STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225489	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvidere Healthcare Center	500 Wentworth Avenue Lowell, MA 01852

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45984 Based on observation and interview, the facility failed to provide a dignified dining experience for Residents on the Right Wing unit. Findings include: The surveyor made the following observations: - On 5/14/24 at 8:19 A.M., a Certified Nursing Assistant (CNA) was observed feeding a resident in bed while standing over him/her, not at eye level. - On 5/14/24 at 11:47 A.M., a resident was observed sitting at a table in the dining room with a second resident. The first resident received his/her tray at 12:08 P.M. and was being assisted by staff. At 12:08 P.M., the staff assisting the resident told the other resident Your food is in the next truck. The second resident received his/her meal at 12:42 P.M., 55 minutes after the first resident had begun eating. - On 5/15/24 at 8:13 A.M., a resident was observed sitting in a Broda chair at a dining room table with another resident who was being assisted with breakfast. At 8:17 A.M., a CNA was observed leaning on the initial resident's Broda chair talking to another CNA at a different table. At 8:27 A.M., a CNA sat down with the resident and assisted with feeding him/her, 14 minutes after the other resident at the table had begun eating. - On 5/15/24 from 8:19 A.M. to 8:27 A.M., a Certified Nursing Assistant was observed feeding a resident in bed while standing over him/her, not at eye level. During an interview on 5/16/24 at 8:30 A.M., the Nursing Supervisor said staff should be sitting at eye level when feeding residents and not standing over residents while they are assisting with feeding. The Nursing Supervisor continued to say when residents are sitting at a table together for meals they should be served at the same time. During an interview on 5/16/24 at 10:27 A.M., the Director of Nursing (DON) said staff should not be standing over residents while they are assisting them with feeding. The DON also said residents sitting at the same table during meals should be served at the same time.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review, and interview, the facility failed to protect one Resident (#54) from abuse out of a total of 22 sampled residents. Specifically, Occupational Therapist (OT) #1 yelled at Resident #54 in the presence of other residents and staff for not following his/her directions. Findings include: Review of the facility's Abuse Prohibition policy dated 2/20/23 indicated: *The facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, family, friends, etc. Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers and staff of other agencies serving the resident. *Types of abuse: Verbal: oral, written or gestured language, that willfully includes disparaging and derogatory terms, to the resident/patient or their families, or within their hearing distance to describe resident/patient. Mental/Emotional Abuse: includes but is not limited to, humiliation, harassment and threats of punishment or deprivation. *Training: Staff will maintain a manner of courtesy and respect toward residents and their families. Staff will refrain from all actions that could be considered abuse, mistreatment and/or neglect. Any employee who as a Resident #54 was admitted to the facility in April 2024 with diagnoses including cerebral infarction (stroke), cognitive communication deficit and unspecified dementia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #54 scored a 14 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating he/she is cognitively intact. On 5/14/24 at 12:05 P.M., the surveyors were at the nurses station, along with Nurse #1, the Wound Physician and Certified Nursing Assistant (CNA) #1 on the left side unit. The surveyors and facility staff observed Resident #54 being wheeled in his/her wheelchair by OT #1. OT #1 was loudly and sternly repeating to Resident #54, Pick up your feet! Pick up your feet! Resident #54 appeared unsure of these directions, stood up in the wheelchair and OT #1 abruptly, loudly and aggressively said What are you doing!? Where are you going!? Resident #54 then responded saying that he/she was picking up his/her feet and OT #1 yelled No! I told you to sit! and gestured to a nearby resident indicating she wanted Resident #54 to be seated next to him/her. The resident OT #1 was referring to was seated close by and attempted to intervene and speak and OT #1 said to him/her, you're not helping. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #54 then attempted to speak with OT #1 and he/she loudly and aggressively yelled Sit down! Resident #54 then turned slowly to sit down in the wheelchair with his/her shoulders slumped down and turned his/her head down. OT #1 then brought Resident #54's wheelchair and placed him/her next to the resident who attempted to intervene and said, There. Now you two can gripe together!, and walked into Resident #54's room to obtain his/her tray table. The surveyor approached Resident #54. Resident #54's face was drawn and sad. Resident #54 looked at the surveyor and said, She's so mean. She's just so mean. She's always yelling at me. At that time one surveyor left the area to alert the Director of Nursing and Administrator, and one surveyor remained and observed OT #1 bring Resident #54 his/her table. OT #1 then aggressively and repeatedly told Resident #54 I said pick up your feet, pick up your feet! At no time during the observation did staff intervene, remove OT #1 from the area or check on Resident #54 while he/she was being yelled at in the hallway. During an interview on 5/14/24 at 12:24 P.M., the DON said that OT #1 had been suspended from the building due to the interaction between her and Resident #54. During an interview on 5/14/24 at 1:00 P.M., Nurse #1 said that OT #1's behavior was inappropriate and she would not have wanted someone to speak to her in that way. During an interview on 5/14/24 at 12:38 P.M., Resident #54 said that he/she was upset during and after being yelled at by OT #1 in the hallway. Resident #54 said he/she was embarrassed. Resident #54 said that OT #1 is always like that. She's so mean. I just want to be treated like a person.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review, policy review and interviews, the facility failed to ensure one Resident (#13) was free from restraints by locking the remote control for the bed, preventing the Resident to reposition him/herself in bed, out of a total sample of 22 residents. Findings include: Review of the facility policy titled, Physical Restraints, dated 1/1/17, indicated the following: -The facility recognizes each resident's right to be treated with respect and dignity including the right to be free from any physical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical condition. -The policy includes an interdisciplinary process of assessment and reassessment in order to ensure that when a restraint is necessary to treat a resident's medical condition the least restrictive is utilized for the least amount of time to treat the resident's medical condition with the plan for continued assessment and reduction. -Components of constraint use: interdisciplinary assessment, MD order, consent, care planning, see period end. C.N.A. care card, reduction plan, reassessment. -Physical restraint is defined as any manual method, physical or mechanical device, equipment or material that meets the following criteria: restricts the patient's freedom of movement or normal access to his/her body. Resident #13 was admitted to the facility in December 2021 with diagnoses including dementia, diabetes, heart failure and pulmonary disease. Review of Resident #13's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15, which indicated the Resident had moderate cognitive impairment. The MDS also indicated the Resident is dependent on staff for all functional daily tasks. During an interview on 5/15/24 at 8:00 A.M., Resident #13 said he/she felt stuck in bed and that the staff had purposely broken his/her bed remote so that he/she could not change positions in bed. Resident #13 said he/she would like to be able to move his/her bed so his/her legs could be in different positions. Resident #13 was observed lying in bed with the foot of the bed flat and his/her bed remote was under the bed. The surveyor observed the bed remote and the buttons on the remote were lit up as locked so the foot of the bed and height of the bed could not be changed. Resident #13 said he/she never agreed to having the remote buttons locked. Review of Resident #13's medical record, including all care plans, failed to indicate a safety need for the bed remote to be locked or a restraint assessment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 8:08 A.M., Certified Nursing Assistant (CNA) #2 said Resident #13 is a high fall risk and the facility intentionally locks the buttons on the Resident's bed remote so he/she can't move the bed. CNA #2 said the Resident used to raise the bed high and/or raise the foot of the bed high creating a fall risk so the facility started locking the bed remote to eliminate his/her ability to do so. During an interview on 5/15/24 at 8:16 A.M., the Nursing Supervisor said Resident #13 is cognitively intact and he/she is still capable of making his/her own decisions. The Nursing Supervisor said Resident #13 likes to play with his/her bed remote and at times put the bed in an unsafe position, which had caused the decision to lock his/her bed remote. The Nursing Supervisor said she could see how this could be a restraint due to the Resident not being able to change his/her position in bed. During an interview on 5/15/24 at 8:38 A.M., the Director of Nursing said a restraint assessment is completed whenever a device is in place that could limit a resident's movement. The DON said that if a resident is cognitively and physically able to use a bed remote, the remote should be within reach for a resident to use independently. The DON said she did not believe Resident #13's bed remote being locked was considered a restraint.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure staff followed its abuse policies and procedures for one Resident (#54) out of a total of 22 sampled residents. Specifically, staff who were present when Occupational Therapist (OT) #1 yelled at Resident #54 did not intervene or remove OT #1 from the unit per policy. Findings include: Review of the facility's Abuse Prohibition policy dated 2/20/23 indicated: *The facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, family, friends, etc. Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers and staff of other agencies serving the resident. *Types of abuse: Verbal: oral, written or gestured language, that willfully includes disparaging and derogatory terms, to the resident/patient or their families, or within their hearing distance to describe resident/patient. Mental/Emotional Abuse: includes but is not limited to, humiliation, harassment and threats of punishment or deprivation. *Identification: Instruct staff staff, resident/patient, family, visitor, etc to report immediately without fear of reprisal, any knowledge or suspicion of suspected abuse, neglect, mistreatment, and/or misappropriation of property. *Protection: Provide for the immediate safety of the resident/patient, upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property; move resident/patient to another room or unit. provide 1:1 monitoring as appropriate. Immediate suspension of suspected employee pending outcome of the investigation. Resident #54 was admitted to the facility in April 2024 with diagnoses including cerebral infarction (stroke), cognitive communication deficit and unspecified dementia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #54 scored a 14 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating he/she is cognitively intact. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 12:05 P.M., the surveyors were at the nurses station, along with Nurse #1, the Wound Physician and Certified Nursing Assistant (CNA) #1 on the left side unit. The surveyors and facility staff observed Resident #54 being wheeled in his/her wheelchair by OT #1. OT #1 was loudly and sternly repeating to Resident #54, Pick up your feet! Pick up your feet! Resident #54 appeared unsure of these directions, stood up in the wheelchair and OT #1 abruptly, loudly and aggressively said What are you doing!? Where are you going!? Resident #54 then responded saying that he/she was picking up his/her feet and OT #1 yelled No! I told you to sit! and gestured to a nearby resident indicating she wanted Resident #54 to be seated next to him/her. The resident OT #1 was referring to was seated close by and attempted to intervene and speak and OT #1 said to him/her, you're not helping. Resident #54 then attempted to speak with OT #1 and he/she loudly and aggressively yelled Sit down! Resident #54 then turned slowly to sit down in the wheelchair with his/her shoulders slumped down and turned his/her head down. OT #1 then brought Resident #54's wheelchair and placed him/her next to the resident who attempted to intervene and said, There. Now you two can gripe together!, and walked into Resident #54's room to obtain his/her tray table. The surveyor approached Resident #54. Resident #54's face was drawn and sad. Resident #54 looked at the surveyor and said, She's so mean. She's just so mean. She's always yelling at me. At that time one surveyor left the area to alert the Director of Nursing and Administrator, and one surveyor remained and observed OT #1 bring Resident #54 his/her table. OT #1 then aggressively and repeatedly told Resident #54 pick up your feet, pick up your feet! and then left the area. At no time during the observation did staff intervene, remove OT #1 from the area or check on Resident #54 while he/she was being yelled at in the hallway. During an interview on 5/14/24 at 12:24 P.M., the DON said that OT #1 had been suspended from the building. During an interview on 5/14/24 at 12:38 P.M., Resident #54 said that he/she was upset during and after being yelled at by OT #1 in the hallway. Resident #54 said he/she was embarrassed. Resident #54 said that OT #1 is always like that. She's so mean. I just want to be treated like a person. During interviews on 5/14/24 at 1:00 P.M., and 5/15/24 at 8:08 A.M. Nurse #1 said that OT #1's behavior was inappropriate and she should have intervened and said something during the observation. Nurse #1 said she would not want someone to speak to her the way OT #1 spoke to Resident #54. During an interview on 5/15/24 at 8:47 A.M., CNA #1 confirmed she just started at the facility this week. CNA #1 said she thought Nurse #1 was going to say something and intervene during the incident. During an interview on 5/14/24 at 2:18 P.M., the Social Worker said that staff should have intervened while observing the interaction between OT #1 and Resident #54.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36876 Based on record review and interview, the facility failed to report an allegation of neglect to the state agency as required for one Resident (#285) out of a total of 22 sampled residents. Findings include: Review of the facility's Abuse Prohibition policy, dated 2/20/23 indicated: The Administrator is responsible for ensuring that there has been notification [to] local law enforcement and the State Survey Agency within two hours of allegation after identification of alleged/suspected incident. All alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of an unknown source and misappropriation of resident property are reported immediately but not later than two hours after the allegation is made. Review of the grievance book included a grievance dated 6/13/23 which indicated that Resident #285's family member had found Resident #285 in his/her room not wearing oxygen (02). The grievance indicated that nurse staff then took Resident #285's 02 saturation level and he/she was at an Oxygen saturation of 81 percent. The family member documented on the grievance form this is neglect. Review of the facility's reporting history to the state agency failed to indicate the allegation of neglect was filed with he state agency regarding Resident #285's lack of needed oxygen. During an interview on 5/16/24 at 7:45 A.M., the Director of Nursing (DON) reviewed the grievance with the surveyor and said she recalled the incident. The DON said she wasn't sure if the incident was filed with the state agency.

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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** 43846 Based on record review, observations and interviews, the facility failed to ensure resident centered care plans were implemented for three Residents (#64, #182, #23) to ensure aspiration risk precautions were followed, out of a total sample of 22 residents. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs), dated December 2022, indicated To provide support, assistance, and encouragement to remain as independent as possible with activities of daily living, including hygiene, mobility, elimination, dining, and communication; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. A resident who is unable to carry out activities of daily living will receive the services to maintain good nutrition, grooming, and personal and oral hygiene. 1. Resident #64 was admitted to the facility in June 2023 with diagnoses including dysphagia, type 2 diabetes, and chronic obstructive pulmonary disease (COPD). Review of Resident #64's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. On 5/14/24 at 8:31 A.M., the surveyor observed Resident #64 in bed eating his/her breakfast, no staff were present in the room. On 5/14/24 from 11:53 A.M. to 12:01 P.M., the surveyor observed Resident #64 in the hallway eating his/her lunch tray. No staff were present supervising the Resident, staff were observed passing out other trays to other residents. The Residents' tray was noted to have ground meat and not pureed meat. On 5/15/24 at 8:11 A.M. to 8:20 A.M., the surveyor observed Resident #64 in the hallway eating his/her breakfast tray. No staff were present supervising the Resident, staff were observed passing out other trays to other residents. The Resident was observed to be using his/her hands trying to open his/her milk container and observed to cough and sneeze multiple times through out the meal. On 5/15/24 from 12:14 P.M. to 12:31 P.M., the surveyor observed Resident #64 in the hallway eating his/her lunch tray. No staff were present supervising the Resident, staff were observed passing out other trays to other residents. The Resident was observed to be coughing multiple times through out the meal. On 5/16/24 from 8:13 A.M. to 8:20 A.M., the surveyor observed Resident #64 in the hallway eating his/her breakfast tray. No staff were present supervising the Resident, staff were observed passing out other trays to other residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 12:26 P.M., the surveyor observed Resident #64 in the hallway eating his/her lunch tray. No staff were present supervising the Resident, staff were observed passing out other trays to other residents. Review of Resident #64's Speech Therapy Discharge Summary, dated 8/14/23, indicated Supervision: How often does the patient require supervision/assistance at mealtime d/t swallow safety? 91-100% of the time. Review of Resident #64's physician order, dated 6/21/23, indicated CCD diet, Pureed texture, Nectar consistency. Review of Resident #64's activity of daily living care plan, dated 3/4/24, indicated EATING: Resident requires Physical Assist/dependent. Review of Resident #64's aspiration risk care plan, revised 3/4/24, indicated encourage to clear throat/cough after every 2-3 bites/sips. Review of Resident #64's active Certified Nurse Aide (CNA) Care Card, indicated the Resident is an aspiration risk and is a total dependent (fed) for eating. During an interview on 5/15/24 at 9:25 A.M., the Day Shift Nursing Supervisor said the CNA care cards are active and should be up to date so the CNA's can care for each resident appropriately. If there is a major change therapy or nursing update it immediately. The Nursing Supervisor said that the CNA's should be following what the care card says for each resident. During an interview on 5/15/24 at 12:15 P.M., the Director of Rehab said therapy keeps care cards up to date when major changes are made like a diet or transfer status. During an interview on 5/16/24 at 8:30 A.M., the Speech Therapist said supervision means someone being close by to remind Resident #64 of clearing his/her throat and to take sips of fluids. The Speech Therapist said the Resident has specific interventions and is an aspiration risk. The Speech Therapist reviewed the speech discharge summary for Resident #64 and said he/she should be closely supervised by staff. During an interview on 5/16/24 at 8:57 A.M., CNA #1 said that she follows each resident's care card and if a resident should be supervised [NAME] a staff member should be with that resident. During an interview on 5/16/24 at 9:13 A.M., the Director of Nurses (DON) said she expects that if a Residents plan of care says they should be supervised she expects staff to be in close proximity to the resident they are supervising so they can monitor for aspiration or assist the resident as needed. 2. Resident #182 was admitted to the facility in May 2024 with diagnoses that included pneumonia, type 2 diabetes, and end stage renal disease requiring dialysis. On 5/14/24 at 8:35 A.M., the surveyor observed Resident #182 in bed alone with his/her breakfast. No staff were present in the room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 from 11:54 A.M. to 12:01 P.M., the surveyor observed Resident #182 in bed alone with his/her lunch. No staff were present in the room. On 5/16/24 from 8:36 A.M. to 8:40 A.M., the surveyor observed Resident #182 in bed alone with his/her breakfast. No staff were present in the room. On 5/16/24 at 12:27 P.M., the surveyor observed Resident #182 in bed alone with his/her lunch. No staff were present in the room. Review of Resident #182's physician order, dated 5/13/24, indicated the Resident needs to be out of bed and in a supervised area (for meals). Review of Resident #182's physician order, dated 5/14/24, indicated Renal diet, Regular texture, Nectar consistency. Review of Resident #182's active Certified Nurse Aide Care Care, indicated Diet: Regular, thin liquids. Review of Resident #182's nursing progress note, dated 5/14/24, indicated patient coughing with thin liquids, new order for nectar thick liquids, no straws and crush meds. Review of Resident #182's speech therapy evaluation and plan of treatment, dated 5/3/24, indicated Swallow Strategies: Upright with all PO (by mouth) and following 30 minutes, small bites and sips, supervision with meals. Review of Resident #182's speech therapy evaluation and plan of treatment, dated 5/14/24, indicated Patient and nsg (nursing) educated regarding recommendation for NTLs (nectar thick liquids), upright as tolerated with PO (by mouth), no straws. Education and training completed including but not limited to recommended diet change, supervision and positioning during meals and PO between meals. Review of Resident #182's nursing progress notes did not indicate that the resident refused staff to supervise him/her in his/her room. During an interview on 5/15/24 at 9:25 A.M., the Day Shift Nursing Supervisor said the CNA care cards are active and should be up to date so the CNA's can care for each resident appropriately. If there is a major change therapy or nursing update it immediately. The Nursing Supervisor said that the CNA's should be following what the care card says for each resident. During an interview on 5/16/24 at 8:43 A.M., the Speech Therapist said the Resident should be out of bed and closely supervised by a staff member. The Speech Therapist said the Resident is an aspiration risk and at risk for pneumonia. The Speech Therapist said Resident #182 does not refuse to be supervised. During an interview on 5/16/24 at 8:57 A.M., CNA #1 said that she follows each resident's care card and if a resident should be supervised then a staff member should be with that resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/24 at 9:13 A.M., the Director of Nurses (DON) said she expects that if a Residents plan of care says they should be supervised she expects staff to be in close proximity to the resident they are supervising so they can monitor for aspiration or assist the resident as needed. 50338 3.Resident #23 was admitted to the facility in 04/21 with diagnoses including cerebrovascular accident (CVA) or a brain attack, is an interruption in the flow of blood to cells in the brain, also known as a stroke with left hemiparesis, paralysis that affects only one side of your body and can result from a CVA. Review of the Minimum Data Set (MDS) dated [DATE] and Brief Interview for Mental Status (BIMS) assessment, indicated Resident #23 scored 6 out of a possible 15, indicating severe cognitive impairment. Further review indicated Resident #23 required moderate assist with eating. During an observation on 5/14/24 at 8:30 A.M., the surveyor observed resident sitting up in bed, being fed by a Certified Nursing Assistant (CNA). The meal was pureed with nectar thick liquids. The nectar thick liquid was being provided via a cup. During an observation on 5/14/24 at 12:42 P.M., the surveyor observed Resident #23 sitting up in bed eating with set up and supervision. The Resident was drinking thick liquids from a cup. During an observation on 5/15/24 at 1:27 P.M., the surveyor observed a CNA providing nectar thick milk to resident via a straw. Resident was observed coughing after drinking. During an observation on 5/16/24 at 8:42 A.M., CNA #2 was feeding resident breakfast. The CNA was alternating bites of puree food with sips of nectar milk from cup. Resident #23 had 2 episodes of coughing during the meal. Review of dietary communication sheet dated 2/12/24 indicated nectar thick liquids via spoon. Review of Resident #23's speech therapy (ST) discharge summary recommendation dated 9/8/23 indicated, to facilitate safety and efficiency, it is recommended that the patient use the following strategies during oral intake: - one bite at a time and swallow, small bites/sips, no straws, take a sip after every 2 bites -alteration of liquids/solids -lingual sweep, an oral motor exercise that involves moving the tongue between the cheek and teeth, and up and down, to clear the oral cavity with written and verbal cues and general swallow techniques/precautions Review of Resident #23's speech therapy discharge summary recommendation dated 4/19/24 indicated nectar thick liquids via spoon only. (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 the Fiberoptic Endoscopic Evaluation of Swallowing (FEES) test, a procedure that assesses how well someone swallows, results dated 8/17/23 indicated the following: -reflux finding score total score=9. The score is considered: higher than typical score; of concern for Laryngopharyngeal Reflux (LPR) or silent reflux which is when stomach contents reflux into the esophagus. Recommendation for feeding: upright during and after meal, elevate head of bed at non-feeding times, liquids by spoon only, assist with meals. Review of Resident #23's aspiration care plan indicated the following intervention: -No straws. Review of Resident #23's physician orders indicated the following: -pureed texture, nectar consistency, nectar thick liquids via spoon, add sauces and gravy to all puree meat. During an interview on 5/15/24 at 1:27 P.M., CNA #3 was asked if she knew of any dietary/feeding adaptations that are needed to ensure this Resident's safe swallowing. CNA #3 stated that Resident had pureed and thickened liquids. She stated that she learns what is required to provide care to a resident by asking other CNA's and nurses and by reviewing the care card (a form indicating the level of assistance required). CNA #3 confirmed Resident #23 was coughing during meal. During an interview on 5/16/24 at 8:42 A.M., CNA #2 said that Resident's precautions for eating include lip plate, built up utensils, puree and nectar thick liquid alternating with 2 bites of food. CNA #2 stated the dietician or nurse will communicate any changes in diets and that there is a communication at desk from SLP to sign off that received the education. During an interview on 5/15/24 at 1:36 P.M., Nurse #3 states resident's diet is puree, nectar thick and needs extra gravy/sauce if food is dry. Nurse #3 said she is not aware of any restrictions or needs. Nurse #3 said if a change is made to a resident's diet or specific recommendations are made by the speech therapist, a communication slip is brought to the unit and the nurse enters the order and updates CNA's and the care plan. During an interview on 5/15/24 at 1:47 P.M., the Nursing Supervisor states Resident #13's's diet needs are pureed texture, thickened liquids, lip plate, right sided angled and built-up utensils. The nursing Supervisor said Resident #13 can feed him/herself 50% of the time and the other 50% he/she needs to be fed. The nursing Supervisor said a communication slip is placed in the chart and a copy to kitchen for any diet change or adaptive equipment. Changes are put in care card binder for CNAs to learn of any changes. The Nursing Supervisor said all recommendations from the speech therapist should be followed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/24 at 8:35 A.M., the Speech Therapist said when a recommendation is made, a diet communication form goes to the kitchen, it is signed by someone in kitchen, a photocopy is made to keep in the chart, and a second copy is kept for therapy. The Speech Therapist said when a resident is receiving speech therapy or is being discharged from SLP services, the staff is educated via an in-service sheet or verbally. The Speech Therapist said she would expect aspiration precautions to be followed because the risk of not being followed would be detrimental (aspiration). She said she would expect aspiration precautions to be always followed, as even one time not being followed has potential for aspiration. The Speech Therapist said Resident #23 had completed a FEES exam and in the past and the test showed resident was at significant risk for aspiration. The Speech Therapist said she discharged Resident #23 from services with recommendations for nectar liquids via spoon and part of education when discharged was that spoon was safest way to provide thickened liquids, always by spoon, never by straw as high risk for aspiration. The Speech Therapist has noticed inconsistency with staff following aspiration precautions in the 2 months since she has been at facility. During an interview on 5/16/24 at 10:31 A.M., the Director of Nursing (DON) said when a resident is discharged from speech therapy, the resident is followed at the weekly at-risk meeting and daily at morning meetings. The DON said the restorative aide checks diets ad does audits regularly. The DON said the risk for not following aspiration precautions is aspiration pneumonia and aspiration precautions should be always followed because even one time of not following the precautions can put resident at risk. w

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review, policy review and interviews, the facility failed to provide showers for one Resident (#62) out of a total sample of 22 residents. Findings include: Review of the facility policy titled, Activities of Daily Living, dated 12/22/21, indicated the following: -the resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #62 was admitted to the facility in January 2024 with diagnoses including heart failure. Review of Resident #62's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15, which indicated Resident #62 had moderate cognitive impairment. The MDS also indicated Resident #63 required substantial assistance from staff for bathing tasks. During an interview on 5/14/24 at 7:44 A.M., Resident #62 said he/she had not received a shower in a long time and would like one. Resident #63 said he/she used to have regular shower but now just gets washed in bed. Review of Resident #63's decline in function care plan last revised, 4/18/24, indicated: -Assist with bathing, dressing tasks but encouraged to participate. The care plan failed to indicate Resident #63 refuses showers. Review of the Certified Nursing (CNA) documentation indicated Resident #63 was last provided with a shower on 4/5/24, 40 days ago. The documentation failed to indicate the Resident refused a shower. During an interview on 5/15/24 at 12:35 P.M., Nurse #3 said Resident #62 does not refuse activities of daily living care. During an interview on 5/15/24 at 12:38 P.M., CNA said all residents are scheduled to receive at least one shower a week. CNA #2 said she knows Resident #63 well and the Resident does not refuse care. CNA #2 said she does not know the last time the Resident received a shower. During an interview on 5/15/24 at 1:51 P.M., the Director of Nursing (DON) said all residents are scheduled to receive a shower at least once a week. The DON said the facility has been auditing the shower schedule because getting showers for people and determining from documentation when they last had a shower has been an issue at the facility. The DON reviewed the CNA documentation for Resident #62 with the surveyor and conformed the Resident's last shower was on 4/5/24.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45984 Based on observation, record review and interview, the facility failed to provide vision services as requested for one Resident (#60) out of a total sample of 22 residents. Specifically, the facility failed to follow up with the Resident's and physician's request to schedule an appointment for glasses for Resident #60. Findings include: Review of the facility policy titled Vision and Hearing, dated and revised 12/21/21, indicated the following: - The facility will provide from an outside source ophthalmology and audiology services to meet the needs of the residents. - The facility will, if necessary or requested, assist the resident with: making appointments, arranging transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision of hearing assistive devices. - Assistive devices to maintain vision include, but are not limited to, glasses During an interview on 5/14/24 at 7:49 A.M., Resident #60 told the surveyor that he/she cannot see and he/she needs glasses. During an interview on 5/15/24 at 8:54 A.M., Resident #60 told the surveyor that he/she cannot see and it is hard to see. During an observation on 5/16/24 at 8:48 A.M., Resident #60 was speaking to another resident saying that he/she needs glasses and he/she was gesturing towards his/her eyes. Review of Resident #60's physician's order dated 6/5/23 indicated the following: - podiatry, audiology, dental, ophthalmology consults as needed. Review of Resident #60's comprehensive eye exam dated 1/8/24 indicated the following: - Plan: Monitor; order eyeglasses if pt. (patient) requests Review of Resident #60's physician's visit documentation dated 3/26/24 indicated the following: - The patient has also stated in the recent past that he/she would like to see an eye doctor. This has been related [sic] to the nursing staff. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 8:48 A.M., the Nursing Supervisor said if a resident requests to be seen by the eye doctor they will be put on the list to be seen. The Nursing Supervisor reviewed the upcoming schedule for the eye doctor and Resident #60 was not on the list to be seen. The Nursing Supervisor and the surveyor reviewed the previous eye doctor visit notes and physician's notes and she said that Resident #60 should have been seen or scheduled to be seen by the eye doctor. During an interview on 5/16/24 at 10:27 A.M., the Director of Nursing (DON) said Resident #60 should have been seen or scheduled to be seen by the eye doctor. The DON said that nursing staff was not notified by the doctor of Resident #60's request to be seen and it was missed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on record review, observations, and interviews, the facility failed to ensure that a resident admitted with an indwelling catheter is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates continued catheter use is necessary for one Resident (#23) in a total sample of 22 residents. Findings include: Review of the facility policy which is according to the Resident Assessment Instrument (RAI), indicated the following: -Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding. Resident # 23 was admitted to the facility in 04/18/2021 with diagnoses including left hemiparesis and readmitted after hospitalization in 01/26/2024 with diagnoses including acute kidney injury and urinary retention. Review of the Minimum Data Set (MDS) assessment dated [DATE] and Brief Interview for Mental Status (BIMS) indicated Resident #23 scored 6 out of a possible 15, indicating severe cognitive impairment. Further review indicated Resident #23 required an indwelling catheter. Review of the Physician's order dated 01/26/2024 indicated: Foley catheter #16 with 10 ml balloon due to urinary retention. Review of resident's care plan dated 01/31/2024 indicated: Has an Indwelling Foley Catheter for urinary retention. Review of the resident's medical history and diagnosis lists failed to indicate a diagnosis that indicates the continued need/use of a catheter. Review of Resident #23's record indicated that he/she was hospitalized from 1/21/24-1/26/24. The hospital paperwork indicated the following: -the Resident had catheter inserted due to urinary retention. -the hospital recommended a voiding trial to possible remove the catheter. Further review of Resident #23's medical record failed to indicate a voiding trial was completed at the facility. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/2024 at 10:41 A.M., the Director of Nursing said the reason for having an indwelling foley catheter would be an approved diagnoses of neurogenic bladder or obstructive uropathy. The DON stated she was aware the Resident did not have a required diagnosis for the long-term use of a catheter. A resident that has an indwelling catheter without an approved diagnoses should have a voiding trial.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review, and interview, the facility failed to address the nutritional status in a timely manner for one Resident (#19) out of a total sample of 22 residents. Specifically, the facility failed to address a significant weight loss in a timely manner for Resident #19. Findings include: Review of the facility policy titled Weight Monitoring, revised and dated 12/22/21, indicated the following: - Any weight change of 5% or more since the last weight assessment will be retaken within 24 hours for confirmation. If the weight is verified, nursing will notify the Dietitian, Physician and the resident/responsible party. - The Dietitian will review the weights monthly to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. The plan of care will be updated as needed. - The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month - 5% weight loss is significant. b. 3 months - 7.5% weight loss is significant. c. 6 months - 10% weight loss is significant. Resident #19 was admitted to the facility in July 2022 with diagnoses including Parkinsonism, hyperlipidemia and anxiety disorder. Review of Resident #19 most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 5 out of a possible 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident requires assistance with activities of daily living. Review of Resident #19's weight log indicated the following: - 1/5/24: 125.7 lbs. (pounds) - 2/7/24: 116 lbs. - 2/8/24: 115.9 lbs. - 2/9/24: 115 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/16/24: 115.7 lbs. - 2/26/24: 113 lbs. - 3/8/24: 113 lbs. - 3/15/24: 114.8 lbs. - 3/20/24: 112.1 lbs. - 3/29/24: 115.6 lbs. - 4/5/24: 113.1 lbs. - 4/5/24: 113.1 lbs. - 5/3/24: 110 lbs. - 5/6/24: 112 lbs. From 1/5/24 to 2/7/24, Resident #19 had a significant weight loss of 7.72%. From 2/7/24 onwards, Resident #19's weight remained less than 116 lbs. Review of Resident #19's physician's order dated 1/25/24 indicated the following: - Record monthly weight every day shift starting on the 5th and ending on the 5th every month. Review of Resident #19's Nutrition risk care plan, dated and revised 4/10/24 indicated the following interventions: - Notify RD (Registered Dietitian), Physician and family of significant weight change. Review of Resident #19's comprehensive Nutrition assessment dated [DATE] indicated the following: - Nutrition Goal: Maintain weight - Additional comments: Resident #19 is flagging for 11.2% significant weight loss since 11/3/23 when he/she weighed 127.3 lbs. Rec (Recommend) adding 237 mL (milliliter) Ensure (a nutrition supplement) daily to better meet nutrition needs. Will continue to monitor. Care plan reviewed and updated. Review of Resident #19's physician's order dated 4/11/24 indicted the following: - Ensure supplement: one time a day Resident #19's documented significant weight loss was not addressed until the Nutrition Assessment on 4/10/24, over two months since the significant weight loss was documented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/24 at 8:20 A.M., the Nursing Supervisor and the surveyor reviewed Resident #19's weights and she said the Resident has had some weight loss and has not gained any weight back. During an interview on 5/16/24 at 9:31 A.M., the Registered Dietitian (RD) said she started working in the facility in late March and works in the facility two days each week. The RD said the nursing aides take the residents' weights and once documented in the medical record she will review the weights for any significant weight changes. The RD said a significant weight loss is a loss of 5% in one month, 7.5% in 3 months and 10% in six months. The RD said if a significant weight loss is identified, a reweigh will occur to check accuracy, once confirmed, she will speak with the resident and interdisciplinary team and assess the resident. She would then recommend interventions for significant weight loss. The RD said she is continuing to catch up with all the residents' nutritional status as she just started the position. When asked about Resident #19's significant weight loss, she said he/she should have been assessed sooner than the 4/10/24 assessment so interventions could have been started sooner to combat the weight loss.

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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** 45984 Based on observations, record review and interview, the facility failed to provide respiratory care services in accordance with professional standards of practice one Resident (#8) out of a total sample of 22 residents. Specifically, the facility failed to follow Resident #8's physician's orders to implement the correct oxygen flow rate and ensure the external filter was clean. Findings include: Review of the facility policy titled Equipment Change/Disinfection, undated, indicated the following: - Oxygen Concentrators: Rinse and dry the external filter weekly and PRN (as needed) when visibly dusty. Resident #8 was admitted to the facility in March 2023 with diagnoses including chronic heart failure, type 2 diabetes mellitus and pneumonia. Review of Resident #8's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 13 out of a possible 15 indicating intact cognition. Further review of the MDS indicated that Resident #8 requires assistance with all activities of daily living and requires supplement oxygen. The surveyor made the following observations during survey: - On 5/14/24 at 8:03 A.M. and 12:41 P.M., Resident #8 was sleeping in bed receiving oxygen via nasal cannula at 1.5 Liters (L). The external filter on the back of the machine was covered in white dust. - On 5/15/24 at 7:04 A.M., Resident #8 was sleeping in bed receiving oxygen via nasal cannula at 1.5L. The external filter on the back of the machine was covered in white dust. - On 5/16/24 at 7:06 A.M., Resident #8 was sleeping in bed receiving oxygen via nasal cannula at 1.5L. The external filter on the back of the machine was covered in white dust. Review of Resident #8's physician's orders indicated the following: - Dated 4/12/24: Clean O2 (oxygen) concentrator filter and sponges every Tues and Fr 11-7 - Dated 4/30/24: O2 at 3L via N/C (nasal cannula to maintain sats (saturation) >90%. Review of Resident #8's care plan or pneumonia care dated 5/6/24 indicated the following intervention: - O2 as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's care plan for bouts of shortness of breath dated 3/7/24 indicated the following intervention: - Resident can have O2 at 2L via n/c to maintain O2 sats >90% due to shortness of breath. Review of a nursing progress note dated 4/29/23 at 11:07 P.M., indicated the following: - O2 bump up to 3L. During an interview on 5/16/24 at 8:20 A.M., the Nursing Supervisor said when a resident is on oxygen, there are physician's orders stating the flow rate and for the external filter to be cleaned at least weekly. The Nursing Supervisor and the surveyor reviewed Resident #8's physician's orders and the Nursing Supervisor said his/her oxygen flow rate should be at 3 liters and the external filter should be changed on Tuesdays and Fridays. The Nursing Supervisor and the surveyor then observed Resident #8's oxygen concentrator, it was set to 1.5 L and the external filter was visibly covered in white dust. The Nursing Supervisor said the oxygen flow rate was incorrect and she corrected it, she then said the filter was very dirty and proceeded to clean it. The Nursing Supervisor said the night nursing staff should be cleaning the filter. During an interview on 5/16/24 at 10:27 A.M., the Director of Nursing said physician's orders should be followed for oxygen flow rate and for cleaning the external filter.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43846 Based on observation, policy review, and interview, the facility failed to ensure treatment carts on two of two units were locked and secured while not in use. Findings include: Review of the facility policy titled, Storage of Medications, not dated, indicated the following: -Medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only to licensed nursing staff is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. On 5/14/24 from 7:35 A.M. to 8:06 A.M., the surveyor observed the the Left Unit treatment cart unlocked and unsupervised in the hallway. On 5/15/24 at 7:52 A.M., the surveyor observed the the Left Unit treatment cart unlocked and unsupervised in the hallway. On 5/15/24 at 8:08 A.M., the surveyor observed the the Right Unit treatment cart unlocked and unsupervised in the hallway. During an interview on 5/16/24 at 9:11 A.M., Nurse #4 said the expectation is that the treatment carts are always locked unless a nurse is present at the cart. During an interview on 5/16/24 at 9:14 A.M., the Director of Nurses said she expects that treatment carts to be locked unless a nurse is present at the cart.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45984 Based on observations, interviews, resident group meeting, and test tray results, the facility failed to ensure foods provided to residents were prepared by methods that conserve nutritional value, flavor, were palatable and at appetizing temperatures on 2 out of 2 units. Findings include: During the screening portion of the survey, numerous residents expressed concerns about poor food quality, palatability, and temperature. During the resident group meeting on 5/15/24 at 11:00 A.M., 8 out of 8 participating residents said that they did not like the food being served at the facility. Residents described the food as gross or disgusting. Review of the grievances book included two resident grievances regarding the quality of the food, food delivery and accurate meal orders. On 5/15/24 at 1:01 P.M., the left-wing unit food truck arrived. At 1:11 P.M., all resident trays were served, and the surveyors received test trays. The following results were recorded: 1a) -Pureed Chicken: 131 degrees Fahrenheit, no flavor, very bland. Warm to taste, not hot. - Pureed Vegetables: 132 degrees Fahrenheit, no flavor, very bland. Warm to taste, not hot. - Mashed potatoes: 136 degrees Fahrenheit, no flavor, very bland. Warm to taste, not hot. - Milk: 50 degrees Fahrenheit. Slightly warm, not cold to taste. - Coffee: 148 degrees Fahrenheit, no concerns. - Pureed fruit: 60 degrees Fahrenheit, cool, not cold to taste. 1b) - Macaroni and Cheese: 115 degrees Fahrenheit, cool to taste. No flavor, very bland and mushy. - Mixed vegetables: 114 degrees Fahrenheit. Cool to taste, mushy consistency, and no flavor. - Pineapple: 60 degrees Fahrenheit, had a canned, metallic taste. - Dinner Roll: 110 degrees Fahrenheit, no concerns. - Juice: 60 degrees Fahrenheit, slightly warm to taste. 1c) - Baked Chicken: 125 degrees Fahrenheit. Cool, not hot to taste. - Mashed Potatoes: 130 degrees Fahrenheit, warm, not hot to taste. No flavor, very bland. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Mixed Vegetables: 130 degrees Fahrenheit. Warm, not hot to taste. Mushy, no flavor. - Pineapple: 65 degrees Fahrenheit, slightly warm, not cold to taste. - Milk: 50 degrees Fahrenheit. Cool, not cold to taste. On 5/15/24 at 12:52 P.M., the left-wing unit food truck arrived. At 1:02 P.M., all resident trays were served, and the surveyor received a test tray. The following results were recorded: - Macaroni and Cheese: No flavor, very bland and mushy. During an interview on 5/16/24 at 8:09 A.M., the Activity Director said that residents report concerns about the food regularly during resident council meetings. During an interview on 5/16/23 at 8:30 A.M., the Nursing Supervisor said she has heard residents complaining about the poor quality and temperature of the food often. During an interview on 5/16/24 at 9:10 A.M., the Foodservice Director said she is aware that residents have been complaining about the food quality and temperature. During an interview on 5/16/24 at 10:27 A.M., the Director of Nursing (DON) said she knows the food is not good and they are trying to make it more palatable for the residents.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, interviews and record review, the facility failed to provide food in a form to meet the needs of three Resident (#64, #13, and #23) out of a sample of 22 residents. Specifically, for Residents #64 and #24, the facility to provide the correct diet texture during meals. For Resident #13, the facility failed to provide the correct diet during meals and failed to prevent the Resident from consuming food that was of a texture not ordered by the physician. Findings include: 1. Resident #64 was admitted to the facility in June 2023 with diagnoses including dysphagia, type 2 diabetes, and COPD chronic obstructive pulmonary disease. Review of Resident #64's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. On 5/14/24 from 11:53 A.M. to 12:01 P.M., the surveyor observed Resident #64 in the hallway with his/her lunch tray. The Residents' tray was observed to have ground meat and not pureed meat. Review of Resident #64's physician order, dated 6/21/23, indicated Pureed texture, Nectar consistency. Review of Resident #64's aspiration risk care plan, revised 3/4/24, indicated encourage to clear throat/cough after every 2-3 bites/sips. The surveyors obtained a sample of the pureed lunch meat served that day. During an interview on 5/14/24 at 1:01 P.M., the Nursing Supervisor observed the pureed meat and said it looked like ground meat and that it was not moist enough to be pureed texture. The Nursing Supervisor said this has been an issue at times at the facility. During an interview at 5/14/24 at 1:21 P.M., the Speech Therapist observed the pureed meat and said it looked like it was ground consistency. The Speech Therapist said the meat would need to be smoother and have more moisture to be pureed. During an interview on 5/14/24 at 1:24 P.M., the Director of Nursing (DON) observed the pureed meat and said it looked like ground meat. The DON said the meat would need to be smoother and have more moisture to be pureed. 50338 (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #23 was admitted to the facility in 04/21 with diagnoses including cerebrovascular accident (CVA) or a brain attack, is an interruption in the flow of blood to cells in the brain, also known as a stroke with left hemiparesis, paralysis that affects only one side of your body and can result from a CVA. Review of the Minimum Data Set (MDS) dated [DATE] and Brief Interview for Mental Status (BIMS) assessment, indicated Resident #23 scored 6 out of a possible 15, indicating severe cognitive impairment. Further review indicated Resident #23 required moderate assist with eating. During an observation on 5/14/24 at 12:42 P.M. the surveyor observed Resident #23 sitting up in bed, being fed by a CNA. The Residents' tray was observed to have ground meat and not pureed meat. There was no gravy on the meat. Review of Resident #23's physician orders indicated the following order: - Pureed texture, nectar consistency, nectar thick liquids via spoon, add sauces and gravy to all puree meat, initiated on 2/12/24. The surveyors obtained a sample of the pureed lunch meat served that day. During an interview on 5/14/24 at 1:01 P.M., the Nursing Supervisor observed the pureed meat and said it looked like ground meat and that it was not moist enough to be pureed texture. The Nursing Supervisor said this has been an issue at times at the facility. During an interview at 5/14/24 at 1:21 P.M., the Speech Therapist observed the pureed meat and said it looked like it was ground consistency. The Speech Therapist said the meat would need to be smoother and have more moisture to be pureed. During an interview on 5/14/24 at 1:24 P.M., the Director of Nursing (DON) observed the pureed meat and said it looked like ground meat. The DON said the meat would need to be smoother and have more moisture to be pureed. 41456 3. Resident #13 was admitted to the facility in December 2021 with diagnoses including dementia, diabetes, heart failure and pulmonary disease. Review of Resident #13's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15, which indicated the Resident had moderate cognitive impairment. The MDS also indicated the Resident is dependent on staff for all functional daily tasks. Review of Resident #13's physician order initiated on 12/22/23 indicated the following: -NAS (no added salt) diet, pureed texture, thin liquids consistency. Review of Resident #13's nutritional care plan last revised 3/20/24, indicated the following: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide meals per physician diet orders. a.) On 5/14/23 at 12:40 P.M., Resident #13 was served lunch. The lunch tray was observed to have ground meat on the tray without any gravy on the meal. The surveyors obtained a sample of the pureed lunch meat served that day. During an interview on 5/14/24 at 1:01 P.M., the Nursing Supervisor observed the pureed meat and said it looked like ground meat and that it was not moist enough to be pureed texture. The Nursing Supervisor said this has been an issue at times at the facility. During an interview at 5/14/24 at 1:21 P.M., the Speech Therapist observed the pureed meat and said it looked like it was ground consistency. The Speech Therapist said the meat would need to be smoother and have more moisture to be pureed. During an interview on 5/14/24 at 1:24 P.M., the Director of Nursing (DON) observed the pureed meat and said it looked like ground meat. The DON said the meat would need to be smoother and have more moisture to be pureed. b.) Review of the facility policy titled, Family/Visitor Provided Food, dated 4/29/20, indicated the following: -Licensed nurse in charge, or nursing supervisor of the facility of the resident's unit will be notified by the visitor that they have brought their family member friend food or beverage. Nurse in charge or nursing supervisor will verify the resident's texture and restrictions. Throughout all days of survey, Resident #13 was observed lying in bed with several food items on his/her bedside table and in bags next to the bed that he/she could reach independently. The Resident was observed eating Oreo cookies, hard mints, and Cheez-it crackers. Review of Resident #13's medical record failed to indicate the Resident and/or his/her family was educated regarding the risks of eating foods not in pureed texture. During an interview on 5/15/24 at 8:16 A.M., the Nursing Supervisor said the Resident is prescribed a pureed food diet. The Nursing Supervisor said the Resident's family brings in food and that it does not meet the requirements of a pureed diet. The Nursing Supervisor said she is unaware if education had been provided to the Resident and/or his family regarding the risks of eating foods not in pureed texture. The Nursing Supervisor said a physician order also needs to be in place if a Resident chooses to consume food not in the texture ordered by the physician. During an interview on 5/15/24 at 8:38 A.M., the Director of Rehabilitation (DOR) said she was unaware Resident #13 had had food that is not allowed with his/her diet in his/her room. The DOR said the speech therapist would typically be told about that and would get involved to see if diet can be increased and if it is safe for the Resident to eat that texture of food. The DOR said Resident #13 had not had a speech therapy evaluation. During an interview on 5/15/24 at 8:58 A.M., the Director of Nursing said food in a resident's room should be in the texture of the physician order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation and interview the facility failed to properly store food items and properly follow sanitation and food handling practices to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Findings include: Review of the facility policy titled Food Receiving and Storage, undated, indicated the following: - Foods shall be received and stored in a manner that complies with safe food handling practices. - Food Services, or other designated staff, will maintain clean food storage areas at all times. - All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) The surveyor made the following observations in the walk-in refrigerator during the initial walk-through of the kitchen on [DATE] at 7:10 A.M.: - A pan containing raw chicken was observed covered in plastic wrap with the date [DATE] written. The chicken was observed to be covered in slimy, pink juices. - A pan containing a cooked meat product covered with aluminum foil. There was no date or label identifying what the product was. - A sheet pan containing cooked bacon covered with plastic wrap with two dates written on it, [DATE] and [DATE]. - A pan of pasta salad covered with plastic wrap with the date [DATE] written on it. - A box of raw mushrooms containing multiple mushrooms that were covered in brown, soft spots resembling decay. During the follow-up visit to the kitchen on [DATE] at 11:25 A.M., the surveyor observed the following on the tray line: - At 11:30 A.M., the diet aide left the tray line and was observed putting on new gloves without washing her hands before returning to the tray line. - At 11:34 A.M., a diet aide began preparing soup broth on a counter beside the tray line. She changed her gloves afterwards without washing her hands and returned to the tray line. - At 11:35 A.M., a diet aide entered the kitchen holding two drinking cups with bare hands. The diet aide was observed opening the ice machine and scooping ice directly into the cups while holding them with bare hands. Hand hygiene was not performed prior to this. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 11:38 A.M., a diet aide was observed bringing over a food truck to the tray line. She then put on gloves without washing her hands. - From 11:25 A.M. through 11:40 A.M., the cook was observed grabbing dinner rolls directly with her gloved hands. The cook then asked a diet aide to bring her tongs. The aide grabbed the tongs by the part that touches the food with her bare hands and handed it to the cook. The cook then put the tongue in the pan containing the dinner rolls. During an interview on [DATE] at 9:10 A.M., the Foodservice Director (FSD) said staff should wash their hands before putting on gloves and staff should not be directly touching food with their hands, they should be using utensils. The FSD continued to say all food stored in the walk-in refrigerator should be labeled with an identifier and when it was put in the walk-in. The FSD said after three days of the written date the food needs to either be used or discarded. The FSD reviewed the surveyor's photos of the expired food and she said they should have been thrown away.

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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** 41456 Based on record review and interview, the facility failed to accurately document one Resident's (#2) skin assessment out of a total sample of 22 residents. Findings include: Resident #2 was admitted to the facility in June 2021 with diagnoses including multiple sclerosis. Review of Resident #2's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, which indicated the Resident was cognitively intact. Review of the wound documentation dated 5/7/24 and 5/14/24 indicated Resident #2 had a stage 2 pressure wound to his/her right buttock, which first appeared on 5/5/24. Review of Resident #2's skin assessment dated [DATE] failed to indicate a right buttock pressure wound. During an interview on 5/16/24 at 8:41 A.M., Nurse #4 said all residents receive a skin assessment weekly and all skin issues are documented on those assessments regardless of the wound doctor documentation. During an interview on 5/16/24 at 8:51 A.M the Nursing Supervisor said skin assessments are completed weekly and should include any and all skin concerns. The Nursing Supervisor said if all skin issues are not documented on the assessment, the assessment would be inaccurate.