STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 42741 Based on interview and record review, the facility failed to ensure that a Resident's choices were honored when requested by his/her Resident Representative for one Resident (#14) out of a total sample of 18 residents. Specifically, the facility failed to evaluate whether the Resident Representatives' request for Resident #14 to receive double meal portions was appropriate for him/her, and implement the request if it was determined to be appropriate for the Resident indicated by family as always being hungry. Findings include: Resident #14 was admitted to the facility in June 2019, with a diagnosis of Dementia with Behavioral Disturbance (progressive disease with impairment in memory and functioning that includes symptoms such as depression, anxiety, psychosis, agitation, aggression, disinhibition, and sleep disturbances). During an interview on 4/30/24 at 12:01 P.M., Resident Representative #1 said he/she had requested double meal portions for Resident #14 on multiple occasions. Resident Representative #1 said when family visited with Resident #14, he/she was always hungry. Resident Representative #1 further said that he/she had not been provided with follow -up from facility staff on the request for double meal portions, and he/she was unsure if the request had been addressed. Review of the Nursing Progress Note dated 11/30/23, indicated that the Resident Representative had spoken with nursing and requested meal portions be increased. Review of the Resident's Current Diet Order and Communication slip provided by the facility's kitchen, dated 4/29/23, did not indicate that Resident #14 received double meal portions. During an interview on 5/1/24 at 11:55 A.M., the Food Service Director (FSD) said Resident #14 received single portion meals and that she was not made aware that the Resident's Representative had requested double portions for meals. The FSD further said when a request for increased portions was made, she would let the Dietitian know and the Dietitian would then have assessed whether the Resident was appropriate for increased portions, but no one had made her aware of Resident #14's request. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 12:17 P.M., the Dietitian said she was unaware that Resident #14's Resident Representative had requested double meal portions for the Resident. The Dietitian further said when someone requests increased meal portions, she would evaluate whether increased portions were appropriate for the Resident. The Dietitian said if the Resident was not appropriate for increased meal portions, she would provide the Resident Representative with education on why increased meal portions were not appropriate and get further feedback from the Resident Representative on why they felt the Resident needed increased meal portions.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46138 Based on observation, interview and record review, the facility failed to ensure that the Minimum Data Set (MDS) Assessments were accurately coded for two Residents (#22 and #29), out of a total sample of 18 residents. Specifically, the facility failed to: 1. For Resident #22, accurately code the MDS to reflect pressure ulcers as present on re-admission to the facility and not facility acquired. 2. For Resident #29, accurately code the MDS to reflect the use of IV (intravenous- within a vein) hydration. Findings include: 1. Resident #22 was admitted to the facility in December 2021, with diagnosis including Diabetes Mellitus with Autonomic Neuropathy (a condition that occurs when the body develops insulin resistance and no longer responds effectively to insulin and causes nerve damage because of high blood sugar levels). Review of the Nursing Progress Note dated 12/6/22 indicated Resident #22: -Had been on a medical leave of absence (MLOA) -Returned to the facility with a pressure area on the coccyx (the last bone at the bottom of your spine) noted with a circular pressure wound measuring 1.5 centimeters (cm) x 1.5 cm x 0.1 cm. Review of the Stage Four Pressure Ulcer Care Plan initiated 12/20/22, indicated the following: -Administer treatments as ordered and monitor effectiveness. -Assess, record, monitor wound healing. Review of the MDS Assessments dated 11/7/23 and 2/6/24, indicated Resident #22: -Had one or more unhealed pressure ulcer(s) at Stage One or higher. -Number of Stage Four pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed often includes undermining and tunneling) was coded as one. -Stage Four pressure ulcers present at the time of admission or re-entry [12/6/22] was coded as zero (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/2/24 at 3:01 P.M., the MDS Nurse said Resident #22's MDS Assessments dated 11/7/23 and 2/6/24, were coded incorrectly and should have reflected the Resident's Stage Four pressure ulcer to the coccyx was present on re-admission to the facility and was not facility acquired. 42741 2. Resident #29 was admitted to the facility in February 2022, with a diagnosis of Dementia with Psychotic Disturbance (progressive disease with impairment in memory and functioning with symptoms including psychosis, hallucinations, and or delusions). Review of the February 2024 Physician's orders indicated the following order: -May insert peripheral line (small tubing inserted into the vein used to provide intravenous (IV) medication or hydration) for IV administration, initiated 2/27/24. Review of the Nursing Progress Notes dated 2/27/24, indicated the Resident had the peripheral line inserted and received 500 milliliters (mls) of normal saline (medication used to treat dehydration) infused through his/her peripheral line. Review of the comprehensive MDS assessment dated [DATE], indicated that the Resident did not have IV hydration provided during the assessment period. During an interview on 5/1/24 at 2:34 P.M., the MDS Nurse said Resident #29 was receiving IV hydration during the look back period of the 2/27/24 MDS Assessment and that the Assessment was coded incorrectly and needed to be modified.

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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** 42741 Based on observation, interview and record review, the facility failed to ensure that care plans were developed and implemented accordingly for one Resident (#14) out of a total sample of 18 residents. Specifically, -For Resident #14 the facility failed to develop a care plan related to the Resident's behavior of eating nonfood items and topical medications. Findings include: Review of the facility policy titled Behavioral Assessment, Intervention, and Monitoring, revised March 2019, indicated the following: -The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Resident #14 was admitted to the facility in June 2019 with a diagnosis of Dementia with Behavioral Disturbance (progressive disease with impairment in memory and functioning that includes symptoms such as depression, anxiety, psychosis, agitation, aggression, disinhibition, and sleep disturbances). Review of a Nursing Progress Note dated 7/26/23, indicated that Resident #14 was found eating the foil covering off of his/her applesauce cup. Review of a Nursing Progress Note dated 11/10/23, indicated that Resident #14 had ingested [NAME] Lotion (an anti-itch topical [applied to the skin] medicated lotion). Review of a Nursing Progress Note dated 3/30/24, indicated that Resident #14 had ingested a calamine (anti-itch topical medication), hydrocortisone (an anti-itch topical mediation), zinc paste (a skin protectant topical medication) mixture (the facility's house barrier cream [a cream used as a skin protectant]). During an interview on 4/30/24 at 11:58 A.M., Resident Representative #1 said Resident #14 had a tendency to eat nonfood items and that Resident Representative #1 made sure the Resident did not have items within his/her reach that he/she could put into his/her mouth. During an interview on 5/1/24 at 12:06 P.M., with Nurse #1 and Certified Nurses Aide (CNA) #1, Nurse #1 said Resident #14 had a tendency to eat nonfood items. CNA #1 said staff could not leave any items within the Resident's reach as he/she would put them in his/her mouth. CNA #1 further said said staff needed to make sure items such as the Resident's meal ticket or tops that were removed from containers of food were taken off his/her meal tray or he/she would put those items in his/her mouth. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14 care plan indicated no documented care plan addressing the behavior of eating nonfood items and interventions that should be used to deter the Resident from eating nonfood items. During an interview on 5/1/24 at 2:56 P.M., the Director of Nurses (DON) said Resident #14 did not have a care plan in place that addressed the eating of nonfood items. The DON further said any time a resident had a behavior that required intervention a care plan should be developed so staff is aware of how to provide interventions for the behavior, and this was not done for Resident #14. Please Refer to F761

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on record review and interview, the facility failed to conduct interdisciplinary care plan meetings after Minimum Data Set (MDS) assessments were completed, and also failed to involve the Resident and/or Resident Representative in the care planning process for four Residents (#2, #67, #3, and #60) out of a total sample of 18 residents. Specifically, the facility failed to: 1. For Resident #2, provide evidence that the Resident and/or their invoked HCP had participated in the care planning process and that Interdisciplinary Team (IDT) care plan meetings were held for the Resident in 2024 following the MDS assessments completed on 1/9/24 and 4/9/24. 2. For Resident #67, provide evidence that the Resident and/or the Resident's Representative participated in the care planning process, or that a care plan meeting was held with the IDT following the MDS assessment completed on 1/24/24. 3. For Resident #3, provide evidence of care plan meetings being held, or that the Resident and/or Representative had participated in the care planning process following the MDS assessments completed on 12/12/23 and 3/12/24. 4. For Resident #60, provide evidence of two care plan meetings held after MDS assessments were completed on 5/9/23 and 8/8/23 and that the Resident was included in the care planning process for two care plan meetings held on 11/22/23 and 2/22/24. Findings include: Review of the facility policy titled Care Planning - Interdisciplinary Team, dated 2001 and revised September 2013, included: -The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. -Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated 2001 and revised December 2016, included: -The Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -The IDT includes the resident and the resident's legal representative (to the extent practicable) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: participate in the planning process; . participate in establishing the expected goals and outcomes of care; . -The care planning process will: facilitate resident and/or representative involvement; . -An explanation will be included in the resident's medical record if the participation of the resident and his/her resident's representative for developing the resident's care plan is determined not to be practicable. -The comprehensive care plan is developed within 7 days of the completion of the required comprehensive assessment (MDS). 1. Resident #2 was admitted to the facility in March 2019 with diagnoses including Anxiety Disorder, Unspecified (feeling of unease, such as worry or fear, that can be mild or severe/intense, excessive, and persistent worry and fear about everyday situations), Schizophrenia Unspecified (a mental disorder characterized by recurring episodes of psychosis that are correlated with a general misperception of reality), and Major Depressive Disorder, Recurrent, Unspecified (a mental disorder characterized by a pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Review of the Resident's Health Care Proxy (HCP - an appointed person to make health care decisions on your behalf if you are unable to make or communicate those decisions) indicated that the Resident had signed the form on 3/14/19 designating a HCP to make decisions for them. Review of the Resident's clinical record included a Documentation of Resident Incapacity, signed by the Physician on 3/20/19, indicating that the Resident lacked the capacity to make decisions and activating (invoking) the HCP for lifetime due to moderate cognitive impairment. Review of the Resident's clinical record indicated that MDS assessments had been completed on 1/9/24 and 4/9/24. Review of the MDS dated [DATE] indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 12 out of a possible 15. During an interview on 4/30/24 at 10:32 A.M., the Resident said that they were not sure they had ever been to a care plan meeting. Review of the Resident's clinical record did not provide any evidence of care plan meetings being held from January 2024 through April 2024, nor evidence that the Resident or their invoked HCP had participated in the care planning process. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/24 at 10:08 A.M., Social Worker (SW) #1 said that she sends the invitations to the care plan meetings out at least a month in advance. SW #1 said that she invites residents and responsible parties, and even if the HCP is invoked, she still invites the residents. SW #1 said that she uses a care plan attendance document. SW #1 said the documents are not kept in the resident records, and that all care plan meeting invitations and attendance records are kept in a binder in the SW's office. When the surveyor asked SW #1 to provide the care plan attendance sheets for Resident #2 relative to the MDS assessments completed on 1/9/24 and 4/9/24, SW #1 was unable to provide evidence that the Resident or the Resident's Representative participated in the care planning process following the MDS completion on 1/9/24 and 4/9/24. SW #1 was also unable to provide evidence that a care plan meeting was held with the IDT following the MDS assessments completed on 1/9/24 and 4/9/24. During an interview on 5/1/24 at 4:27 P.M., the Administrator said that he was unable to provide evidence that any Interdisciplinary Team (IDT) care plan meetings were held for Resident #2 in 2024. 2. Resident #67 was admitted to the facility in January 2024, with diagnoses including Type II Diabetes (DM II - condition in which the body does not produce enough insulin and had trouble controlling blood sugar levels) and Acquired Absence of Right Leg Below Knee (Amputation of the right leg below the knee). Review of the Resident's clinical record indicated that a Minimum Data Set (MDS) assessment had been completed on 1/24/24. Review of the MDS assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 13 out of a possible 15. During an interview on 4/30/24 at 8:59 A.M., the Resident said that he/she did not recall ever being invited to, or participating in a care plan meeting. Review of the Resident's clinical record did not provide evidence of care plan meetings being held from January 2024 through April 2024, nor evidence that the Resident or their Representative had participated in the care planning process after the MDS assessment completed on 1/24/24. During an interview on 5/1/24 at 10:08 A.M., the surveyor asked SW #1 to provide the care plan attendance sheet for Resident #67 relative to the MDS assessment completed on 1/24/24. SW #1 was unable to provide evidence that the Resident or the Resident's Representative participated in the care planning process following the MDS completion on 1/24/24. SW #1 was also unable to provide evidence that a care plan meeting was held with the IDT following the MDS completed on 1/24/24. During an interview on 5/1/24 at 4:27 P.M., the Administrator said that he was unable to provide evidence that an Interdisciplinary Team (IDT) care plan meeting was held for Resident #67 in 2024. 50320 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #3 was admitted to the facility in September 2018 with diagnoses of Chronic Respiratory Failure (CRF - long term condition in which airways are damaged limiting movement of air through the body), Chronic Obstructive Pulmonary Disease (COPD - a type of progressive lung disease characterized by long term respiratory symptoms and restricted air flow), and Unspecified Dementia (symptoms of cognitive dysfunction do not meet the criteria for a specific type of Dementia). Review of the Resident's clinical records indicated that Minimum Data Set (MDS) assessments were completed on 12/12/23 and 3/12/24. Review of the MDS assessment dated [DATE], indicated that the Resident had a Brief Interview of Mental Status (BIMS) score of 11 out of a possible 15, indicating Resident #3 was moderately cognitively impaired. During an interview on 4/30/24 at 8:42 A.M., the Resident said he/she did not know they had care plans. Review of the Resident's clinical record did not provide evidence of care plan meetings being held from December 2023 through April 2024, nor evidence the Resident or their representative had participated in the care planning process after the MDS assessments completed on 12/12/23 and 3/12/24. During an interview on 5/1/24 at 4:28 P.M., the Administrator said he could not provide evidence of care plan meetings being held since December 2023 for Resident #3, after MDS assessments were completed on 12/12/23 and 3/12/24. 48206 4. Resident #60 was admitted to the facility in May 2023 with diagnoses including history of Stroke (damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area of the brain) and Hemiplegia (weakness or paralysis of one side of the body). During an interview on 4/20/24 at 9:54 A.M., Resident #60 said that he/she had a desire to discharge and return to the community but he/she had not had any care plan meetings to discuss discharge planning. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #60 had mild cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15. Review of the MDS assessment calendar indicated that comprehensive assessments were completed on the following dates: -5/9/23 -8/8/23 -11/7/23 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2/6/24 Further review of Resident #60's medical record did not provide evidence that the participation of Resident #60 in developing his/her plan of care was determined not to be practicable. During an interview on 5/1/24 at 4:27 P.M., the Administrator provided documentation of two care plan meetings held on 11/22/23 and 2/22/24. The Administrator said there was no evidence of care plan meetings held relative to the 5/9/23 and 8/8/23 comprehensive assessments. Review of the Care Plan Meeting Summary dated 11/22/23, indicated that the meeting included the Social Worker (SW), the Director of Nursing (DON), Resident #60's Representative, and the Representative's spouse. The meeting summary did not indicate that the Resident was invited to participate in the care plan meeting and declined, or that Resident #60 was included in the care planning process. Review of the Care Plan Meeting Summary dated 2/22/24, indicated the meeting included the SW, the DON, Resident #60's Representative, and the Representative's spouse. The meeting summary note did not indicate that the Resident was invited to participate in the care plan meeting and declined, or that Resident #60 was included in the care planning process.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on observation, interview, policy and record review, the facility failed to provide nutrition care and services that meet professional standards of practice in identifying and preventing a significant weight loss for one Resident (#65) recieving artificial nutrition via a Jejunostomy tube (J-Tube: a feeding tube that passes directly into the small intestine), out of a total sample of 18 Residents. Specifically, the facility staff failed to: -appropriately implement, monitor and evaluate weekly weights as ordered for the Resident, and reassess Resident refusal to be weighed. -assess tube feeds recommendations made by the Registered Dietitian (RD), and refer and/or offer alternative options when the Resident was unable to tolerate increased tube feeds and calorie goals. Findings Include: Review of the Professional Standards of Practice in the [NAME] NURSING PROCEDURES, 9th edition 2023, indicates the following relative to Enteral (method of feeding that uses the gastrointestinal (GI) tract to deliver nutrition and calories) .Jejunal tube feedings: -Monitor the patient's weight and nutritional, fluid, electrolyte, and metabolic status, as ordered, to evaluate the effectiveness of enteral feedings. Review of the facility policy titled Nutritional Services, reviewed October 2023, indicated the following: -The height and weight of residents is measured upon admission to the facility. Following admission residents are weighed weekly x 4 weeks, then monthly and as needed per doctor order. -Residents are weighed upon readmission to the facility and the decision to initiate weights weekly based on significant weight loss/gain triggers. -Weights are verified and documented in the medical record as they are obtained. -Check the previous monthly weight for any significant change. If there is a significant change of + or - 5% in 30 days, 7.5% in 90 days, or 10% in 180 days, the resident should be re-weighed within 24 hours. -Diets and fluids are provided as ordered and as appropriate to meet estimated needs. -Residents are encouraged to be involved with their care as able and opportunities for education are addressed. Review of the facility policy titled Weights, revised February 2017, indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The weight of each resident will be monitored on a regular basis no less than monthly. Weight monitoring on a regular basis will allow for identification of weight changes and subsequent appropriate care planning and evaluation. -All residents will be weighed within 24 hours of admission/readmission and then weekly for the next three weeks for a total of four weeks. -All residents will be weighed monthly by the 7th of each month. -The Nursing Assistants will record the weights on the Weight Sheet. -The Unit Manager will document the weights directly into the weight book which is kept on each unit. -A weight gain or loss of 5 lbs or more will require the Unit Manager to notify the Dietician . -The Dietician will review all monthly weights and report to the IDT (Interdisciplinary Team) any significant changes in the resident's weight. -The Dietician will make the determination if the resident needs to be weighed on a more frequent basis. -Residents that have experienced a significant weight loss will be reviewed by the IDT to determine the root cause . Resident #65 was admitted to the facility in December 2023, with diagnoses including severe protein-calorie malnutrition (an imbalance between the nutrients the body needs to function and the nutrients the body gets), malignant neoplasm of esophagus (cancer in the tube from the mouth to the stomach), Dysphagia (difficulty swallowing), and received artificial nutrition via a Jejeunostomy tube (J-Tube). Review of the full Nutrition Risk Assessment, dated 12/16/23, indicated the following: -Resident #65's ideal body weight was 160 lbs -Resident originally went to the hospital in August 2023, with reports of 45 lb weight loss x3 months -Resident's most recent weight was 127.0 pounds (lbs.) on 12/12/23 -Discharge (DC) instructions from the Hospital were tube feedings Vital AF 1.2 @ 85 ml/hr to progress over 16 hours, and increase 10 ml (milliliters) daily to goal of 105 ml/hr as tolerated. -Recommend 100 ml H20 (free water) flushes Q (every) 8 hrs. Review of the Progress Notes by the Physician and Nurse Practitioner (NP) indicated the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/13/23 - Unexplained weight loss of greater than 45 pounds. Continue tube feedings as scheduled. We will monitor patient's weight closely work with the Dietician to optimize patient's nutritional status. 12/27/23 - Continue tube feeding at 85 ml/hr for 16 hours a day. 1/19/24 - Patient currently on tube feeds due to dysphagia for malignant neoplasm of the esophagus. Staff reports that he/she has not been meeting nutritional goals. We will follow-up with Nutritionist to review tretament plan and make recommendations. Continue to monitor weight and adjust tube feeds per nutrition recommendations. 1/24/24 - Spoke with patient. We will increase [tube] feed rate to 83 ml/hr, goal is to have patient greater than 100 ml an hour, however he/she has difficulties tolerating the tube feed. We will slowly upward titrate his/her rate as tolerated. 1/25/24 - Patient has not been tolerating the increased rate of 83 ml/hr. He/she is requesting to go back to 80 ml/hr. As it stands, current feed is not meeting his/her nutritional needs or goals. We will dial back to 80 ml/hr. Additionally recommended increase rate over less period of time however [patient] is not agreeable to this. Continue tube feeding at 80 ml/hr for 16 hours a day. 2/29/24- Continue with tube feeds at 80 ml/hr. Continue to monitor weight and adjust regimen as needed, follow-up with Nutritionist. 3/5/24 - Continue with tube feeds at 80 ml/hr. Continue to monitor weight, follow-up with Nutritionist as needed. 3/14/24 - Continue with tube feeds at 80 ml/hr. Continue to monitor weight, follow-up with Nutritionist as needed. Review of the full Nutritional Risk Assessment, dated 3/18/24, indicated the following: -Resident's ideal body weight was 160 lbs -Resident originally went to hospital in 8/23 with reports of 45 lb weight loss x3 months -Resident's most recent weight was 122.0 on 2/14/24 -Plan to monitor and evaluate weight, intake and tolerance, and nutrition related labs -Assessment that weight has been stable since admission in 12/23 -Discharge (DC) instructions from the Hospital were tube feedings Vital AF 1.2 @ 85 ml/hr to progress over 16 hours and to increase 10 ml daily to goal of 105 ml/hr as tolerated. -Recommend Vital AF 1.2 @ 85 ml/hr over 16 hours and to increase 10 ml daily to goal of 105 ml [per hour] as tolerated and 100 ml H20 water flushes Q8 hrs. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15. -The Resident had a diagnosis of Malnutrition -No weight was available for the past 30 days -The Resident had Tube Feeds for artificial nutrition -The Resident received more than 51% of total calories via tube feeding -The Resident received more than 501 cc (cubic centimeters or milliliters (ml)) per day or more of fluids via tube feeding -The Resident did not demonstrate any behaviors or refusals of care Review of the April 2024 Physician's orders indicated the following: -Enteral (passing through the intestine in an artificial opening): Vital AF 1.2 cal (calorie) liquid via feeding tube THROUGH JEJUNOSTOMY PORT, hung up at 0600 (6:00 A.M.) and taken down at 2200 (10:00 P.M.), given via feeding pump set at 80 ml/hr one time a day and remove per schedule; active, initiated 1/25/24 -Enteral: Flush gastric [sic] tube with 30 ml of water before and after medication administration. Meds and flushes given through Jejunal port every shift; active, initiated 3/26/24 -Enteral: Flush Jejunal tube with 5 ml of water in between each medication administered through gastric [sic] tube every shift; active, initiated 3/26/24 -Nutrition Evaluation; active, initiated 2/21/24 -Weekly weight every day shift every Wed (Wednesday) for monitoring; active, initiated 2/24/24 Review of the Resident's Weight and Vitals Summary indicated the following weights: -12/12/23: 127 lbs [Admission Weight] -1/1/23: 116.6 lbs -1/12/24: 117.5 lbs (-7.8% change since 12/12/23) -2/14/24: 122 lbs (+3.8% change since 1/12/24, -3.9% change since 12/12/23) -5/1/24: 111.6 lbs (pounds) (-8.5% change since 2/14/24, and -12.1% change since 12/12/23) Review of the Medication Assisted Treatment Records for February 2024, March 2024, and April 2024 relative to weekly weights indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/14/24: 122 lbs -No weights were obtained on the following Wednesdays: 3/6/24, 3/13/24, 3/20/24, 3/27/24, 4/3/24, 4/9/24, or 4/23/24. Review of the Nursing Progress Notes indicated the Resident refused to be weighed on 3/6/24, 3/20/24, 3/27/24, 4/3/24, 4/9/24 and 4/10/24. Further review of the Nursing Progress Notes did not indicate reasons why a weight was not obtained on 3/13/24 or 4/23/24. Review of the Resident's Tube Feeding plan of care, initiated 12/12/23 and last revised 4/2/24, indicated the following interventions: -dependent with tube feeding and water flushes. See MD orders for current feeding orders. -RD (Registered Dietitian) to evaluate quarterly and PRN (as needed). Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. -Discuss with [Resident]/family/caregivers any concerns about tube feeding, advantages, disadvantages, potential complications. Review of the Nutrition Progress Note dated 4/20/24 indicated the following: -Registered Dietician (RD) met with Resident #65 at his/her request. -Resident desired to gain weight. -Resident refuses care and refuses to be weighed. -Resident was educated on the need to obtain an accurate weight to assess tube feeding requirements. -Resident agreed to let nursing weigh him/her. Review of the Nutrition Note dated 5/2/24 indicated: -Resident #65 weighed 111.6 lbs (-8.5% change since 2/14/24, and -12.1% change since 12/12/23) -Weight loss was noted and recommend increasing tube feedings as tolerated, see full [Nutrition] assessment (dated 3/18/24) for recommendations. Further review of the Nutritional Risk Assessment (3/18/24) and Nutrition Progress Notes (4/20/24) did not indicate: -that the Resident refusals to be weighted weekly (between 2/14/24 - 4/20/24) were addressed and Resident education provided prior to 4/20/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-any interventions occurred to increase the tube feed rate. -that the increased tube feed rate was not tolerated by the Resident. -that weight loss was unavoidable due to disease progression or illnesses. -consistent RD monitoring of weights and tube feed goals, and/or re-assessment of the Resident nutritional status. During an interview on 5/1/24 at 1:03 P.M., the RD said that she is in the facility for 8 hours a week, that staff contact her via email or phone regarding diet changes, and she coordinates with the NP. The RD said that Resident #65 was admitted to the facility on the tube feeds and his/her diagnosis was poor. The RD said the NP contacted her about the Resident wanting to gain weight and she met with the Resident on 4/20/24. The surveyor and the RD reviewed the Resident's weights including the weight obtained on 5/1/24 at 111.6 lbs. The RD said she has concerns about weight loss and will review and discuss with the NP. The RD said that the Resident's nutritional needs are not being met if his/her goal is to gain weight and that he/she refuses to be weighed. During an interview on 5/1/24 at 2:49 P.M., Nurse #3 said staff perform weekly weights on Wednesdays and that Resident #65 often refuses weights. The Nurse said if Resident #65 refuses, staff would re-approach later in the day, and then if he/she continues to refuse to be weighed, staff would defer weights until the next week. Nurse #3 said that any refusal of weights would be documented in the Medication Administration Record (MAR) and Progress Notes. During an interview and observation on 5/2/24 at 10:26 A.M., Resident #65 said that he/she was concerned about his/her weight and would be willing to trial an increase in his/her tube feedings. The Resident said his/her goal on admission to the facility was to stabilize medically to participate in chemotherapy or other treatments to improve. Resident #65 said that he/she does feel that the medical staff in the facility have listened to his/her wishes. The surveyor observed the tube feeding of Vital AF 1.2 was connected and running at a rate of 80 ml/hr. During an interview on 5/2/24 at 11:25 A.M., CNA #3 said that resident weights are typically done at 6:00 A.M. and the Nurse provides a list of residents who need weights obtained. CNA #3 said if a resident refuses to be weighed, she will approach the resident three times and let the Nurse know if the resident refuses to be weighed. CNA #3 said the Nurses document the refusal of weights in the Nursing record. CNA #3 said that Resident #65 has had a decline and often refuses to be weighed. During an interview on 5/2/24 at 11:47 A.M., the NP said she spoke with Resident #65 today after he/she had an updated weight and the Resident expressed concerns about his/her weight. The NP said the Resident's current nutrition needs are not being met. The NP further said that if a Resident is refusing weights, then she would expect that staff would document approaching the Resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on observation, interview, policy and record review, the facility failed to provide respiratory care and services consistent with professional standards of practice for two Residents (#272 and #3), out of 3 applicable residents, out a total sample of 18 residents. Specifically, the facility staff failed to: 1) For Resident #272, a) ensure that the aerosol compressor (a large volume nebulizer that is used in tracheostomy patients to deliver a high-volume mist that moisturizes/ humidifies the airway) was monitored and maintained for optimal humidification of the Resident's tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube) tube, b) ensure a Physician's order was obtained for oxygen use and increased liter flow, and c) that oxygen tubing equipment was changed as required to prevent contamination and the spread of infections. 2) For Resident #3, change oxygen tubing and nebulizer tubing and mask as ordered to ensure that the respiratory equipment were maintained in a sanitary manner to prevent the spread of organisms and infections. Findings include: Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with physicians' orders or inadequate instruction for oxygen therapy. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in PaCO2. -Equipment maintenance and supervision: All oxygen delivery equipment should be checked at least once daily Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Resident #272 was admitted to the facility April 2024 with diagnoses including Chronic Respiratory Failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), Malignant Neoplasm of Larynx (cancer of the vocal cords), Chronic Obstructive Pulmonary Disease (COPD- chronic lung disorders resulting in blocked air flow in the lungs and breathing problems) and required the use of a Tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing) tube. Review of the Progress Note on 4/17/24 by the Medical Physician indicated the Resident had a Tracheostomy tube placed in the hospital due to respiratory failure. Review of the April 2024 Physician's orders failed to indicate the parameters for oxygen use, humidifier/aerosol use, monitoring the Resident's response to oxygen therapy, or the maintenance schedule of oxygen and tracheostomy humidification equipment. Review of the Resident's Tracheostomy Plan of Care, initiated 4/18/24, indicated the following: -[The Resident] had a Tracheostomy related to impaired breathing techniques. -The goal was to have no signs or symptoms of infection through the next review date. -Interventions include monitoring/document for restlessness, agitation, confusion, increased heart rate (tachycardia) and bradycardia (reduced heart rate). -Intervention to monitor/document respiratory rate, depth, and quality. Check and document Q [every] shift as ordered. During an observation and interview on 4/30/24 at 9:31 A.M., the surveyor observed Resident #272 lying in bed with head of bed elevated and several respiratory equipment at his/her bedside, including a suction machine, an aerosol compressor, and an oxygen concentrator. Resident #272 said that he/she was actively being treated for throat cancer and recently had the Tracheostomy placed during his/her recent hospitalization . Resident #272 said that he/she uses the aerosol compressor which hooks up to the oxygen at night that is directly connected to his/her tracheostomy tube. During an observation and interview on 5/1/24 at 8:41 A.M., the surveyor observed the oxygen tubing and blue corrugated aerosol tubing was undated and hanging on the right bed rail. An aerosol drainage bag attached halfway along the blue corrugated tubing was observed to be placed directly on the floor. The surveyor also observed that the water container in the aerosol compressor machine was empty. During an interview at the time, Resident #272 said that the aerosol compressor had run out of water last night and he/she had turned the machine off. The surveyor observed two gallon containers of distilled water located in the room and the Resident said the distilled water were for the aerosol compressor use. The surveyor further observed the oxygen concentrator was set at 5 liters per minute (LPM - flow rate of oxygen) but was not currently in use by the Resident. The Resident said the oxygen concentrator and aerosol compressor are only used at night. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 3:11 P.M., Nurse #4 said that the aerosol compressor used by Resident #272 came with instructions on the settings for use and that it is only used at night for the Resident. Nurse #4 said the orders for the aerosol compressor settings was obtained from hospital paperwork. Nurse #4 demonstrated to the surveyor where the max fill line on the aerosol water container should be and said that the max fill amount typically lasts through the night. Nurse #4 further demonstrated the settings for the aerosol compressor to be set at 30 percent (%) and said the oxygen flow rate is usually set between 2 and 3 LPM. During an observation on 5/2/24 at 7:20 A.M., the surveyor observed Resident #272 lying in bed sleeping with the tracheostomy mask in place over his/her tracheostomy tube. The surveyor also observed that the oxygen concentrator with the aerosol corrugated tubing attached to the trach mask were in use. The surveyor further observed the aerosol compressor was set at 30% and the oxygen concentrator was set and running at 5 LPM. During an observation and interview on 5/2/24 at 1:05 P.M., the surveyor and the Director of Nurses (DON) observed Resident #272 lying in bed. The surveyor observed that the oxygen tubing, trach mask and blue corrugated aerosol tubing were all laying on the floor. The DON said that all the tubings and the trach mask should be stored in a bag and off of the floor and this would be immediately addressed for the Resident. During a follow-up interview on 5/2/24 at 3:27 P.M., the DON said that Resident #272 should have Physician orders in place to reflect the 5 LPM of oxygen in use with the aerosol compressor and orders to address the oxygen tubing changes. The DON further said these orders should have been in place but were not. 50320 2. Review of the facility policy titled Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, indicated the following procedure: -When equipment is completely dry, store in a plastic bag with the Resident's name and date on it. -Change equipment every 7 days, or according to the facility protocol. Resident #3 was admitted to the facility in September 2018 with diagnoses of Chronic Respiratory Failure (CRF - long term condition in which airways are damaged limiting movement of air through the body), Chronic Obstructive Pulmonary Disease (COPD - a type of progressive lung disease characterized by long term respiratory symptoms and restricted air flow), and Congestive Heart Failure (CHF - a condition where your heart cannot pump enough blood to meet your body's needs). Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 11 out of a possible 15. Review of the April 2024 Physician's orders indicated the following: -Oxygen continuous with Special Directions to titrate to maintain O2 SATS >90%, every shift for Shortness of Breath and O2 Sat Results, active, start date 11/12/20 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ipratropium-Albuterol Solution 0.5 - 2.5 (3) mg/3 ml, inhale orallyin the evening related to Acute and Chronic Respiratory Failure With Hypoxia, active, start date 5/17/23 -Nebulizer mask and tubing changed weekly one time a day every Fri (Friday) related to COPD, active, initiated 11/13/20 -Oxygen tubing changed weekly every night shift every Fri (Friday) date, active, initiated 11/13/20 Review of the April 2024 Treatment Administration Record (TAR) indicated that the nebulizer mask and tubing and the oxygen tubing were changed on (Friday) 4/26/24. During an interview and observation on 4/30/24 at 8:54 A.M., the Resident said the staff did not change the oxygen tubing. The surveyor observed that the oxygen tubing and the nebulizer tubing were dated 4/23/24. The surveyor also observed that the nebulizer tubing and nebulizer mask were placed directly on the Resident's bedside table. On 5/1/24 at 8:04 A.M., the surveyor observed Resident #3 seated in a wheelchair in the hallway receiving Oxygen therapy. The surveyor observed that the oxygen tubing was dated 4/23/24. On 5/2/24 at 9:41 A.M., the surveyor observed Resident #3 seated in a wheelchair in his/her room receiving Oxygen therapy. The surveyor observed that both the oxygen tubing and the nebulizer tubing were dated 4/23/24, and that the nebulizer tubing and mask were placed directly on the Resident's bedside table. During an interview on 5/2/24 at 9:41 A.M., Nurse #2 said the Resident should have the nebulizer mask and tubing in a bag, but the Resident currently did not have a bag. Nurse #2 said she was aware the current nebulizer mask and tubing and oxygen tubing needed to be changed. During an interview on 5/2/24 at 12:40 P.M., the Director of Nurses (DON) said nebulizer masks and tubing and oxygen tubing should be changed weekly and kept at the bedside. The DON said she was not aware of how [nebulizer] tubing and masks should be stored when not in use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206 Based on interview, policy and record review, the facility failed to provide services consistent with professional stands of practice related to hemodialysis (a procedure to remove waste products and fluid from the blood by passing it through a special machine, necessary when the kidneys are unable to filter the blood) were provided for one Resident (#17), out of a total sample of 18 residents. Specifically, the facility failed to monitor Resident #17's AV (Arterio-Venous) Fistula (dialysis access site) for signs and symptoms of patency and infection. Findings include: Review of the facility policy titled Care of a Resident with End Stage Renal Disease (ESRD, the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life), revised September 2010, indicated the following: -Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. -Education and training of staff includes, specifically: a. The nature and clinical management of of ESRD (including infection prevention and nutritional needs); b. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis; c. Signs and symptoms of worsening conditions; d. How to recognize and intervene in medical emergencies such as hemorrhages or septic infections; e. How to recognize and manage equipment failure or complications (according to the type of equipment used in the facility); f. The care of grafts and fistulas; and g. The handling of waste -The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. Review of the policy titled Hemodialysis Access Care, revised September 2010, indicated the following: -Care of AVFs (Arterio-Venous Fistula) . (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Care involves the primary goals of preventing infection and maintaining patency of the catheter (preventing clots). 2. To prevent infection/clotting: a. Keep the access site clean at all times b. Do not use the access site arm to take blood samples, administer IV fluids or give injections. c. Check for signs of infection (warmth, redness, tenderness or edema [swelling]) at the access site when performing routine care and at regular intervals. d. Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals e. Check the patency of the site at regular intervals. Palpate (examination by touch) the site to the thrill or use a stethoscope (sic) to the whoosh or bruit of blood flow through the access (bruit - audible sound determined via stethoscope/ thrill - vibration that is felt when palpating the skin over an AV [arteriovenous - surgical connection between an artery and vein] fistula). -Documentation: The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (interventions if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observation post-dialysis. Resident #17 was admitted to the facility in September 2023, with diagnoses including End Stage Renal Disease (ESRD - a condition where the kidneys have reached an advanced state of loss of function) and received his/her Hemodialysis treatments three days a week via an AVF. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of total possible 15. Review of the Hemodialysis Plan of Care, last revised 1/10/24, indicated the following: -The Resident has a new fistula on his/her right lower extremity. -The goal is to have no signs or symptoms of complications from dialysis through the next review date. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions include: >Monitor/document for peripheral edema. >Monitor/document/report to MD PRN (as needed) for signs or symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. >Monitor/document/report to MD PRN (as needed) for signs/symptoms of the following: bleeding, hemorrhage, bacteremia, septic shock. Review of Resident #17's Order Summary Report dated 5/2/24, indicated the following: -Dialysis treatment received on Tuesday, Thursday, Saturday. Pick up time: 5:30 A.M., start date 10/7/23 -Dry Dialysis weights only *DO NOT WEIGHT IN HOUSE* Enter dry Dialysis Weight upon return every day shift every Tues, Thu, Sat, start date 9/28/23 -Hemodialysis General Care Orders: Center Nursing Staff may NOT perform any of the following procedures on external hemodialysis catheters: Infuse medications/ solutions; Flush catheter; change end caps; remove or repair catheter; obtain blood specimens; Change dressing. start date 9/12/23 -Monitor for pain every shift, start date 9/12/23 Review of the April 2024 and May 2024 Physician's Orders did not indicate that nursing interventions for monitoring for signs and symptoms of patency and infection at the fistula site were in place. Review of the Facility Progress Note dated 4/2/24, indicated the Resident: -returned from Dialysis and was unable to be dialyzed due to arm swelling -the swelling increased and was down to wrist in the right arm -requested to go to the Emergency Department (ED) for evaluation -the Nurse Practitioner (NP) was in agreement with the plan Review of the NP Progress Note on 4/2/24, indicated the following: -Resident #17 was evaluated for concern of right arm swelling and significant brushing [SIC]. -The Resident noticed increased swelling last night, he/she went to dialysis and was sent back as they were unable to perform dialysis. -Diagnosis of pain in right arm with unknown etiology (origin). -Questioning complication of fistula. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Significant bruising, pain, and swelling with restricted range of motion to the RUE (right upper extremity). -Resident requested to be evaluated at the ED. -Resident will need higher level of care for assessment as he/she missed dialysis as well as fistulogram (a special x-ray procedure that identifies abnormalities in the blood flow through the dialysis access site). During an interview on 4/30/24 at 11:20 A.M., Resident #17 said that he/she had recent issues with bruising and swelling to his/her arm with the fistula. Resident #17 said he/she was sent to the ED from the facility when he/she could not receive scheduled dialysis treatment. Resident #17 further said that he/she was hospitalized ,d+[DATE] days and required surgery to his/her right arm. During an interview on 5/1/24 at 3:01 P.M., Nurse #3 said she recalled Resident #17 returning from dialysis on 4/2/24 and noted significant bruising to his/her arm. Nurse #3 said the Resident told her that the issue occurred at dialysis, that the dialysis staff had difficulty accessing the fistula, and the Resident returned to the nursing facility. Nurse #3 said that sometimes the fistula site for the Resident is bruised when the Resident returns from dialysis. Nurse #3 further said that nursing staff check the fistula daily, review the dressing, monitor for bleeding, and note if there is bruit and thrill. During an interview on 5/2/24 at 2:15 P.M., the Director of Nurses (DON) said that the Physician's orders were updated to include checking access and monitoring the fistula for signs and symptoms of infection. The DON said that the orders for monitoring should have been initiated when the fistula was placed, but had not been.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interview and record review, the facility failed to ensure that medications were stored safely and remained inaccessible to one Resident (#14) out of a total of 18 sampled residents. Specifically, the facility failed to: -ensure that [NAME] Lotion (an anti-itch topical [applied to the skin] medication) was safely stored, and locked up out of reach for Resident #14, resulting in him/her ingesting the medication and requiring hospitalization . -ensure that house barrier cream (a skin protectant cream) was safely stored and not easily accessible to Resident #14, resulting in him/her ingesting the medication and requiring monitoring for possible gastrointestinal upset. Findings include: Review of the facility policy titled Medication Storage in the Facility, revised 2019, indicated the following: -Medications and biologicals are stored safely, securely, and properly . -The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Resident #14 was admitted to the facility in June 2019, with a diagnosis of Dementia with Behavioral Disturbance (progressive disease with impairment in memory and functioning that includes symptoms such as depression, anxiety, psychosis, agitation, aggression, disinhibition, and sleep disturbances). Review of the Nursing Progress Note dated 11/10/23, indicated Resident #14 was found to be ingesting (swallowing) [NAME] Lotion, ingested six to eight ounces, and was subsequently sent to the hospital emergency room for evaluation. Review of the Root Cause Analysis (RCA) provided by the facility, dated 11/10/23, indicated the [NAME] Lotion had been placed on the nurse's station desk, not locked up, and was left unattended. The Resident was observed ingesting the lotion from the bottle. No additional documentation was provided to the surveyor regarding what interventions were put into place, or what education was provided to staff following the incident to reduce the likelihood that a similar incident would occur. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Note dated 3/30/24, indicated Resident #14 had ingested a calamine (anti-itch topical medication), hydrocortisone (an anti-itch topical mediation) zinc paste (a skin protectant topical medication) mixture (the facility's house barrier cream) and needed to be monitored for possible gastrointestinal upset. Review of the RCA provided by the facility dated 4/1/24, indicated the Resident was being provided care and the cup containing the house barrier cream was within reach of the Resident. The RCA further indicated that the Resident was able to stick his/her fingers in the house barrier cream, and placed his/her fingers in his/her mouth ingesting the cream. The RCA indicated an order was given by the Nurse Practitioner (NP) to monitor for gastrointestinal upset. No additional documentation was provided to the surveyor regarding what interventions were put into place, or what education was provided to staff following the second incident to reduce the likelihood that a similar incident would occur. During an interview on 5/1/24 at 1:02 P.M., the Director of Nurses (DON) said staff education was not completed following the two incidents of Resident #14 ingesting non-food items. During a follow-up interview on 5/1/24 at 2:56 P.M., the DON said nursing staff should not leave any medication unattended at the nurse's station or within reach of a resident. The DON again stated to the surveyor that she was unable to provide any documentation that education regarding proper storage of medication was completed with staff following the two incidents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on interview and record review, the facility failed to maintain complete and accurate medical records for one Resident (#14) out of 18 residents sampled. Specifically, for Resident #14, the facility staff failed to accurately update the Resident's Physician's orders to accurately match the Massachusetts Medical Order for Life-Sustaining Treatment (MOLST- form that indicates a person's medical wishes regarding life sustaining treatments). Findings include: Resident #14 was admitted to the facility in [DATE], with a diagnosis of Dementia with Behavioral Disturbance (progressive disease with impairment in memory and functioning that includes symptoms such as depression, anxiety, psychosis, agitation, aggression, disinhibition, and sleep disturbances). Review of the Resident's MOLST signed by the Resident Representative on [DATE], and by the Physician, Nurse Practitioner, or Physician's Assistant on [DATE], indicated the following request: -Do Not Resuscitate (do not perform cardiopulmonary resuscitation [CPR]-chest compressions) Review of the [DATE] Physician's orders indicated the following order: -Full Code (indicating the Resident wanted all life-sustaining treatment, including CPR) with an order date of [DATE]. During an interview on [DATE] at 9:42 A.M., Nurse #1 said if Resident #14 was to go into cardiac distress she would look in the electronic medical record (EMR) to see if the Resident had an order in place that he/she was a DNR or if he/she was a Full Code. The surveyor and Nurse #1 reviewed the Physician's orders and Nurse #1 said the Physician's orders said the Resident was a Full Code. Nurse #1 said she was not sure if the Physician's orders were accurate, and the surveyor and Nurse #1 next reviewed the Resident's MOLST. Nurse #1 said the MOLST indicated the Resident is a DNR and chest compressions should not be started if the Resident was in cardiac distress. Nurse #1 further said the Physician's orders and the MOLST should match and when the MOLST was completed, it did not appear that the Physician's orders had been updated to match.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48206 Based on observation, interview, record and policy review, the facility failed to adhere to infection control standards for one Resident (#272) out of a total sample of 18 residents, putting the Resident at risk for contamination and the spread of infection. Specifically, the facility staff failed to: -identify the need for Enhanced Barrier Precautions (EBP) for Resident #272, when the Resident was indicated with indwelling medical devices of tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube) and gastrostomy tube (G -Tube: a tube that is placed directly into the stomach through an abdominal wall incision for the enteral [passing through the gastrointestinal tract] administration of food, fluids, and medication). -provide appropriate signage and communication to staff relative to EBP and the appropriate PPE (personal protective equipment) usage. Findings include: Review of the Centers for Medicare and Medicaid Memo QSO-24-08-NH, dated 3/20/24, indicated the following: -Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities. -EBP are used in conjunction with standard precautions and expand the use of Person Protective Equipment (PPE) to donning of gown and gloves during high-contact resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing -EBP is indicated for nursing home residents with .wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. -Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. -EBP should be used for any residents who meet the above criteria. -For residents whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, Tracheostomy/ventilator, and wound care: any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #272 was admitted to the facility in April 2024, with diagnoses including Chronic Respiratory Failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), Malignant Neoplasm of Larynx (cancer of the vocal chords), Chronic Obstructive Pulmonary Disease (COPD - chronic lung disorders resulting in blocked air flow in the lungs and breathing problems) and required the use of a Tracheostomy and enteral feeding via a G-tube (gastrostomy tube: a tube that is placed directly into the stomach through an abdominal wall incision for the enteral [passing through the gastrointestinal tract] administration of food, fluids, and medication). During an observation on 4/30/24 at 9:57 A.M., the surveyor observed Rehabilitation (Rehab) Staff #1 assisting Resident #272 to ambulate towards the bathroom and proceeded to assist him/her into the bathroom. The surveyor observed that Rehab Staff #1 was wearing only a mask and gloves, and was not wearing a gown. The surveyor did not observe any signage within or outside the Resident's room indicating Enhanced Barrier Precautions (EBP). During an interview on 4/30/24 at 10:07 A.M., Rehab Staff #1 said that she should wear a mask and gloves when assisting Resident #272 in the bathroom. Rehab Staff #1 said that she would know if a resident was on Enhanced Barrier Precautions if there was signage outside of the Resident's Room and there would also be a Physician's order in the medical record indicating any Precautions. Rehab Staff #1 also said that she would ask the Nurse before entering a room with EBP signage to determine which resident had the EBP Precautions in place. During an interview on 5/2/24 at 10:20 A.M., the Assistant Director of Nursing (ADON) said that residents who needed to be on EBP would include those with G-tubes and tracheostomies. The ADON said the need for precautions would be communicated to staff via EBP signage outside of the residents' room and that facility staff have been educated on the proper use of PPE for EBP. During an observation and interview on 5/2/24 at 1:05 P.M., the surveyor and the Director of Nurses (DON) observed no signage indicating EBP was present for Resident #272's room. The DON said that anyone with wounds or openings such as feeding tubes or tracheostomies should be on EBP. The DON said the EBP signage indicates which PPE staff are to use when providing high-contact care for residents. The DON said there should be EBP signage outside of Resident #272's room and there was not.