STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225491	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shrewsbury Rehabilitation and Nursing at Southgate	40 Julio Drive Shrewsbury, MA 01545

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 51571 Based on record review and interview, the facility failed to complete an accurate comprehensive assessment, according to the required Resident Assessment Instrument (RAI) process in the Minimum Data Set Assessment (MDS), for one Resident (#6) out of a total sample of 18 residents. Specifically, the facility staff failed to assess Resident #6's cognitive and mood status through the required Resident interview process when the Resident had adequate hearing, clear speech, and sometimes made him/herself understood and sometimes understood others. Findings include: Review of the Centers for Medicare and Medicare Services (CMS) Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11, dated October 2023, included the following: -Assessment Reference Date (ARD) refers to the specific endpoint for the observation (or look-back) periods in the comprehensive Minimum Data Set (MDS) assessment process. - The standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated. - The interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. - Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood. - If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard no information code (a dash -) entered in the resident interview items. - Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted but was not done. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 was admitted to the facility in October 2024, with diagnoses including Dementia (progressive disease with impairment in memory and functioning) with Agitation (a condition in which a person is unable to relax and be still. The person may be very tense and irritable, and become easily annoyed by small things), Anxiety Disorder (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), and Hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there). Review of the Resident #6 Admission Nursing Progress Note dated 10/8/24, indicated the following: - Resident was cooperative - BIMS interview Score 0 out of a total possible 15 - BIMS interview category: severe impairment Review of Resident #6's comprehensive Minimum Data Set (MDS) Assessment, dated 10/14/24, indicated the following: - The Resident had adequate hearing. - The Resident had clear speech. - The Resident could sometimes make him/herself understood. - The Resident could sometimes understand others. - The Brief Interview for Mental Status (BIMS) should be attempted with all residents. - The BIMS was not assessed. - The Mood interview should be attempted with all residents. - The Resident's mood was not assessed. During an interview on 11/27/24 at 7:51 A.M., the MDS Nurse said that nursing staff on the floor are not trained to assess BIMS upon admission for Residents and said that the Social Worker was responsible for assessing Residents' BIMS upon admission. The MDS Nurse also said that if BIMS assessment were not completed within the time frame allowed during the assessment reference period which is 14 calendar days by CMS, then he had to indicate that the BIMS was not assessed. The MDS Nurse said that BIMS should have been assessed when Resident #6 was admitted to the facility in October 2024 and on the comprehensive MDS assessment. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/27/24 at 9:05 A.M., Nurse #3 said that Nurses on the floor are not trained to assess a Resident's BIMS. Nurse # 3 also said that BIMS assessment opened as part of the Nursing Admission Assessment in Point Click Care (PCC, a cloud based healthcare software platform that offers electronic health records and other solutions for a variety of healthcare settings) but the Nurses were not trained to complete the BIMS with residents and that the Social Workers was responsible for the BIMS. Nurse #3 further said that Social Workers are responsible for assessing Resident's BIMS the following day after Resident's are admitted to the facility. Nurse #3 reviewed the clinical records with the surveyor which indicated Resident #6's BIMS was not assessed in October 2024, when the Resident was admitted . During an interview on 11/27/24 at 11:30 A.M., the Director of Nursing (DON) said that BIMS and Mood assessments were completed for Resident #6 after the comprehensive assessment ARD date, so the BIMS and Mood scores were not included on the comprehensive assessment.

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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** 42761 Based on interview and records reviewed, the facility failed to accurately complete the Minimum Data Set (MDS) Assessment for one Resident (#83) out of a total sample of 18 residents. Specifically, facility staff failed to accurately code the use of antianxiety (used to treat symptoms of anxiety [feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome] medication on one MDS Assessment for Resident #83. Findings include: Resident #83 was admitted to the facility in June 2024 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 Resident #83's active Physician Orders indicated the following order dated 11/12/24: - Ativan (antianxiety medication) oral tablet 0.5 milligrams (mg). - Give 0.5 mg by mouth every eight hours as needed for Anxiety/Agitation for 180 days. Review of Resident #83's MDS Assessment, dated 11/8/24, indicated the Resident received antianxiety medication during the MDS Assessment observation period (11/2/24-11/8/24). Review of Resident #83's November 2024 Medication Administration Record did not indicate any Ativan was administered to resident #83 during the observation period for the Resident's MDS assessment dated [DATE]. During an interview on 11/22/24 at 2:20 P.M., the MDS Nurse said that Resident #83 did not receive any antianxiety medication during the observation period for the MDS assessment dated [DATE] and that antianxiety medication should not have been coded on the MDS Assessment as having been taken during the observation period. The MDS Nurse further said that coding use of antianxiety medication on Resident #83's MDS Assessment, dated 11/8/24, was a coding error.

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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 0646 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. 42761 Based on interviews and records reviewed, the facility failed to notify the State mental health authority promptly after a significant change in the mental condition for resident review for one Resident (#83) out of 18 total sampled residents which increased the Resident's risk for not receiving specialized services in a timely manner. Specifically, facility staff failed to notify the State mental health authority of the need for resident review when: - Resident #83 exhibited a new onset of paranoia (unwarranted or delusional belief that one is being persecuted, harassed, or betrayed by others, occurring as part of a mental condition), delusions (unshakable belief in something that is untrue; type of psychotic disorder [collection of symptoms that affect the mind, where there has been some loss of contact with reality]), and visual hallucinations (experience involving the apparent perception of something not present). - Resident #83 had newly added diagnoses of: Delusional Disorders, Paranoid Personality Disorder, and Psychotic Disorder with Delusions. - Resident #83 required treatment with an antipsychotic medication, when the Resident had not previously required antipsychotic medications use. Findings include: Resident #83 was admitted to the facility in June 2024 with a diagnosis of Dementia with Behavioral Disturbance. Review of Resident #83's Preadmission Screening and Resident Review (PASRR) Level One Screening, dated 6/13/24, indicated the following: - The Resident had not been diagnosed with Delusional Disorder, Paranoia, or Other Psychotic Disorder. - The Resident's screen for Serious Mental Illness (SMI) was negative. - A Level Two PASRR Evaluation was not indicated. Review of Resident #83's Minimum Data Set (MDS) Assessment, dated 6/20/24, indicated the Resident did not exhibit any hallucinations or delusions. Review of Resident #83's Initial Psychiatric Diagnostic Evaluation, dated 7/9/24, indicated the following: - The resident was referred for psychiatric evaluation due to concerns for adjustment, motivation, and depression. (continued on next page)

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F 0646 Level of Harm - Potential for minimal harm Residents Affected - Some	- The Resident had no known previous psychiatric history. - No psychotropic medications were in use for the Resident. - The Resident had Adjustment Disorder with Depressed Mood. Review of Resident #83's Nursing Progress Note, dated 8/28/24 and written at 2:49 P.M., indicated the Resident was alert with delusions and hallucinations. Review of Resident #83's Nursing Progress Note, dated 8/28/24 and written at 9:10 P.M., indicated the following: - The Resident was difficult to redirect during the shift. - The Resident wanted to call 911 and was seeking exit. - The Resident spoke with his/her healthcare proxy (HCP: individual designated to make healthcare decisions for one determined incapacitated) over the phone, requested the HCP contact 911, and stated that his/her phone conversation was being recorded by the FBI. - Facility staff contacted the Physician and the Physician ordered a one-time dose of Seroquel (antipsychotic medication) to be administered to the Resident. - The Physician gave approval for a repeat dose of Seroquel to be administered that same night if needed. - The Seroquel was effective for the Resident. Review of Resident #83's Skilled Progress Note, dated 8/29/24, indicated the following: - The Resident was alert and oriented, with confusion and delusions. - The Resident wandered and sought exit. - The Resident was difficult to redirect at times. Review of Resident #83's Psychiatric Nurse Practitioner Visit Note, dated 8/29/24, indicated the following: - The reasons for the Visit were paranoia, aggression, and exit seeking. - The Resident had received a one-time dose of Seroquel on 8/28/24 with good effect. - The Resident had no psychotropic medications ordered for use. - Consider starting Seroquel 12.5 mg BID (two times per day) for aggressive behaviors and distressing delusions. (continued on next page)

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F 0646 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of the Psychiatric Nurse Practitioner Visit Note indicated the recommendation for starting Seroquel was reviewed with the Physician and approved to start on 9/3/24. Review of Resident #83's Order Recap Report indicated the following: - Seroquel Oral Tablet, give 12.5 mg by mouth two times a day for Anxiety, dated 9/4/24 and discontinued 9/13/24. - Seroquel Oral Tablet, give 12.5 mg by mouth two times a day for hallucinations/delusions, dated 9/13/24 and discontinued 10/3/24. - Seroquel Oral Tablet, give 25 mg by mouth two times a day for hallucinations/delusions, dated 10/3/24 with no stop date. Review of Resident #83's September 2024 Medication Administration Record indicated Seroquel was administered to the Resident, as ordered, while the Resident was in the facility. Review of Resident #83's Diagnosis Listing Report indicated new diagnoses were added as follows: - Paranoid Personality Disorder on 9/5/24. - Delusional Disorders on 9/5/24. - Psychotic Disorder with Delusions due to Known Physiological Condition on 9/27/24. Review of Resident #83's clinical record did not indicate any evidence facility staff notified the State mental health authority of the Resident's newly indicated serious mental illness (SMI) and decline in condition. Review of Resident #83's Nurses Progress Note, dated 9/30/24, indicated the following: - Facility staff observed the Resident pushing on the door from the Unit that led to the stairwell. - The Resident said that he/she had been kidnapped and was being held against his/her will. - The Resident said that he/she was going to go down the stairs or go through the door to jump out the window to leave. - The Resident was pushing aggressively on the door, setting off the door alarm. - Facility staff offered the Resident a drink and snack and offered to assist the Resident back to his/her room with no effect. - The Physician was in the facility and attempted to talk with the Resident. - The Nurse placed a wander guard (device used to alert caregivers when a Resident gets close to an exit door) on the Resident's wheelchair. (continued on next page)

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F 0646 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #83's Physician Progress Note, dated 9/30/24, indicated the following: - The Resident was seen urgently by the Physician due to paranoia and agitation. - The Resident appeared very aggravated and paranoid, and not reasonable. - The Resident was transferred to the hospital for management of psychotic episode. Review of Resident #83's clinical record indicated the following: - The Resident returned to the facility from the hospital on 10/3/24. - The State mental health authority was not notified of the Resident's need for Resident Review until 10/7/24. During an interview on 11/21/24 at 3:45 P.M., Unit Manager (UM) #2 said that she had been assisting the facility with completing PASRR screenings and submissions to the State mental health authority for resident reviews during the time that Resident #83's mental condition changed, requiring the use of Seroquel for new diagnoses of Paranoid Personality Disorder and Delusional Disorders. UM #2 said that she had not been made aware of the Resident's newly added diagnoses and use of antipsychotic medication until a Consultant Social Worker alerted her of the diagnoses and use of Seroquel when the Resident returned from the hospital on 10/3/24. UM #2 said that she did not complete the request for resident review through the State mental health authority until 10/7/24. During an interview on 11/22/24 at 10:42 A.M., the Consultant Social Worker (SW) said that when a resident had a change in mental condition with a newly added diagnosis of Paranoid Personality Disorder, Delusional Disorder, or Psychotic Disorder and required a change in treatment for antipsychotic use when psychotropic medications were not previously prescribed, the facility was required to promptly submit a resident review to the State mental health authorities for a Level Two PASRR Evaluation to be completed. The Consultant SW said that facility staff's submission for a resident review on 10/7/24 was not completed promptly and should have been completed when the Resident's change in condition occurred.

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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** 50138 Based on observation, record review, and interviews, the facility failed to ensure professional standards of practice for medication administration for one Resident (#15) out of a total of 18 residents sampled. Specifically, the facility staff failed to administer Ativan (a medication used to treat anxiety [persistent worry and fear about everyday situations]) in accordance with the physician order. Findings include: Review of facility policy titled Medication orders, dated 5/1/2024, indicated the following: -Elements of medication order: > Date and time of the order written > The resident's full name > Name of the medication > Dosage (strength) of the medication > Frequency (how often) of the administration (provided) > Duration, if applicable. > Route (location) of administration > Type/formulation (if applicable). > Hour of administration (if applicable). > Diagnosis or indication for use. > PRN (pro re nata [as needed]) orders should also specify the condition for which they are being administered (e.g. [exempli gratia (for example)] as needed for sleep). - Documentation of medication orders: > Each medication order should be documented with the date, time and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR). > Clarify the order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	> If using electronic medication records, input the medication order according to the electronic health record (EHR) instructions and per facility policy. > Transcribe (to put data into written or printed form) newly prescribed medications on the MAR or treatment record or ensure the order is in the electronic MAR. Review of the facility policy titled Medication Administration, dated 5/1/24 indicated: - Medications are administered by licensed nurses . as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. > Ensure that the six rights of medication administration are followed: 1. Right resident 2. Right medication 3. Right dosage 4. Right route 5. Right time 6. Right documentation > Review the MAR to identify medication to be administered. > Administer medication as ordered. > Correct any discrepancies and report to nurse manager. Review of Nursing2024 Drug Handbook, Edition 44 [NAME] &Wilkins, indicated the following professional standard of practice: -The rights of medication administration include the five well known rights: 1. Right patient: ensuring the medication is given to the correct patient. 2. Right drug: ensuring the medication matches the prescribed drug. 3. Right dose: administer the correct dose. 4. Right route: administer the medication through the appropriate route. 5. Right time: administer the medication at the scheduled time or frequency. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15 was admitted to the facility in September 2023 with diagnoses including Dementia (a group of symptoms affecting memory, thinking and social abilities which interferes with daily life) and Anxiety (intense, excessive, and persistent worry and fear about everyday situations). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #15 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of two out of a total possible score of 15. Review of Resident #15 ' s comprehensive medical record indicted the following: -Activation of Health Care Proxy (HCP- a legally authorized person to make medical decisions on behalf of another person), effective 9/28/2023. -A comprehensive, person-centered care plan for Anxiety which indicated interventions for administering anti-anxiety medication (like Ativan) as ordered by physician, effective 10/9/24. -Physician order for Ativan 0.5 mg (mg-milligrams) by mouth every morning and bedtime for anxiety, initiated 7/29/2024. -Physician order for Ativan 0.5 mg PO (per os [by mouth]) daily (once a day) PRN as needed anxiety/agitation, initiated 11/18/24. Review of Resident #15 ' s November 2024 MAR indicated the following: -An order for Ativan oral tablet 0.5 mg - give 0.5 mg by mouth as needed for anxiety/agitation for 14 days with start date of 11/19/2024. -Documented administration of Ativan 0.5 mg PO twice a day PRN on 11/20/24 at 1:44 A.M. and 5:51 A.M. During an interview on 11/26/24 at 10:17 A.M., the Unit Manager #1 (UM#1) said Resident #15 was unaware of his/her prescribed medications due to his/her dementia. The UM#1 said that Resident #15 had increased episodes of anxiety and the physician recently ordered a daily PRN dose of Ativan, as a result. The UM said Resident #15 was given PRN Ativan twice on 11/20/24 at 1:44 A.M. and 5:51 A.M. and should not have been, because the PRN Ativan was ordered for once a day. The UM then said the PRN Ativan had been transcribed incorrectly to the MAR and did not include a frequency. The UM said medication frequency was part of the five rights of medication administration and should be included on the transcribed order. The UM said Resident #15 was high risk due to his/her dementia and too much Ativan could increase his/her confusion. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/27/24 at 10:45 A.M., the Director of Nursing (DON) said that orders for medication should be transcribed to the MAR by the unit nurse and include the five rights of administration which were the right resident, medication, dose, route, and frequency. The DON said that the five rights should be followed for all residents as a professional standard of practice. The DON said that all nurses are educated on transcription of orders upon hire. The DON said that the 11:00 P.M. to 7:00 A.M. shift nurses also completed a chart check to ensure that the order for Ativan was transcribed correctly but the order for Ativan had not been transcribed correctly for Resident #15 as the frequency had been omitted. The DON said that the PRN Ativan had not been administered in accordance to the Physicians order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, record review, and interviews, the facility failed to ensure its staff maintained professional standards of practice to prevent the development and promote healing of pressure ulcers/skin injuries for one Resident (#55) out of a total sample of 18 residents. Specifically, for Resident #55, the facility staff failed to perform a wound treatment as ordered by the physician, placing the Resident at risk for delayed wound healing. Findings include: Review of the facility policy titled Wound Treatment Management, last revised 5/1/24, indicated: -To promote healing of various types of wounds, it is the policy of this facility to provide evidence based treatments in accordance with current standards of practice and physician orders. -Wound treatments will be provided in accordance with physician orders, including; the cleansing method, type of dressing, and frequency of dressing change. -Dressings will be applied in accordance with manufacturers recommendations. Resident #55 was admitted to the facility in July 2024 with diagnoses including paraplegia (a condition that causes paralysis of the lower half of the body, including the legs, hips, stomach, and chest) and a Deep Tissue Injury (DTI: damage to tissues beneath the skin that occurs due to pressure or shear forces that can progress into large deep wounds). Review of a Minimal Data Set (MDS) assessment dated [DATE] indicated Resident #55 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. Review of the clinical record indicated Resident #55 had been transferred to the hospital 8/16/24 and returned to the facility 8/27/24. Further review of the clinical record indicated a Physician progress note dated 8/27/24 that indicated Resident #55 had developed a Stage IV pressure ulcer (a deep wound that extends beyond the skin layers reaching muscles, tendons, or bone). Review of the Active Physician orders dated 11/26/24 indicated the following: - Sacral ulcer: Wash with antibacterial soap and irrigate with saline, pat dry, apply Santyl (a prescription medicine that removes dead tissue from wounds so that they can start to heal properly) to wound base (the open area of the wound also known as the wound bed) followed by a damp to dry dressing, cover with border foam dressing every day and evening shift for wound healing, initiated on 10/24/24. (continued on next page)

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Shrewsbury Rehabilitation and Nursing at Southgate	40 Julio Drive Shrewsbury, MA 01545

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 11:27 A.M., the surveyor observed Nurse #2 and Unit Manager #2 (UM #2) perform a wound care treatment to Resident #55's Stage IV sacral wound. The surveyor observed UM #2 positioned on one side of Resident #55's bed, and Nurse #2 positioned on the opposite side of the bed with Resident #55 positioned on his/her side facing UM #2. The surveyor observed Nurse #2 perform hand hygiene, don clean gloves, remove the old dressing from the wound, discard the dressing, remove gloves, and perform hand hygiene. Nurse #2 then put on clean gloves, cleansed the wound as ordered and placed a clean damp gauze into the wound covering the wound base. The surveyor then observed Nurse #2 to apply Santyl around the outside of the wound with a cotton tipped applicator and place a border foam dressing over the wound. At no time did the surveyor observe Nurse #2 apply Santyl to the wound base of Resident #55's sacral wound. During an interview on 11/25/24 at 11:57 A.M., UM #2 said that she could not see what Nurse #2 did with the Santyl because she was on the opposite side of the bed. UM #2 said that the Physician's order for the wound care to Resident #55's sacral wound indicated to apply the Santyl to the wound bed and not around the wound. During an interview on 11/25/24 at 12:02 P.M., Nurse #2 said that the Physician's order for the wound care for Resident #55's sacral wound said to apply the Santyl to the wound bed. Nurse #2 said she applied the Santyl around the wound but did not apply the Santyl to the wound bed as ordered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interviews, and records reviewed, the facility failed to adequately assess wandering and elopement risk for one Resident (#83) out 18 total sampled residents which increased the Resident's risk for unsafe wandering and elopement. Specifically, facility staff failed to: - Accurately complete Resident #83's Admission Assessment for Wandering according to the instructions provided in the facility's Admission Wandering Assessment for the Resident. - Assess Resident #83's wandering risk, when the Resident exhibited changes in behavior and demonstrated exit seeking behaviors that were not present when the Resident was admitted to the facility. - Establish a resident-centered plan of care relative to wandering when Resident #83 began exhibiting wandering behaviors and seeking exit from the facility. Findings include: Review of the facility's policy titled Elopements and Wandering Residents, dated 5/1/24, indicated the following: - This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement . receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. - Wandering is random or repetitive locomotion that may be goal directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed and aimless. - The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, . - Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. - The interdisciplinary team will evaluate the unique factors contributing to risk on order to develop a person-centered care plan. - Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #83 was admitted to the facility in June 2024 with diagnoses including Parkinson's Disease (movement disorder of the nervous system that worsens over time), Dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change) with Behavioral Disturbance, and Right Femur (thigh bone) Fracture. Review of Resident #83's Wandering Risk Scale Assessment, dated 6/13/24, indicated instructions for staff to complete the assessment on admission/readmission, at 72 hours, and one month later, with any change of condition, and annually for all residents. Further review of the Assessment indicated: - The Resident could follow instructions. - The Resident could move without assistance while in his/her wheelchair. - The Resident could communicate. - The Resident had no history of wandering. - The Resident had no diagnosis of Dementia/cognitive impairment; diagnosis impacting gait/mobility or strength. - The Assessment sections G (complete 72 hours post admission), H (complete at one month, ., and adhoc [when needed] screening) were not completed. - The Resident's Wandering Risk Scale Score was two (low risk). Review of Resident #83's Minimum Data Set (MDS) Assessment, dated 6/20/24, indicated the following: - The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out 15 total possible points. - The Resident exhibited no wandering behaviors. - The Resident reported no mood problems. Review of Resident #83's Nurses Note, dated 7/25/24, indicated the following: - The Resident was non-compliant with safety measures. - The Resident transferred him/herself to the bathroom and bed. Review of Resident #83's Behavior Note, dated 7/25/24, indicated the following: - The Resident attended activities in the Main Dining Room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- During transport back to the Unit, the Resident refused to come back and attempted to exit. - Facility staff had difficulty redirecting the Resident. - The Resident eventually agreed to return to the Unit. - The Resident transferred him/herself and ambulated without the use of an assistive device or staff member. Review of Resident #83's clinical record did not include any evidence that: - The Resident's wandering or elopement risk was assessed when the Resident exhibited refusal to return to the Unit from the Main Dining Room. - A care plan relative to risk for wandering and elopement had been initiated for the Resident. Review of Resident #83's clinical record indicated the Resident was transferred to the hospital related to a medical change in condition on 7/28/24 and returned to the facility on [DATE]. Further review of the clinical record did not include any evidence Resident #83's risk for wandering and elopement was assessed upon readmission to the facility on [DATE]. Review of Resident #83's clinical record indicated the Resident was transferred to the hospital after sustaining a fall on 8/18/24 and returned to the facility on [DATE]. Review of Resident #83's Nursing Readmission Evaluation, dated 8/19/24 and completed 8/20/24, indicated the following relative to elopement risk: - The Resident was confined to chair/bed. - The Resident was unable to walk. - The Resident was not an elopement risk. Review of Resident #83's Physician Progress Note, dated 8/22/24, indicated the following: - The Resident was seen due to increasing paranoia, delusions, possible hallucinations observed by staff. - The Resident was wheeling him/herself into other residents' rooms and was intrusive. - The Resident had Parkinson's Disease and cognitive impairment. Review of Resident #83's clinical record did not include any evidence that: - The Resident had been assessed for wandering and elopement risk when the Resident exhibited wandering into other residents' rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A care plan relative to wandering and elopement had been initiated for the Resident. Review of a Nurses Progress Note, dated 8/28/24, indicated the following: - The Resident exhibited delusions, hallucinations, and paranoia. - The Resident was difficult to redirect during the shift. - The Resident wanted to call 911 and stated that he/she was being held at the facility against his/her will. - The Resident stood to grab the phone. - The Resident was seeking exit. Review of a Nurses Progress Note, dated 8/29/24 at 9:13 A.M., indicated the Resident was redirected that same morning for exit seeking. Review of Resident #83's Nurses Progress Note, dated 8/29/24 at 1:45 P.M., indicated the following: - The Resident was reviewed at Risk Meeting. - The Resident had delusional, paranoid, and exit seeking behaviors. - Will assess for elopement risk. Review of Resident #83's Skilled Progress Note, dated 8/29/24, indicated the Resident wandered, sought exit, and was difficult to redirect at times. Review of Resident #83's clinical record did not include any evidence facility staff assessed the Resident's risk for elopement when the Resident exhibited exit seeking behaviors on 8/28/24 and 8/29/24, and per the recommendation of the facility's Risk Meeting held on 8/29/24. Further review of the Resident's clinical record did not include any evidence a care plan relative to the Resident's risk for wandering and elopement had been initiated. Review of Resident #83's Nurses Progress Note, dated 9/2/24, indicated the following: - The Resident was alert and confused. - Facility staff found the Resident in another resident room in the evening. - The Resident was sitting behind the closed door to the other resident room, staring at both residents in that room. Review of Resident #83's Nurses Progress Note, dated 9/17/24, indicated the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Resident continually sought out staff to report that he/she did not belong among residents with Dementia. - The Resident requested to see the Social Worker to get out of here. - The Resident was redirected with little effect. Review of Resident #83's MDS Assessment, dated 9/18/24, indicated the following - The Resident was moderately cognitively impaired as evidenced by a BIMS score of 12 out of 15 total possible points. - The Resident reported feeling down, hopeless, or depressed several days during the assessment reference period for the MDS Assessment. - The Resident exhibited wandering behavior one to three days during the assessment reference period for the MDS Assessment. Review of Resident #83's Quarterly Elopement Risk Evaluation, dated 9/18/24, indicated the following: - The Resident was ambulatory or used a wheelchair. - The Resident had one or more of the following predisposing conditions: Dementia, Organic Brain Syndrome, Alzheimer's Disease, Mental Illness, Traumatic Brain Injury. - The Resident had intermittent confusion. - The Resident had poor safety/environment awareness. - The Resident's elopement risk score was 14 (10 or higher indicates high risk). - The Resident resided on the locked unit and had made no attempts to elope from the Unit. Further review of the Elopement Risk Evaluation indicated instructions as follows: If the total score is 10 or greater, the resident should be considered at high risk for elopement. A prevention protocol should be initiated immediately and documented on the care plan. Review of Resident #83's Nurses Progress Note, dated 9/30/24, indicated the following: - Facility staff observed the Resident pushing on the door from the Unit that led to the stairwell. - The Resident said that he/she had been kidnapped and was being held against his/her will. - The Resident said that he/she was going to go down the stairs or go through the door to jump out the window to leave. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Resident was pushing aggressively on the door, setting off the door alarm. - Facility staff offered the Resident a drink and snack and offered to assist the Resident back to his/her room with no effect. - The Physician was in the facility and attempted to talk with the Resident. - The Nurse placed a wander guard (device used to alert caregivers when a Resident gets close to an exit door) on the Resident's wheelchair. Review of Resident #83's Physician Progress Note, dated 9/30/24, indicated the following: - The Resident was seen urgently by the Physician due to paranoia and agitation. - The Resident appeared very aggravated and paranoid, and not reasonable. - The Resident was transferred to the hospital for management of psychotic episode. Review of Resident #83's Nursing Elopement Risk Evaluation, dated 9/30/24, indicated the following: - The Resident was ambulatory with assistive devices. - The Resident was disoriented at all times. - The Resident exhibited purposeful exit seeking. - The Resident exhibited one elopement episode in the past three months. - A wander guard was placed on the Resident's wheelchair that same day. - The Resident's elopement risk score was 20 (high risk). Review of Resident #83's active care plan indicated the following: - The Resident was at risk for elopement related to elopement attempt, delusions. - The elopement care plan was not initiated until 9/30/24. - The Resident's Behavior Care Plan was not revised to include exit seeking behaviors until 10/8/24. On 11/21/24 at 7:59 A.M., the surveyor observed Resident #83 self mobilizing in his/her wheelchair in the hallway on the Unit. The surveyor observed Resident #83 using his/her feet and using the handrail while mobilizing in the wheelchair. The surveyor observed Resident #83 mobilize to the end of the hallway, facing the door that led to the stairwell outside of the Unit. The surveyor observed Resident #83 sit and face the door for approximately four minutes, then the Resident began to push on the door handle until the door alarm sounded. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24, the Assistant Director of Nursing (ADON) said that she was the Nurse who responded to Resident #83's attempt to exit the Unit on 9/30/24. The ADON said that Resident #83 did not exit through the door into the stairwell, but that the Resident was pushing on the door and was threatening to leave. The ADON said that she was eventually able to redirect Resident #83 away from the door, but the Resident's behaviors continued, the Resident could not be reasoned with and required transfer to the hospital. The ADON said that she was not working at the facility when the Resident was admitted in June 2024, so she could not speak to the Resident's presentation at the time of admission. The ADON said she would have to review the Resident's clinical record to determine when the Resident should have been assessed for wandering and elopement and for when individualized interventions for wandering and elopement should have been added into the Resident's care plan. During an interview on 11/26/24 at 8:00 A.M., Unit Manager (UM) #1 said Residents were assessed for wandering and elopement risk upon admission/readmission, quarterly, annually, and if a status change occurred where a resident attempted to leave or voiced wanting to leave the facility. UM #1 said she completed an elopement assessment for Resident #83 on 8/19/24, when the Resident returned to the facility from the hospital after having had a fall. UM #1 said that at the time she completed the assessment, Resident #83 was lethargic, sleepy and bedbound, and the Resident was assessed to be not at risk for elopement. UM #1 further said that the Resident needed to gain some strength before becoming mobile again. The surveyor inquired whether Resident #83's risk for wandering and elopement should have been reassessed when the Resident exhibited exit seeking behaviors on 8/28/24, UM #1 said that she did not think the Resident had been exit seeking at that time. During an interview on 11/26/24 at 11:35 A.M., the Director of Nursing (DON) said assessments for wandering and elopement risk were to be completed for residents upon admission/readmission to the facility, quarterly, annually, and with a change in condition where exit seeking behaviors are increased from the resident's baseline exit seeking behavior. The DON said that she completed an elopement assessment and revised Resident #83's plan of care on 9/30/24 when the Resident attempted to exit the Unit and was transferred to the hospital. The DON said she would need to review Resident #83's clinical record to determine whether the Resident's wandering and elopement risk should have been assessed and a care plan relative to wandering and elopement developed prior to 9/30/24. During a follow-up interview on 11/26/24 at 4:05 P.M., the DON said she reviewed Resident #83's clinical record and that the Resident's initial Wandering Risk Scale Assessment, dated 6/13/24, should have been completed to indicate that the Resident had a diagnosis of Dementia/cognitive impairment and diagnosis impacting gait/mobility or strength since the Resident was admitted with a diagnosis of Dementia and a hip fracture. The DON also said staff should have reassessed the Resident's wandering and elopement risk when the Resident began exit seeking and again when the IDT recommended an elopement assessment be completed on 8/29/24. The DON also said that staff should have developed a plan of care with individualized interventions relative to Resident #83's wandering and exit seeking behaviors prior to 9/30/24 when the Resident required hospital transfer relative to exit seeking behaviors.

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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. 44337 Based on observation and interview, the facility failed to remove expired medications from one medication cart, out of a sample of three medication carts. Specifically, the facility failed to remove and dispose two bottles of expired Ferrous Gluconate liquid (Iron Supplement), increasing the risk of non-therapeutic benefit when the medication is administered. Findings include: Review of the facility policy titled Medication Storage, revised 5/1/24, indicated: -All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) . -The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. Review of the facility policy titled Medication Administration, revised 5/1/24, indicated: -Identify expiration date. If expired, notify nurse manager. On 11/26/24 at 10:33 A.M., the surveyor and Nurse #2 observed the medication cart on the Station 3 nursing unit to contain two bottles of Ferrous Gluconate liquid with labels that indicated expiration dates of 5/2024 and 10/2024. During an interview at the same time, Nurse #2 said the expired Ferrous Gluconate liquid medications should not have been administered to residents and should have been removed from the medication cart when they expired. Nurse #2 said she would notify the Unit Manager and have the expired medications removed from the medication cart.

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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** 48206 Based on record review and interview, the facility failed to maintain an accurate medical record for one Resident (#34) out of a total sample of 18 residents. Specifically, the facility failed to accurately document a behavioral incident by Resident #34 putting his/her roommate at risk for potential abuse. Findings include: Review of the facility policy titled Documentation in Medical Record, initiated 5/1/24, indicated: - Each residents' medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. - Principles of documentation include, but are not limited to: > Documentation shall be factual, objective, and resident centered. > False information shall not be documented > Record descriptive and objective information based on first hand knowledge of the assessment, observation or service provided. > Documentation shall be accurate, relevant, complete, and containing sufficient details about the resident's care and/or responses to care. Resident #34 was admitted to the facility in August 2017 with diagnoses including Dementia (progressive disease with impairment in memory and functioning), Expressive Aphasia (an acquired language disorder caused by damage to the brain's language centers, characterized by partial loss of the ability to produce language [spoken, manual, or written], although comprehension generally remains intact), Generalized Anxiety Disorder (a mental condition characterized by excessive or unrealistic anxiety about two or more aspects of life [work, social relationships, financial matters, etc.]). Review of the Minimum Data Set (MDS) assessment, dated 11/1/24, indicated: - Resident #34 had clear speech - Resident #34 was usually able to understand others and usually able to make themselves understood - Resident #34 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of a total possible of 15. - Resident #34 did not exhibit any behaviors. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 12:09 P.M., Family Member #1 said that Resident #34 had an incident with his/her roommate over the past weekend and Resident #34 got mad at her roommate. Review of the Nurses Note dated 11/17/24 at 23:02 indicated: - Resident #34 had two episodes of behavior Issues. - Resident #34 became very mean and angry. - Yelling at roommate, - Pointing finger in [roommate's] face and - Attempted to strike roommate with his/her wheelchair. - While cursing at roommate and calling him/her fowl (sic) names. - Redirected with poor effect. Review of the Witness Statement by Nurse #1, dated 11/21/24, indicated that Nurse #1 was called to the room as Resident #34 was yelling out from his/her bed. The statement indicated Resident #34 was unable to say why he/she was upset and had used foul language. The statement further indicated that Resident #34 and their roommate did not touch each other, did not make contact, and both calmed down when staff intervened. During an interview on 11/21/24 at 4:49 P.M. the Director of Nurses (DON) said that she would have expected more accurate documentation and the nursing note to reflect that the incident did not rise to the level of abuse at that time. During an interview on 11/22/24 at 9:20 A.M. Nurse #1 said that she recalled Resident #34's behavioral incident on 11/17/24. She said that she observed Resident #34, and his/her roommate seated in their beds at opposite ends of the room and that Resident #34 was calling the staff foul names, not his/her roommate, and pointing his/her finger at the staff and anyone in the room. Nurse #1 said that she did not observe any action relative to Resident #34 using his/her wheelchair to strike at his/her roommate. Nurse #1 said that when Resident #34 becomes upset, he/she will swear and use foul language. During a second interview on 11/22/24 at 1:34 P.M., the DON said that the Nurse's Progress Note about the incident on 11/17/24 was inaccurate based on the witness statement provided by Nurse #1 and that the progress note would be corrected.