STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Lowell	30 Princeton Boulevard Lowell, MA 01851

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48671 Based on observation, interviews, and reviewed records, the facility failed to ensure staff treated residents in a dignified manner to effectively communicate in a language they understand for one Resident (#2) out of a total sample of 28 Residents. Findings include: The facility failed to indicate a language/communication policy was available as requested during the survey. Resident #2 was admitted to the facility in January 2023 with diagnoses including weakness, hemiplegia and hemiparesis following cerebral infarction effecting right dominant side, and weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/27/25, indicated Resident #2 did not have a Brief Interview for Mental Status assessment completed and was assessed by staff to have moderately impaired cognition. The MDS further indicated Resident #2 speaks Cantonese. Review of Resident #2's communication care plan dated, 2/19/25, indicated the following interventions: -Resident has impaired communication related to primary language is Cantonese. -Enlist use of communication devices as needed (i.e.) communication board, sign language specify. -Allow time to process information -Anticipate resident needs if resident is unable to express needs. -Assess body and facial expressions. During an observation on 3/25/25 at 8:33 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. Certified Nursing Assistant (CNA) #3 entered the dining room and was observed walking over to the Resident, moved the wheelchair closer to the table and then walked out of the dining room. CNA #3 did not speak to Resident #2 during the observation. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/26/25 at 7:46 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The surveyor observed a staff member deliver a breakfast tray to Resident #2. The staff member was observed speaking to Resident #2 in English. Resident #2 did not try to engage or acknowledge the staff member. During an observation on 3/26/25 at 8:20 A.M., the survey observed CNA #2 deliver a breakfast tray to Resident #2. The CNA was observed speaking to Resident #2 in English. Resident #2 did not try to engage or acknowledge CNA #2. During an observation on 3/26/25 at 9:24 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The surveyor observed a staff member walk into the dining room and was observed speaking English to two other residents seated in the dining room. The staff member did not try to engage or acknowledge Resident #2. During an observation on 3/26/25 at 9:42 A.M., Family Member #2 was observed asking staff if someone could take Resident #2 to the bathroom. Resident #2 was observed engaging, smiling and talking to Family Member #2 in Cantonese. CNA #2 walked over to Resident #2 and began pushing him/her in the wheelchair down the hall to the Residents room without engaging or speaking to Resident #2. CNA #2 and Occupational Therapist (OT) #1 were then observed undressing Resident #2, pulling his/her pants down and placing him/her on the toilet and then both exited the bathroom. CNA #2 and OT #1 did not speak or engage with Resident #2 during the entire observation. During an observation on 3/26/25 at 9:54 A.M., Unit Manager #1 and the Infection Control Nurse entered Resident #2's room and began to assist Resident #2 off the toilet. Unit Manager #1 and the Infection Control Nurse were observed speaking English to Resident #2 and said, Here you can wash your hands, as they turned the wheelchair towards the sink and turned the water on. Resident #2 did not engage or acknowledge the staff members. Family Member #2 was observed speaking to the Resident in Cantonese and the Resident could be heard exchanging in the conversation. Family Member #2 said she would wash the Residents' hands. Unit Manager #1 and the Infection Control Nurse then exited the Residents room. Throughout the observations a communication board was not observed or utilized and staff did not utilize a language line for interpreter services. During an interview on 3/26/24 at 10:00 A.M., Family Member #2 said Resident #2 understands and can communicate in Cantonese, but staff do not understand him/her and do not try to communicate in any way other than speaking English, which the Resident does not understand. During an interview on 3/26/25 at 10:04 A.M., CNA #2 said she does not know what language Resident #2 speaks and said she can't understand Resident #2 because he/she does not speak English. When the surveyor asked CNA #2 how she communicates with Resident #2 she said the family is usually here. When asked how she communicates if the family is not present CNA #2 said I'm not sure. During an interview on 3/26/25 at 10:06 A.M., Nurse #4 said Resident #2 speaks Cantonese and does not understand English and said there is a kitchen staff member who speaks Cantonese that could help if needed. Nurse #2 said he was not aware of a translation or language line in the facility and has never seen or used a communication board for the Resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/25 at 10:09 A.M., Unit Manager #1 said Resident #2 doesn't speak English and said if he/she is shouting or grimacing staff will know he/she needs to use the bathroom. Unit Manager #1 said staff can use the language line if needed and said staff should communicate with Resident #2 during care. Unit Manager #1 said she has not used the language line and has not seen a communication board used with Resident #2. During an interview on 3/27/25 at 8:34 A.M., Nurse #5 said Resident #2 speaks Cantonese and said if he/she yells out she will know the Resident needs to use the bathroom or is in pain. Nurse #5 said the facility does not use an interpreter line and is not aware of any communication board used for Resident #2. Nurse #2 said she speaks to the Resident in English, but he/she can't understand what she is saying. During an interview on 3/27/25 at 10:27 A.M., Director of Nurses (DON) said Resident #2 requires translation services and said staff should be utilizing the translation line to communicate with the Resident. The DON said the communication care plan should be followed by all staff and she expects staff to use a communication board to assist with communication.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48671 Based on observations, record review, and interviews, the facility failed to ensure a call light was within reach for one Resident (#2) out of a total sample of 28 residents. Findings include: Resident #2 was admitted to the facility in January 2023 with diagnoses including weakness, hemiplegia and hemiparesis following cerebral infarction effecting right dominant side, and weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/27/25, indicated Resident #2 did not have a Brief Interview for Mental Status assessment completed and was assessed by staff to have moderately impaired cognition. The MDS further indicated Resident #2 speaks Cantonese. During an observation on 3/25/25 at 7:27 A.M., Resident #2 was in bed, the call light was located behind the bed on the floor. The call light was out of reach. During an observation on 3/26/25 at 7:12 A.M., Resident #2 was in bed, the call light was located behind the bed on the floor. The call light was out of reach. During an interview on 3/26/25 at 10:05 A.M., CNA #2 said Resident #2 uses the call light and staff will check on him/her during the day. During an interview on 3/26/25 at 10:07 A.M., Nurse #4 said Resident #2 can use the call light if he/she needs to but will yell out if he/she needs something. During an interview on 3/26/25 at 10:10 A.M., Unit Manager #1 said Resident #2 can use the call light and said the call light should be accessible at all times. During an interview on 3/27/25 at 10:28 A.M., Director of Nurses (DON) said she expects all residents to have access to call lights and said call lights should be functioning and within reach of the Resident.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, interviews and policy review, the facility failed to maintain a homelike environment on 2 out of 2 resident units in the facility. Specifically on 2 of 2 units there were stained ceiling tiles, missing thresholds, broken blinds, holes in walls, gouged walls, peeling baseboards, missing baseboards, peeling wallpaper, dark and brown substance on ceiling tiles, stained floor tiles and missing closet doors. Findings include: A review of the facility policy titled, Resident Rights: Accommodation of Needs and Preferences and Homelike Environment, not dated, indicated that the facility will provide a safe, clean, comfortable and homelike environment. On 3/27/25 between 7:22 A.M. and 8:45 A.M., the surveyor observed the following in the bedrooms on the first floor unit: 100: A hole in the bathroom ceiling next to the vent. 101: The door bed had a brown substance was on the wall and the toilet was continuously running. 102: A wall was patched white and not painted. 103: A wall was patched white and not painted, the bathroom faucet was loose, the bifold closet doors were broken. 104: The bathroom toilet was continuously running, the bathroom radiator was rusted. 105: A wall was patched white and not painted, the bathroom radiator was rusted. 106: The bathroom ceiling was stained brown, the ceiling over the door bed was stained brown, the ceiling over the window had plaster and paint falling down, the top edge of window frame with peeling paint falling onto the window ledge. 107: The bathroom walls had 2 holes and ripped wall paper, the ceiling above the window was stained brown with plaster and paint peeling and the phone jack behind the window bed was pulled out of the wall. 108: The ceiling above the window was stained brown with plaster and paint peeling, and the ceiling above the window bed was stained brown. 109: The door bed's privacy curtain had multiple brown spots, the ceiling above the window had a hole and was stained brown with plaster and paint peeling. The window bed's privacy curtain was stained brown. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	110: The ceiling above the window had a hole and was stained brown with plaster and paint peeling. 111: The walls were scuffed and the ceiling above the window was stained brown with paint peeling. 112: The ceiling above the window was stained brown with plaster, wallpaper and paint peeling. 113: The edge of the bathroom radiator was coming off, the ceiling above the window was stained brown with plaster, wallpaper and paint peeling. 114: The wall behind both beds had white patches and were not painted, the bathroom ceiling was stained brown and peeling and the toilet was continuously running. 115: The ceiling above the window was stained brown with plaster and paint peeling. 116: The ceiling above the window was patched white and not painted. 117: The ceiling above the door bed was stained brown. 118: The closet door was missing, corner of the baseboard was missing. 119: The plaster above the window was cracked. 120: The ceiling was stained brown, and the toilet was continuously running. 121: The bathroom shelf was rusted, the ceiling over the tub was coming down, the walls and ceiling was patched white and not painted, and the wall behind the window bed was gauged. Additionally on the unit the following was observed: -Two ceiling tiles in the hallway between rooms [ROOM NUMBERS] were stained brown. -The wall corners in the dining room were gauged. -The wallpaper border in the hallway was peeled off. On 3/27/25 between 9:01 A.M. and 10:15 A.M., the surveyor observed the following in the bedrooms on the second floor unit: 200: The tiles around the toilet were missing and the toilet was being held in place with pieces of cardboard. 201: The bathroom faucet was loose, the window screen has a hole and blind slats were missing. 202: The blind slats were missing and broken. 203: The toilet was continuously running, the faucet was loose and the wall was patched white and not painted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	204: The wall was patched white and not painted. 205: The sink faucet was loose and the wall was patched white and not painted. As well, the wall was gauged behind the window bed. 206: The wall behind the window bed was gauged, the walls were patched without paint, the window blinds were broken, and the sink drain was leaking onto the floor. 207: The blinds were broken, the wall behind the bed was gauged, scuffed and patched without paint. 208: The bathroom faucet was loose. 209: The closet door was broken. 210: The door bed's mattress had hole in the center. 211: The bottom drawer of a dresser was without a handle and would not close, the wallpaper border was peeling in multiple areas and the wall behind the window bed was gauged. 212: The wall behind the door bed was gauged. 213: The bathroom threshold was partially missing and partially held together with green tape, the tiles surrounding the toilet were stained a blackish brown and there were circular brown stains throughout floor of the room. 214: The sink drain was leaking onto the floor, the bathroom threshold was missing with broken tiles. 215: There was a hole in the wall behind the door bed, gauges in the wall behind the window bed, walls were patched but not painted, the corner of the wall next to the bathroom was broken with missing plaster. 216: The window blinds were broken, the walls were scuffed in the room and bathroom. 217: The toilet paper holder was broken and parts missing, the walls were patched and without paint. 218: The walls were scuffed. 219: The window blind slats were missing and the wall was scuffed. 220: The wall was scuffed with paint missing. During an interview on 3/27/25, at 6:55 A.M., the Administrator said that there was not a specific plan in place to fix the environment other than ongoing continued maintenance. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/27/25, at 8:19 A.M., The Director of Maintenance said he is the only member of the maintenance department. He said that he tries to keep up with the needed repairs, but an extra set of hands would help. When asked if he was able to keep up with the needed repairs he said that he was not able to answer that question. The Maintenance Director said that he completes room rounds monthly. By the end of the survey the Maintenance Director was unable to produce documentation to support room rounds were completed.

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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 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. 48671 Based on observation, interviews, and reviewed records, the facility failed to implement a communication care plan for one Resident (#2) out of a total sample of 28 Residents. Findings include: Resident #2 was admitted to the facility in January 2023 with diagnoses including weakness, hemiplegia and hemiparesis following cerebral infarction effecting right dominant side, and weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/27/25, indicated Resident #2 did not have a Brief Interview for Mental Status assessment completed and was assessed by staff to have moderately impaired cognition. The MDS further indicated Resident #2 speaks Cantonese. Review of Resident #2's communication care plan dated, 2/19/25, indicated the following interventions: -Resident has impaired communication related to primary language is Cantonese. -Enlist use of communication devices as needed (i.e.) communication board, sign language specify. -Allow time to process information -Anticipate resident needs if resident is unable to express needs. -Assess body and facial expressions. During an observation on 3/25/25 at 8:33 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. Certified Nursing Assistant (CNA) #3 entered the dining room and was observed walking over to the Resident, moved the wheelchair closer to the table and then walked out of the dining room. CNA #3 did not speak to Resident #2 during the observation. During an observation on 3/26/25 at 7:46 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The surveyor observed a staff member deliver a breakfast tray to Resident #2. The staff member was observed speaking to Resident #2 in English. Resident #2 did not try to engage or acknowledge the staff member. During an observation on 3/26/25 at 8:20 A.M., the survey observed CNA #2 deliver a breakfast tray to Resident #2. The CNA was observed speaking to Resident #2 in English. Resident #2 did not try to engage or acknowledge CNA #2. During an observation on 3/26/25 at 9:24 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The surveyor observed a staff member walk into the dining room and was observed speaking English to two other residents seated in the dining room. The staff member did not try to engage or acknowledge Resident #2. (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 observation on 3/26/25 at 9:42 A.M., Family Member #2 was observed asking staff if someone could take Resident #2 to the bathroom. Resident #2 was observed engaging, smiling and talking to Family Member #2 in Cantonese. CNA #2 walked over to Resident #2 and began pushing him/her in the wheelchair down the hall to the Residents room without engaging or speaking to Resident #2. CNA #2 and Occupational Therapist (OT) #1 were then observed undressing Resident #2, pulling his/her pants down and placing him/her on the toilet and then both exited the bathroom. CNA #2 and OT #1 did not speak or engage with Resident #2 during the entire observation. During an observation on 3/26/25 at 9:54 A.M., Unit Manager #1 and the Infection Control Nurse entered Resident #2's room and began to assist Resident #2 off the toilet. Unit Manager #1 and the Infection Control Nurse were observed speaking English to Resident #2 and said, Here you can wash your hands, as they turned the wheelchair towards the sink and turned the water on. Resident #2 did not engage or acknowledge the staff members. Family Member #2 was observed speaking to the Resident in Cantonese and the Resident could be heard exchanging in the conversation. Family Member #2 said she would wash the Residents' hands. Unit Manager #1 and the Infection Control Nurse then exited the Residents room. Throughout the observations a communication board was not observed or utilized, and staff did not utilize a language line for interpreter services. During an interview on 3/26/24 at 10:00 A.M., Family Member #2 said Resident #2 understands and can communicate in Cantonese, but staff do not understand him/her and do not try to communicate in any way other than speaking English, which the Resident does not understand. During an interview on 3/26/25 at 10:04 A.M., CNA #2 said she does not know what language Resident #2 speaks and said she can't understand Resident #2 because he/she does not speak English. When the surveyor asked CNA #2 how she communicates with Resident #2 she said the family is usually here. When asked how she communicates if the family is not present CNA #2 said I'm not sure. During an interview on 3/26/25 at 10:12 A.M., Unit Manager #1 said staff can use the language line if needed and said staff should communicate with Resident #2 during care. Unit Manager #1 said staff should follow the care plan when providing care. During an interview on 3/27/25 at 10:29 A.M., Director of Nurses (DON) said the communication care plan should be followed by all staff and she expects staff to use a communication board to assist with communication.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 36797 Based on observations, interviews, and records reviewed, the facility failed to provide an activities program to: 1. Residents on two of two units observed, and 2. One Resident (#2) out of a total sample of 28 residents. Findings include: Review of the facility policy titled Daily Programming, not dated, indicated that it is the policy of the facility to provide meaningful activities appropriate to the Resident's cognitive, physical, and social abilities on a regular basis, to enhance their quality of life. Review of the facility policy titled Activity Program for Residents with Cognitive Impairment, not dated, indicated that it is the policy of this facility to offer meaningful activity programs to residents who display disorientation to time place and/or person. 1. Review of the activity schedule for 3/25/25 indicated the following: 9:45 A.M., a coffee social. 10:15 A.M., Movin N Groovin-1st 10:45 A.M., Stretch and Tone-2nd 1:30 P.M., Room visits 2:00 P.M., Travelogue 3:00 P.M., Bingo 3:45 P.M., Room Visits On 3/25/25 between 9:00 A.M. and 11:33 A.M. the surveyor observed 4 residents sitting in the dining room on the second floor. The television was on but no scheduled activity was taking place. The surveyor also observed that none of the residents were watching the television. Two were sleeping and 2 were staring forward. On 3/25/25 between 1:30 P.M. and 3:30 P.M. the surveyor observed no activity taking place on the second floor. Two residents were sitting in the dining room, there was no music, no TV and no individualized activities for the residents. During an interview on 3/25/25 at 3:30 P.M. supervisor Unit Manager #1 said activities are always happening on the floor. When asked why activities were not occurring on the unit she was not able to give an answer. Review of the activity schedule for 3/26/25 indicated the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:45 A.M., a coffee social. 10:00 A.M., communion 10:45 A.M., Stretch and Tone. 2:00 P.M., Target Practice 3:00 P.M., Family Feud 3:45 P.M., Room Visits On 3/26/25, between 9:30 A.M., and 11:00 A.M. the surveyors observed no activities on the 1st and 2nd floor units all morning. During an interview on 3/26/25, at 11:57 A.M., Certified Nurse's Aide #3 said that mostly bingo happens on the 2nd floor but there are not many activities for residents with dementia. She said that they don't have activities sometimes. During resident group meeting on 3/26/25 at 11:00 A.M., 4 out of 4 residents said that there has been no activities director for awhile and as a result there has been a reduction in the number of activities. They said that the posted activities calendar is not accurate and the activities posted don't happen. 4 out of 4 also said that there are no activities seen for dementia residents, activities are sparse and dementia residents sit in the dining room not doing much. Review of the activity schedule for 3/27/25 indicated the following: 9:45 A.M., a coffee social. 10:15 A.M., Movin N Groovin-1st (sic) 10:45 A.M., Stretch and Tone-2nd 1:00 P.M., Art Group 2:00 P.M., Bingo 3:00 P.M., Men's Group 3:45 P.M., Room Visits On 3/27/25 from 8:30 A.M., to 10:15 A.M., the surveyor observed several residents sitting in the dining room. The surveyor observed the television on but no one was watching. One resident was sleeping, one resident was staring off into space and one resident was trying to engage all passers by in conversation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Lowell	30 Princeton Boulevard Lowell, MA 01851

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 10:20 A.M., Activity Assistant (AA) #1 said that on 3/25/25, she was the only staff in the activity department for the day. AA #1 then said that no activities took place 3/25/25 on the second floor. AA #1 then said that her hours start at 9:45 A.M. and the other Activity Assistant starts her day at 10:00 A.M. AA #1 also said that there has not been an activity director for several months. AA #1 then acknowledged that there are residents with dementia who are sitting in the dining rooms for long periods of time without any activity. 48671 2. Resident #2 was admitted to the facility in January 2023 with diagnoses including hemiplegia and hemiparesis following cerebral infarction effecting right dominant side and weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/27/25, indicated Resident #2 did not have a Brief Interview for Mental Status assessment completed and was assessed by staff to have moderately impaired cognition. The MDS further indicated Resident #2 speaks Cantonese, has clear speech but is rarely/never understood, and is dependent on staff for care. Review of Section F. on the MDS indicated an interview for daily and activity preferences should not be conducted and indicated the Resident is rarely/never understood and family/significant other not available. On 3/25/25 the following was observed: -At 9:30 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The television was on. -At 9:45 A.M., the activity calendar had Coffee Social, as the activity. The activity was not observed on the unit and Resident #2 remained in the dining room sitting alone at a table. On 3/26/25 the following was observed: - At 9:24 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The television was on. - The activity calendar lists 9:45 A.M., Coffee Social, as the activity. The activity was not observed on the unit and Resident #2 remained in the dining room sitting alone at a table. - At 9:35 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The television was on. -At 9:40 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The television was on. -The activity calendar lists 10:00 A.M., Communion, as the activity. The activity was not observed on the unit and Resident #2 remained in the dining room sitting alone at a table. -At 10:10 A.M., Resident #2 was observed sitting in the main dining room in a wheelchair. The television was on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The activity calendar lists 10:45 A.M., Exercise Group, as the activity. The activity was not observed on the unit and Resident #2 remained in the dining room sitting alone at a table. During an interview on 3/26/24 at 10:02 A.M., Family Member #2 said Resident #2 speaks Cantonese and enjoys watching television, listening to music and talking with others and can communicate in Cantonese, but staff do not try to communicate in any way other than speaking English, which the Resident does not understand. Family Member #2 said he/she would enjoy conversation, music or movies in his/her language. Review of Resident #2's activity care plan indicated the following interventions: -Resident has a potential for altered activity patter(n) related to routine involvement with the following: -Introduce to other residents with similar interests, disabilities, and/or limitations. -Invite resident to activities that promote additional intake of food and fluids as allowed. Ensure that all snacks and beverages offered comply with diet restrictions prescribed. -Invite to scheduled activities. -Offer to assist/escort resident to activity functions. During an interview on 3/27/25 12:38 P.M., Activities Assistant #2 said Resident #2 doesn't speak English and can't participate in most activities due to a language barrier. The Activities Assistant #2 said she talks to the resident, but he/she can't understand her. Activities Assistant #2 said she called Resident #2's family member today because she did not know what language the Resident speaks. The Activities Assistant said the television is on in the dining room but Resident #2 does not understand English and just sits in his/her chair. Review of the February 2025 and March 2025 Recreation Participation Record indicated the following: February 2025, 9 out of 28 days indicated Resident #2 was coded as I for Independent with Socializing/Socials/ Talking on Phone/Visits/ Sending Cards and Relaxing/Looking out/People Watching & window/ Resting/Thinking. -Six days indicated S for Sleeping / In Bed during Baking/ Cooking Refreshments Carts. March 1st - March 24th 2025, indicated Likes to sit and watch T.V. in Day Room. Resident #2 was coded as L for limited engagement with Movies/TV, Socializing/Socials/ Talking on Phone/Visits/ Sending Cards and Relaxing/Looking out/People Watching & window/ Resting/Thinking. During an interview on 3/27/25 at 12:41 P.M., the Director of Activities said she expects the calendar to be followed as scheduled and said staff should invite all residents to the activities. The Activities Director said she expects care plans to be implemented and followed and said staff should know how to communicate with the Resident and offer activities he/she may be interested in. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 12:54 P.M., the Director of Nurses (DON) said activities should be conducted and offered to all residents and said if a resident does not enjoy group activities staff should offer other opportunities and attempt to engage with the Residents in ways he/she may enjoy and understand. The DON said an activities assessment should indicate the types of things Resident #2 enjoys doing and should include his/her language needs. Further review of the medical record failed to indicate an activity assessment was completed. During a follow up interview on 3/31/25 at 8:35 A.M., the DON said Resident #2 did not have an activities assessment completed and said all Residents should have an activities assessment completed with care plan interventions specific to his/her needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observation, record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for one Resident (#51), out of a total sample of 28 residents. Specifically, the facility failed to identify a skin wound to the right elbow and document it on a skin assessment. Findings include: Resident #51 was admitted to the facility in January 2025 with diagnoses including sepsis, non-pressure chronic ulcer of lower leg, generalized edema, peripheral vascular disease, and kidney failure. Review of Resident #51's most recent Minimum Data Set (MDS) assessment, dated 2/25/25, indicated the Resident scored a 15 out of total 15 on the Brief Interview for Mental Status indicating intact cognition. The MDS further indicated Resident #51 requires substantial/maximal assistance with activities of daily living tasks. During an observation on 3/25/25 at 12:07 P.M., the surveyor observed Resident #51 in bed with both arms exposed. The Resident was observed to have a dime sized dark pink, raised swollen, circular scabbed area to the right elbow. The center of the scab was yellow and brown with what appeared to be white and yellow dried skin surrounding the center. The skin around the scab was raised, swollen and pink. The Resident reported occasional pain when he/she rubs the area on surfaces and said they know about it, I show them my arms. Review of Resident #51's weekly skin checks, dated 2/28/25, 3/1/25, 3/7/25, and 3/14/25, and 3/21/25 indicated the Residents skin was not intact with open areas documented to right and left shin that were not new areas. No skin impairment to the right elbow was documented on the skin checks. Review of Resident #51's skin integrity care plan dated 1/17/25, indicated the following: Focus area of Vascular wound to r (right) shin, Advanced Age, Decreased/impaired mobility or function and Decrease sensory perception. Interventions include: -Monitor for signs and symptoms of infection. -Protective skin care with incontinent care. -Skin assessments weekly. -Turn and reposition every 2 hours. Review of Resident #51's most recent [NAME] plus pressure ulcer scale, dated 2/9/25, indicated the Resident was at high risk for developing pressure injuries. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the active physician orders indicated the following: -Barrier Cream: Apply House Barrier Cream to bony prominences ever [sic] shift and as needed to prevent skin breakdown. Every shift for preventative measures. Start date 1/16/25. Review of Resident #51's Medication and Treatment Administration Record for the month of March 2025 indicated the order for Barrier Cream was documented as administered as ordered during the month. Review of the progress notes entered in Resident #51's medical record failed to indicate any nursing progress note related to changes in Resident #51's skin, specifically the area to his/her right elbow. During an interview on 3/25/25 at 1:36 P.M., CNA #2 said Resident #51 has a lot of swelling to his/her lower legs and said the Resident scratches his/her skin a lot and has an area on the right arm that has been there a while. During an observation on 3/26/25 at 8:39 A.M., Nurse #4 and the surveyor observed Resident #51 sitting up in bed with his/her right arm exposed. Nurse #4 observed the area to the right elbow and said he was not aware of the area to the right elbow and said he would document the area to the right elbow on a skin check and notify the provider for treatment orders. Nurse #4 and the surveyor reviewed Resident #51's medical record and Nurse #4 said he completed the last skin check on 3/21/25 and did not notice the area to the right elbow and said it looked like an old open area that is scabbed over. Nurse #4 said the area must be documented and reported for follow-up and treatment. During an interview on 3/26/25 at 9:05 A.M., Unit Manager #1 said Resident #51 has weekly skin checks and said she was not aware of the area to the right elbow and said the area should have been documented on a skin check and a treatment order should be in place. Unit Manager #1 said she would notify the Nurse Practitioner to get a treatment order and said she would add the right elbow to the weekly wound rounds to keep an eye on it because it could become a pressure area because of the location. During an interview on 3/26/25 at 9:15 A.M., the Director of Nurses (DON) said the area to the Residents' right elbow is not new and said it should have been documented on the weekly skin checks and said a treatment order should have been in place. The DON said the area looks like an unstageable wound because of the scabbed top layer and said she can't see the depth of the wound. The DON said the area should be included in the weekly wound rounds to prevent additional skin breakdown. Review of Resident #51's medical record on 3/27/25 failed to indicate a skin assessment was completed after 3/21/25, and further review of the medical record failed to indicate any nursing progress notes related to the skin area on the right elbow. During a phone interview on 3/27/25 at 10:39 A.M., Nurse Practitioner #2 said she would expect wounds and skin conditions to be assessed and documented and said she was not aware of any open skin areas and would need to check her notes on Resident #51. Review of the active physician orders on 3/27/25 failed to indicate any new treatment orders were implemented to the area on the right elbow. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 3/27/25 at 8:25 A.M., the Director of Nurses said a skin check should have been completed when the area to the right elbow was observed and said the physician should have been notified for treatment orders to be implemented.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44095 Based on observation, record review, and interview, the facility failed to ensure professional standards of practice for the care of a suprapubic urinary catheter (a tube placed through the suprapubic region into the bladder to drain urine) for one Resident (#47) out of a total sample of 28 residents. Specifically, the facility failed to ensure nursing changed Resident #47's urinary catheter in accordance with physician's orders. Findings include: Review of the facility policy titled Catheter Insertion- Male, dated as revised 4/2022, indicated verify that there is a physician's order. 4. Use the smallest catheter possible, consistent with good drainage, to minimize urethral trauma. Resident #47 was admitted to the facility in March 2022 with diagnoses including urethral fistula, urinary retention, and neuromuscular dysfunction of the bladder. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/20/25, indicated that Resident #47 was rarely understood. This MDS indicated Resident #47 had an indwelling catheter. Review of Resident #47's plan of care related to suprapubic catheter care, dated 1/5/23, indicated: - 14 French 10 cc balloon related to neurogenic bladder. Review of Resident #47's *RC Nursing Evaluation assessment, dated 2/26/25, indicated: - 3c. 14 F catheter 10 cc. Review of Resident #47's active physician's order, dated 12/8/23, indicated: - Suprapubic Catheter 14 French / 10 milliliter continuous to a drainage bag, every shift. Review of Resident #47's active physician's order, dated 11/15/24, indicated: - Change suprapubic catheter every 30 days and as needed for blockage. 14 French, inflate with 10 cc, every evening shift every 4 weeks, on Thursday. Review of Resident #47's Treatment Administration Record (TAR), dated 3/13/25, indicated nursing changed his/her suprapubic catheter as ordered by the physician. On 3/25/25 at 3:16 P.M., and on 3/27/25 at 8:07 A.M., the surveyor observed Resident #47 with a 16 French 5 cc balloon suprapubic urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of indwelling catheter sizing indicates a 14 French catheter is 4.7 millimeters in diameter and a 16 French catheter is 5.3 millimeters, which the 16 French is 0.6 millimeters larger in diameter than at 14 French catheter. During an interview on 3/27/25 at 8:38 A.M., Nurse #1 said she changed Resident #47's suprapubic catheter based on the physician's order. During an interview on 3/27/25 at 10:33 A.M., the Infection Control Nurse said that Nurse #1 should have changed Resident #47's suprapubic catheter according to the physician's order. The Infection Control Nurse observed Resident #47's suprapubic catheter which was sized 16 French 5 cc balloon. During an interview on 3/27/25 at 11:15 A.M., the Director of Nursing said nursing should implement the catheter size in accordance with the physician's order and that the consequences of inserting a size too large could potentially result in pain and necrosis.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to maintain the highest practicable physical, mental, and psychosocial well-being for one Resident (#7) with a history of suicidal ideation (SI) and depression, out of a total sample of 28 residents. Specifically, Resident #7 was not provided with appropriate behavioral health services following verbalization of SI and attempted to kill him/herself at the facility by ingesting nail polish remover. Findings include: Review of the facility policy titled Behavior Management, dated ,d+[DATE], indicated the following: - The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. - The IDT staff will identify, document, and inform the physician about specific details regarding changes in an individuals mental status, behavior, and cognition including: * Onset, duration, intensity and frequency of behavioral symptoms * Any precipitating or relevant factors or environmental triggers (e.g., medication changes, infection, recent transfer from hospital) and * New onset or changes in behavior will be documented. - The interdisciplinary team (IDT) will elevate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition. - The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary, to protect the resident and others from harm. - Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. Psychiatric recommendations will be reviewed by the IDT and will implement as indicated. - Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* A description of the behavioral symptoms * Targeted and individualized interventions for the behavioral and/or psychosocial symptoms; * The rationale for interventions and approaches; * Specific and measurable goals for targeted behaviors; and * How the staff will monitor for effectiveness of the interventions - Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of psychoactive medication to manage behavioral symptoms. Review of the facility policy titled Suicide Threats, dated [DATE], indicates the following: - All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. - As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be indicated. - If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. Review of the facility assessment, dated [DATE], indicated that the facility manages, on average, 30 residents with behavioral health needs. Review of the facility assessment indicated the facility is able to manage the medical conditions and mental health conditions related to psychiatric symptoms and behavior, assessment of gradual dose reduction, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (post-traumatic stress disorder), other psychiatric diagnoses, intellectual or developmental disabilities, contract with external psychological services, utilize a code system, and trauma informed care planning. The facility assessment indicated the facility had a contracted Social Worker for 16 hours per week for a census of 59 residents. Resident #7 was admitted in [DATE] with diagnoses including major depressive disorder, history of suicidal ideations, post-traumatic stress disorder (PTSD), and bipolar disorder. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #7 scored a 14 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. During an interview on [DATE] at 9:49 A.M., Resident #7 said Some staff care and some don't. I am depressed a lot and take medication for that. I have 3 kids but they don't talk to me and this past August I tried to kill myself. I was really low and depressed. When I did what I did, I screamed cause it hurt. My heart stopped and I died on the table at the hospital. Three or four weeks before, I started getting really down, I had no one to talk to and it just got worse I was letting myself go. I wasn't eating and was staying in my room more and more and then I drank nail polish remover. Now I lay in bed a lot and watch tv and cry because I miss my kids and it is sad. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the current care plan indicated Resident #7 has a history of suicidal ideation with the following interventions: - Provide a safe environment, free from things that may harm the client (initiated [DATE]) - Encourage the client to avoid decisions during the time of crisis until alternatives can be considered (initiated [DATE]) - Encourage the client to talk freely about feelings and help plan alternative ways of handling disappointment, anger and frustration (initiated [DATE]) - Encourage the client to talk about their feelings and problem solve alternatives (initiated [DATE]) - Monitor resident for signs and symptoms of suicidal ideation (initiated [DATE]) - Social services to check in periodically with the resident to ensure safety (initiated [DATE]) - [DATE] Resident mloa (medical leave of absence) d/t (due to) suicide attempt (initiated [DATE]) - Encourage out of room activities (initiated [DATE]) Review of the psychiatric consultant progress note, dated [DATE], indicated Resident #7 had symptoms of anxiety and depression and indicated the following: Patient reported on his/her mood and stated 'I am always depressed. I just keep to myself and it's easier now that I have the room to myself. I prefer it this way and just to spend some time thinking.' Patient was receptive to offered support and feedback. Review of the progress note indicated a plan to follow up with Resident #7 in two weeks. Review of the nursing progress note, dated [DATE], indicated the following: Resident had suicidal ideation. Told one of the staff that he/she would like to kill him/herself but he/she doesn't have a plan. NP (nurse practitioner) notified and gave an order to send resident to hospital for evaluation. Unable to reach son via phone. Resident transferred to hospital. Review of a nursing progress note, dated [DATE], indicated the following: Resident returned from hospital emergency room at approximately 1900 (7:00 P.M.). There was no medication changes. He/she is to follow up with the physician and psych. Upon returning no vocalization of wanting to die/harm him/herself. He/she continues to deny having a plan. Declined dinner, offered alternate but refused On 20 minute checks. No acute distress note. Physician on call notified of his/her return. HCP (healthcare proxy) called but no answer. Review of the medical record failed to indicate that 20 minute checks were completed or that there was a physician's order for 20 minutes checks. Review of the hospital discharge paperwork, dated [DATE], indicated the following: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Pt (patient) tells this writer that he/she did make SI (suicidal ideation) statements; 'wanting to die, take my life, I've just had it and got to a point,' and 'tired of anything.' Pt denies a plan and denies any intent. Pt reports he/she has been feeling this way on and off for the past month and only today did he/she disclose it. This writer stated the nurse said he/she was having a good day up until 2:50 P.M. when the activities lady went into pt's room and pt disclosed SI thoughts to this staff person. Pt cannot recall if he/she took medication for depression . pt had been at his/her current facility for the past 6 years and states it is lonely, 'I'm by myself all the time'. Pt used to have a roommate but states he/she was difficult. Pt denies any history of attempts, gestures, SIB (self injurious behavior) or psych hospitalization s. This writer spoke to the nurse prior to meeting with the pt and the nurse reported pt had a boyfriend at the facility but the relationship ended about ,d+[DATE] months ago . Pt reports being upset that he/she has not heard from his/her children in months. Review of the psychiatric progress note from the hospital, dated [DATE], indicated the following: Discussed talk therapy referral and pt was agreeable stating he/she just needs someone to talk to. Review of the clinical record failed to indicate that social services or psychiatric services; specifically talk therapy, had been provided upon Resident #7's return to the facility after the verbalization of suicidal ideation on [DATE]. Review of the nursing progress note, dated [DATE], indicated the following: Resident seen by physician today. New order received to increase Seroquel (and antipsychotic medication used for Bipolar disorder) to 200 mg (milligrams) twice daily, 150 mg daily at 1 pm, add Wellbutrin xl (a medication used to treat depression) 150 mg daily and psych consult. Review of the consultant psychiatric nurse practitioner note, who provides medication management, dated [DATE], indicated the following: Resident reports he/she has been more depressed starting last week and made end of life statement. Reports he/she still feels this way but with no plan in place . Of note, resident was previously in a relationship with another resident, which did not end well. Since then resident has been more depressed and isolated to his/her room. Review of the note indicated a recommendation to discontinue the Wellbutrin and obtain labs. Review of Nurse Practitioner #1's progress note, dated [DATE], indicated Resident #7 said he/she will not attempt to hurt him/herself, but does not really have much to live for. Review of the plan indicated the following: Depression with attention seeking behavior. Psych does not feel that he/she will harm him/herself. They feel that he/she is confused, although I did sit with him/her today for quite some time. He/she answers questions appropriately, does engage and is able to conduct meaningful conversation. Review of the medical record failed to indicate behavioral health services had provided talk therapy since [DATE] or that a referral was made for talk therapy services, as recommended from the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Lowell	30 Princeton Boulevard Lowell, MA 01851

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record failed to indicate that social services had provided any services or initiated any talk therapy after Resident #7's verbalization of suicidal ideation on [DATE]. Review of the nursing progress note, dated [DATE], indicated the following: Resident shouted from his/her room 'help, I'm dying'. When the nurse got to the resident's room, the resident was on a wheelchair and seemed to be weak an not on [sic] his/her baseline, then he/she stated he/she had taken something which he/she does not want to tell. 2 cups were on the table, one had coffee and another one had pink liquid ,d+[DATE] full which immediately we identified as nail polish remover. 911 was activated, vital signs taken and staff stayed with him/her. On call doctor and DON notified, unable to reach son over the phone. Resident transferred to hospital. Review of the hospital discharge paperwork, dated [DATE], indicated the following: presented to hospital for suicide attempt of ingesting nail polish remover in the context of multiple environmental stressors, and worsening of depressive episode. per ED (emergency department) records, the patient is a resident of a Nursing facility. Focal to the SA (suicide attempt), patient reports an increase of hopelessness and loneliness after attempting to contact his/her son multiple times failed. After ingestion of nail polish remover, he/she called for help and was brought to the ED, and transferred to ICU (intensive care unit) after multiple episodes of non-sustained V. Tach (ventricular tachycardia- a heart rate of over 100 beats per minute) and acute encephalopathy (disorder of the brain which can cause confusion) (,d+[DATE]-[DATE]). He/she was diagnosed with Non- STEMI (non-ST- segment myocardial infarction) (heart attack) on presentation thought to be secondary to demand ischemia (decreased blood flow) in the setting of cardiomyopathy (disease of the heart muscle). Patient arrived to hospital .I interviewed the patient on [DATE]. Patient is alert, oriented to person, date, month, year and place. He/she is aware of the admission, and is able to express clearly that he/she took sips of the acetone nail polish remover, in an attempt to end his/her life. He/she expresses regret, remorse over the act stating 'it was stupid'. He/she is not able to clearly say what precipitated the event, but says 'I had just had it'. He/she adamantly denies that he/she would ever do this again stating, 'I would never do this, it scared the hell out of me, I don't want to die'. He/she identifies that his/her thoughts are active in the evening and race impacting his/her sleep and ability to fall asleep. Additionally he/she adds images, or 'flashbacks' to past traumas of previous abusive relationships. He/she denies any AH (actual harm), HI, no longer expressing SI . The patient is oriented x3, has a clear understanding of events leading to his/her admission, is understanding of his/her medications benefits and side effects, is wanting treatment and agreeable to treatment. Review of the Patient Safety Plan provided by the hospital on discharge on [DATE] indicated the following: - Warning signs: feeling depressed and lonely, lack of contact with family, medication issues, nursing home placement, and loss of past roles - Internal coping strategies: Playing bingo and poker with activities department (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- People and social settings that provide distraction: activities in the dayroom at the facility - People who I can ask for help: the director of nursing - Making environment safe: spending more time in the milieu and less isolating in room. Review of the care plan indicated the following revisions completed after Resident #7's attempted suicide: - [DATE]: [DATE] resident mloa d/t suicide attempt - [DATE] : encourage out of room activities During a follow-up interview on [DATE] at 8:04 A.M., Resident #7 said that he/she had had the nail polish remover in his/her possession since she originally admitted to the facility. During an interview on [DATE] at 10:50 A.M., Certified Nursing Assistant (CNA) #3 said that she has been working at the facility about a year and knows about Resident #7's suicide attempt. CNA #3 said she was taking care of Resident #7 the morning of the suicide attempt, but was not made aware of the incident until after it occurred. During an interview on [DATE] at 10:55 A.M., Nurse #4 said that he knows Resident #7 and that the Resident has on and off days related to his/her mood and has verbalized that he/she is depressed. Nurse #4 said that on the day of the suicide attempt he went into the room when he heard Resident #7 screaming and found the nail polish remover. Nurse #4 said that Resident #7 has a history of being sent out and leading up to that event had been down, but could not tell them why. Nurse #4 remembers Resident #7 was having a down day and was not happy in the morning before the incident and that he did what he normally does when Resident #7 is down and let him/her be. Nurse #4 said he does not remember the social worker seeing Resident #7 on that day, or at all during that time period. During an interview on [DATE] at 12:14 P.M., Social Worker #1 said that she is in the facility two days per week, and that her main role is doing assessments and ensuring the facility is in compliance with necessary things such as care plan reviews. Social Worker #1 said if a Resident expresses suicidal ideation then she would expect to be told of the incident and she would see the resident upon return from the psych hospitalization . Social Worker #1 said that the outside services that are offered from contracted staff are medication management and talk therapy. Social Worker #1 said that although she was in the building on [DATE], following Resident #7's hospital assessment for SI, she was not notified of the suicidal ideation from Resident #7; therefore, she did not see or speak with Resident #7. During an interview on [DATE] at 12:23 P.M., Activities Assistant #1 said that Resident #7 is involved in activities, but that she had noticed a change in Resident #7's attendance to activities leading up to the suicide attempt, as she indicated in a witness statement at the time of the incident. (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:42 P.M., the psychiatric Nurse Practitioner (NP) said that she provides strictly medication management in the facility and has a colleague that provides talk therapy to residents. The psychiatric NP said that Resident #7's medications were adjusted after the suicidal ideation incident, but that the therapeutic effects of medications can take up to ,d+[DATE] weeks to take effect. The psychiatric NP said she notified her colleague, who provides talk therapy, the day of her evaluation of Resident #7 on [DATE]. The psychiatric NP said that if a Resident is expressing suicidal ideation, then the environment should be checked and be free of harmful items and the care plan should be updated. During an interview on [DATE] at 8:11 A.M., the contracted psychiatric Social Worker said that she comes in bi-weekly to provide individual psychotherapy to residents. The psychiatric Social Worker said that she was not made aware of Resident #7's suicidal ideation until her colleague told her on [DATE], seven days after the initial SI verbalization. The psychiatric Social Worker said that by the time she came into the facility, Resident #7 had already gone out to the hospital for the suicide attempt. During an interview on [DATE] at 8:46 A.M., Nurse Practitioner #1 said that if a Resident expresses suicidal ideation, then she would expect psychiatric services or the social worker to see the Resident immediately to determine the appropriate action. Nurse Practitioner #1 said she would have expected psych services or social services to be provided for Resident #7 after his/her suicidal ideation on [DATE]. During an interview on [DATE] at 9:05 A.M., the Director of Nursing said that when a Resident expresses suicidal ideation or returns from the hospital after expressing suicidal ideation, then behavioral services, including talk therapy, should be initiated immediately. She said that although the talk therapist comes in every two weeks, that they can reach out to the psychiatric service provider and have someone else come in to see a resident if there is a need. The Director of Nursing said that it should all be documented in the medical record and if 20 or 30 minute checks were done then they should be uploaded in the record. The Director of Nursing said that the Resident's environment should always be assessed for safety. The Director of Nursing said that Resident #7 was previously in a relationship and it was a terrible time and had a huge affect on him/her. The Director of Nursing said that just before the suicidal ideation, Resident #7 was really wrapped up in his/her kids not calling and that it was difficult because he/she already has major depression. The Director of Nursing said that if there is an increase in worsening depression, then there is always someone from psychiatric services they can call.

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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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to provide the appropriate treatment and services for one Resident (#7), with a known history of depression and suicidal ideation out of a total sample of 28 residents. Specifically, for Resident #7, the facility failed to implement and update the plan of care, resulting in an attempted suicide after the vocalization of suicidal ideation (SI). Findings include: Review of the facility policy titled Behavior Management, dated ,d+[DATE], indicated the following: -The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. - The IDT staff will identify, document, and inform the physician about specific details regarding changes in an individuals mental status, behavior, and cognition including: * Onset, duration, intensity and frequency of behavioral symptoms * Any precipitating or relevant factors or environmental triggers (e.g., medication changes, infection, recent transfer from hospital) and * New onset or changes in behavior will be documented. - The interdisciplinary team (IDT) will elevate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition. - The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary, to protect the resident and others from harm. - Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. Psychiatric recommendations will be reviewed by the IDT and will implement as indicated. - Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum: (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* A description of the behavioral symptoms * Targeted and individualized interventions for the behavioral and/or psychosocial symptoms; * The rationale for interventions and approaches; * Specific and measurable goals for targeted behaviors; and * How the staff will monitor for effectiveness of the interventions - Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of psychoactive medication to manage behavioral symptoms. Review of the facility policy titled Suicide Threats, dated [DATE], indicates the following: - All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. - As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be indicated. - If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. Review of the facility assessment, dated [DATE], indicated that the facility manages, on average, 30 residents with behavioral health needs. Review of the facility assessment indicated the facility is able to manage the medical conditions and mental health conditions related to psychiatric symptoms and behavior, assessment of gradual dose reduction, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (post-traumatic stress disorder), other psychiatric diagnoses, intellectual or developmental disabilities, contract with external psychological services, utilize a code system, and trauma informed care planning. The facility assessment indicated the facility had a contracted Social Worker for 16 hours per week for a census of 59 residents. Resident #7 was admitted in [DATE] with diagnoses including major depressive disorder, history of suicidal ideations, post traumatic stress disorder (PTSD), and bipolar disorder. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #7 scored a 14 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. During an interview on [DATE] at 9:49 A.M., Resident #7 said Some staff care and some don't. I am depressed a lot and take medication for that. I have 3 kids but they don't talk to me and this past August I tried to kill myself. I was really low and depressed. When I did what I did, I screamed cause it hurt. My heart stopped and I died on the table at the hospital. Three or four weeks before, I started getting really down, I had no one to talk to and it just got worse I was letting myself go. I wasn't eating and was staying in my room more and more and then I drank nail polish remover. Now I lay in bed a lot and watch tv and cry because I miss my kids and it is sad. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the current care plan indicated Resident #7 has a history of suicidal ideation with the following interventions: - Provide a safe environment, free from things that may harm the client (initiated [DATE]) - Encourage the client to avoid decisions during the time of crisis until alternatives can be considered (initiated [DATE]) - Encourage the client to talk freely about feelings and help plan alternative ways of handling disappointment, anger and frustration (initiated [DATE]) - Encourage the client to talk about their feelings and problem solve alternatives (initiated [DATE]) - Monitor resident for signs and symptoms of suicidal ideation (initiated [DATE]) - Social services to check in periodically with the resident to ensure safety (initiated [DATE]) - [DATE] Resident mloa (medical leave of absence) d/t (due to) suicide attempt (initiated [DATE]) - Encourage out of room activities (initiated [DATE]) Review of the nursing progress note, dated [DATE], indicated the following: Resident had suicidal ideation. Told one of the staff that he/she would like to kill him/herself but he/she doesn't have a plan. NP (nurse practitioner) notified and gave an order to send resident to hospital for evaluation. Unable to reach son via phone. Resident transferred to hospital. Review of a nursing progress note, dated [DATE], indicated the following: Resident returned from hospital emergency room at approximately 1900 (7:00 P.M.) . There was no medication changes. He/she is to follow up with the physician and psych. Upon returning no vocalization of wanting to die/harm him/herself. He/she continues to deny having a plan. Declined dinner, offered alternate but refused. On 20 minute checks. No acute distress note. Physician on call notified of his/her return. HCP (healthcare proxy) called but no answer. Review of the medical record failed to indicate that 20 minute checks had been initiated or that a physician's order was put in place for 20 minute checks. Review of the hospital discharge paperwork, dated [DATE], indicated the following: Pt (patient) tells this writer that he/she did make SI (suicidal ideation) statements; 'wanting to die, take my life, I've just had it and got to a point,' and 'tired of anything.' Pt denies a plan and denies any intent. Pt reports he/she has been feeling this way on and off for the past month and only today did he/she disclose it. This writer stated the nurse said he/she was having a good day up until 2:50 P.M. when the activities lady went into pt's room and pt disclosed SI thoughts to this staff person. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Pt cannot recall if he/she took medication for depression . pt had been at his/her current facility for the past 6 years and states it is lonely, I'm by myself all the time. Pt used to have a roommate but states he/she was difficult. Pt denies any history of attempts, gestures, SIB (self injurious behavior) or psych hospitalization s. This writer spoke to the nurse prior to meeting with the pt and the nurse reported pt had a boyfriend at the facility but the relationship ended about ,d+[DATE] months ago . Pt reports being upset that he/she has not heard from his/her children in months. Review of the psychiatric progress note from the hospital, dated [DATE], indicated the following: Discussed talk therapy referral and pt was agreeable stating he/she just needs someone to talk to. Review of the consultant psychiatric nurse practitioner note, who provides medication management services, dated [DATE], indicated the following: Resident reports he/she has been more depressed starting last week and made end of life statement. Reports he/she still feels this way but with no plan in plan . Of note, resident was previously in a relationship with another resident, which did not end well. Since then resident has been more depressed and isolated to his/her room. Review of the note indicated a recommendation to discontinue the Wellbutrin and obtain labs. Review of Nurse Practitioner #1's progress note, dated [DATE], indicated Resident #7 said he/she will not attempt to hurt him/herself, but does not really have much to live for. Review of the plan indicated the following: Depression with attention seeking behavior. Psych does not feel that he/she will harm him/herself. They feel that he/she is confused, although I did sit with him/her today for quite some time. He/she answers questions appropriately, does engage and is able to conduct meaningful conversation. Review of the clinical record failed to indicate that the care plan was reviewed, updated, or implemented upon Resident #7's return to the facility after the verbalization of suicidal ideation on [DATE]. Review of the medical record failed to indicate a referral for talk therapy services was made or that Resident #7 received talk therapy from psych services or social services. Review of the nursing progress note, dated [DATE], indicated the following: Resident shouted from his/her room 'help, I'm dying'. When the nurse got to the resident's room, the resident was on a wheelchair and seemed to be weak an not on [sic] his/her baseline, then he/she stated he/she had taken something which he/she does not want to tell. 2 cups were on the table, one had coffee and another one had pink liquid ,d+[DATE] full which immediately we identified as nail polish remover. 911 was activated, vital signs taken and staff stayed with him/her. On call doctor and DON notified, unable to reach son over the phone. Resident transferred to hospital. Review of the hospital discharge paperwork, dated [DATE], indicated the following: presented to hospital for suicide attempt of ingesting nail polish remover in the context of multiple environmental stressors, and worsening of depressive episode. (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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	per ED (emergency department) records, the patient is a resident of a Nursing facility. Focal to the SA (suicide attempt), patient reports an increase of hopelessness and loneliness after attempting to contact his/her son multiple times failed. After ingestion of nail polish remover, he/she called for help and was brought to the ED, and transferred to ICU (intensive care unit) after multiple episodes of non-sustained V. Tach (ventricular tachycardia- a heart rate of over 100 beats per minute) and acute encephalopathy (disorder of the brain which can cause confusion) (,d+[DATE]-[DATE]). He/she was diagnosed with Non- STEMI (non-ST- segment myocardial infarction) (heart attack) on presentation thought to be secondary to demand ischemia (decreased blood flow) in the setting of cardiomyopathy (disease of the heart muscle). Review of the Patient Safety Plan provided by the hospital on discharge on [DATE] indicated the following: - Warning signs: feeling depressed and lonely, lack of contact with family, medication issues, nursing home placement, and loss of past roles - Internal coping strategies: Playing bingo and poker with activities department - People and social settings that provide distraction: activities in the dayroom at the facility - People who I can ask for help: the director of nursing - Making environment safe: spending more time in the mileu and less isolating in room. Review of the current care plan indicated the following revisions after the attempted suicide: - [DATE]: [DATE] resident mloa d/t suicide attempt - [DATE] : encourage out of room activities During a follow-up interview on [DATE] at 8:04 A.M., Resident #7 said that he/she had had the nail polish remover in his/her possession since she originally admitted to the facility. During an interview on [DATE] at 12:14 P.M., Social Worker #1 said that she is only in the facility two days per week, and that her main role is doing assessment and ensuring the facility is in compliance with needed things such as care plan reviews. Social Worker #1 said if a Resident expresses suicidal ideation then she would expect to be told of the incident and she would see the resident as soon as possible upon return from the psychiatric hospitalization . Social Worker #1 said that the outside services that are offered from contracted staff are medication management and talk therapy. Social Worker #1 said that although she was in the building on [DATE], following Resident #7's hospital assessment for SI, she was not notified of the suicidal ideation from Resident #7. She said that she did not see or speak with Resident #7 and was then away the week after that. Social Worker #1 said that if she had seen or assessed Resident #7, it would be documented in the medical record. Social Worker #1 said that she would expect the care plan to be updated and an interdisciplinary team review of the Resident following a statement of suicidal ideation. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:42 P.M., the psychiatric Nurse Practitioner (NP) said that if a Resident is expressing suicidal ideation, then the environment should be checked and be free of harmful items and the care plan should be updated. During an interview on [DATE] at 9:05 A.M., the Director of Nursing said that when a Resident expresses suicidal ideation or returns from the hospital after expressing suicidal ideation, then behavioral health services, including talk therapy, should be initiated immediately. The Director of Nursing said that the Resident's environment should always be assessed for safety. The Director of Nursing said that Resident #7 was previously in a relationship and it was a terrible time and had a huge affect on him/her. The Director of Nursing said that just before the suicidal ideation, Resident #7 was really wrapped up in his/her kids not calling and that it was difficult because he/she already has major depression. The Director of Nursing said that if there is an increase in worsening depression, then there is always someone from psychiatric services they can call. The Director of Nursing said, after verbalization of suicidal ideation, she updates the care plan and notifies the interdisciplinary team. The Director of Nursing said that anything that was developed at the hospital would be reviewed in the facility and make sure it's appropriate.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to provide medically related social services to one Resident (#7) out of a total sample of 28 residents, after their verbalization of suicidal ideation (SI). Findings include: Review of the facility policy titled Suicide Threats, dated [DATE], indicates the following: - All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. - As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be indicated. - If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. Review of the facility policy titled Behavior Management, dated ,d+[DATE], indicated the following: - The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Resident #7 was admitted in [DATE] with diagnoses including major depressive disorder, history of suicidal ideations, post traumatic stress disorder (PTSD), and bipolar disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #7 scored a 14 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of the care plan, initiated [DATE], indicated Resident #7 has a history of suicidal ideation with the following interventions: - Provide a safe environment, free from things that may harm the client (initiated [DATE]) - Encourage the client to avoid decisions during the time of crisis until alternatives can be considered (initiated [DATE]) - Encourage the client to talk freely about feelings and help plan alternative ways of handling disappointment, anger and frustration (initiated [DATE]) (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Encourage the client to talk about their feelings and problem solve alternatives (initiated [DATE]) - Monitor resident for signs and symptoms of suicidal ideation (initiated [DATE]) - Social services to check in periodically with the resident to ensure safety (initiated [DATE]) During an interview on [DATE] at 9:49 A.M., Resident #7 said Some staff care and some don't. I am depressed a lot and take medication for that. I have 3 kids but they don't talk to me and this past August I tried to kill myself. I was really low and depressed. When I did what I did, I screamed cause it hurt. My heart stopped and I died on the table at the hospital. Three or four weeks before, I started getting really down, I had no one to talk to and it just got worse I was letting myself go. I wasn't eating and was staying in my room more and more and then I drank nail polish remover. Now I lay in bed a lot and watch tv and cry because I miss my kids and it is sad. Review of the nursing progress note, dated [DATE], indicated the following: Resident had suicidal ideation. Told one of the staff that he/she would like to kill him/herself but he/she doesn't have a plan. NP (nurse practitioner) notified and gave an order to send resident to hospital for evaluation. Unable to reach son via phone. Resident transferred to hospital. Review of a nursing progress note, dated [DATE], indicated the following: Resident returned from hospital emergency room at approximately 1900 (7:00 P.M.). There was no medication changes. He/she is to follow up with the physician and psych. Upon returning no vocalization of wanting to die/harm him/herself. He/she continues to deny having a plan. Declined dinner, offered alternate but refused On 20 minute checks. No acute distress note. Physician on call notified of his/her return. HCP (healthcare proxy) called but no answer. Review of the hospital discharge paperwork, dated [DATE], indicated the following: Pt (patient) tells this writer that he/she did make SI (suicidal ideation) statements; 'wanting to die, take my life, I've just had it and got to a point,' and 'tired of anything.' Pt denies a plan and denies any intent. Pt reports he/she has been feeling this way on and off for the past month and only today did he/she disclose it. This writer stated the nurse said he/she was having a good day up until 2:50 P.M. when the activities lady went into pt's room and pt disclosed SI thoughts to this staff person. Pt cannot recall if he/she took medication for depression . pt had been at his/her current facility for the past 6 years and states it is lonely, 'I'm by myself all the time'. Pt used to have a roommate but states he/she was difficult. Pt denies any history of attempts, gestures, SIB (self injurious behavior) or psych hospitalization s. This writer spoke to the nurse prior to meeting with the pt and the nurse reported pt had a boyfriend at the facility but the relationship ended about ,d+[DATE] months ago . Pt reports being upset that he/she has not heard from his/her children in months. Review of the psychiatric progress note from the hospital, dated [DATE], indicated the following: Discussed talk therapy referral and pt was agreeable stating he/she just needs someone to talk to. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record failed to indicate behavioral health services had provided talk therapy since [DATE]. Review of the medical record failed to indicate that social services had provided any services or initiated any talk therapy after Resident #7's verbalization of suicidal ideation on [DATE]. Review of the nursing progress note, dated [DATE], indicated the following: Resident shouted from his/her room 'help, I'm dying'. When the nurse got to the resident's room, the resident was on a wheelchair and seemed to be weak an not on [sic] his/her baseline, then he/she stated he/she had taken something which he/she does not want to tell. 2 cups were on the table, one had coffee and another one had pink liquid ,d+[DATE] full which immediately we identified as nail polish remover. 911 was activated, vital signs taken and staff stayed with him/her. On call doctor and DON notified, unable to reach son over the phone. Resident transferred to hospital. During an interview on [DATE] at 12:14 P.M., Social Worker #1 said that she is in the facility two days per week, and that her main role is doing assessments and ensuring the facility is in compliance with necessary things such as care plan reviews. Social Worker #1 said if a Resident expresses suicidal ideation then she would expect to be told of the incident and she would see the resident upon return from the psych hospitalization . Social Worker #1 said that the outside services that are offered from contracted staff are medication management and talk therapy. Social Worker #1 said that although she was in the building on [DATE], following Resident #7's hospital assessment for SI, she was not notified of the suicidal ideation of Resident #7; therefore, she did not see or speak with Resident #7. During an interview on [DATE] at 12:42 P.M., the psych Nurse Practitioner (NP) said that she provides strictly medication management in the facility and has a colleague that provides talk therapy to residents. The psych NP said that Resident #7's medications were adjusted after the suicidal ideation incident, but that the therapeutic effects of medications can take up to ,d+[DATE] weeks to take effect. The psych NP said she notified her colleague, who provides talk therapy, the day of her evaluation of Resident #7 on [DATE]. The psych NP said that if a Resident is expressing suicidal ideation, then the environment should be checked and be free of harmful items and the care plan should be updated. During an interview on [DATE] at 8:11 A.M., the contracted psych Social Worker said that she comes in bi-weekly to provide individual psychotherapy to residents. The psych Social Worker said that she was not made aware of Resident #7's suicidal ideation until her colleague told her on [DATE], seven days after the initial SI verbalization. The psych Social Worker said that by the time she came into the facility, Resident #7 had already gone out to the hospital for the suicide attempt. During an interview on [DATE] at 9:05 A.M., the Director of Nursing said that when a Resident expresses suicidal ideation or returns from the hospital after expressing suicidal ideation, then psych services, including talk therapy, should be initiated immediately and that she would expect the facility Social Worker to be notified and see the resident to provide support.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on record reviews and interviews, the facility failed to ensure they provided laboratory services to meet the needs of its residents. Specifically, the facility failed to maintain a current Clinical Laboratory Improvement Amendment (CLIA) certificate appropriate for the level of testing performed within the facility. Findings include: On [DATE] at 7:15 A.M., the surveyor observed a CLIA certificate posted on the bulletin board adjacent to the lobby near the Administrator's office with an expiration date of [DATE]. On [DATE] the surveyor requested the facility's CLIA certificate. On [DATE], the Administrator provided the surveyor with a CLIA certificate dated as expired [DATE] and the following document indicating Application Name: CLIA Laboratory Program dated [DATE], which indicated the payment was made on [DATE], for a CLIA renewal application. Further review of the documents provided by the facility indicated that an incomplete application was submitted but not followed up on until the day of survey on [DATE]. During an interview on [DATE] at 1:00 P.M., the Administrator said the facility provides testing that requires a CLIA certificate and said the certificate should have been renewed but was not. The Administrator said she started the application process but did not follow up on additional documents that were needed to renew the certificate.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 44095 Based on observation, interview, and record review, the facility failed to provide foods that accommodates resident preferences to one Resident (#6) out of a total sample of 28 residents. Specifically, the facility failed to consistently honor Resident #6's food preferences. Findings include: Review of the facility policy titled Food and Nutrition Services, dated as revised 1/2025, indicated that each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 4. Reasonable efforts will be made to accommodate resident choices and preferences. 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. a. If an incorrect meal is provided to a resident, nursing staff will report it to the food service manager. During the initial screening process on 3/25/25 and through the Recertification survey, the team of surveyors received several complaints of resident's food preferences not being consistently honored at meal times. Resident #6 was admitted to the facility in January 2025 with diagnoses including morbid obesity, heart failure, pemphigoid, and fibromyalgia. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/4/25, indicated that Resident #6 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. During an interview on 3/25/25 at 7:47 A.M., Resident #6 said that the kitchen never gets his/her meals correctly. The Resident said that he/she used to have a phone in his/her room to call the kitchen, but there is no phone in this room. Resident #6 said that the food could improve by offering more choices, the Resident continued to say he/she is not always getting preferences for meals and receives corn which he/she does not like. During a follow up interview on 3/25/25 at 12:18 PM Resident #6 said that the kitchen staff did not get his/her lunch correctly and he/she needed to wait for staff to bring back the correct meal. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 12:10 P.M., the surveyor observed the [NAME] serving the lunch meal line in the first-floor unit dining room. The surveyor observed Resident #6's meal ticket which included dislikes of corn, peas, and wax beans. The [NAME] said Resident #6 complains about not getting the correct meal preferences and she needs to pay extra close attention to what she serves Resident #6. The [NAME] read Resident #6 dislikes, and she said that Resident #6 dislikes wax beans and then the [NAME] plated Resident #6's lunch tray which included a mixed vegetable containing green beans, corn, peas, and carrots. At 12:11 P.M., the surveyor followed the Activities Assistant to Resident #6's room where Resident #6 was served the mixed vegetables containing green beans, corn, and peas. Resident #6 became angry and yelled at the Activities Aide and the Infection Control Nurse. Resident #6 said that staff never get his/her meals correct. The surveyor and the Infection Control Nurse reviewed Resident #6's diet slip, and the Infection Control Nurse said that staff did not honor Resident #6's preferences. During an interview on 3/27/25 at 12:51 P.M., the Food Service Director said that he was aware of Resident #6's ongoing food preference concerns, and he said that staff should honor his/her food preferences. During an interview on 3/27/25 at 12:43 P.M., the Dietitian said she was aware of Resident #6's ongoing food preference concerns, and she said that staff should honor his/her food preferences. During an interview on 3/27/25 at 12:59 P.M., the Administrator said that staff should honor Resident #6's food preferences.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 44095 Based on observations, diet manual review, and interviews, the facility failed to ensure that the [NAME] consistently prepared meals according to the therapeutic diet manual as ordered by the physician. Specifically, the facility failed to ensure the [NAME] consistently served the IDDSI 6 (soft and bite sized) therapeutic diet in accordance with 13 applicable resident's physician's order. Findings include: Review of the facility policy titled Therapeutic Diet, dated as revised 4/22, indicated that therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. 1. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet. 2. A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). The attending physician may delegate this task to a registered or licensed dietitian as permitted by state law 3. Diet order should match the terminology used by the food and nutrition services department. 4. A 'therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: d. altered consistency diet. 5. If a diet is ordered, the provider will specify the texture modification. The International Dysphagia Diet Standardization Initiative (IDDSI), through consultation and following best practice principles, has developed a global standardized way of describing foods and drinks that are safest for people with feeding, chewing or swallowing problems. Review of the IDDSI Food and Drinks Classification Adults, dated 8/7/24, indicated the following: - Level 7: Regular, includes normal everyday foods of various textures that are developmentally and age appropriate. Biting and chewing ability needed. - Level 6: Soft and Bite- Sized, includes tender and moist throughout, with no thin liquid leaking or dripping from the food. Chewing ability is needed. https://www.iddsi.org/images/Publications-Resources/Poster/posterenglishinternational7aug2024.pdf (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of the facility's diet manual titled Therapeutic Breakdowns, dated as revised 9/15/16, indicated the following therapeutic diet breakdown for Tuesday 3/25/25: - IDDSI 7 Regular Texture: Pork, 3 ounces 1/2 inch strips Roasted Potatoes, 4 ounces quartered Mixed Vegetables, 4 ounces sliced carrots - IDDSI 6 Soft and Bite Size: Pork, 3 ounces 1/2 inch diced Roasted Potatoes, 4 ounces 1/2 inch soft mashable, no skin Mixed Vegetables, 4 ounces mashable mixed vegetables (no peas or corn) On 3/25/25 at 12:11 P.M., during a lunch time observation the surveyor observed three different residents who had diet slips which indicated IDDSI 6 Soft and Bite Size. - The residents received pork that served cubed, the cubes were cut greater than 1/2 inch and the cubes of pork were not diced. - The residents received potatoes were the same potatoes served to the IDDSI 7 residents, and there was skin on the potatoes. - The residents received the same mixed vegetables served to the IDDSI 7 residents which included whole green and yellow beans measuring approximately 2-3 inches in length and baby whole carrots approximately 2 inches in length. The surveyor observed one Resident (#4) who was served the IDDSI 6 meal, and he/she was edentulous and he/she was unable to eat his/her meal. b. Review of the facility's diet manual titled Therapeutic Breakdowns, dated as revised 9/15/16, indicated the following therapeutic diet breakdown for Wednesday 3/26/25: - IDDSI 7 Regular Texture: Chicken Pot Pie, 1/24th of a pan Broccoli, 4 ounces - IDDSI 6 Soft and Bite Size: Chicken Pot Pie, 6 oz 1/2 inch diced chicken with mashable vegetable. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Broccoli, 4 oz mashable On 3/26/25 during the lunch meal tray line the surveyor observed the [NAME] serve six different residents who had diet slips which indicated IDDSI 6 Soft and Bite Size. - The residents received the same chicken pot pie as the IDDSI 7 residents. - The residents received the same broccoli as the IDDSI 7 residents. On the 3/26/25 at 12:12 P.M., the surveyor conducted a test tray of IDDSI 6 Soft and Bite Size diet, the chicken in the chicken pot pie were long thick pieces of pulled chicken greater than 1 inch in length and the chicken was not diced according to the therapeutic breakdown. The broccoli was served whole (floret, flower buds and stem, stalk) approximately 1 inch in length and 2 inches in diameter, the stems were firm, and the surveyor was unable to mash the broccoli. During an interview on 3/26/25 at 12:15 P.M., the [NAME] said she prepared the meal for lunch on 3/26/25. The [NAME] said that she prepared the IDDSI 7 and IDDSI 6 chicken pot pie in the same manner, she boiled chicken thighs and then shredded the chicken meat with a fork, and she was serving the same pot pie to both the IDDSI 7 and IDDSI 6 diet textures. The surveyor observed five residents who had been served the IDDSI 6 diet, two of the Residents said that the broccoli was too hard to eat. c. Review of the facility's diet manual titled Therapeutic Breakdowns, dated as revised 9/15/16, indicated the following therapeutic diet breakdown for Thursday 3/27/25: - IDDSI 7 Regular Texture: Au Gratin Potato, 4 ounce - IDDSI 6 Soft and Bite Size: Au Gratin Potato, 4 ounce 1 mashable cubes no skin. On 3/27/25 between 11:45 A.M., through 12:05 P.M., during the lunch meal tray line the surveyor observed the [NAME] serve five different residents who had diet slips which indicated IDDSI 6 Soft and Bite Size. The [NAME] was serving au gratin potatoes for both the IDDSI 7 and IDDSI 6 diet from the same pan. The pan contained slices of potatoes, some of which were greater than 1 inch in diameter. The top of the au gratin potatoes was crispy. During an interview on 3/27/25 at 12:05 P.M., the [NAME] said she doesn't always pay attention to the IDDSI numbers, and she said that IDDSI 7 is regular texture and the IDDSI 6 is chopped texture The [NAME] said that the Residents who were receiving IDDSI 7 and IDDSI 6 are receiving the same au gratin potatoes today which included sliced potatoes. On 3/27/25 at 12:15 P.M., the surveyor and the Director of Nursing observed a Resident (#9) who required an IDDSI 6 diet. He/she was served au gratin potatoes that were served greater than 1 inch in diameter and he/she couldn't eat because it was too hard and big. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 12:43 P.M., the Dietitian said the [NAME] should follow meal textures according to the therapeutic diet manual. The surveyor shared the observations of the lunch meals from 3/25/25, 3/26/25, and 3/27/25 and the Dietitian said that the [NAME] did not follow the therapeutic diet breakdown for the IDDSI 6 diets. During an interview on 3/27/25 at 12:51 P.M., the Food Service Director said the [NAME] should follow meal textures according to the therapeutic diet manual. The surveyor shared the observations of the lunch meals from 3/25/25, 3/26/25, and 3/27/25 and the Food Service Director said that the [NAME] did not follow the therapeutic diet breakdown for the IDDSI 6 diets. During an interview on 3/27/25 at 12:59 P.M., the Administrator said the [NAME] should follow meal textures according to the therapeutic diet manual. The surveyor shared the observations of the lunch meals from 3/25/25, 3/26/25, and 3/27/25 and the Administrator said that the [NAME] did not follow the therapeutic diet breakdown for the IDDSI 6 diets. The Administrator provided the surveyor with a list of therapeutic diets, and she said there were 13 residents with physician ordered IDDSI 6 diets on 3/25/25, 3/26/25, and 3/27/25.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 41105 Based on interview and record review, the facility failed to develop, implement and maintain a Quality Assurance and Performance Improvement (QAPI) program, which focuses on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility failed to ensure a QAPI plan was implemented and addressed concerns regarding the behavioral health services and medically related social services provided when a Resident (#7) with a known history of suicidal ideations (SI) attempted suicide at the facility. Findings include: The facility policy titled Quality Assurance Performance Improvement, dated 4/17, indicated the following: -The facility has a Quality Assurance / Performance Improvement Program which systematically monitors, analyzes and improves its performance to improve resident outcomes. II. Feedback, Data systems and Monitoring. a.a. QAPI is integrated into the responsibilities and accountabilities of all senior management. b.b. The following data is monitored through QAPI: i. Input from caregivers, residents, families, and others; ii. Adverse events; iii. Performance indicators; iv. Survey findings. Review of the medical record for Resident #7 indicated the following: -A nursing progress note, dated 8/7/24, indicated: Resident had suicidal ideation. Told one of the staff that he/she would like to kill herself but he/she doesn't have a plan. NP (nurse practitioner) notified and gave an order to send resident to hospital for evaluation. Unable to reach son via phone. Resident transferred to hospital. Review of the psychiatric progress note from the hospital, dated 8/7/24, indicated the following: Discussed talk therapy referral and pt was agreeable stating he/she just needs someone to talk to. Review of the clinical record failed to indicate that social services or psychiatric services; specifically talk therapy, had been provided upon Resident #7's return to the facility after the verbalization of suicidal ideation on 8/7/24. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record failed to indicate behavioral health services had provided talk therapy since 7/23/24 or that a referral was made for talk therapy services, as recommended from the hospital. -A nursing progress note, dated 8/17/24: Resident shouted from his/her room 'help, I'm dying'. When the nurse got to the resident's room, the resident was on a wheelchair and seemed to be weak an not on [sic] his/her baseline, then he/she stated he/she had taken something which he/she does not want to tell. 2 cups were on the table, one had coffee and another one had pink liquid 3/4 full which immediately we identified as nail polish remover. 911 was activated, vital signs taken and staff stayed with him/her. On call doctor and DON notified, unable to reach son over the phone. Resident transferred to hospital. Resident #7 was hospitalized following this suicide attempt from 8/17/24 - 9/19/24. During an interview on 3/27/25 at 1:14 P.M., with the Nursing Home Administrator (NHA) and Director of Nursing (DON) the facilities QAPI process was reviewed, including how new QAPI projects are determined. The surveyor asked if adverse events are something that it is analyzed by the QAPI team and the NHA responded absolutely. The surveyor asked if a QAPI was initiated after the actual suicide attempt by Resident #7 in August 2024 and the NHA responded no. Both the NHA and DON then indicated that they would considered an attempted suicide in the facility an adverse event.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Lowell	30 Princeton Boulevard Lowell, MA 01851

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, interview and policy review the facility failed to provide a safe environment on one of two nursing units. Specifically, in an resident room on the unit, that was not secured and was accessible to residents and staff, a radiator cover was removed and the electric radiator parts/motors were spread out on the floor, exposing electric wires within the radiator. Findings include: A review of the facility policy titled Resident Rights: Accommodation of Needs and Preferences and Homelike Environment, not dated, indicated that the facility will provide a safe, clean, comfortable and homelike environment. On 3/27/25, at 8:25 A.M., the surveyor observed room [ROOM NUMBER] to be an unoccupied room on a resident unit, that was not secured and was accessible to residents and staff. In the room a radiator cover was removed and the electric radiator parts/motors were spread out on the floor, exposing electric wires within the radiator During an interview on 3/27/25 at 8:39 A.M., Nurse #2 said that there are residents with dementia and behavior of wandering that reside on the unit. Nurse #2 said that room [ROOM NUMBER] would not be safe for them to go into. Nurse #2 said that the room should be secured so residents couldn't wander in and hurt themselves. During an interview on 3/27/25 at 8:41 A.M., the Minimum Data Set Nurse said that there are residents with dementia and behavior of wandering that reside on the unit. She said that room [ROOM NUMBER] would not be safe for them to go into.