

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/18/2024
NAME OF PROVIDER OR SUPPLIER  Royal Norwell Nursing & Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 329 Washington Street Norwell, MA 02061	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>36542</p> <p>Based on observation, interview, and record review, the facility failed to promote the rights of one Resident (#60) to have fluids of choice, in a total sample of 18 residents. Specifically, the facility restricted the fluids of Resident #60, despite the removal of the order for a fluid restriction three weeks prior.</p> <p>Findings include:</p> <p>Resident #60 was admitted to the facility in March 2024 with diagnoses of hard of hearing, polydipsia (excessive thirst), and dementia.</p> <p>Review of the medical record indicated Resident #60 had an activated Health Care Proxy.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 9/18/24, indicated Resident #60 was cognitively intact, scoring 13 out of 15 on the Brief Interview for Mental Status.</p> <p>Review of the medical record indicated Resident #60 had exhibited behaviors of taking drinks off of the nurse's medication carts, taking cups to fill with water from the faucet or the toilet, and constantly asking for drinks.</p> <p>Review of the care plans for Resident #60 indicated a Focus for behavior management for a new repetitive behavior of continuously asking for water, drinking excessive amounts of water from the faucet, toilet and other people's cups (initiated 9/13/24) with the following Approaches:</p> <ul style="list-style-type: none"> <li>-educate Resident on the importance of drinking from appropriate sources; encourage use of personal tumbler to drink fluids from (initiated 10/11/24)</li> <li>-encourage self-calming behaviors such as breathing exercises, meditation, guided imagery (initiated 9/13/24)</li> <li>-ensure my labelled cup is filled with fluids (initiated 10/11/24)</li> <li>-establish boundaries and limits with the Resident (initiated 9/13/24)</li> <li>-known to drink out of the toilet, re-direct when this occurs (initiated 9/18/24)</li> </ul> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-remind to drink from tumbler filled with liquids when I ask for more water (initiated 10/11/24)</p> <p>Review of the care plans for Resident #60 indicated a Focus for potential for fluid volume overload related to psychogenic polydipsia (initiated 10/14/24) with the following Approaches:</p> <ul style="list-style-type: none"> <li>-educate on the importance of self-limiting fluid intake to minimize the risk of fluid overload (initiated 10/14/24)</li> <li>-known to be non-adherent with diet orders (initiated 10/14/24)</li> <li>-monitor for signs and symptoms of fluid overload (initiated 10/14/24)</li> <li>-family is aware of polydipsia as evidenced by drinking soda when living with them (initiated 10/14/24)</li> <li>-obtain and monitor laboratory work as ordered (initiated 10/14/24)</li> <li>-provide Resident with their own tumbler cup labeled with name to encourage drinking from appropriate sources (initiated 10/14/24)</li> </ul> <p>Review of the Physician's Orders indicated as of the time of the survey (10/15/24) the Resident did not have a fluid restriction (discontinued 9/24/24) and was on thin liquids as of 10/14/24.</p> <p>Review of the nursing progress notes indicated on 9/24/24 the Resident had been seen by the Nurse Practitioner and the Resident had continued to be non-compliant with the fluid restriction. The Nurse Practitioner had discontinued the fluid restriction related to the Resident refusing and the Resident drinking from the toilet.</p> <p>Following the discontinuation of the fluid restriction on 9/24/24 the following nursing progress notes were written:</p> <ul style="list-style-type: none"> <li>-10/5/24: Resident was very behavioral, non-compliant with fluid restriction</li> <li>-10/9/24: Resident continues excessively drinking water from anywhere, staff are continuously trying to redirect to try to restrict fluid intake</li> <li>-10/11/24: Nursing provided Resident with a large tumbler labelled with name to encourage drinking from appropriate sources</li> <li>-10/14/24: meeting with Health Care Proxy, Nurse Practitioner, and nursing with new order to discontinue thickened liquids related to Resident non-compliance and Resident/family wishes for thin liquids</li> </ul> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/16/24 at 1:15 P.M., the surveyor observed Resident #60 ask Nurse #2 for ginger ale. Unit Manager #2 provided Resident #60 with a 5-ounce cup of ginger ale. At 1:26 P.M., the surveyor observed Resident #60 ask Nurse #2 for more ginger ale. Nurse #2 told Resident #60 they can have one more small cup of ginger ale, but not until 2:00 P.M. (attempting to set a boundary, as indicated in the care plan) and gave him/her another 5-ounce cup. At 1:43 P.M., the surveyor observed Resident #60 approach Nurse #2 and ask for ginger ale. The Nurse reminded the Resident of the plan to return at 2:00 P.M. and the Resident said he/she did not have a clock in their room.</p> <p>On 10/16/24 at 4:21 P.M., the surveyor observed Resident #60 approach Nurse #6 and ask for ginger ale. The Nurse informed Resident #60 they would get ginger ale with dinner and said, Not right now. Resident #60 was unable to hear Nurse #6 and continued to ask while telling the nurse that he/she could not hear them. The Nurse was observed to tell Resident #60 that there was no ginger ale.</p> <p>At 4:24 P.M., Nurse #6 gave Resident #60 a 5-ounce cup of water, the Resident repeatedly asked if there was ginger ale and the nurse responded No, no, no. Can you hear that? The Resident responded, You told me to wait until 4:30 P.M., and the Nurse responded, You have to wait until dinner. At this time, the surveyor observed a drink cart on the unit with a bottle of ginger ale. The Nurse was not observed to check if there was water in the designated tumbler.</p> <p>At 4:36 P.M., Resident #60 asked a Certified Nursing Assistant (CNA) for a drink and the CNA told the Resident to ask the nurse. The Resident asked Nurse #6 who told the Resident to go watch television. The Resident said, Never mind and walked away. Neither the CNA nor the Nurse were observed to check the Resident's tumbler to make sure it had water.</p> <p>At 4:52 P.M., the surveyor observed Resident #60 asking Unit Manager #2 for ginger ale. Unit Manager #2 told the Resident No.</p> <p>At 4:58 P.M., the surveyor observed Nurse #6 to have her medication cart across (blocking) the doorway of Resident #60's room. Unit Manager #2 and Nurse #6 were in the room with Resident #60. Resident #60 asked if he/she could go see what time it was, Unit Manager #2 replied, No, we know what time it is, it's 4:58 P.M., it's not time yet, you have to wait until 5:00 P.M. Unit Manager #2 filled the blue tumbler with water. Resident #60 asked if he/she could have ice in their drink and the Unit Manager replied, Nope, we don't have any. Unit Manager #2 told Nurse #6 that Resident #60 can have any amount of water, but not any amount of ginger ale or juice because he/she was diabetic.</p> <p>At 5:00 P.M., Resident #60 attempted to leave the room and Unit Manager #2 said, You can't leave. At 5:02 P.M., Resident #60 asked Nurse #6 when dinner was and the Nurse responded, You have to stop asking me, I need to tend to other people. At 5:03 P.M., Unit Manager #2 was observed bringing Resident #60 their dinner meal with ginger ale.</p> <p>During an interview with observation on 10/17/24 at 2:10 P.M., the surveyor observed Resident #60 having difficulty hearing the surveyor who had to get very close and speak loudly. The Resident said he/she did not have a clock in their room. The surveyor did not observe a clock in the Resident's room.</p> <p>During an interview on 10/17/24 at 12:39 P.M., CNA #2 and CNA #5 said Resident #60 had behaviors of looking for water and sneaking drinks and that redirection did not work. They said the only thing that worked was giving the Resident what they wanted for a drink.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 1:49 P.M., the Social Worker said Resident #60 had an increased obsession with drinking water following a stroke. He said the Resident would continuously ask staff for water. He said the family had decided during a meeting to remove the fluid restriction, but he was not sure if this had improved the Resident's behaviors.</p> <p>During an interview on 10/17/24 at 2:15 P.M., Nurse #4 said he was assigned to care for Resident #60 on this day, but he was unfamiliar with the Resident. He said during the shift there had been a question of if Resident #60 had a fluid restriction, but the Resident did not have any fluid restrictions and the Resident liked to have ice with their water.</p> <p>During an interview on 10/17/24 at 2:35 P.M., Unit Manager #2 said all Resident #60 wanted to do was drink fluids. She said the fluid restriction was discontinued a couple of weeks prior. She said they give the Resident a cup and fill it with water. She said the staff try to restrict sugary drinks because the resident had a diagnosis of diabetes, but that the Resident was not on a diabetic diet with any restrictions. She said diet ginger ale was available for the Resident. She said she tried to limit the ginger ale intake the previous day because the Resident had had too much already. She said there was no tracking to say how much the Resident had or an order to indicate how much fluid was too much. She said she was telling the Resident not to leave the room yesterday because the Resident did not really want to know what time it was, the Resident wanted to go to the drink cart and grab a drink and was trying to manipulate the staff. She said the Resident did not need to know what time it was because herself and the maintenance man had told the Resident what time it was. She said she had not looked to see if the Resident had a clock in their room. The Unit Manager said the staff cannot stop the Resident from drinking, but the staff had to use common sense on how much they were going to give the Resident to drink.</p> <p>During an interview on 10/18/24 at 8:00 A.M., the Director of Nurses said the staff were still trying to determine what approaches worked for Resident #60 to decrease the Resident interrupting nurses while passing medications to other residents. She said that although she could not speak directly to why the staff had attempted to limit the drinks for the Resident on 10/16/24 she thinks the staff and the Unit Manager were probably trying to limit the amount of fluids the Resident was having because they knew he/she had too much fluids already. She said there was no fluid restriction and no tracking for fluid intake. She said the best approach right now really came down to quality of life and this was what the staff should be focused on.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>50740</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a reasonable accommodation was made for one Resident (#5), of 18 sampled residents. Specifically, the facility failed to ensure the call system was accessible to the Resident to call for staff assistance.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Resident Call System, undated, indicated but was not limited to:</p> <p>-When in their rooms and toilet and bathing areas, residents will have a means of directly contacting caregivers.</p> <p>Resident #5 was admitted to the facility in March 2017 with diagnoses including dementia and history of falling.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 9/4/24, indicated a Brief Interview for Mental Status (BIMS) for Resident #5 was not completed as the Resident is rarely/never understood. Further review of the MDS indicated that the Resident was dependent on staff for activities of daily living and able to ambulate with supervision or touching assistance.</p> <p>Review of Resident #5's Care Plan indicated, but was not limited to, the following:</p> <p>-Focus: I am at risk for falls r/t (related to) deconditioning, gait instability, dementia, decreased awareness of safety needs, wandering behavior, and use of antidepressant medication. h/o (history of) epidemic vertigo, muscle weakness</p> <p>-Approaches: Be sure [Resident #5]'s call light is within reach and encourage [Resident #5] to use it for assistance as needed. [Resident #5] needs prompt response to all requests for assistance.</p> <p>On 10/15/24 at 10:00 A.M., the surveyor observed Resident #5 lying in bed and the call light cord was gathered and clipped above the bed and out of the Resident's reach.</p> <p>On 10/16/24 at 10:26 A.M., the surveyor observed Resident #5 lying in bed and the call light cord was gathered and clipped above the bed and out of the Resident's reach.</p> <p>On 10/16/24 at 11:56 A.M., the surveyor observed Resident #5 lying in bed and the call light cord was gathered and clipped above the bed and out of the Resident's reach.</p> <p>On 10/16/24 at 4:28 P.M., the surveyor observed Resident #5 lying in bed and the call light cord was gathered and clipped above the bed and out of the Resident's reach.</p> <p>During an interview on 10/16/24 at 4:40 P.M., Nurse #1 said the call light should not be out of reach and should be where the Resident can reach it at all times.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 3:00 P.M., the Director of Nursing said that call lights or an alternative means of contacting staff, such as hand bells, should be accessible to residents at all times.</p> <p>During an interview on 10/17/24 at 4:07 P.M., Unit Manager #2 said that call lights should be within reach for all residents.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>46562</p> <p>Based on record review and interviews, for one Resident (#36), of 18 sampled residents, the facility failed to implement policies and procedures for alleged abuse. Specifically, the facility failed to investigate and report an allegation of sexual abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse Policy, dated May 2023, indicated but was not limited to:</p> <p>-Identification: Reporting of suspected alleged violations shall be encouraged by staff. Incidents of alleged violations shall be reviewed by the facility's Quality Assessment and Assurance Committee for detection of patterns and trends.</p> <p>-Reporting: An employee who suspects an alleged violation shall immediately notify the Executive Director (ED) or his/her designee. The ED shall also notify the appropriate State agency in accordance with state law. The results of all investigations must be reported immediately to the ED or his/her designee and to the appropriate State agency, as required by State law with initial report submitted within two hours and follow up within five working days of the violation.</p> <p>-Policy and Procedure:</p> <p>A. If a family member, resident or staff reports an incident of abuse/mistreatment/neglect, it is to be reported to the Director of Nursing Services (DNS) or manager immediately and an Incident/Accident report is to be completed.</p> <p>B. The supervisor is to initiate the following steps:</p> <ol style="list-style-type: none"> <li>1. Immediate investigation into the alleged incident.</li> <li>2. Interview staff member implicated. Get a written statement.</li> <li>3. Interview other staff members.</li> <li>4. Interview with resident or resident witnesses.</li> </ol> <p>C. Send initial report to the Department of Public Health (DPH) immediately but no later than two hours.</p> <p>D. Final reports to be submitted to the Department of Public Health within five business days of the initial report.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #36 was admitted to the facility in June 2018 with the following diagnoses: vascular dementia and post-traumatic stress disorder (PTSD, a mental health condition that is triggered by an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being).</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 9/4/24, indicated Resident #36 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15.</p> <p>Review of Resident #36's incident report and fall packet, dated 5/16/24, indicated but was not limited to:</p> <p>-Resident #36 was being assessed after being found on the floor and he/she reported to Nurse #3 that someone had just molested him/her. Nurse #3 indicated that Resident #36 could not provide any additional information.</p> <p>Review of the Health Care Facility Reporting System (HCFRS, a web-based system that health care facilities must use to report incidents and allegations of abuse, neglect, and misappropriation) failed to indicate the alleged abuse had been reported.</p> <p>During an interview on 10/17/24 at 12:06 P.M., the Director of Nurses (DON) said the facility did not have a record of a reportable incident for Resident #36 in the last six months.</p> <p>During an interview on 10/17/24 at 1:22 P.M., Unit Manager #2 said when any form of abuse is alleged or suspected, the facility should ensure the resident is safe, report the allegation to the state agency, and fully investigate the potential abuse. Unit Manager #2 said anytime there is a suspicion or allegation, the facility should follow the policy to investigate and report it.</p> <p>During an interview on 10/17/24 at 2:29 P.M., the Administrator said she was unaware of the alleged abuse. The Administrator said all allegations of abuse should be investigated and reported to the State agency through HCFRS.</p> <p>During an interview on 10/17/24 at 2:57 P.M., the Administrator said the alleged abuse had not been investigated or reported.</p> <p>During an interview on 10/17/24 at 4:20 P.M., the DON said the allegation had not been investigated or reported and it should have been.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46562</p> <p>Based on record review and interviews, for one Resident (#36), of 18 sampled residents, the facility failed to ensure an allegation of sexual abuse was reported timely to the state agency as required.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse Policy, dated May 2023, indicated but was not limited to:</p> <p>-Identification: Reporting of suspected alleged violations shall be encouraged by staff.</p> <p>-Reporting: An employee who suspects an alleged violation shall immediately notify the Executive Director (ED) or his/her designee. The ED shall also notify the appropriate State agency in accordance with state law. The results of all investigations must be reported immediately to the ED or his/her designee and to the appropriate State agency, as required by State law with initial report submitted within two hours and follow up within five working days of the violation.</p> <p>-Policy and Procedure:</p> <p>A. If a family member, resident or staff reports an incident of abuse/mistreatment/neglect, it is to be reported to the Director of Nursing Services (DNS) or manager immediately and an Incident/Accident report is to be completed.</p> <p>B. The supervisor is to initiate the following steps:</p> <ol style="list-style-type: none"> <li>1. Immediate investigation into the alleged incident.</li> <li>2. Interview staff member implicated. Get a written statement.</li> <li>3. Interview other staff members.</li> <li>4. Interview with resident or resident witnesses.</li> </ol> <p>C. Send initial report to the Department of Public Health (DPH) immediately but no later than two hours.</p> <p>D. Final reports to be submitted to the Department of Public Health within five business days of the initial report.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>46562</p> <p>Based on record review and interviews, for one Resident (#36), of 18 sampled residents, the facility failed to ensure allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated. Specifically, for Resident #36, the facility failed to ensure an allegation of sexual abuse was investigated.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse Policy, dated May 2023, indicated, but is not limited to:</p> <p>-Identification: Reporting of suspected alleged violations shall be encouraged by staff. Incidents of alleged violations shall be reviewed by the facility's Quality Assessment and Assurance Committee for detection of patterns and trends.</p> <p>-Reporting: An employee who suspects an alleged violation shall immediately notify the Executive Director (ED) or his/her designee. The ED shall also notify the appropriate State agency in accordance with state law. The results of all investigations must be reported immediately to the ED or his/her designee and to the appropriate State agency, as required by State law with initial report submitted within two hours and follow up within five working days of the violation.</p> <p>-Policy and Procedure:</p> <p>A. If a family member, resident or staff reports an incident of abuse/mistreatment/neglect, it is to be reported to the Director of Nursing Services (DNS) or manager immediately and an Incident/Accident report is to be completed.</p> <p>B. The supervisor is to initiate the following steps:</p> <ol style="list-style-type: none"> <li>1. Immediate investigation into the alleged incident</li> <li>2. Interview staff member implicated. Get a written statement</li> <li>3. Interview other staff members</li> <li>4. Interview with resident or resident witnesses</li> </ol> <p>C. Send initial report to the Department of Public Health (DPH) immediately but no later than two hours</p> <p>D. Final reports to be submitted to the Department of Public Health within five business days of the initial report.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/18/2024
NAME OF PROVIDER OR SUPPLIER  Royal Norwell Nursing & Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 329 Washington Street Norwell, MA 02061	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #36 was admitted to the facility in June 2018 with the following diagnoses: vascular dementia and post-traumatic stress disorder (PTSD, a mental health condition that is triggered by an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being).</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 9/4/24, indicated Resident #36 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15.</p> <p>Review of Resident #36's incident report and fall packet, dated 5/16/24, indicated but was not limited to:</p> <p>-Resident #36 was being assessed after being found on the floor and he/she reported to Nurse #3 that someone had just molested him/her. Nurse #3 indicated that Resident #36 could not provide any additional information.</p> <p>During an interview on 10/17/24 at 12:06 P.M., the Director of Nurses (DON) said the facility did not have a reportable for Resident #36 in the last six months.</p> <p>During an interview on 10/17/24 at 1:22 P.M., Unit Manager #2 said when any form of abuse is alleged or suspected the facility should ensure the resident is safe and fully investigate the potential abuse. Unit Manager #2 said anytime there is a suspicion or allegation, the facility should follow the policy to investigate.</p> <p>During an interview on 10/17/24 at 2:29 P.M., the Administrator said she was unaware of the alleged abuse. The Administrator said all allegations of abuse should be investigated.</p> <p>During an interview on 10/17/24 at 2:57 P.M., the Administrator said the alleged abuse had not been investigated.</p> <p>During an interview on 10/17/24 at 4:20 P.M., the DON said the allegation had not been investigated and it should have been.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>36542</p> <p>Based on observation, interview, and record review, the facility failed to follow professional standards of practice specific to following physician's orders for two Residents (#19 and #48) in a sample of 18 residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> <li>1. For Resident #19, to follow physician's orders to discontinue an antipsychotic medication timely; and</li> <li>2. For Resident #48, to ensure staff implemented physician's orders for:               <ol style="list-style-type: none"> <li>a. air mattress settings;</li> <li>b. 1:1 (one to one) supervision with oral intake; and</li> <li>c. fall mat to side of his/her bed.</li> </ol> </li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy for Medication and Treatment Order and Administration Policy, undated, indicated the following:               <ul style="list-style-type: none"> <li>-orders for medications and treatments will be consistent with principles of safe and effective order writing</li> <li>-verbal orders must be recorded immediately in the resident's chart by the person receiving the order</li> </ul> </li> </ol> <p>Resident #19 was admitted to the facility in May 2018 with a diagnosis of dementia.</p> <p>Review of the medical record indicated Resident #19 had an order for Abilify (an antipsychotic) 2.5 milligrams (mg) one time a day, start date 6/7/24.</p> <p>Review of a Psychiatric Nurse Practitioner's Progress Note, dated 9/15/24, indicated a recommendation to stop the Abilify.</p> <p>Review of a nursing progress note, dated 9/19/24, indicated the antipsychotic was no longer needed, as recommended by the Psychiatric Nurse Practitioner and the medical Nurse Practitioner and the Health Care Proxy were aware and in agreement.</p> <p>Review of the medical record indicated the order to discontinue the Abilify was not implemented until 10/11/24, three weeks later.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/17/24 at 10:35 A.M., Unit Manager #2 said she had written the nursing progress note on 9/19/24. She said the process was the team would have meetings with the Psychiatric Nurse Practitioner and recommendations would be made. She said the Director of Nurses (DON) would then tell her what to write in a progress note and the DON would be the one to physically discontinue the order in the electronic medical record.</p> <p>During an interview on 10/17/24 at 12:05 P.M., the DON said recommendations were made from behavior rounds regarding antipsychotic medications and if approved by the primary physician, the orders would be implemented. She said she was responsible for making the changes in the electronic medical record. She said she had not been at the behavior meeting on 9/13/24 and that was why the changes had not been implemented timely.</p> <p>46562</p> <p>2. Resident #48 was admitted to the facility in October 2022 with the following diagnoses: dementia, dysphagia (difficulty swallowing), and repeated falls.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 8/7/24, indicated Resident #48 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Further review of the MDS indicated Resident #48 was dependent on staff to eat.</p> <p>Review of Resident #48's Physician's Orders indicated but was not limited to:</p> <p>-Air mattress: pressure set per resident's most recent weight; +/- 10 pounds. Document weight. Check placement and function every shift, 10/8/24</p> <p>-1:1 supervision during oral intake. Ensure complete clearance of mouth prior to next bite. Alternate liquids/solids, encourage to re-swallow if food still present. Position at 90 degrees for 30-40 minutes with meals for dysphagia, 10/17/23</p> <p>-Fall mat to left side of bed when resident is in bed, every shift for safety, dated 10/3/24</p> <p>a. Review of the facility's policy titled Prevention of Pressure Ulcers/Injuries, dated May 2023, indicated but was not limited to:</p> <p>-Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors.</p> <p>Review of Resident #48's weight record indicated his/her most recent weight was obtained on 10/3/24, and he/she weighed 135 pounds.</p> <p>On the following dates of survey, the surveyor observed Resident #48 in bed with his/her air mattress set at approximately 350 pounds:</p> <p>-10/15/24 at 10:37 A.M.</p> <p>-10/16/24 at 8:28 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-10/17/24 at 8:47 A.M.</p> <p>-10/17/24 at 9:06 A.M.</p> <p>-10/17/24 at 3:31 P.M.</p> <p>During an interview on 10/17/24 at 3:34 P.M., Certified Nursing Assistant (CNA) #7 said she was not sure how the air mattress settings worked and did not know what Resident #48's air mattress should be set at.</p> <p>During an interview with observation on 10/17/24 at 3:39 P.M., the surveyor and Nurse #5 observed Resident #48 in bed with his/her air mattress set at approximately 350 pounds. Nurse #5 said the Resident's physician's orders gave instruction for the air mattress. Nurse #5 reviewed Resident #48's record and said his/her most recent weight was 135 pounds and the order indicated the air mattress settings should be set within 10 pounds of his/her weight.</p> <p>During an interview with observation on 10/17/24 at 4:07 P.M., Unit Manager #2 said Resident #48's air mattress should be set plus or minus ten pounds of their current weight. The surveyor and Unit Manager #2 observed the Resident in his/her bed with the air mattress set at approximately 350 pounds. Unit Manager #2 said the Resident did not weigh 350 pounds and the air mattress setting was incorrect.</p> <p>During an interview on 10/17/24 at 4:20 P.M., the DON said air mattresses should be set at the correct settings and physician's orders should be followed.</p> <p>b. On 10/17/24 at 8:47 A.M., the surveyor observed Resident #48 lying in bed with his/her bed positioned between 45 and 60 degrees. Resident #48 was eating his/her breakfast alone and was pulling him/herself forward to grab the food from the breakfast tray. Resident #48 was not observed alternating liquids with solids.</p> <p>During an interview on 10/17/24 at 9:01 A.M., CNA #4 said Resident #48 required assistance with meals, should have been positioned at 90 degrees, and should not have been eating his/her breakfast alone.</p> <p>During an interview on 10/17/24 at 9:03 A.M., Nurse #4 said Resident #48 required 1:1 supervision and assistance with meals. Nurse #4 said he/she should be sitting upright at a 90-degree angle and should not have been left alone with his/her breakfast.</p> <p>During an interview on 10/17/24 at 4:07 P.M., Unit Manager #2 said Resident #48 had a history of dysphagia and required 1:1 supervision with meals and should be positioned at 90 degrees when eating and for at least 30 minutes after.</p> <p>During an interview on 10/17/24 at 4:20 P.M., the DON said all physician's orders should be followed including those for feeding and assisting residents with meals.</p> <p>c. On the following dates of survey, the surveyor observed Resident #48 in bed with no fall mat on the side of his/her bed:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-10/15/24 at 10:37 A.M.</p> <p>-10/16/24 at 8:28 A.M.</p> <p>-10/17/24 at 8:47 A.M.</p> <p>-10/17/24 at 9:06 A.M.</p> <p>-10/17/24 at 3:31 P.M.</p> <p>During an interview on 10/17/24 at 3:34 P.M., CNA #7 said interventions to keep Resident #48 safe while in bed included a low bed and making sure the call light was within reach. CNA #7 did not know about an intervention for a floor mat to the left side of the bed.</p> <p>During an interview with observation on 10/17/24 at 3:39 P.M., the surveyor and Nurse #5 observed Resident #48 in his/her bed with no floor mat on the side of the bed. Nurse #5 said she was not aware of an order to keep a floor mat on the side of Resident #48's bed. Nurse #5 and the surveyor reviewed the physician's orders and Nurse #5 said there was an order for a fall mat to the left side of the bed and one should have been in place.</p> <p>During an interview on 10/17/24 at 4:07 P.M., Unit Manager #2 said Resident #48 should have a floor mat on the left side of the bed when he/she was in bed per physician's orders.</p> <p>During an interview on 10/17/24 at 4:20 P.M., the DON said Resident #48 had an order for a floor mat to the left side of his/her bed as a fall intervention and the floor mat should have been in place when he/she was in bed. The DON said all physician's orders should be followed.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50740</p> <p>Based on records reviewed and interviews, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed for one Resident (#21), out of a total census of 70 residents, to ensure safe storage of medications and biologicals according to current standards of practice.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Storage of Medications, undated, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>-Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.</li> <li>-Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing dugs and biologicals are locked when not in use.</li> </ul> <p>Review of the facility's policy titled Self-Administration of Medications, dated May 2023, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> <li>-If the staff determine that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications.</li> <li>-Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for bedside storage, for return to the family or responsible party.</li> </ul> <p>Resident #21 was admitted to the facility in June 2023 with diagnoses including pain, diabetes, and heart failure.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 8/28/24, indicated that Resident #21 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15.</p> <p>Review of Resident #21's medical record indicated that on 8/6/24, a Self-Administration of Medication evaluation was completed for the Resident. The evaluation indicated that Resident #21 was not approved for self-administration of medications and may not keep medications at the bedside.</p> <p>On the following dates/times of survey, the surveyor observed two bottles of eye drops on Resident #21's nightstand and three bottles of eye drops and one bottle of acetaminophen (an over-the-counter pain/fever reliever) on the Resident's windowsill:</p> <ul style="list-style-type: none"> <li>-10/15/24 at 9:40 A.M.,</li> <li>-10/16/24 at 12:28 P.M.,</li> </ul> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-10/16/24 at 4:49 P.M., and</p> <p>-10/17/24 at 9:12 A.M.</p> <p>During an interview on 10/16/24 at 12:28 P.M., Resident #21 said that his/her family provides eye drops and acetaminophen to him/her and that he/she administers his/her own eye drops and acetaminophen. Resident #21 said that he/she does not record the date and time he/she administers the medications anywhere.</p> <p>During an interview on 10/16/24 at 4:49 P.M., Nurse #1 said that Resident #21 was not able to self-administer medications. Nurse #1 said that the Resident should not have any medications in his/her room and that his/her medications should be stored in the medication cart.</p> <p>During an interview on 10/17/24 at 9:25 A.M., Unit Manager #2 said that Resident #21 is not able to self-administer medications and should not have any medications in his/her room.</p> <p>During an interview on 10/17/24 at 4:20 P.M., the Director of Nursing said that no medications should be left out at the bedside. The Director of Nursing said that Resident #21 is not able to self-administer medications and should not have any medications in his/her room.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46562</p> <p>Based on observation, interview, and policy review, for one Resident (#36), of 18 sampled residents, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, for Resident #36, the facility failed to implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms to residents with increased risk).</p> <p>Findings include:</p> <p>Review of the Centers for Medicare and Medicaid Services (CMS) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>-Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities.</li> <li>-EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing</li> <li>-EBP are indicated for residents with any of the following: <ul style="list-style-type: none"> <li>a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or</li> <li>b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO</li> </ul> </li> <li>-EBP should be used for any residents who meet the above criteria, wherever they reside in the Facility</li> </ul> <p>Review of the facility's policy titled Enhanced Barrier Precautions, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> <li>-Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a multidrug-resistant organism as well as those at increased risk of multidrug-resistant organism acquisition (e.g. residents with wounds or indwelling medical devices)</li> <li>-Enhanced Barrier Precautions require the use of gown and gloves only for high contact resident care activities</li> </ul> <p>Review of the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precaution sign indicated but was not limited to:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-In addition to standard precautions Staff and Providers must:</p> <p>-Clean hands prior to entering and when exiting the room</p> <p>-Wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, and wound care.</p> <p>Resident #36 was admitted to the facility in June 2018 with the following diagnoses: vascular dementia and chronic ulcer of lower extremities.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 9/4/24, indicated Resident #36 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15.</p> <p>Review of Resident #36's orders indicated but were not limited to:</p> <p>-Staff to maintain enhanced barrier precautions related to (wounds) every shift for infection control, dated 10/15/24</p> <p>Review of Resident #36's care plan indicated but was not limited to:</p> <p>-Staff to maintain enhanced barrier precautions related to auto-immune induced wounds and lower extremity wounds, revised 10/15/24</p> <p>On the following dates of the survey, an EBP Precaution Sign was posted at the entrance to Resident #36's room:</p> <p>-10/15/24, -10/16/24, and -10/17/24</p> <p>On 10/16/24 at 9:57 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 assisting Resident #36 with personal hygiene. CNA #1 was not wearing a gown.</p> <p>On 10/16/24 at 10:34 A.M., the surveyor observed CNA #1 and CNA #3 transferring Resident #36 from his/her bed to the wheelchair, neither employee was wearing a gown.</p> <p>On 10/17/24 at 10:10 A.M., the surveyor observed CNA #5 assisting Resident #36 with personal hygiene. CNA #5 was only wearing gloves and had not donned a gown.</p> <p>On 10/17/24 at 10:36 A.M., the surveyor observed two hospice consultants assisting Resident #36 with personal hygiene, both consultants were only wearing gloves and had not donned a gown.</p> <p>During an interview on 10/17/24 at 10:17 A.M., CNA #5 said the precaution sign was intended for the nurses during wound care.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 10:40 A.M., Unit Manager #2 said Resident #36 required EBP for high contact care and included the use of gloves and a gown.</p> <p>During an interview on 10/17/24 at 4:20 P.M., the Director of Nurses (DON) said Resident #36 required EBP for high contact care activities and staff should have donned gloves and a gown.</p>		