STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225478	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Meadow View Center	134 North Street North Reading, MA 01864

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation, policy review, and interview the facility failed to provide a dignified dining experience for 2 Residents (#80 and #85) out of a total sample of 27 Residents. Specifically, the facility failed to ensure that staff members were not standing over Residents #80 and #85 while providing feeding assistance. Findings include: Review of the undated facility policy titled Resident Rights indicated the following: -The resident has the right to be treated with respect and dignity. 1. Resident #80 was admitted to the facility in October 2022 with diagnoses including Alzheimer's Disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #80 scored a 4 out of 15 on a Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Further review of the MDS indicated Resident #80 was dependent on staff for partial/moderate feeding assistance. On 2/27/24 at 9:08 A.M., the surveyor observed a staff member providing feeding assistance to Resident #80 in the dining room of the View unit. The Resident was seated at a table and the staff member was standing over him/her while providing assistance. The staff member and the Resident were not at eye level. 2. Resident #85 was admitted to the facility in January 2024 with diagnoses including stroke and hemiparesis or hemiplegia (weakness or paralysis of one side of the body). Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #85 was unable to complete a Brief Interview for Mental Status (BIMS) due to being rarely or never understood. Further review of the MDS indicated Resident #85 was dependent on staff for substantial/maximum feeding assistance. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/24 at 9:18 A.M. the surveyor observed a staff member providing feeding assistance to Resident #85 in the Resident's room. The staff member was standing over the Resident while providing assistance and not at eye level; the Resident's bed was not raised. During an interview on 2/29/24 at 7:58 A.M., the Director of Nursing (DON) said staff should always be seated and at eye level with a resident while providing feeding assistance. The DON said it would be unacceptable for staff to stand over a resident while providing feeding assistance as this would be a dignity issue.

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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** 48671 Based on observations and interviews, the facility failed to ensure resident rooms were maintained in good repair, clean and homelike on 2 of 3 resident care units. Findings include: On 2/27/24 & 2/28/24, the following observations were made on the Meadow unit in the following rooms: room [ROOM NUMBER]- The nightstand had dark scuff marks, chipped paint, and bubbling paint on the pull-out drawer. The bathroom door had dark scuff marks on the bottom right side near the wall. The exterior door to the hallway had gouges in the wood, chipped paint, and chipped lamination with discoloration. room [ROOM NUMBER]- The left armrest of the wheelchair was peeling with yellow foam exposed. The nightstand had scuff marks, and peeling paint throughout. The bottom left side of the exterior bathroom door had chipped paint with scuff marks, bottom right of the bathroom wooden door was chipped and had discoloration. The white dresser bureau had three drawers that would not close, and the middle drawer had a broken hinge. room [ROOM NUMBER] The floor of the bathroom had nine missing tiles and had exposed chipped cement visible on the floor. The toilet seat was stained with brown and yellowing steaks. The exterior bathroom door frame had chipped paint and discoloration along the bottom. The baseboard to the left of the toilet was peeling off the wall, was covered in a thick dark hard substance and was chipped. The right side of the toilet had dark paneling that was not attached to the wall and was sticking out from the wall. The ceiling had dark and light brown water stains above the toilet seat. The light above the bathroom sink was missing a cover leaving the light bulb exposed. The white dresser bureau drawers would not close and had chipped, scuffed paint throughout. The bottom left side of the window had a large crack and was sharp to touch, was disconnected to the top piece and was moveable. The ceiling tile located to the right of the window had a large brown and yellow stain. The baseboard under the window had gray and black scuff marks along the front. room [ROOM NUMBER] The baseboards were scuffed with brown and yellow discoloration and peeling. The closet cabinet door was peeling in four spots and had chipped laminate. The wallpaper was peeling along the baseboards and had visible brown and yellow discoloration. room [ROOM NUMBER] The top of the over bed table had peeling and scratched laminate scattered on the top and edges. The baseboards had scratch marks and cracked paint near the wall. The wall next to bathroom had discolored yellow wallpaper. The baseboard had brown and yellow stains with chipped, cracked paint on the corner of the wall. (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] There was a very large brown and yellow water stain on the interior of the bathroom along the edge of the ceiling vent. The ceiling vent was pulled away from the ceiling tile and was not flushed with the ceiling tile. There were twelve missing floor tiles in the bathroom with exposed cement in front of the toilet creating a divot. The bathroom door had missing chipped and scratched wood along the bottom of the door. There was a large yellow and brown water stain on the ceiling located above the toilet and the ceiling tile was detached from the support beam and was sagging down. There were multiple holes in the wall next to the mirror above the bathroom sink. room [ROOM NUMBER] The wall next to the window had a large hole along the edge of the tiles. There was peeling and chipped paint and cracked plaster throughout the wall. The window had dark green and black spots along the edge and the wallpaper was peeling off the wall. The bathroom window had a crack on the right side and there was peeling wallpaper along the wall tile at the bottom of the window. The dresser bureau had chipped and peeling paint along with three drawers that would not close. The bottom drawer had hardware that was not attached and located inside the dresser drawer. The exterior door had chipped wood, peeling paint, scuffed and chipped laminate with scratches and discolorations. room [ROOM NUMBER] The dresser bureau had chipped peeling paint and scuff marks throughout and the top and middle drawers would not close. The wall near the bathroom had a large area located near the floor that was missing green wallpaper and had chipped plaster and scuff marks along the side corner and up the wall. The baseboard was discolored with brown and yellow matter throughout. The window had a broken clasp in the middle and a missing handle on the bottom left side. There were visible water stains and scratches on the wood near the window. The bathroom had a dark brown, yellow, and black scattered water stain on the ceiling near a light fixture. The stain covers two ceiling tiles and the foam inside the ceiling tile was visibly discolored brown, black and tan. There were two additional water stains near the bathroom ceiling vent that were yellow and brown that extend to three tiles. The bathroom had one wall near the toilet that had large areas of peeling sections of wallpaper that extended across the wall under the grab bar and toilet paper holder. The wallpaper was peeling off and detached from the wall. The wall behind the bathroom door had peeling wallpaper and the baseboard was stained yellow and brown. There was peeling wallpaper above the bathroom door that extended across the top of the door. The toilet was missing a seat and had exposed holes where a toilet seat would be placed on top of the toilet. The bottom right of the outside of the toilet had a one-inch exposed loose screw. Throughout the hallways on the Meadow unit black scuff marks could be seen on the walls. Meadow Unit - Large water stain on the ceiling above the water fountain entering the unit. On 2/27/24 & 2/28/24, following was observation were made on the View unit in the following rooms: On the second floor View unit, a water fountain was attached to the wall with visible cracked plaster and chipped paint located on the back right side. (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] The wooden closet door had five large holes across the middle where the outside doorknob hit the door. There were two small holes located on the top left of the door. To the right of the bathroom window there was missing wallpaper and exposed peeling and chipped plaster. The wall was covered with dark gray and black spots throughout and discoloration along the entire area that was yellow, brown, gray, and black. The area was unpainted and had various peeling and chipped areas. The wallpaper above the bathroom window was peeling and discolored and the frame of the window had light brown and dark spots along all sections. The baseboard under the window was scuffed with chipped paint along the wall. There was a large brown and yellow stain under the bed that expanded to four floor tiles. The white dresser bureau had scuffs and chipped paint throughout, and the top drawer would not close. There were exposed screws and holes visible along the front edges of the top drawer. The second bureau had scuffed areas and missing paint throughout, and the top drawer had a missing left handle. There was a rectangular light fixture attached to the wall behind the bed that was discolored with brown, tan, black stains along the front panel and chipped cracked paint along the bottom. room [ROOM NUMBER] The bedside table drawer was pushed in and was stuck. The table had scattered scuff marks and missing chipped paint throughout. room [ROOM NUMBER] The dresser bureau had broken drawers that would not close, and the middle drawer was off the hinge and was slanted. The bureau had scuffed, chipped areas throughout. The bathroom window had chipped, cracked dark brown and black areas throughout along the right side and the wallpaper was peeling with water stains. The tile along the bathroom window was cracked and chipped. room [ROOM NUMBER] Floor tiles located under the bed are stained dark yellow and brown and extend throughout nine tiles. The paneling along the back of the wall was scuffed and was peeling off the walls. The dark bureau had chipped wood and scratches along the top. The bathroom door had chipped, cracked and peeling laminate along the bottom. During an interview on 2/29/24 at 11:28 A.M., the Director of Maintenance (DOM) said he conducts monthly environmental unit rounds on each unit and addresses areas that need to be fixed himself. The DOM said he notifies the administrator verbally and would make recommendations for outside vendors if he can't fix issues in the building. The DOM then showed the surveyor the maintenance logs for each unit and one out of the three units had a documented maintenance log request last dated 9/17/23. The document failed to indicate a completed date and time. The DOM said he would expect to see any maintenance log request completed and signed at the time of the repair. The DOM said the facility does have access to an online reporting system for tracking and reports building issues but said only a few staff have been training and use the system. The DOM said he would expect staff to report environmental issues and that the issues should be documented and addressed at the time they are reported. The DOM said if he observes any water stains, broken glass, chipped tiles, or broken cabinets he would fix the issues right away and not leave them unattended. The DOM said the facility had five broken windows that were identified in 2023 by the prior director of maintenance and reports one of those windows was located on the dementia unit. The DOM said he did not assess the broken windows for safety, that he would not know how to assess the windows for safety and that a window company was called but did not come out to fix the broken windows. During an interview on 2/29/24 at 12:01 P.M., the Administrator said that she was not aware of the environmental issues and relied on the head of maintenance to let her know of issues within his department. (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 2/29/24 at 12:42 P.M., with the Administrator and Director of Maintenance, the Administrator said the broken windows were identified last year and a window company was called but she did not know if the windows were replaced. The Administrator said she did not visualize the broken windows and that they have made no contact to replace the windows since last year. The Administrator said the windows should have been fixed when the cracks were identified. During an interview on 2/29/24 12:59 P.M., with the Regional Director of Maintenance (RDOM), he said he visualized the broken windows last year, deemed them not safe and notified the Administrator that they needed to be replaced. The RDOM said no immediate safety measures were put into place because it was not necessary unless a resident were to put pressure on the windows as this would push the window outside. The RDOM said he did not follow up with the Administrator or the DOM to ensure the windows were fixed. During an interview on 2/29/24 at 1:24 P.M. the Director of Nurses (DON) said identified broken windows are a safety concern for residents and must be addressed when identified. The DON said she would expect safety measures to be implemented immediately.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, record review, and interview, the facility failed to identify and assess the use of pillows placed underneath a fitted sheet below the side rails on both sides of the bed as a potential restraint for one Resident (#72), out of a total sample of 27 residents. Findings include: Review of the undated facility policy, titled Use of Restraints, indicated the following: -Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or restricts access to one's body. -Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. -Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. Resident #72 was admitted to the facility in February 2024 with diagnoses including stroke with resulting left sided hemiplegia (Paralysis affecting one side of the body). Review of the Minimum Data Set, dated dated dated [DATE], indicated Resident #72 scored a 5 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Further review indicated that Resident #72 was dependent on staff for all aspects of daily living. On 2/27/24 at 7:51 A.M. and 9:56 A.M., the surveyor observed Resident #72 lying in bed with pillows under the fitted sheet on the right side of the bed and a pillow on the left side of the mattress below the side rail. On 2/28/24 at 7:44 A.M., two surveyors observed two pillows under the fitted sheet on the right side of the bed, running the length of the mattress and a pillow on the left side of the mattress. On 2/28/24 at 11:25 A.M. and 12:30 P.M., the surveyor observed Resident #72 lying in bed with his/her right leg draped over the top of the pillow under the fitted sheet and hanging off of the bed. The surveyor observed Resident #72 to be restless in the bed. Review of the medical record failed to indicate an order for a pre-restraining assessment to determine if the use of pillows under the fitted sheet acts as a restraint. Further review failed to indicate a restraint elimination assessment had been completed to determine the least effective restraint for the least amount of time. Review of the nurse's note dated 2/23/24, indicated that Resident #72 was restless and attempted to get out of bed during the night. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan failed to indicate an intervention to place pillows under a fitted sheet to prevent falls out of bed. Review of the doctors orders for February 2024 failed to indicate an order for restraints. During an interview on 2/28/24 at 8:09 A.M., Certified Nurse's Aide #1 said that Resident #72 attempts to get out of bed and the pillows are there to prevent him/her from having an accident and falling out of bed. During an interview on 2/28/24 at 8:11 A.M., Nurse #2 said Resident #72 is agitated and attempts to get out of bed, mostly at night, and that the pillows are there so he/she doesn't fall out of bed. During an interview on 2/29/24 at 8:08 A.M., the Director of Nursing said that pillows under a fitted sheet running the length of the mattress would constitute a restraint if the resident was capable of moving in bed. The DON then said that a pre-restraining assessment should have been completed prior to instituting anything that could constitute a restraint, a care plan developed and a restraint elimination assessment completed periodically.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on interview and record review the facility failed to develop and implement a baseline care plan within 48 hours of admission for one Resident (#90), who was at risk for elopement, out of a total sample of 27 residents. Findings include: Review of the facility policy titled Care Plans - Baseline, dated May 2023, indicated the following: -To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. -The interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders; b. Physician orders; c. Dietary orders; d. Therapy Services; e. Social services; and f. PASARR recommendation, if applicable. Resident #90 was admitted to the facility in January 2024 with diagnoses including dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #90 scored an 8 out of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Review of Resident #90's hospital discharge paperwork indicated Resident #90 had multiple instances of exit seeking behavior, and an elopement on 11/2/23. Review of Resident #90's nursing admission summary, dated 1/24/24, indicated Resident #90 was wandering and at risk for elopement. During an interview on 2/29/24 at 8:22 A.M., Certified Nursing Assistant (CNA) #4 said Resident #90 had a history of wandering. (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 Resident #90's electronic, and physical record indicated that care plans were not initiated until 6 days after admission. Review of the elopement assessment dated [DATE], indicated Resident #90 had not exhibited wandering behaviors in the last 60 days, and that the Resident does not have a history of exiting this facility or previous places of residence. The elopement assessment concluded that the Resident was not at risk for elopement. During an interview on 2/29/24 at 8:28 A.M., Nurse #6 said the elopement assessment conducted on 1/26/24 was inaccurate as the Resident had attempted to elope prior to admission and had an exhibited behavior of wandering which made Resident #90 a known risk for elopement. Nurse #6 said she would expect that a baseline care plan specific to wandering and elopement should be developed within 48 hours of admission for any resident determined to be at risk for elopement. During an interview on 2/29/24 at 8:32 A.M., Unit Manager #1 said Resident #90 is a known risk for elopement as the Resident had attempted to elope prior to admission and had exhibited behaviors of wandering. Unit Manager #1 said the elopement assessment conducted on 1/26/24, was inaccurate, and if it had been completed accurately it would have triggered the nurse to develop an elopement care plan. Unit Manager #1 said since Resident #90 was a known risk of elopement on admission that a baseline care plan to address elopement should have been developed within 48 hours of admission. During an interview on 2/29/24 at 10:32 A.M., the Director of Nursing (DON) said Resident #90 should have been considered at risk for elopement on admission as the Resident had a history of elopement while hospitalized and had exhibited wandering behaviors. The DON said that the elopement assessment conducted on 1/26/24, was inaccurate. The DON said that baseline care plans should be developed within 48 hours of admission, which include all care plans necessary to address any immediate care and/or safety needs. The DON said that a care plan specific to elopement should have been developed as part of Resident #90's baseline care plans. The DON said that baseline care plans are documented in the electronic medical record with the Resident's comprehensive care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, record review, and interview, the facility failed to develop a care plan for the use of pillows under a fitted sheet as a potential restraint for one Resident (#72), out of a total sample of 27 residents. Findings include: Resident #72 was admitted to the facility in February 2024 with diagnoses including stroke with resulting left sided hemiplegia (Paralysis affecting one side of the body). Review of the Minimum Data Set, dated dated dated [DATE], indicated Resident #72 scored a 5 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Further review indicated that Resident #72 was dependent on staff for all aspects of daily living. On 2/27/24 at 7:51 A.M. and 9:56 A.M., the surveyor observed Resident #72 lying in bed with pillows under the fitted sheet on the right side of the bed and a pillow on the left side of the mattress below the side rail. On 2/28/24 at 7:44 A.M., two surveyors observed two pillows under the fitted sheet on the right side of the bed, running the length of the mattress and a pillow on the left side of the mattress. On 2/28/24 at 11:25 A.M. and 12:30 P.M., the surveyor observed Resident #72 lying in bed with his/her right leg draped over the top of the pillow under the fitted sheet and hanging off of the bed. The surveyor observed Resident #72 to be restless in the bed. Review of the medical record failed to indicate the development of a care plan for the use of pillows under the fitted sheet as a potential restraint. During an interview on 2/29/24 at 8:08 A.M., the Director of Nursing said that pillows under a fitted sheet running the length of the mattress would constitute a restraint if the resident is capable of moving in bed. The Director of Nursing then said that a care plan should have been developed for the use of restraints.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41105 Based on observations, record review and interviews the facility failed to maintain professional standards of practice for medication administration for one Resident (#54) out of a total sample of 27 residents. Specifically, for Resident #54, who resides on the facility's Dementia Speciality Care Unit, the nurse failed to ensure Resident #54 had swallowed the medication that she administered. Findings include: Review of the facility policy titled Administering Medications, dated August 2023, indicated the following: -Medications shall be administered in a safe and timely manner, and as prescribed. -Residents may self administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Resident #54 was admitted to the facility in July 2023 with diagnoses that include dementia and essential hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/24/24, indicated that on the Brief Interview for Mental Status exam Resident #54 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #54 had no behavior of refusing care. Review of the medical record failed to indicate Resident #54 was assessed for the ability to safely administer medication independently. On 2/28/24 at 8:35 A.M., the surveyor observed Resident #54 seated on the bed in his/her room and no staff were present. Resident #54 had a pill in his/her left hand and a cup of water in the right hand. Resident #54 placed the pill in his/her mouth and bit down on it. The Surveyor entered the room and upon request, Resident #54 handed the surveyor the cup that he/she was holding that contained 2 additional pills in water. During an interview on 2/28/24 at 8:37 A.M., the surveyor brought the cup of pills to the nurses station and showed it to Nurse Unit Manager #1. Nurse Unit Manager #1 said that Resident #54 is not assessed to take pills independently and that it is the expectation that the nurse's stay with residents until they have swallowed all the pills they have been given. During a interview on 2/28/24 at 8:40 A.M., with Resident #54's Nurse (#1) she said that she had just administered Resident #54's medication and that she thought that the Resident had swallowed the pills During a follow-up interview on 2/28/24 at 9:25 A.M., Nurse #1 identified the 2 medications that Resident #54 had in the cup and said that they were Lisinopril 20 milligrams (mg) (used to treat hypertension) and Amlodipine 10 mg (used to treat hypertension). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Meadow View Center	134 North Street North Reading, MA 01864

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/29/24 at 9:03 A.M., the Director of Nursing said that it is the expectation that nurses stay with the residents until they have swallowed all of the medication administered and until they have assessed to ensure the resident hasn't pocketed the medication (in their mouth).

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on record review, observation and interview the facility failed to provide the necessary services to ensure 1 Resident (#85) out of a total sample of 27 residents, was able to effectively communicate his/her needs. Findings include: Review of the undated facility policy, titled Translation and/or interpretation of Facility Services, indicated, but was not limited to, the following: -This facilities language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. -Competent oral translation of vital information that is not available in written translation, and non-vital information shall be provided in a timely manner and at no cost to the resident through the following means (as available to the facility): a. A staff member who is trained and competent in the skill of interpreting. b. A staff interpreter who is trained and competent in the skill of interpreting; c. Contracted interpreter service; d. Voluntary community interpreters who are trained and competent in the skill of interpreting; and e. Telephone interpretation service. -It is understood that providing meaningful access to services provided by this facility requires also that the LEP resident's needs and questions are accurately communicated to the staff. Oral interpretation services therefore include interpretation from the LEP resident's primary language to English. Resident #85 was admitted to the facility in January 2024 with diagnoses including stroke and hemiparesis or hemiplegia (weakness or paralysis of one side of the body). Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #85 was unable to complete a Brief Interview for Mental Status (BIMS) due to being rarely or never understood. Further review of the MDS indicated Resident #85 was dependent on staff for feeding assistance, oral hygiene, toileting, showering/bathing, dressing, personal hygiene, bed mobility, transferring, and ambulating. The MDS also indicated the Resident's preferred language was Russian, and that the Resident required an interpreter. Review of Resident #85's communication care plan indicated the Resident is Russian Speaking only and included the following interventions: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Anticipate and meet Resident #85's needs. -Provide translator as necessary to communicate with the resident. Translator is: Son -Resident #85 is able to communicate by: using communication board and translator: Son During an interview on 2/27/24 at 8:05 A.M., Resident #85 spoke to the surveyor in Russian, the Resident said he/she does not speak or read English. The Resident's son was not present to provide translation if needed, and there was no communication board present in Resident #85's room. There was a scrap piece of paper posted on a bulletin board providing the Russian translation for the words water, drink, and pain. The translation for the words were written out phonetically in English and would not be legible to a Resident who can't read in English. The Resident's TV was on and in English, the Resident had a stack of magazines at his/her bedside which were in English. During an observation and interview on 2/27/24 at 1:08 P.M., the surveyor observed Certified Nursing Assistant (CNA) #4 providing set-up assistance for lunch in the Residents room. The Resident said in Russian that he/she does not want juice because it is too sweet, and that he/she would like water. CNA #4 asked Resident #85 if he/she would like butter in English. CNA #4 said she doesn't speak Russian and that she does not know what Resident #85 is saying. CNA #4 said providing care for Resident #85 can be challenging because of the language barrier. The Resident's son was not in the room to translate, and there was no communication board present in the room. The Resident's TV was on and in English, the Resident had a stack of magazines at his/her bedside which were in English. On 2/28/24 at 9:11 A.M., the surveyor observed a staff member entering Resident #85's room to bring his/her breakfast tray. The staff member greeted the Resident in English, and instructed the Resident to lean forward in English. The Resident's son was not present to provide translation and there was no communication board present in Resident #85's room. The Resident's TV was on and in English, the Resident had a stack of magazines at his/her bedside which were in English. On 2/28/24 at 10:57 A.M. the surveyor observed Resident #85 in his/her room. The Resident's TV was on and in English, the Resident had a stack of magazines at his/her bedside which were in English. The Resident's son was not present to provide translation if needed, and there was no communication board present in Resident #85's room. On 2/28/24 at 12:55 P.M., the surveyor observed a staff member entering Resident #85's room during lunch time. The staff member asked the Resident how his/her lunch was in English, Resident #85 did not reply. The Resident's son was not present to provide translation and there was no communication board present in Resident #85's room. The Resident's TV was on and in English, the Resident had a stack of magazines at his/her bedside which were in English. During a follow up interview on 2/28/24 at 12:57 A.M. CNA #4 said to communicate she could write on paper or a board, but doesn't know if Resident #85 would be able to read in English as she hasn't tried it yet. CNA said there is no communication board in the room or an interpreter other than the son available to her. During an interview on 2/28/24 at 1:04 P.M., CNA #5 said Resident #85 does not speak English. CNA #5 said the Resident's son visits often but has not been in the facility for the last few days, CNA #5 said there is no communication board or interpreter other than the son available to staff. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/24 at 1:36 P.M., Nurse #4 said she would expect the interventions listed in a communication care plan to be implemented. Nurse #4 said Resident #85 does not speak English, and that she has never used a translator to communicate with the Resident. Nurse #4 said that a communication board should be comprehensive to facilitate communication regarding all aspects of Resident #85's activities of daily living, and that she would not consider the scrap piece of paper with the words water, drink, and pain to be adequate for communicating all of Resident #85's needs. During an interview on 2/29/24 at 7:58 A.M., the Director of Nursing (DON) said she would expect interventions developed as part of Resident #85's communication care plan to be followed. The DON said a communication board would include, at a minimum, all aspects of Resident #85's activities of daily living, and that she would not consider the scrap piece of paper with the words water, drink, and pain to be adequate for communicating all of Resident #85's needs. The DON said she would expect staff to use a communication board and/or interpreter when communicating with the Resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on observations, record review and interviews the facility failed to ensure supervision with meals was provided for one Resident (#44) out of a total sample of 27 residents. Findings include: The facility policy titled Activities of Daily Living (ADLs), dated as reviewed [DATE], indicated the following: -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: d. Dining (meals and snacks) Resident #44 was admitted to the facility in [DATE] and has diagnoses that include Alzheimer's disease and epilepsy. Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated that on the Brief Interview for Mental Status exam Resident #44 scored a 9 out of a possible 15, indicating moderately impaired cognition. The MDS further indicated that Resident #44 had no behavior of refusing care. Review of the current Activities of Daily Living (ADL) care plan included the following intervention: -Eating-supervision On [DATE] at 1:05 P.M., the surveyor was standing at the nurse's station and overheard profuse coughing coming from Resident #44's room. The surveyor walked to Resident #44's room (approximately 30 feet away) and observed Resident #44 seated on the bed, coughing profusely with a lunch tray directly in front of him/her. There were no staff present. The surveyor observed that there were 4 staff in the hall near to Resident #44's room, however none were within eyesight of the Resident. No staff responded to Resident #44's profuse coughing or checked on Resident #44's status, nor did the staff provide the needed supervision. There was a Nurse in the room across the hall, feeding another resident. The nurse turned her head and appeared to listen to the coughing, then went back to the feeding the resident. The surveyor continued to make the following observations: -For the next 5 minutes Resident #44 coughed profusely and at 1:10 P.M., Resident #44 lay back on the bed and began wiping his/her eyes that were tearing as he/she coughed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 1:11 P.M., Resident #44 stood up, exited the room and said to the surveyor oh my god, I took a bite of that cake and I almost choked to death. Resident #44 walked toward a staff person and repeated that he/she almost choked to death and said God, that was scary I thought I couldn't breathe. The staff person gave Resident #44 a cup of water and then Resident #44 walked back into his/her bedroom, to the meal, and remained unsupervised. On [DATE] at 8:59 A.M., the surveyor observed a Certified Nursing Assistant (CNA) deliver breakfast to Resident #44 in his/her room. The CNA briefly entered, then exited the room, and continued to pass out trays to other residents. Resident #44 was seated alone in the room, in the dark, with a tray of food directly in front of him/her and no staff were present to supervise Resident #44 with the meal. The surveyor continued to make the following observations: -At 9:03 A.M., Resident #44 started coughing. There was one staff person in the hall, nearby to Resident #44's room, but not within eyesight of the Resident. The staff person did not acknowledge the coughing or enter the room to supervise Resident #44. The surveyor entered the room and observed Resident #44 coughing on the bite of biscuit he/she had taken. When Resident #44 stopped coughing he/she said to the surveyor I almost choked to death yesterday. -By 9:16 A.M., Resident #44 remained alone with the breakfast and no staff had supervised the Resident since the meal was served 17 minutes earlier. On [DATE] at 12:54 P.M., the Nurse Unit Manager (#1) delivered lunch to Resident #44, then exited the room to continue passing trays to other residents. Resident #44 was alone in his/her room, unsupervised. The surveyor continued to make the following observations: -By 1:05 P.M., Resident #44 remained alone in the room, eating lunch. Resident #44 told the surveyor lunch was good but that he/she almost died yesterday when I choked on my cake at lunch. During an interview on [DATE] at 11:23 A.M., Nurse (#3) said that she had been the nurse in the room across the hall the previous day when Resident #44 began choking on his/her meal. Nurse #3 said that it had been her first day working at the facility and that she did not get a good report regarding the resident's needs and status. According to Nurse #3 while feeding a resident across the hall from Resident #44's room the previous day, she heard the coughing. Contrary to direct observation by the surveyor, Nurse #3 said that she stopped feeding and went to Resident #44 and asked if he/she was okay. Nurse #3 said that she did a mouth sweep of Resident #44's mouth to ensure he/she was okay and reported the incident to the other nurse. Nurse #3 was not aware that Resident #44 required supervision with meals. During an interview on [DATE] at 2:27 P.M., with Nurse Unit Manager (#1) she said that if a resident requires supervision with meals, and they eat in their room, it is the expectation that staff stay with the resident for the entire meal. During an interview on [DATE] at 8:02 A.M., with CNA (#3) she said that she has access to the resident's care plans and that she is aware that Resident #44 requires supervision with meals. CNA #3 said that supervision for residents that eat in their room means that you are supposed to stay with the resident for the entire meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on [DATE] at 8:26 A.M., with Nurse Unit Manager #1 she said that Resident #44 should be encouraged to come out of his/her room for meals and if Resident #44 wishes to eat in the room, then staff should stay with Resident #44 to provide the required supervision. During an interview on [DATE] at 9:06 A.M., with the Director of Nursing (DON) she said Resident #44 should be supervised with meals and someone should stay in his/her room for meals, if he/she doesn't want to eat in the supervised dining room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on policy review, record review and interview the facility failed to maintain acceptable parameters of nutrition status for 1 Resident (#13) out of a total sample of 27 residents. Specifically, the facility failed to review or implement the Registered Dietitian's (RD's) recommendation for increasing the frequency of Resident #13's nutritional supplement. Findings Include: Review of the undated facility policy titled Weight Surveillance, indicated, but was not limited to, the following: -Significant weight change is considered if 5% or more gain or loss within one month, 7.5% or more gain or loss in three months, or 10% or more gain or loss in six months. -Dietitian to reassess and document interventions to address significant weight loss or gain. Resident #13 was admitted to the facility in August 2023 with diagnoses including dementia and adult failure to thrive. Review of the Minimum Data Set (MDS), dated [DATE], indicated that a Brief Interview for Mental Status (BIMS) was unable to be completed as Resident #13 was rarely/never understood. Review of Resident #13's care plans indicated Resident #13 was at nutritional risk with a history of weight loss and poor intake. Review of the Weight Report for Resident #13 indicated the following weights: 8/11/2023 154.0 Lbs. (pounds) 8/21/2023 147.4 Lbs. 9/10/2023 145.1 Lbs. 9/19/2023 139.0 Lbs. 9/24/2023 136.0 Lbs. 10/8/2023 134.9 Lbs. 10/22/2023 126.8 Lbs. 11/12/2023 124.4 Lbs. 12/17/2023 127.8 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/31/2024 126.9 Lbs. 2/7/2024 110.0 Lbs. 2/21/2024 110.6 Lbs. Review of the Weight Report indicated that Resident #13 had experienced an 11.4 Lb. weight loss between 8/21/23 and 9/24/23, which is equivalent to a clinically significant and severe 7.7% of Resident #13's total body weight lost in 1 month. Further review of the weight report indicated Resident #13 had an additional 9.2 Lb. weight loss between 9/24/23 and 10/22/23, which is the equivalent to a clinically significant and severe 6. 7% of Resident #13's total body weight lost in 1 month. Review of the weight report also indicated Resident #13 had an additional 16.3 Lb. weight loss between 9/24/23 and 10/22/23, which is the equivalent to a clinically significant and severe 12.8% of Resident #13's total body weight lost in 1 month. Review of Resident #13's Dietitian/Nutritional progress note dated 9/21/23 indicated a recommendation to increase Resident #13's nutrition supplement to TID (three times a day). Review of Resident #13's Nutrition Assessment, dated 11/9/23, indicated a recommendation to increase Resident #13's frequency of supplementation from twice a day to three times a day. Review of Resident #13's physician orders indicated the following discontinued order: Ensure (a supplemental shake enriched with calories, protein, vitamins and minerals) two times a day - initiated 8/23/23 and discontinued 9/25/23. Further Review of Resident #13's physician orders indicated the following active order: House supplement 240 milliliters two times per day - initiated 9/26/23. During an interview on 2/29/24 at 8:56 A.M., the RD said recommendations get communicated verbally to nursing staff and in her documentation, nursing then communicated the recommendation to the physician and/or nurse practitioner (NP) so that an order can be placed; the RD said nutritional supplements require a physician order. The RD said the physician and NP have never disagreed with a recommendation she has made. The RD said that she had recommended the frequency of Resident #13's supplementation increase from twice a day to three times a day, and that this should have been implemented when the recommendation was made. The RD said that the Resident was put at risk for further weight loss by not implementing this intervention, as increasing the frequency of supplementation would increase the amount of calories the Resident had access to. The RD said that the house supplement is nutritionally equivalent to Ensure, and that the order was changed when the facility switched from Ensure to another brand of supplement on 9/26/23. During an interview on 2/29/24 at 12:12 P.M., Unit Manager #1 said the RD communicates recommendations to nursing staff who will then notify the physician to place, adjust, or discontinue an order. Unit Manager #1 said the frequency of Resident #13's supplementation should have been increased from twice a day to three times a day per the RD's recommendation, and that the order must have been re-entered as twice instead of three times a day in error on 9/26/23.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Specifically, the facility failed to conduct an assessment for trauma per the facility policy, and develop a comprehensive plan of care for Post Traumatic Stress Disorder (PTSD) including triggers for re-traumatization for two Residents (#67 and #24) who had an active diagnosis of PTSD out of a total sample of 27 Residents. Findings include: Review of the facility policy titled Trauma Informed Care, dated reviewed December 2023, indicated the following: A. an assessment is completed consisting of several questions that are worded to assess past experiences and not trigger an episode. B. If a resident has a history of trauma that is documented . the Social Worker and the Interdisciplinary Team (IDT) need to immediately formulate a plan of care to assist the resident in coping within the facility with whatever issue has been identified. C. The care plan needs to be specific and include anything that has been sheared that can trigger a memory of the incident. 1. For Resident #67 the facility failed to conduct an assessment for trauma per the facility policy, and develop a comprehensive plan of care for Post Traumatic Stress Disorder (PTSD) including triggers for re-traumatization Resident #67 was admitted to the facility in June 2021 with a diagnoses including Post Traumatic Stress Disorder (PTSD) and major depressive disorder, recurrent. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #67 had a diagnosis of PTSD. Further review indicated Resident #67 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Review of Resident #67's care plan failed to indicate triggers for retraumatization and how Resident #67 exhibits an activation of PTSD when it occurs. 41456 2. Resident #24 was admitted to the facility in September 2022 with diagnoses including Post-Traumatic Stress Disorder (PTSD). (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 Resident #24's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, which indicated he/she had moderate cognitive impairment. Review of Resident #24's PTSD care care plan created 12/6/22 and revised 9/25/23 indicated the following interventions: *I (the Resident) may need staff assistance with modifying my environment if needed to increase my sense of security. *I may require staff assistance with referral to psychiatric services as needed. *I require assistance with monitoring me for signs or symptoms of anxiety, hyper-arousal or panic *I require staff assistance with assessing my behavioral triggers *I require staff assistance with monitoring for signs or symptoms of depression including low self-esteem and trust issues. Review of Resident #24's care plan failed to indicate triggers for retraumatization and how Resident #24 exhibits an activation of PTSD when it occurs. During an interview on 2/28/24 at 1:04 P.M., the Social Worker (SW) said that she tries to find out what the resident's triggers are if they are willing to talk. She then said she asked the resident about their past and will then observe the resident. She said that she makes determinations mostly through conversation with the resident to determine a resident's triggers. The SW then said that a resident's PTSD triggers should be in the care plan, how they exhibit PTSD and how to help the resident during a triggered episode. The SW then said when she sees the PTSD diagnosis she puts a PTSD care plan in the resident's medical record and then her consultant will review the care plans periodically.

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Royal Meadow View Center	134 North Street North Reading, MA 01864

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, record review and interview, the facility failed to ensure that; 1. Sufficient staffing levels were maintained to adequately meet residents' care needs. 2. For 2 Residents (#50 and #86) the facility failed to provide care when requested out of a total of 27 residents sampled. Findings include: 1. On 2/27/24, at 7:30 A.M., the surveyor observed that there was one Certified Nurse's Aide (CNA) working on the Court Unit. The surveyor also observed there were 18 residents currently residing on the Court Unit. During an interview on 2/27/24 at 9:58 A.M., The Director of Nursing said that staffing the units has been an ongoing challenge. Review of the facility assessment dated as reviewed 10/25/23, indicated that the average daily census in the building is between 80 and 90 residents per day. Further review indicated that the amount of Certified Nurse's Aides (CNA's) needed to care for the residents, at the acuity level of the residents as determined by the facility, is 33 full time equivalents (FTE) per day. Review of the facility document titled Detailed Census Report dated February 2024, indicated that the average daily census ranged between 91 and 97 residents per day. Higher than the Facility Assessment predicted. Review of the actual worked staffing hours for the month of February 2024 indicated that the number of CNA staff daily ranged from 18 to 24, significantly below the 33 the facility assessed was need to adequately care for the residents. During an interview on 2/29/24 at 9:49 A.M., Nurse #7 said that it is very difficult to provide care when there is only one Certified Nurse's Aide (CNA) on the unit. During an interview on 2/29/24 at 9:52 A.M., CNA #1 said that he was the only CNA on the unit and he was not able to do everything that the residents needed on the unit. CNA #1 said that he had 18 residents on the unit and he was responsible for all of their activities of daily living except for a few that could help themselves. 2. Resident #50 was admitted to the facility in November 2023 with diagnoses including anxiety and depression. Review of the most recent Minimum Data Set (MDS) dated [DATE], indicated that Resident #50 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/29/24 at 9:53 A.M., Resident # 50 said that one CNA is not enough and residents are waiting a long time to get care. Resident #50 said that sometimes it is impossible to get help. 3. Resident #86 was admitted to the facility in September 2023 with diagnoses including cancer and traumatic brain injury. Review of the Minimum Data Set, dated dated dated [DATE], indicated that Resident #86 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. During an interview on 2/29/24 at 9:55 A.M., Resident #86 said that he/she doesn't get the care he/she needs due to insufficient staffing on the unit. Resident #86 said that he/she doesn't get showers as often as he/she would like, and often has to wait long periods of time before a CNA answers his/her call light. Resident #86 said that he/she has to wheel him/herself out to the hallway to find help. During an interview on 2/29/24 at 10:25 A.M., with the Director of Nursing and the Administrator. The Administrator was unable to say if the staffing levels were adequate to provide care to the residents. The Administrator also said that she did not know what the ratios of direct care staff to residents was or should be according to the facility assessment. The Administrator then said that she reviews the staffing every day and is aware that sometimes staffing is lower than it should be because of call outs. The Administrator said that no new initiative had been put in place to enhance recruitment of CNA staff. The Director of Nursing then said that the acuity levels of the residents had actually increased over the past several months since the Facility Assessment was reviewed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48671 Based on observations, interviews, and records reviewed, the facility failed to ensure it was free from a medication error rate of greater than 5% when two out of two nurses observed made 4 errors out of 33 opportunities resulting in a medication error rate of 12.12 %. Those errors impacted two Residents (#23, and #28), out of 4 residents observed. Findings include: Review of the facility's policy titled Administering Medication, dated August 2023, indicated the following: 1.) Medications shall be administered in a safe and timely manner, and as prescribed. 2.) Medications must be administered in accordance with the orders, including any required time frame. Medications cannot be given without an order. 3.) Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 1. For Resident #23, Nurse #5 administered a medication within 30 minutes of eating breakfast. On 2/28/24 at 8:10 A.M., Nurse #5 prepared and administered the following medication for Resident #23: - Glipizide Oral Tablet 5 mg (Milligrams). Give 0.5 tablet by mouth two times a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. TAKE 30 Minutes BEFORE MEALS. Medication scheduled daily for 7:30 A.M. and 4:30 P.M. On 2/28/24 at 8:15 A.M. Resident #23 was observed eating breakfast just after medication administration. During an interview on 2/28/24 at 8:18 A.M., Nurse #5 said she should have given the medication prior to the resident eating breakfast and followed the order to wait 30 minutes before meals. 2. For Resident #28, the surveyor observed Nurse #2 prepare and administer the following medications on 2/28/24 at 9:03 A.M.: -Vitamin D 100 mcg (Micrograms). Oral tablet. 1 tablet was administered. -Ferrous Sulfate Oral Tablet 325 (65 Fe) mg. 1 tablet was administered. -Levothyroxine Sodium Oral Tablet 125 mg. 1 tablet was administered. -Vitamin B-12 100 mcg Oral Tablet. 1 tablet was administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current physician's orders indicated the following: -Calcium + Vitamin D3 Oral Tablet 600-10 MG-MCG (Calcium Carbonate-Cholecalciferol) Give 1 tablet by mouth one time a day for general health. Medication scheduled daily for 9:00 A.M. -Ferrous Sulfate Oral Tablet 325 (65 Fe) mg. Give 1 tablet by mouth one time a day every Monday, Wednesday, Friday for general health. Medication scheduled for 9:00 A.M. -Levothyroxine Sodium Oral Tablet 125 mcg. (Levothyroxine Sodium) Give 1 tablet by mouth one time a day for Hypothyroidism. Medication scheduled daily for 9:00 A.M. Medication card indicates Administer on an empty stomach preferably before breakfast. Separate by 4 hrs from Iron, Calcium, Magnesium & Aluminum containing products. -Vitamin B-12 Oral Tablet 1000 mcg (Cyanocobalamin). Give 1 tablet by mouth one time a day every Monday, Wednesday, Friday for general health. Medication scheduled for 9:00 A.M. During an interview on 2/28/24 at 10:59 A.M., Nurse #2 said she did not give the correct Vitamin D3 + Calcium tablet and she did not give the correct dose of Vitamin B12. Nurse #2 said she should have looked at the correct dosage on the bottles and followed the physician's order. Nurse #2 said she should not have administered the Levothyroxine with Iron or Calcium, and she should have followed the pharmacy recommendations written on the medication card. During an interview on 2/28/24 at 11:40 A.M., unit manager #3 said physician orders should be followed as written and medications should not have be given with Iron or calcium as indicated on the medication card. During an interview on 2/29/24 at 8:20 A.M., the Director of Nursing (DON) said nursing staff should have administered the medications as ordered and medications should be administered following instructions as indicated. The DON said the nurse should not have administer the medications together and should have checked the correct name and dosage according to the physician's order.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41456 Based on observation and interviews, the facility failed to serve food that is palatable, and at a safe and appetizing temperature, on two out of two units. Findings include: A group meeting was held on 2/28/24 at 11:00 A.M. During this meeting, 12 out of 12 participants said the food was not hot when it was served to them. A test tray was completed on 2/28/24 on the Meadows Unit at 12:27 P.M. with the following findings using the facility thermometer: *Meatloaf was 90 degrees Fahrenheit and tasted warm. *Green beans were 80 degrees Fahrenheit and tasted luke warm and bland. *Potatoes were 84 degrees Fahrenheit and tasted luke warm and bland and had a grainy/gritty texture. *Apple pie was 60 degrees Fahrenheit and tasted cold with a gummy texture. *Milk was 40 degrees Fahrenheit and tasted cold. *Apple juice was 50 degrees Fahrenheit and tasted cold. A test tray was completed on 2/28/24 on the Dementia Unit at 12:56 P.M. with the following findings: *Meatloaf was 135.1 degrees Fahrenheit and tasted warm. *Green beans were 123.4 degrees Fahrenheit and tasted luke warm and bland. *Potatoes were 132.6 degrees Fahrenheit and tasted warm with a grainy/gritty texture. *Apple pie was 52.3 degrees Fahrenheit and had a gummy, undercooked texture. *Milk was 55 degrees Fahrenheit. *Apple juice was 54.4 The Dietitian provided results of a recent test tray the facility completed on 12/5/23 to the surveyor. The results were: *Hot dog:140 degrees Fahrenheit in the kitchen and 110 degrees Fahrenheit when tasted on the unit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Roasted potato: 145 degrees Fahrenheit in the kitchen and 91 degrees Fahrenheit when tasted on the unit. *Carrots: 132 degrees Fahrenheit in the kitchen and 91 degrees Fahrenheit when tasted on the unit. *Sliced pears: 67 degrees Fahrenheit in the kitchen and 70 degrees Fahrenheit when tasted on the unit. *Milk: 40 degrees Fahrenheit in the kitchen and 60 degrees Fahrenheit when tasted on the unit. *Cranberry juice: 39 degrees Fahrenheit in the kitchen and 41 degrees Fahrenheit when tasted on the unit. During an interview on 2/29/24 at 8:56 A.M. the Registered Dietitian (RD) said she collaborates with the Food Service Director to conduct test trays periodically. The RD said the metrics used to evaluate test trays are outlined on the test-tray form, and that hot foods should be greater than 120 degrees Fahrenheit and cold foods should be less than 50 degrees Fahrenheit. 41105

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation, interview, and record review the facility failed to accommodate a food intolerance for 1 Resident (#19) out of a total sample of 27 Residents. Specifically, the facility failed to ensure that gluten-containing food was not served to a Resident with celiac disease (an auto-immune condition triggered by the consumption of gluten, a protein found in wheat, rye, barley, and triticale, which results in inflammation and damage to the lining of the small intestine). Findings include: Review of the facility policy titled Food Allergies and Intolerance's, dated May 2023, indicated the following: -Residents are assessed for a history of food allergies and intolerance's upon admission and as part of the comprehensive assessment. -All resident reported food allergies and intolerance's are documented in the assessment notes and incorporated into the resident's care plan. -Residents with food intolerance's and allergies are offered appropriate substitutions for foods that they cannot eat. Resident #19 was admitted to the facility in November 2023 with diagnosis including celiac disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #19 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. Review of Resident #19's active allergy list indicated the Resident had a gluten intolerance. Review of Resident #19's Nutritional Admission Assessment, dated 11/30/23, indicated Resident #19 followed a gluten free diet, and that the Registered Dietitian (RD) recommended for the Resident to continue to follow a gluten free diet restriction. During an interview on 02/28/24 at 12:37 P.M., Resident #19 said he/she follows a strict gluten free diet. Resident #19 said he/she experiences a negative reaction if he/she eats wheat. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/28/24 at 11:51 A.M., the surveyor observed a kitchen staff member ask the cook for a gluten free meal. The cook plated a beef patty and a gluten free roll and then poured gravy on top of the food. The cook then handed the plate to the kitchen staff who placed the plate on a tray and into the cart to be served to the Resident. The kitchen staff said the meal was for Resident #19. Review of Resident #19's meal ticket indicated the Resident's meal should be free of gluten. The cook said only one variation of gravy was prepared for the meal and it was made by using the classic chicken gravy mix, which is what was served to Resident #19. Review of the ingredient label on the classic chicken gravy mix indicated the product contained enriched bleached flour (made from wheat flour). The Food Service Director (FSD) said residents on a gluten free diet are not allowed products containing wheat and that the wheat-containing gravy should not have been served to Resident #19. During an interview on 2/29/24 at 8:56 A.M., the Registered Dietitian (RD) said residents with a diagnosis of celiac should follow a gluten free diet, and that wheat should not be served to those residents because consuming gluten could lead to intestinal damage. The RD said Resident #19 should not have been served the wheat-containing gravy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45763 Based on observation, policy review and interview the facility failed to handle food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure that nursing staff did not touch resident food directly with their bare hands during set-up and feeding assistance in the dining room of the View unit. Findings include: Review of the facility policy titled Food Preparation and Service dated May 2023, indicated the following: -Bare hand contact with food is prohibited. Gloves must be worn when handling food directly. On 2/27/24 the surveyor made the following observations in the View unit dining room during the breakfast meal: -At 8:41 A.M. a staff member picked up a Resident's toast with her bare hands to apply jelly and then served the toast to the Resident. At 8:44 A.M. a staff member picked up a Resident's toast with her bare hands to apply jelly and then served the toast to the Resident. -At 8:47 A.M. a staff member opened a Resident's milk using her bare hands, the staff member stuck her finger into the spout of the milk to open it. The milk was then served to the resident without a glass so that the Resident would have to drink out of the contaminated spout. -At 8:51 A.M. a staff member picked up a Resident's toast with her bare hands to apply jelly and then served the toast to the Resident. -At 8:55 A.M. a staff member picked up a Resident's toast with her bare hands to apply jelly and then served the toast to the Resident. -At 9:16 A.M. a staff member sat with a Resident to provide feeding assistance, the staff member handed the Resident his/her toast using her bare hands. On 2/27/24 the surveyor made the following observations in the View unit dining room during the Lunch meal: -At 12:44 P.M. a staff member handed a Resident his/her sandwich using her bare hands. -At 12:47 P.M. a staff member touched a Resident's sandwich with her bare hands while cutting it. -At 12:50 P.M. a staff member picked up a Resident's hot dog with her bare hands to apply mustard, the staff member then served the hot dog to the Resident. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/24 at 11:58 A.M., the Food Service Director said staff should not be touching ready-to-eat food with their bare hands, and that gloves should be used to handle ready-to-eat food. During an interview on 2/29/24 at 7:58 A.M., the Director of Nursing said staff should not be touching ready to eat food with their bare hands. 41105

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 36797 Based on interview and review of the Quality Assurance Performance Improvement (QAPI) meeting minutes for 2023, the facility staff failed to ensure an effective QAPI plan was in place. Findings include: Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) dated June 2023 indicated the following: The QAA (Quality Assessment and Assurance) program committee will prioritize topics for PIPs (Performance Improvement Projects) based on current needs of the residents and our organization. Review of all the 12 months of QAPI meeting minutes for 2023 failed to indicate a prioritizing process was implemented, failed to indicate that a root cause analysis was completed for identified problems and failed to indicate the tracking of outcomes for any interventions put in place to determine their effectiveness. Review of the Quarterly December 2023 QAPI meeting minutes failed to indicate that, for known areas of concern, a performance improvement plan was implemented to ensure the following: 1. Adequate staffing. 2. Food quality. 3. Environmental concerns/needed repairs. 4. Continuation of the water management program. During an interview on 2/27/24 at 1:00 p.m., the Maintenance Director said he could not speak to the water management program. The Maintenance Director was unable to say if the facility had a water management program or how the facility assesses the risk of legionella in the facility. During an interview on 2/27/24 at 2:00 p.m., the Maintenance Director provided the surveyor with a facility risk assessment for legionella. The risk assessment was dated 2/27/24 and the Maintenance Director said he and the Administrator completed the assessment today. During an interview on 2/29/24 at 11:28 A.M., the Director of Maintenance (DOM) he conducts monthly environmental unit rounds on each unit and addresses areas that need to be fixed himself. The DOM said he notifies the administrator verbally and will make recommendations for outside vendors if he can't fix issues in the building. During an interview on 2/29/24 at 12:01 P.M., the Administrator said that she was not aware of the environmental or water management program issues and relied on the head of maintenance to let her know of issues within his department. The Administrator also said that she was aware of the concerns with staffing and food quality but there was no QAPI in place for either.

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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. 48671 Based on observations, policy review and interviews the facility failed to ensure infection control standards of practice for the prevention of infections were implemented. Specifically, the facility failed to 1) ensure nursing staff performed hand hygiene appropriately during medication administration and follow recommended disinfectant guidelines and 2) complete a risk management assessment for the possible development and spread of legionella. Findings include: 1. Review of the facility policy titled Infection Prevention and Control Program, not dated, indicated An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. a. (3) Educating staff and ensuring that they adhere to proper techniques and procedures. Review of the facility policy titled Administering Medications, Dated August 2023, indicated Medications shall be administered in a safe and timely manner, and as prescribed. 19.) Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. During medication pass on 2/28/24 at 8:04 A.M., the surveyor observed Nurse #5 don (apply) gloves, then open a container of Sani-Cloth Germicidal Disposable Wipes (wipes used to disinfect equipment), removed a cloth and wiped down a vitals sign machine including the blood pressure cuff. Nurse #5 was then observed to remove her gloves, using her ungloved hand, touching the soiled part of her other gloved hand. Nurse #5 did not perform hand hygiene after touching the soiled glove. Nurse #5 then picked up two medication cups from on top of the medication cart and touched the outside of one medication cups, containing a liquid medication, and placed the cup inside a second medication cup containing medication pills. Nurse #5 then used her ungloved hand to push the vital sign machine close to a resident and placed the wet blood pressure cuff around the resident's arm to obtain a blood pressure. Nurse #5 removed the blood pressure cuff and administered medication to the resident without performing hand hygiene. During an interview on 2/28/24 at 8:18 A.M., Nurse #5 said she should not have touched the outside of her glove with her bare hand and said she should not have used the wet blood pressure cuff on the resident. Nurse #5 then said she should not have stacked the medication cups inside one another because the cups are not clean on the bottom. Nurse #5 said she should use hand sanitizer before and after removing gloves and before administering medication to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/29/24 at 8:15 A.M., the Director of Nurses (DON) said Nurse #5 should not have used her bare hand to remove the glove and she expects staff to use hand hygiene before and after the use of gloves and when administering medications. The DON said medication cups should not be placed on top of one another. The DON said Nurse #5 should have waited for the disinfectant to dry for two minutes before using the equipment. 41456 2. Review of the facility policy titled, Legionella Surveillance and Detection dated 10/2023 indicated the following: *Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease will be included as part of our infection surveillance activities. Review of the facility policy titled, Water Management Program (WMP), undated indicated: *The facility will develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce risk of growth and spread legionella to other opportunistic pathogens in water, *Facility to complete an initial WMP Risk Assessment using the Legionella Water Management Program Risk Assessment. During an interview on 2/27/24 at 1:00 p.m., the Maintenance Director said he could not speak to the water management program. The Maintenance Director was unable to say if the facility had a water management program or how the facility assesses the risk of legionella in the facility. During an interview on 2/27/24 at 2:00 p.m., the Maintenance Director provided the surveyor with a facility risk assessment for legionella. The risk assessment was dated 2/27/24 and the Maintenance Director said he and the Administrator completed the assessment today. During an interview on 2/28/24 at 8:44 A.M., the Administrator said she remembers completing the risk assessment prior but cannot find it so had to complete it again during survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225478	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Meadow View Center	134 North Street North Reading, MA 01864

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on interview and record review the facility failed to ensure that a system was developed to conduct comprehensive inspections of resident's mattresses in zone 7, to reduce the potential hazard of entrapment for beds in the facility. Specifically, the facility failed to identify a greater than 12 inch bed gap for one Resident (#67) and a 5.5 inch gap for one Resident (#72) out of a total sample of 27 residents. Findings include: According to The Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment Document issued on March 10, 2006 by the U.S. Department of Health and Human Services Food and Drug Administration Center for Devices and Radiological Health, The HBSW (Hospital Bed Safety Workgroup) identified 7 potential entrapment zones for hospital beds. Further review indicated that to prevent entrapment a space of no greater that four and 3/4 inches should exist between the bed frame, the mattress and the side rails. Review of the facility policy titled Bed Safety, not dated, failed to indicate adherence to the guidelines for bed safety. Further review indicated that only zones one through four were evaluated for the potential for entrapment. 1. Resident #67 was admitted to the facility in June 2021 with a diagnoses including Post Traumatic Stress Disorder (PTSD) and major depressive disorder, recurrent. On 2/27/24, at 8:00 A.M. and 1:48 P.M. the surveyor observed Resident #67 lying in bed. The surveyor also observed that there was a gap of greater than 12 inches between the headboard and the mattress (zone 7). During an interview on 2/27/24 at 8:00 A.M., Resident #67 said his/her mattress was way to short. 2. Resident #72 was admitted to the facility in February 2024 with diagnoses including stroke with resulting left sided hemiplegia (Paralysis affecting one side of the body). Review of the Minimum Data Set, dated dated dated [DATE], indicated Resident #72 scored a 5 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Further review indicated that Resident #72 was dependent on staff for all aspects of daily living. On 2/27/24, at 7:51 A.M. the surveyor observed Resident #72 lying in bed. The surveyor also observed the mattress on the bed did not extend to the foot board and had a 5.5 inch gap between the mattress and the foot board (zone 7). The surveyor also observed that a gap filler had been placed between the footboard and the mattress but it had fallen below the mattress. During an interview on 2/27/24 at 2:15 P.M., the Maintenance Director said that he doesn't measure the distance from the mattress to the headboard or footboard. He then said that he uses the guidance that was given to him in the facility policy which measures only zones one through four.