/29/25 at 1:42 P.M., Unit Manager #3 said she found seven bottles (nips) of sealed vodka in Resident #29's room while cleaning out hoarded food on 9/24/24. She said she had no idea how the Resident brought the alcohol into the facility, Unit Manger #3 said she suspects the attendant who takes the Resident out weekly purchased the alcohol for him/her. Unit Manager #3 said the weekly visits outside the facility with the attendant continue to happen. Unit Manager #3 said she does random room searches when the Resident returns from the community with permission from the HCP. Unit manager #3 said she is the only staff member who conducts the room searches. She said that information should be put in the care plan so all staff are aware of the room search process. The Unit manager also said information about the Resident having alcohol in his/room should also be added to the care plan. She said the Resident is currently taking Trazodone and Depakote, she said it would be dangerous for the Resident to consume alcohol while on these medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/25 at 12:28 P.M., Nurse Practitioner #2 said Resident #29 has a history of alcoholism. She said he/she was found with bottles of alcohol in his/her room on 9/24/24. She said his/her history of alcoholism care plan should be developed to include this information, she said the care plan should also include a process for staff to follow and when to conduct room searches since the Resident is still going out to the community with an attendant weekly. She said it is imperative that the Resident does not mix alcohol with his/her current medications Depakote and Trazodone. During an interview on 1/30/25 at 7:43 A.M., the Social Worker said the Resident has a history of alcoholism. She said the care plan should be developed to include the Resident's history of having bottles of alcohol in his/her room. She said the room search process when the Resident returns from the community should be care planned so all staff are aware of the process. During an interview on 1/30/25 at 8:42 A.M., the Director of Nurses said Resident #29's current history of alcoholism care plan should be personalized with a history of alcohol bottles being found in his/her room and process for room searches when he/she returns from the community after his/her weekly visits. She said it would be dangerous for the Resident to mix alcohol with his/her current medications, Trazodone and Depakote. During an interview on 1/30/25 at 10:35 A.M., the Administrator said that Resident #29's care plan should not be personalized since he/she does not have a diagnosis of alcohol abuse. She said she was not aware Unit Manger #3 was conducting random room searches after the Resident returned from his/her weekly community visits. The Administrator said the Resident does not have a physician's order to drink alcohol. 49880 3. Resident #18 was admitted to the facility in May 2024 with diagnoses that include osteoarthritis of the knee and age-related physical debility. Review of Resident #18's most recent Minimum Data Set (MDS) assessment, dated 12/14/25, indicated a Brief interview for Mental Status score of 13 out of 15 indicating intact cognition. The MDS also indicated that the resident is on scheduled pain medication and received or was offered PRN (as needed) pain medications in the last 5 days prior to the assessment. Review of admission paperwork from the acute care hospital, titled Physical Therapy Initial Evaluation, dated 5/21/24, indicated, Patient presents with performance deficits including decreased range of motion, decreased strength/ muscular endurance, altered cognition, decreased safety awareness, altered balance, altered skin integrity, pain, decreased ADL status. The paperwork further indicated a pain score of ten out of ten, chronic pain which was worsened by sitting, standing, bending and relieved by rest, medication, and changing position. Further, it indicated that functional limitations in bed mobility, transfers, ambulation, stair negotiation were related to pain. -On 1/28/25 at 7:55 A.M., Resident #18 said that lately he/she was having a lot of pain due to arthritis. The Resident said they take medication for the pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 1/29/25 at 8:00 A.M., Resident #18 was sitting up in their wheelchair. Resident #18 said that they were having a lot of pain this morning in their back. Resident #18 said that they have spinal stenosis and arthritis that causes a lot of pain. Review of Resident #18's active physician's orders indicated the following: -Gabapentin (a medication used to treat pain) Oral Capsule 100 MG (milligrams), Give 4 capsule by mouth one time a day, dated 1/8/25. -Acetaminophen (Tylenol) Oral Tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for pain, dated 8/28/24. -Pain Monitoring: Monitor for pain every shift and document level 0-10 (0 being no pain, 10 being the worst) every shift, dated 6/14/24. Review of the December 2024 Medication Administration Record (MAR) indicated the following: -Resident #18 received scheduled Acetaminophen daily, (physician's order was discontinued 1/13/25). -Resident #18 received as needed Acetaminophen dosing five times. -Resident #18 was assessed as reporting pain greater than 0 during 36 out of 90 shifts. Review of the January 2025 MAR indicated the following: -Resident #18 received scheduled daily gabapentin as ordered after 1/8/25. -Resident #18 received scheduled daily Acetaminophen as ordered until it was discontinued on 1/13/25. -Resident #18 received as needed Acetaminophen dosing nine times through 1/28/25. -Resident #18 was assessed as reporting pain greater than 0 during 22 out of 85 shifts. Review of Resident #18's active care plans failed to indicate an active care plan for pain. During an interview on 1/29/25 at 1:41 P.M., Unit Manager #1 said that when Resident #18 was admitted he/she had knee pain that they complained about. Unit Manager #1 reviewed the active care plan and said that there was not an active care plan for pain management and would look into if Resident #18 needed one. During an interview on 1/30/25 at 8:15 A.M., the Assistant Director of Nursing said that she would expect Resident #18 to have a plan of care in place for pain, but she does not.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to follow eye doctor recommendations for one Resident (#16) out of a total sample of 30 residents. Findings include: Resident #16 was admitted in 12/2023 with diagnoses including dementia and diabetes mellitus. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #16 could not participate in the Brief Interview for Mental Status exam due to impaired cognition. Review of the eye doctor exam note, dated 1/3/25, indicated a recommendation for two new medications. * New Medication Order: Ocusoft Lid Scrub Pads (a pad used for daily eyelid hygiene), apply 1, Both eyes, every morning for indefinitely. * New Medication Order: preservision AREDS 2 (a vitamin used for eye health), 1 Tablet, PO, twice daily for indefinitely; Follow-Up: 5-6 Months; please start areds 2 supplements after clearing w/ pcp. During an interview on 1/30/25 at 8:05 A.M., the Assistant Director of Nursing said that when the eye doctor comes in and makes recommendations, she expects the physician to be notified of the recommendations, review them, and put the order in place. Review of the physician documentation and progress notes failed to indicate that the recommendations were reviewed or the physician was notified of the recommendations. Review of the physician's orders failed to indicate the medications were ordered.