STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225509	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Brookline	99 Park Street Brookline, MA 02146

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 36797 Based on observation, record review and interview, the facility failed to ensure that one Resident (#201) did not self-administer medications out of a total sample of 24 residents. Specifically, Resident #201 was not assessed to be able to safely self-administer medication. Findings include: Review of the facility policy titled, Self Administration of Medications, dated as reviewed February 2021, indicated that as part of the evaluation comprehensive assessment, the interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate. Resident #201 was admitted to the facility in November 2024 with diagnoses including post-traumatic stress disorder, anxiety disorder and depression. On 11/19/24 at 8:08 A.M., and 12:30 P.M. the surveyor observed a bottle of Motrin B on Resident #201's over the bed table. During an interview on 11/20/24 11:15 A.M., Resident #201 said that he/she put the bottle of Motrin in his/her backpack. Review of the medical record failed to indicate Resident #201 was assessed for the ability to self-administer medication. Review of the medical record failed to indicate Resident #201 was assessed for self-administration of medication. Review of the doctor's orders failed to indicate an order for Resident #201 to self-administer medication. Review of the care plan failed to indicate Resident #4 had a care plan for the self-administration of medication. During an interview on 11/20/24 at 11:20 A.M., Nurse #7 said that Resident #201 is not supposed to have medications at bedside.

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 44095 Based on record review and interview, the facility failed to ensure that concerns addressed by the Resident Council Group had sufficient follow-up to address and prevent recurrence. Findings include: Review of the facility policy, Resident Council, dated as revised February 2021, indicated the facility supports residents' rights to organize and participate in the resident council. 1. The purpose of the resident council is to provide a forum for: a. residents, families, and resident representatives to have input in the operation of the facility; b. discussion of concerns and suggestions for improvement; c. consensus building and communication between residents and facility staff; and d. disseminating information and gathering feedback from interested residents. 6. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the items of concern. Review of the facility policy, Menus, undated, indicated that menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Review of the facility policy, Grievances/Complaints, Recording and Investigating, dated as revised 4/12/18, indicated all grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). 1. The Administrator has assigned the responsibility of investigating grievances and complaints to the Grievance Officer. 2. Upon receiving a grievance and complaint report, the Grievance Officer will begin an investigation into the allegations. 3. The department directors of any named employee(s) will be notified of the nature of the complaint and that an investigation is underway. 5. The Grievance Officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log. 6. The Resident Grievance/Complaint Investigation Report Form will be filed with the Administrator within five (5) working days of the incident. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within five (5) working days of the filing of the grievance or complaint. 8. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect, and misappropriation of property, as per state law. During an initial tour of the facility kitchenettes on 11/19/24, the surveyor observed three out of three kitchenettes without condiments such as creamers, butter, salt, and pepper. During an interview on 11/19/24 at 8:22 A.M., Resident #351 said his/her biggest complaint is that he/she is unable to get condiments when he/she asks for them. The Resident said if he/she asks for creamer or ketchup staff are unable to give them anything because the staff say they have none to give. During the Resident Group interview on 11/20/24 at 1:25 P.M., six residents were in attendance and reported the following: - 6 of 6 Residents said menus are not followed as posted. Sometimes they receive potatoes and rice at the same meal and the meal is too starchy. - 5 of 6 Residents said they often do not get condiments on meal trays, such as salt, pepper, sugar, butter, or creamers. The Residents said that often they must wait upwards of 30 minutes for nursing to provide condiments and their hot foods are no longer hot, such as coffee that needs creamers and toast that needs butter, and this diminishes the dining experience. The Residents said that this concern comes up month after month and the residents do not feel that the facility has sufficiently responded to their concerns. Review of the Resident Council Minutes, dated 8/8/24, indicated the following concerns: Dietary: - Kitchenettes are not stocked sometimes. - Residents not receiving the condiments he/she wants. - Menu choices not followed. - Slips don't match trays. - Missing condiments. Review of the Resident Council Minutes, dated 9/12/24, indicated the following concerns: Dietary: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Residents not receiving condiments. - Residents not receiving preferred meal choices. Review of the Resident Council Minutes, dated 10/23/24, indicated the following concerns: Dietary: - No condiments. - Residents feel dietary are not reading the diet slips. During an interview on 11/20/24 at 11:29 A.M., the Ombudsman said she was aware of concerns with the food service department including diets not being followed and concerns with the quality of food. During an interview on 11/21/24 at 8:18 A.M., the [NAME] said that diet aides are responsible for putting the condiments on the Resident's trays. During an interview on 11/21/24 at 9:12 A.M., the Dietitian said she was aware of the Residents condiment concerns as an on-going issue. The Dietician said she is responsible to review any menu substitutions before they are made. During an interview on 11/21/24 at 10:09 A.M., the Food Service Director said condiments should be on the Residents trays and menu changes should be posted. During an interview on 11/21/24 at 9:32 A.M., the Director of Nursing said he conducted the Resident Council meeting on 10/23/24, in the absence of the Activities Director. The DON said that he was aware of the Residents' on-going food concerns. During an interview on 11/21/24 at 9:53 A.M., Administrator #2 said that she attended the Resident Council meeting on 9/12/24. Administrator #2 said there should be condiments available on the Residents' trays and there should be condiments on the units. During an interview on 11/21/24 at 9:47 A.M., Administrator #1 said a grievance should be filed on behalf of the Residents regarding the on-going food service concerns brought forward during Resident Council.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 43846 Based on observations and interviews, the facility failed to ensure resident protected health information (PHI) was secure and not visible to others on two of three nursing units. Findings include: Review of the facility policy titled Confidentiality of Information and Personal Privacy, dated February 2022, indicated the facility will protect and safeguard resident confidentiality and personal privacy. On 11/19/24 at 6:58 A.M., the surveyor observed the computer screen on a medication cart on the first floor. There was no nurse in the area and the computer screen was open displaying various residents' names, photos and identifying information. On 11/19/24 at 8:32 A.M., the surveyor observed the computer screen on a medication cart on the second floor. There was no nurse in the area and the computer screen was open displaying various residents' names, photos and identifying information. On 11/20/24 at 7:06 A.M., the surveyor observed the computer screen on a medication cart on the first floor. There was no nurse in the area and the computer screen was open displaying various residents' names, photos and identifying information. On 11/20/24 from 11:29 A.M. to 11:35 A.M., the surveyor observed the computer screen on a medication cart on the first floor. There was no nurse in the area and the computer screen was open displaying various residents' names, photos and identifying information. During an interview and observation on 11/20/24 at 11:35 A.M., Unit Manager #1 said the medication administration computer screen should never be left open to a resident screen unless the nurse is present at the medication cart. Unit Manager #1 said there was no nurse currently at the cart and the resident screen was open. During an interview on 11/21/24 at 8:20 A.M., the Director of Nursing (DON) said that resident information should not be visible to anyone other than the nurse attending the medication cart.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 36797 Based on record review, policy review, and interview, the facility failed to ensure staff developed and implemented a baseline care plan for one Resident (#201) out of a total sample of 24 residents. Specifically, the facility failed to develop a care plan within 48 hours of the resident's admission, which included the instructions needed to provide effective and person-centered care to the resident which meet professional standards of quality care. Findings include: Review of the facility policy titled Care Plans - Baseline, dated revised March 2022 indicated that a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission. Resident #201 was admitted to the facility in November 2024 with diagnoses including osteomyelitis (infection of the bone), spinal abscess with drains in the back and intravenous antibiotic use. Review of the medical record failed to indicate a baseline care plan was developed within 48 hours of admission to the facility. Further review indicated that as of 5 days post admission, a baseline plan of care had not been developed. During an interview on 11/20/24 at 1:02 P.M., the Director of Nursing said that nursing staff should have developed a baseline care plan for Resident #201 within 48 hours of admission to the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, record review and interview the facility failed to implement resident-centered care plans for one Resident (#77) out of a total sample of 24 residents. Specifically, for Resident #77 the facility failed to implement the use of a hand brace and failed to assist with trimming fingernails. Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered, revised December 2016 indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Resident #77 was admitted to the facility in June 2023 with diagnoses including stroke with left sided hemiplegia/hemiparesis, diabetes and depression. Review of the Minimum Data Set assessment dated [DATE], indicated a score of 13 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Further review indicated that Resident #77 is totally dependent for activities of daily living (ADLs)and has impairments to his/her upper and lower body. Review of the doctor's order dated 10/26/23, indicated an order for left hand splint on in the morning, off in the evening as tolerated. Review of the care plan dated as initiated 6/28/23 indicated a focus of self care deficit with interventions including left hand splint on during the day as tolerated off in the evening. Further review indicated Resident #77 is totally dependent for ADLs and to keep nails trimmed to prevent injury. On 11/19/24, at 8:30 A.M., the surveyor observed Resident #77 in his/her room without a hand brace on the left hand and fingernails that were long and jagged. The surveyor further observed that there was no hand brace in Resident #77's room. During an interview on 11/19/24 at 8:30 A.M., Resident #77 said that he/she has a hand brace for the left hand but it has been missing for about a month. Resident #77 said that the hand brace was sent down to laundry and never came back. Resident #77 then said that he/she needs help cutting his/her fingernails and staff have not helped. On 11/19/24 at 1:06 P.M., the surveyor observed Resident #77 in the 2nd floor dining room without a hand brace on and fingernails that were long and jagged. During an interview on 11/20/24 at 10:39 A.M., Resident #77 was observed to have a blue brace on the left hand but Resident #77 said it was the wrong brace. (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 11/20/24 at 10:39 A.M., Certified Nurse's Aide (CNA) #4 said that it was the responsibility of the CNA to cut fingernails and to apply any braces. During an interview on 11/20/24 10:45 A.M., Unit Manager #2 said that she was not aware that Resident #77 had long nails or that he/she is wearing the wrong brace. During an interview on 11/20/24 10:49 A.M. Physical Therapist (PT) #1 said that Resident #77 is not wearing the correct brace on his/her left hand. She then said that the facility has ordered the correct brace. PT #1 then said that the brace had been ordered on 10/24/24 and received on 10/31/24 but had been given to another resident who went home. PT #1 then said that she dropped the ball and forgot to order Resident #77 another brace. During an interview on 11/20/24 at 11:05 A.M., Unit Manager #2 said that it is the facility protocol for the podiatrist to cut fingernails on residents diagnosed with diabetes. During an interview on 11/20/24 at 11:06 A.M., Unit Secretary #1 said that facility staff had never offered Resident #77 a consent to be seen by a podiatrist. During an interview on 11/20/24 at 1:02 P.M., the Director of Nursing (DON) said the podiatrist does not cut fingernails. The DON then said that CNAs are responsible for cutting fingernails and it is the nurse's responsibility to ensure braces have been applied to the residents requiring them.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 36797 Based on observation, record review and staff interview, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team for one Resident (#14) out of a total sample of 24 residents. Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated as revised December 2016 indicated the Interdisciplinary Team must review and update the care plan: d. At least quarterly, in conjunction with the required quarterly MDS (Minimum Data Set) assessment. Resident #14 was admitted to the facility in July 2024 with diagnoses including schizophrenia, anxiety disorder and depression. Review of Resident #14's clinical record indicated an MDS was completed on 10/22/24. Review of Resident #4's most recent care plan indicated a target date of 10/16/24. Further review indicated the care plan was not reviewed and had not been reviewed since 7/30/24, and target dates for all goals had not been updated . During an interview on 11/20/24 at 8:14 A.M., the Director of Nursing said that care plans are to be reviewed each time the MDS is completed and new target dates should be set for all the goals.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observation, record review and interview, the facility failed to meet professional standards of practice for 5 Residents (#55, #87, #4, #252, #13) out of a total of 24 sampled residents. Specifically, 1. For Resident #55, the facility failed to implement a physician's order to offload heels and to apply waffle boots. 2. For Resident #87, the facility failed to obtain weights as ordered. 3. For Resident #4, the facility failed to ensure nursing implemented a physician's order for weights and failed to document those weights in the electronic health record. 4. For Resident #252, the facility failed to ensure physicians orders were implemented for the monitoring of a peripheral intravenous (IV) site. 5. For Resident 13, the facility failed to obtain physician orders for the care of a central line. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2018, indicated the following: - The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #55 was admitted to the facility in September 2024 with diagnoses that included severe protein-calorie malnutrition, dysphagia, cerebral palsy, and epilepsy. Review of Resident #55's most recent Minimum Data Set (MDS) assessment, dated 10/30/24, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Further review of the MDS indicated the Resident is dependent on staff for activities of daily living (ADLs) and dependent on staff for positioning. Further review of the MDS indicated he/she was at risk for developing pressure ulcers. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #55's Norton Score (a tool to assess the risk of developing pressure ulcers), dated 10/23/24, indicated a score of 9 indicating the Resident is at very high risk for developing pressure ulcers. Review of Resident #55's physician orders, dated 10/23/24, indicated Heels off bed surface at all times, Waffle Boots. On 11/19/24 at 8:19 A.M., 9:09 A.M., and 9:40 A.M., the surveyor observed the Resident laying in bed with his/her feet flat on the bed without wearing waffle boots. On 11/20/24 at 7:00 A.M., 7:44 A.M., 8:49 A.M.,9:38 A.M., and 9:58 A.M. and 10:23 A.M., the surveyor observed the Resident laying in bed with his/her feet flat on the bed and without wearing waffle boots. During an interview and observation on 11/20/24 at 10:32 A.M., Unit Manager #1 said Resident #55's heels are not off loaded and he/she does not have waffle boots on as ordered. Unit Manager #1 said the Resident is at risk for skin breakdown. 2. Resident #87 was admitted to the facility in October 2024 with diagnoses that included adult failure to thrive, chronic diastolic congestive heart failure (CHF), and spinal stenosis. Review of Resident #87's most recent Minimum Data Set (MDS) assessment, dated 11/3/24, indicated he/she scored a 15 out 15 on the Brief Interview for Mental Status (BIMS) exam indicating the Resident is cognitively intact. Review of Resident #87's nutritional assessment, dated 11/1/24, indicated He/she continues to be at risk for weight fluctuations r/t (related to) fluid shifts and CHF. Recommendations: Monitor wts (weights), labs, intake. Review of Resident #87's nutritional care plan, dated 11/3/24, indicated Weights as ordered. Review of Resident #87's Nurse Practitioner (NP) progress note, dated 11/12/24, indicated Cont (continue) with daily weigths [sic] Hypertension. Review of Resident #87's physician order, dated 11/14/24, indicated Daily weight in the morning for Hypertension. Review of Resident #87's Certified Nurse Aide (CNA) Kardex (form explaining the needs of a resident), dated 11/20/24, indicated weigh weekly and weigh PRN (as needed). Review of Resident #87's weights indicated the last weight obtained was on 11/11/24. During an interview on 11/20/24 at 10:24 A.M., Certified Nurse Aide (CNA) #1 said the nurses tell them who needs to be weighed and then they tell the nurse what the weight is. CNA #1 said the daily weights are done at 6:00 A.M. and the night shift staff will weigh those residents. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 10:26 A.M., Nurse #1 said after the Resident is weighed it should be documented in the medical record in the vitals section. During an interview and medical record review on 11/20/24 at 10:30 A.M., Unit Manager #1 reviewed Resident #87's weights with the surveyor and said the last weight that was recorded was on 11/11/24. Unit Manager #1 said staff are supposed to obtain the Resident's weight daily, as ordered. 44095 3. Resident #4 was admitted to the facility in August 2021 with diagnoses including diabetes, atrial fibrillation, heart failure, and pain. Review of the Minimum Data Set (MDS) assessment, dated 11/1/24, indicated Resident #4 had a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15 which indicated he/she was cognitively intact. Review of Resident #4's plan of care related to cardiac disease and congestive heart failure, dated 8/4/21, indicated: - Obtain weights as indicated and report significant changes, dated as revised 2/23/23. Review of Resident #4's plan of care related to nutritional status, dated 8/26/24, indicated: - Weights as ordered. Review of Resident #4's physician's order, dated 7/31/23, indicated: - Weight twice a week, in the morning every Monday, Friday related to type 2 diabetes mellitus with diabetic neuropathy. Review of Resident #4's vital signs on 11/21/24, indicated his/her most recent weight was recorded on 10/17/24 at 8:18 A.M., as 289 pounds. Review of Resident #4's Medication Administration Record (MAR), dated September 2024, October 2024, and November 2024, indicated that nursing implemented the physician's order for twice weekly weights. The MAR indicated nursing staff weighed Resident #4 on the following dates: 9/2/24, 9/6/24, 9/9/24, 9/13/24, 9/16/24, 9/20/24, 9/23/24, 9/27/24, 9/30/24, 10/4/24, 10/7/24, 10/11/24, 10/14/24, 10/18/24, 10/21/24, 10/24/24, 10/28/24, 11/1/24, 11/4/24, 11/8/24, 11/11/24, 11/15/24, and 11/18/24. Further review of the MAR failed to indicate nursing staff documented the obtained weights and there were no weights documented under the weights tab in the electronic health record. During an interview on 11/20/24 at 9:41 A.M., Nurse #3 said that Resident #4 does not have twice weekly weights. Nurse #3 said that if t weights are due the order will show up on the MAR and she will ask the nursing assistants to obtain the weights. Nurse #3 said the nursing assistants inform her of the weights and she then enters these values under the weights and vitals tab. During an interview on 11/21/24 at 6:41 A.M., Resident #4 said he/she has not been weighed in about a month. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 11/21/24 at 6:43 A.M., Nurse #3 said that Resident #4 hasn't been weighed in over a month and Nurse #3 doesn't obtain Resident #4's weights in the morning. The surveyor and Nurse #3 reviewed Resident #4's electronic health record and she said that Resident #4's last weight was like a month ago on 10/17/24 and she said Resident #4 is ordered for monthly weights. During an interview on 11/21/24 at 9:15 A.M., the Director of Nursing said nursing staff are required to implement the physician's orders for weights and enter the values in the clinical record. 36876 4. Review of the Peripheral and Midline IV Dressing Changes policy dated March 2022 indicated: the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter related infections associated with contaminated, loosened, or soiled catheter site dressings. Assess the peripheral/midline access device at least every four hours. Resident #252 was admitted to the facility in November 2024 with diagnoses including urinary tract infection, generalized edema, and depression. There was no Minimum Data Set assessment available for Resident #252. Review of the hospital discharge paperwork dated 11/16/24 indicated Resident #252 was admitted to the facility with a peripheral IV in his/her right arm: Active Lines/Drains: Peripheral IV Right; anterior forearm Placement date: 11/24/23 Size (Gauge): 22 G (indicating the size of the needle) Catheter Length 1.75 inch Line Status: Capped Line Care: Flushed; connections checked and tightened Dressing Type: TSM (transparent Dressing Status: Clean, dry, intact Review of the admission nursing assessment dated [DATE] indicated: Infusions/access sites: Type of device - Peripheral. Site: IV line. Review of the physicians' orders and care plans failed to indicate any orders were initiated or implemented regarding the monitoring or care of Resident #252's IV site. During an interview on 11/21/24 at 7:26 A.M., Unit Manager #1 said that when residents are admitted to the facility with an IV site, the expectation is for physician orders to be initiated and implemented regarding dressing changes, flushes and monitoring the IV site. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 8:20 A.M., The Director of Nursing said that when residents are admitted with an IV site, the expectation would be for physician orders to be initiated upon admission for monitoring and flushing. 36797 5. Resident #13 was admitted to the facility in July 2024 with diagnoses including lung cancer, schizoaffective disorder, and bipolar disorder. On 11/19/24, at 9:10 A.M., the surveyor observed Resident #13 lying in bed with a central line in the upper left chest wall covered by a transparent dressing. The surveyor observed that there was no date on the dressing indicating when the dressing was applied. During an interview on 11/19/24, at 9:10 A.M., Resident #13 said that the central line was placed for Chemotherapy a few days ago. Review of the progress note dated 11/15/24 indicated that Resident #13 had an appointment for Port (central line) placement. Review of the medical record failed to indicate a doctor's order for the care of a central line. Review of the care plan failed to indicate a plan of care for the central line. During an interview on 11/20/24 at 1:02 P.M. the Director of Nursing said that all central lines require a plan of care and doctor's orders for their maintenance.

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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** 36797 Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADLs) for 3 dependent Residents (#14, #77 and #15) out of a total sample of 24 Residents. Specifically, the facility failed to: 1. For Resident #14, cut fingernails and remove unwanted chin hair. 2. For Resident #77, cut fingernails. 3. For Resident #15, remove unwanted chin hair. Findings include: Review of the facility policy titled Activities of Daily Living (ADL), Supporting and dated revised March 2018 indicated that residents that are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 1. Resident #14 was admitted to the facility in July 2024 with diagnoses including schizophrenia, anxiety disorder and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #14 scored an 8 out of 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. Further review indicated that Resident #14 requires substantial assistance with bathing and dressing and requires set up assistance with personal hygiene. On 11/19/24 at 8:54 A.M., the surveyor observed Resident #14 laying in bed. The surveyor also observed Resident #14 to have long, jagged fingernails and inch-long chin hair. During an interview on 11/19/24 at 8:54 A.M., Resident #14 said that he/she is embarrassed by the hairy chin and wants his/her long nails cut. Resident #14 said that he/she is not capable of cutting his/her fingernails or removing unwanted chin hair without staff's help. On 11/20/24 at 10:56 A.M., the surveyor observed Resident #14 sitting in the [NAME] unit dining room. The surveyor also observed Resident #14 to have long, jagged fingernails and inch long chin hair. On 11/21/24 at 8:30 A.M., the surveyor observed Resident #14 with long chin hair. Review of the care plan indicated that Resident #14 requires assistance with daily hygiene, as needed. Further review failed to indicate that Resident #14 refuses care. During an interview on 11/21/24 at 8:30 A.M., Certified Nurse's Aide (CNA) #5 said that it was the responsibility of the CNAs to remove unwanted chin hair and to cut fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #77 was admitted to the facility in June 2023 with diagnoses including stroke with left sided hemiplegia/hemiparesis, diabetes, and depression. Review of the Minimum Data Set assessment dated [DATE], indicated a score of 13 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Further review indicated that Resident #77 is totally dependent for activities of daily living (ADLs) and has impairments to his/her upper and lower body. Review of the care plan dated as initiated 6/28/23 indicated a focus of self-care deficit, including Resident #77 is totally dependent on staff for ADL care. Interventions included keep nails trimmed to prevent injury. On 11/19/24, at 8:30 A.M., the surveyor observed Resident #77 in his/her room with fingernails that were long and jagged. During an interview on 11/19/24 at 8:30 A.M., Resident #77 said that he/she needs help cutting his/her fingernails and staff have not helped. On 11/19/24 at 1:06 P.M., the surveyor observed Resident #77 in the 2nd floor dining room with fingernails that were long and jagged. During an interview on 11/20/24 at 10:39 A.M., CNA #4 said that it was the responsibility of the CNAs to cut fingernails. During an interview on 11/20/24 at 10:45 A.M., Unit Manager #2 said that she was not aware Resident #77 had long nails. During an interview on 11/20/24 at 11:05 A.M., Unit Manager #2 said that it is the facility protocol for the podiatrist to cut fingernails on residents diagnosed with diabetes. During an interview on 11/20/24 at 11:06 A.M., Unit Secretary #1 said that facility staff had never offered Resident #77 a consent to be seen by a podiatrist. During an interview on 11/20/24 at 1:02 P.M., the Director of Nursing (DON) said the podiatrist does not cut fingernails. The DON then said that CNAs are responsible for cutting fingernails and removing unwanted chin hair. 3. Resident #15 was admitted to the facility in July 2022 with diagnoses including cancer, muscle weakness and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #15 is cognitively intact and scored a 13 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #15 is totally dependent on staff for all activities of daily living. On 11/19/24, at 9:10 A.M., the surveyor observed Resident #15 to have a significant amount of chin hair. Resident #15 said that he/she is embarrassed by the chin hair and wanted it removed. Resident #15 then said that he/she doesn't get the help he/she needs to remove the chin hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24, at 12:30 P.M., the surveyor observed Resident #15 to have a significant amount of chin hair. On 11/21/24, at 9:25 A.M., the surveyor observed Resident #15 to have a significant amount of chin hair.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to provide a meaningful activity program for one Resident (#44) out of a total of 24 sampled residents Findings include: Resident #44 was admitted to the facility in June 2023 with diagnoses including malignant neoplasm of frontal lobe and aphasia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #44 is severely cognitively impaired and requires assistance with bathing, dressing and transfers. During an interview on 11/19/24 at 10:20 A.M., the surveyor observed Resident #44 resting in bed. Family Member #1 said that she visits Resident #44 regularly and that Resident #44 is confused and bedbound. Family Member #1 said that she has not seen staff offer Resident #44 in room activities, turn his/her TV on or play music for him/her. Review of Resident #44's Activities Care Plan, dated 6/13/24, indicated: Focus: Resident experiences barriers to activities, especially communication and language barriers. Due to brain neoplasm, experiences cognitive loss and aphasia, Resident #44 is primarily nonverbal. Resident is alert but confused and forgetful. Goals: Resident #44 declines group activities at this time but will socialize weekly during family visits and staff visits. Interventions. Due to Chinese speaking as well as nonverbal, aphasic state, use interpreter as needed, also pay attention to Resident #44 facial expressions and body language, and any indications of discomfort in order to pick up nonverbal cues. Family members to bring in sentimental reminders of resident's life, photos, favorite music, favorite belongings in order to comfort resident. Provide resident daily room visits. On 11/19/24 at 2:00 P.M., Resident #44 was observed in bed awake and able to follow the surveyor with his/her eyes. There was a TV and radio in the room, but they were not on, and Resident #44 lay in the bed in silence. On 11/20/24 at 8:36 A.M., 9:52 A.M., 10:45 A.M., and 1:49 P.M., the surveyor observed Resident #44 awake and in bed. The privacy curtain was pulled, and he/she was not visible and could not see out into the hallway. The overhead light was off, and the room was dimly lit. Resident #44 lay in bed in silence as his/her TV and radio were not on. During an interview on 11/20/24 at 8:48 A.M., Nurse #2 said that Resident #44 is bedbound and refuses to get out of bed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 1:47 P.M., the Activities Assistant said that Resident #44 does not get out of bed or attend activities. The Activities Assistant said in room visits are provided to residents who do not leave their rooms. Review of Resident #44's Activity Participation Record on 11/20/24 indicated he/she had received no in-room activities on 11/5/24, 11/9/24, 11/10/24, 11/12/24, 11/15/24, 11/16/24, 11/17/24, 11/18/24, 11/19/24 and 11/20/24. During an interview on 11/20/24 at 1:59 P.M., the Activities Director said that she has volunteers and staff that provide in-room visits and activities for residents who do not wish to leave their room. She said that they will encourage TV, the use of a radio and provide sensory support. The surveyor and the Activities Director reviewed Resident #44's Activity Participation Record, and the Activity Director said she was not aware that activities were not provided to Resident #44.

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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. 36797 Based on observations, record review and interview, the facility failed to provide respiratory care services in accordance with professional standards of practice for one Resident (#67) out of a total sample of 24 Residents. Specifically, the facility failed to ensure the oxygen filter was clean and the oxygen tubing changed as ordered. Findings include: Review of the facility policy titled Oxygen Administration and dated revised October 2010 failed to indicate how often the oxygen tubing was to be replaced and how often the concentrator filter was to be cleaned. Resident #67 was admitted to the facility in October 2021 with diagnoses including chronic obstructive pulmonary disease, heart disease, and kidney disease. On 11/19/24 at 8:38 A.M., the surveyor observed Resident #67 lying in bed receiving oxygen via nasal cannula, attached to an oxygen concentrator. The surveyor observed the oxygen tubing to be dated 10/11/24. The surveyor also observed the concentrator filter to be covered with a gray fuzzy substance. Review of the doctor's orders indicated an order dated 10/26/22 to change nasal cannula weekly. Further review indicated an order dated 10/11/21 to change all disposable oxygen supplies every week and as needed. Label and date all supplies. During an interview on 11/20/24 at 10:45 A.M., Unit Manager #2 said that all oxygen tubing was supposed to be changed weekly. During an interview on 11/20/24, at 1:02 P.M. the Director of Nursing (DON) said that the concentrator air filters get cleaned according to manufacturer's instructions. The DON was not able to state what those directions were nor was he able to produce the directions to the surveyor.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 44095 Based on observation, record review, and interview, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice for one Resident (#4) out of a total sample of 24 residents. Specifically, for Resident #4 the facility failed to administer the correct dose of a lidocaine patch (topical pain patch that comes in different strengths) and apply the lidocaine patch to the correct location. Findings include: Review of the facility policy, Pain Assessment and Management, dated as revised October 2022, indicated the purpose is to help staff identify pain in the resident, and develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. * Implementing Pain Management Strategies 5. The following are considered when establishing the medication regimen: a. Starting with lower doses and titrating upward as necessary; 6. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications. Resident #4 was admitted to the facility in August 2021 with diagnoses including diabetes, atrial fibrillation, heart failure, and pain. Review of the Minimum Data Set (MDS) assessment, dated 11/1/24, indicated Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated he/she was cognitively intact. This MDS indicated Resident #4 did not complain of pain in the last 5 days. Review of Resident #4's plan of care related to pain, dated as revised 9/13/23, indicated: - Administer pain medication per physician orders, initiated 8/4/21. On 11/19/24 at 10:52 A.M., 11/20/24 at 12:50 P.M., 11/20/24 at 4:11 P.M., and on 11/21/24 at 10:22 A.M., the surveyor observed lidocaine 5% patches applied to Resident #4's right hip and right shoulder. Review of Resident #4's physician's order, dated 3/15/23, indicated: - Lidocaine Patch 4%, apply to left hip. Topically one time a day for pain management. Apply for 12 Hours in a 24-Hour period. Max dose = 3 patches. External use only. Review of Resident #4's physician's order, dated 6/27/24, indicated: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lidocaine Patch 4%, apply to right shoulder topically one time a day for pain management. Apply for 12 Hours in a 24-Hour period. Max dose = 3 patches. External use only. Further review of the physician's orders and location of the lidocaine patch determined that nursing applied the incorrect strength and applied the patch to the wrong hip on 11/19/24, 11/20/24, and 11/21/24. During an interview on 11/20/24 at 12:50 P.M., Nurse #4 said that she applied the lidocaine 5% patches to Resident #4 to his/her right shoulder, right wrist, and right hip. Nurse #4 said that she verified the lidocaine patch strength prior to applying the patches to Resident #4. During an interview on 11/21/24 at 10:20 A.M., Nurse #5 said Resident #4 uses lidocaine 5% patches and she applied the lidocaine 5% patches to Resident #4 this morning. During an interview on 11/21/24 at 9:16 A.M., the Director of Nursing (DON) said nursing should apply the correct lidocaine patches and verify the correct site prior to application.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 36797 Based on record review and interview, the facility failed develop a trauma-informed care plan to address the diagnosis of post-traumatic stress disorder (PTSD) for one Resident (#201) of 24 sampled residents. Findings include: Review of the facility policy titled Trauma Informed Care and Culturally Competent Care dated revised August 2022 indicated that individualized care plans are developed that address past trauma in collaboration with the resident and family as appropriate. Further review indicated to identify and decrease exposure to triggers that may retraumatize the resident. Resident #201 was admitted to the facility in November 2024 with diagnoses including post-traumatic stress disorder (PTSD), osteomyelitis (infection of the bone), spinal abscesses with drains in the back and intravenous antibiotic use. Review of the medical record failed to indicate a baseline care plan for PTSD was developed within 48 hours of admission to the facility. Further review indicated that as of 5 days post admission, a baseline plan of care for PTSD had not been developed. During an interview on 11/20/24 at 1:02 P.M., the Director of Nursing said that nursing staff should have developed a baseline care plan for Resident #201 within 48 hours of admission to the facility. During an interview on 11/20/24 at 3:13 P.M., the Regional Social Service Director said that nursing staff should have developed a baseline care plan within 24 hours for Resident #201's PTSD.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44095 Based on record review and interview, the facility failed to review the consultant pharmacist's recommendations for the monthly medication regimen reviews (MRR) for one Resident (#4), out of a total sample of 24 residents. Specifically, the facility failed to ensure nursing staff and the physician reviewed the consultant pharmacist's recommendations for Resident #4 from 9/23/24 and 10/25/24. Findings include: Review of the facility policy, Medication Regime Reviews, dated as revised May 2019, indicated the consultant pharmacist reviews the medication regimen of each resident at least monthly. 8. Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contains: a. the resident's name; b. the name of the medication; c. the identified irregularity; and d. the pharmacist's recommendation. 11. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator. 12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. 13. An acute change of condition may prompt a request for a MRR. The staff member who identifies the change of condition follows reporting procedures to notify the physician. The physician may request a MRR be conducted within a specific timeframe (e.g., within 24 hours). 14. The consultant pharmacist provides the director of nursing services and medical director with a written, signed, and dated copy of all medication regimen reports. 15. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. Resident #4 was admitted to the facility in August 2021 with diagnoses including diabetes, atrial fibrillation, heart failure, and pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 11/1/24, indicated Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated he/she was cognitively intact. Review of Resident #4's pharmacist progress note, dated 9/23/24, indicated the following: - September Review: discontinue as needed Atarax and Imodium [loperamide] due to nonuse. Review of Resident #4's pharmacist progress note, dated 10/25/24, indicated the following: - September Review: discontinue as needed Atarax and Imodium due to nonuse. - October Review: please evaluate the continued need for scheduled Flonase. Review of Resident #4's active physician's orders on 11/20/24, included the following: - hydroxyzine HCl Oral Tablet (Hydroxyzine HCl/Atarax), give 25 milligrams (mg) by mouth every 6 hours as needed for rash, dated 8/24/23. - Loperamide HCl Oral Tablet 2 mg (Loperamide HCl), give 1 tablet by mouth every 12 hours as needed for diarrhea, dated 2/18/23. - Flonase allergy relief nasal suspension 50 microgram (Fluticasone Propionate (Nasal), 1 spray in each nostril one time a day for congestion, dated 4/4/23. During an interview on 11/20/24 at 6:41 A.M., Nurse #3 said that there is no Unit Manager for the 3rd floor, and the first floor Unit Manager #1 manages the 3rd floor pharmacy recommendations. Nurse #3 was unable to find any pharmacy recommendations for Resident #4. During an interview on 11/20/24 at 9:48 A.M., Unit Manager #1 said she is assisting with completing the pharmacy recommendations for the 3rd floor. Unit Manger #1 said that the September 2024 and October 2024 recommendations should be reviewed and implemented by now. Unit Manager #1 provided the surveyor with stack of August 2024 recommendations, and she said that these are the last recommendations she has from the Director of Nursing. During an interview on 11/21/24 at 9:18 A.M., the Director of Nursing (DON) said he did not receive the pharmacy recommendations from the consultant pharmacist in September 2024 and October 2024, but he should have. The DON said that nursing should review the pharmacy recommendations and implement the recommendations. On 11/21/24 at 10:30 A.M., the facility provided the surveyor with Resident #4's MRRs, that were not addressed by nursing staff or the physician, with the following recommendations: 1. MRR dated 9/23/24, could the following prn, as needed, orders be discontinued for this resident as none have been utilized for some time. Unused PRNs tend to expire and can result in an increased risk of errors and increased cost. - Loperamide 2 mg caps (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hydroxyzine 25 mg tabs 2. MRR dated 10/25/24, resident with long term orders for Flonase Nasal Spray: 1 spray each nostril daily. Please evaluate the continued need/benefit of Flonase Spray and consider a trial tapering off of the drug or changing to as needed only at this time. If Flonase continues to be needed as ordered, please document as such.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 36797 Based on observations, record review, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when three out of three nurses observed made seven errors out of 30 opportunities, resulting in a medication error rate of 23.33%. Those errors impacted three Residents (#15, 22 and #48), out of three residents observed. Findings include: Review of the facility policy titled Administering Oral Medications dated revised October 2010 indicated that; #6: Check the label on the medication and confirm the medication name and dose with the MAR (medication administration record). #8 Check the medication dose. Re-check to confirm the proper dose. 1. Resident #15 was admitted to the facility in July 2022 with diagnoses including cancer, muscle weakness and anxiety disorder. On 11/20/24 at 8:48 A.M., the surveyor observed Nurse #6 give Resident # 15 the following medications: Omeprazole 20 mg (milligrams) 1 tablet Amlodipine 5 mg 2 tablets Refresh eye drops 1 drop each eye. Fluticasone nasal spray one spray each nostril Dairy aid 1 tablet Metoprolol tartrate 25 mg 1 tablet Sertraline 100 mg (3) 1/2 tablets to = 150 mg Review of the doctor's orders indicated to give: Omeprazole 20 mg (milligrams) 1 tablet Amlodipine 5 mg 2 tablets Refresh eye drops 1 drop each eye. Fluticasone nasal spray one spray each nostril (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dairy aid 1 tablet Metoprolol tartrate 25 mg 1 tablet Sertraline 100 mg (3) 1/2 tablets to = 150 mg Aspirin enteric coated tablet delayed release 81 mg (not given) Magnesium Oxide 400 mg give 2 tablets two time a day (not given) 2. Resident #22 was admitted to the facility in August 2020 with diagnoses including heart disease and stroke. On 11/20/24, at 9:48 A.M., the surveyor observed Nurse #4 give Resident #22 the following medications: Sulfasalizine 500 mg 1 tablet Clopidogrel 75 mg 1 tablet Lasix 20 mg 1 tablet Duloxetine 60 mg 1 tablet Gabapentin 300 mg 2 tablets Lisinopril 5 mg 1 tablet Hydroxychloroquine 200 mg 1 tablet Senna 8.6 mg 1 tablet Ferrous Gluconate 324 mg 1 tablet Folic acid 400 mg 2 tablets Vit D3 2000 iu (international units) Acetaminophen 325 mg 2 tablets Review of the doctor's orders indicated to give: Sulfasalizine 500 mg 1 tablet Clopidogrel 75 mg 1 tablet Lasix 20 mg 1 tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Duloxetine 60 mg 1 tablet Gabapentin 300 mg 2 tablets Lisinopril 5 mg 1 tablet Hydroxychloroquine 200 mg 1 tablet Senna 8.6 mg 2 tablets (gave 1 tablet) Ferrous Gluconate 239 mg 1 tablet (gave 324 mg) Folic acid 1000 mg 1 tablets (gave 800 mg) Vit D3 2000 iu (international units) Acetaminophen 325 mg 2 tablets Famotidine 20 mg 1 tablet (not given) 3. Resident #48 was admitted to the facility in November 2024 with diagnoses including osteomyelitis, opioid dependence and liver failure. On 11/20/24 at 8:09 A.M., the surveyor observed Nurse #7 give Resident #48 the following medications: Gabapentin 400 mg 2 tablets Meformin 1000 mg 1 tablet Acetaminophen 325 mg 2 tablets folic acid 1000 mg 1 tablet Lasix 40 mg 1 tablet Jardiance 25 mg 1 tablet Lidocaine 4% patch Losartan Pot. 100 mg 1 tablet multivitamin with iron 1 tablet Vit B1 100 mg 1 tablet Ceftriaxone 2 gm (grams) NS (normal saline) 100 ml (milliliters) IV (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the doctor's orders indicated to give: Gabapentin 400 mg 2 tablets Meformin 1000 mg 1 tablet Acetaminophen 325 mg 3 tablets (gave 2 tablets) folic acid 1000 mg 1 tablet Lasix 40 mg 1 tablet Jardiance 25 mg 1 tablet Lidocaine 4% patch Losartan Pot. 100 mg 1 tablet multivitamin with iron 1 tablet Vit B1 100 mg 1 tablet Ceftriaxone 2 gm (grams) NS (normal saline) 100 ml (milliliters) IV During an interview on 11/20/24 at 1:02 P.M., the Director of Nursing (DON) said that the medication error rate was above acceptable limits. The DON said that all medications are to be given as ordered by the physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation and interview, the facility failed to ensure medications were properly secured. Specifically: 1. The facility failed to ensure medications were not left unattended on medication carts, at nurses' stations and in resident rooms. 2. The facility failed to ensure a medication cart was locked when unattended on the 3rd floor. 3. The facility failed to ensure medications were not left unattended at the bedside for Resident #4. 4. The failed to ensure medications were labeled with date opened. 5. The failed to ensure medications were not left unattended on top if the medication cart. 6. For Resident #201, the facility failed to ensure medication was not stored at bedside. Findings include: Review of the facility's Medication Labeling and Storage policy, dated February 2023, indicated: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and tray carts used to transport such items are not left unattended if open or otherwise potentially available to others. 1. On 11/19/24 at 1:21 P.M., the surveyor observed two medication cards on top of an unlocked medication cart on the 1st floor. One medication card contained one 100 milligram (mg) tablet of gabapentin (a medication used to treat pain), and one card containing eleven 60 MG tablets of Duloxetine (a medication used to treat anxiety and depression). Nurse #2 exited a resident room and approached the cart. Nurse #2 said that the medications should not have been left on top of the cart unattended. On 11/21/24 at 6:51 A.M., the surveyor observed four medication cards unattended on the desk of the first floor nurses station. The medication cards contained twenty-five 50 mg tablets of Hyoscyamine (medication used to treat stomach and intestinal disorders), twenty-one 50 mg tablets of Losartan (medication used to treat blood pressure) and twenty-one tablets of 50 mg Famotidine (a medication used to reduce stomach acid). Unit Manager #1 then arrived to the unit and removed the medication cards. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/24 at 9:43 A.M., the surveyor observed three medication cups on a resident's bedside table. Licensed nursing staff were not in the bedroom. The cups were behind the resident's back, and he/she could not observe them. One medication cup had one small white pill inside, one medication cup had approximately 6 tablets inside, and one medication cup was filled with an amber-like fluid. The medication cups contained the following medications: one capsule Gabapentin 300 mg (used to treat pain), one tablet Torsemide 20 mg (used to treat kidney disease), one darolutamide tablet 300 mg (used to treat prostate cancer), one multi-vitamin tablet, one tablet Pantoprazole Sodium Tablet 40 mg (used to treat acid reflux), one Ferrous Sulfate Tablet 325 mg (used to treat low iron levels), one Finasteride Tablet 5 mg (used to treat prostate cancer), one Amlodipine Tablet 10 mg (used to treat hypertension). During an interview on 11/21/24 at 7:26 A.M., Unit Manager #1 said medications should not be left unattended. 44095 2. The facility failed to ensure a medication cart was locked when unattended on the 3rd floor. On 11/21/24 at 6:46 A.M., the surveyor observed the 3rd floor East medication cart unlocked and unattended. There were two housekeeping employees, two therapy employees, one resident, and the dietitian within the vicinity of the unlocked and unattended medication cart. On 11/21/24 at 6:51 A.M., the surveyor observed Nurse #3 return to the unlocked and unattended medication cart. During an interview on 11/21/24 at 9:25 A.M., the Director of Nursing (DON) said medication carts should be locked when unattended. 3. The facility failed to ensure medications were not left unattended at the bedside for Resident #4. On 11/19/24 at 10:52 A.M., 11/20/24 at 6:39 A.M., 11/20/24 at 8:47 A.M., 11/20/24 at 12:50 P.M., 11/20/24 at 4:11 P.M., 11/21/24 at 6:41 A.M., and on 11/21/24 at 10:22 A.M., the surveyor observed two lidocaine 5% patches on Resident #4's bedside table sitting directly on top of a plastic organizer. On 11/21/24 at 10:22 A.M., the surveyor, accompanied by Nurse #5, went to Resident #4's bedroom. Nurse #4 said that the lidocaine patches should not be left unattended at the bedside. During an interview on 11/21/24 at 9:17 A.M., the DON said the lidocaine patches should be stored in the medication cart and not at Resident #4's bedside. 36797 4. On 11/21/24 at 8:24 A.M. the surveyor observed a Wixela inhaler (used to treat asthma) open without a date inside the [NAME] unit medication cart. Review of the manufacturer's directions indicated to discard the inhaler one month after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the inhaler's pharmacy label indicated that the inhaler was received by the facility on 9/25/24. During an interview on 11/21/24 at 8:24 A.M., Nurse #6 said that the inhaler should have been dated when opened. On 11/21/24 at 8:26 A.M., the surveyor observed a bottle of Tuberculin derivative (used to test for tuberculosis) open and without an opened date. During an interview on 11/21/24 at 8:30 A.M., Nurse #6 said that the bottle of Tuberculin derivative should have been dated when opened. Nurse #6 then said that any accessed bottle of injectable medication is only good for 1 month. 5. On 11/20/24, at 9:50 A.M., the surveyor observed Nurse #4 leave 2 cards of medications on top of the medication cart in the hallway and enter a resident's room, out of sight of the medication cart. During an interview on 11/20/24, at 9:55 A.M., Nurse #4 said that she should not have left the medication on top of the medication cart, unattended. 6. Resident #201 was admitted to the facility in November 2024 with diagnoses including osteomyelitis (infection of the bone), spinal abscess with drains in the back and intravenous antibiotic use. On 11/19/24 at 8:08 A.M., and at 12:30 P.M., the surveyor observed a bottle of Motrin B on Resident #201's over the bed table. Review of the medical record failed to indicate Resident #201 was assessed for self-administration of medication. During an interview on 11/20/24 11:15 A.M., Resident #201 said that he/she put the bottle of Motrin in his/her backpack. During an interview on 11/20/24 11:20 A.M., Nurse #4 said that Resident #201 is not supposed to have medications at bedside.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 15016 Based on record review and interview, the facility failed to accurately document in the clinical records for 4 residents (#30, #67, #77 and #1) of 24 sampled residents. Specifically: 1. For Resident #30, the facility failed to document diabetic foot care. 2. For Resident #67, the facility inaccurately documented O2 (oxygen) tubing changed when it was not. 3. For Resident #77, the facility inaccurately documented a hand splint/brace was on when it was not. 4. For Resident #1, the facility failed to ensure staff documented the administration of medications. Review of the Documentation of Medication Administration policy dated November 2022 indicated: A medication administration record is used to document all medications administered. Documentation of medication administration includes . date and time of administration, reason(s) why a medication was withheld, not administered, or refused (as applicable); initials, signature and title of the person administering the medication. Review of the facility policy titled Charting and Documentation, dated revised July 2017 indicated that documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1. Resident #30 was admitted to the facility in February 2024, and has active diagnoses which include diabetes mellitus and dementia. Resident #30 had no documented incidents of refusing care. Review of Resident #30's physician orders dated 2/15/24 indicated Diabetic foot care every evening shift. Review of Resident #30's Treatment Administration Record (TAR) dated November 2024 indicated staff did not document if diabetic foot care was provided on 11/6/24, 11/8/24, 11/10/24, 11/12/24 and 11/14/24. During an interview with the Director of Nursing (DON) on 11/21/24 at approximately 9:10 A.M., he said licensed nursing staff are required to document whether a physician's order was completed, or not, in the Treatment Administration Record. The DON said diabetic foot care was not documented as complete for Resident #30 on 11/6/24, 11/8/24, 11/10/24, 11/12/24 and 11/14/24. 36797 2. Resident #67 was admitted to the facility in October 2021 with diagnoses including chronic obstructive pulmonary disease, heart disease, and kidney disease. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 at 8:38 A.M., the surveyor observed Resident #67 lying in bed receiving oxygen via nasal cannula, attached to an oxygen concentrator. The surveyor observed the oxygen tubing to be dated 10/11/24. Review of the doctor's orders indicated an order dated 10/26/22 to change nasal cannula weekly. Further review indicated an order dated 10/11/21 to change all disposable oxygen supplies every week and as needed. Label and date all supplies. Review of the Medication Administration Record (MAR) dated November 2024 inaccurately indicated that the O2 tubing was changed 11/6/24 and 11/13/24. During an interview on 11/20/24 at 10:45 A.M., Unit Manager #2 said that all oxygen tubing was supposed to be changed weekly. During an interview on 11/20/24, at 1:02 P.M., the Director of Nursing (DON) said that nursing should not have documented the O2 tubing was changed when it wasn't. 3. Resident #77 was admitted to the facility in June 2023 with diagnoses including stroke with left sided hemiplegia/hemiparesis, diabetes and depression. Review of the Minimum Data Set assessment dated [DATE], indicated a score of 13 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Further review indicated that Resident #77 is totally dependent for activities of daily living (ADLs) and has impairments to his/her upper and lower body. Review of the doctor's order dated 10/26/23, indicated an order for left hand splint on in the morning, off in the evening as tolerated. Review of the care plan dated as initiated 6/28/23 indicated a focus of self care deficit with interventions including left hand splint on during the day as tolerated and off in the evening. On 11/19/24 at 8:30 A.M., the surveyor observed Resident #77 in his/her room without a hand brace on the left hand. The surveyor further observed that there was no hand brace in Resident #77's room. During an interview on 11/19/24 at 8:30 A.M., Resident #77 said that he/she has a hand brace for the left hand but it has been missing for about a month. Resident #77 said that the hand brace was sent down to laundry and never came back. On 11/19/24 at 1:06 P.M., the surveyor observed Resident #77 in the 2nd floor dining room without a hand brace on. Review of the Medication Administration Record (MAR) dated November 2024 indicted that Resident #77 was wearing a splint on the left hand 33 out of 33 possible shifts. During an interview on 11/20/24 at 10:39 A.M., Resident #77 was observed to have a blue brace on the left hand but Resident #77 said it was the wrong brace and he/she didn't know where it came from. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 10:39 A.M., Certified Nurse's Aide (CNA) #4 said that it was the responsibility of the CNA to apply any braces. During an interview on 11/20/24 at 10:45 A.M., Unit Manager #2 said that she was not aware that Resident #77 is wearing the wrong brace. During an interview on 11/20/24 10:49 A.M. Physical Therapist (PT) #1 said that Resident #77 is not wearing the correct brace on his/her left hand. She then said that the facility has ordered the correct brace. PT #1 then said that the brace had been ordered on 10/24/24 and received on 10/31/24 but had been given to another resident who went home. PT #1 then said that she dropped the ball and forgot to order Resident #77 another brace. During an interview on 11/20/24 at 1:02 P.M., the Director of Nursing (DON) said it is the nurse's responsibility to ensure braces have been applied to the residents and to document in the medical record accurately. 36876 4. Resident #1 was admitted to the facility in February 2024 with diagnoses including cerebral infarction and vascular dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 is severely cognitively impaired as evidenced by a score of one out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). Review of the November 2024 Medication Administration Record (MAR) on 11/19/24 indicated the following: Atorvastatin Calcium tablet 80 MG, give via G tube in the evening: nursing did not sign off the medication was administered on 11/5/24, 11/8/24 and 11/18/24. Polyethylene Glycol 3350 Powder; give 17 gram once a day: nursing did not sign off the medication was administered on 11/16/24. Quetiapine Fumarate Oral Tablet 25 MG give 1 tablet at bedtime: nursing did not sign off the medication was administered on 11/5/24, 11/7/24 and 11/9/24. Amlodipine Besylate 5 MG give two times a day; nursing did not sign off the medication was administered during the morning shift on 11/16/24. Acetaminophen Tablet 500 MG give two caplet every 8 hours for pain: Nursing did not sign off the dosages were administered the evening shifts of 11/5/24, 11/8/24, 11/10/24, 11/14/24 and 11/18/24. Enteral Feed every shift Glucerna 1.5 full strength continuously rate: 45 ml/hr: nursing did not sign off the feed was administered on the morning shift on 11/16/24 and evening shifts on 11/5/24, 11/8/24, 11/10/24 and 11/18/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225509	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Brookline	99 Park Street Brookline, MA 02146

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Artificial Tears Solution 1.4%, instill 2 drops in both eyes every 6 hours: nursing did not sign off that the drops were administered on the evening shifts on 11/5/24, 11/8/24, 11/16/24, and 11/18/24. Guaifenesin give 10ML every 6 hours: nursing did not sign off the medication as being administered on the evening shifts on 11/5/24, 11/8/24, 11/16/24 and 11/18/24. Insulin 100 unit/ml, inject 8 units subcutaneously every 6 hours: nursing did not sign off the medication as being administered on the afternoon shift on 11/16/24 and the evening shifts on 11/5/24, 11/7/24 and 11/18/24. Metoclopramide HCL table 5 MG, give 1 tablet four times a day: nursing did not sign off the medication was administered on 11/5/24, 11/8/24, 11/16/24 and 11/18/24. Oxycodone HCL 5MG/ML, give 2.5 ml every six hours: nursing did not sign off the medication was administered on the evening shifts on 11/5/24, 11/8/24, 11/16/24 and 11/18/24. During an interview on 11/21/24 at 8:20 A.M , the Director of Nursing (DON) said that nurses are expected to document the administration or refusals of medications on the MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225509	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Brookline	99 Park Street Brookline, MA 02146

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36797 Based on observation, record review and interview, the facility failed to follow infection control practices to prevent possible spread of infection by failing to follow infection control practices during medication pass. Findings include: Review of the facility policy titled Administering Oral Medications, dated revised October 2010 indicated that for tablets or capsules from a bottle pour the desired number into the bottle cap and transfer to the medication cup. Do not touch the medications with your hands. For unit dose tablets or capsules place the packaged medications directly into the medication cup. During medication pass on 11/20/24, at 9:48 A.M., the surveyor observed Nurse #4 pour 5 out of 7 unit dose medications into her hand before transferring each one into a medication cup, potentially contaminating the poured medications. The surveyor also observed Nurse #4 pour 5 out of 5 medications from different bottles into her bare hand, placing some into medication cups, and returning the unused medications to the bottles, potentially contaminating these 5 bottles of medications. During an interview on 11/20/24, at 10:03 A.M., Nurse #4 said she was not supposed to touch medications with her bare hands. During an interview on 11/20/24, at 1:02 P.M., the Director of Nursing said that nurses are not to touch medications with their bare hands.