STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225513	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Rehab & Skilled Nursing Ctr - Northboro	238 West Main Street Northborough, MA 01532

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on record review and interview, the facility failed to ensure that Advance Directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes) were accurate for two Residents (#27 and #28) out of a total sample of 19 residents. Specifically, the facility failed to: 1. For Resident #27, ensure that the MOLST (Massachusetts Medical Order for Life-Sustaining Treatment) form was valid and reflected the signature of Resident #27's invoked (made active by a Physician) Health Care Proxy (HCP- a legal document that allows you to appoint someone you trust to make medical decisions on your behalf if you are unable to do so). 2. For Resident #28, ensure that the MOLST form was valid and reflected the signature of the Resident's appointed/invoked HCP. Findings include: Review of the facility policy titled Advanced Directives and Massachusetts Health Care Proxy, last revised 2/25/24, indicated the following: -On admission determine if the patient has a validly executed MOLST form or copy of the form. -The Admissions Director or Social Worker will determine if the form has been validly executed and contains the signature of the Resident and the signature of the Physician, Nurse Practitioner (NP) or Physician Assistant (PA). -At the time of the Quarterly Care planning, the Advanced Directives will be reviewed with the patient, or health care agent to determine if they remain valid. 1. Resident #27 was admitted to the facility in May 2023, with diagnoses including vascular Dementia (problems with reasoning, planning, memory, judgement, and other thought processes caused by brain damage from impaired blood flow to the brain). (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #27 was unable to complete the Brief Interview for Mental Status (BIMS) exam and was cognitively impaired. Review of the clinical record revealed a MOLST form that was signed by someone other than the Resident, or Resident #27's appointed HCP on 10/31/14. Review of the Massachusetts Health Care Proxy Designation Form indicated Resident #27 had appointed a HCP on 2/11/16. Review of the clinical record indicated that the Physician had invoked Resident #27's Health Care Proxy (HCP) on 5/17/23. During an interview on 5/8/24 at 12:02 P.M., the Director of Nurses (DON) said the facility did not have evidence that Resident #27's HCP had been activated prior to the date the MOLST form was signed on 10/31/14. The DON also said that a new MOLST form should have been completed on the Resident's admission to the facility and that the MOLST form that was currently on file was not valid. 44337 2. Resident #28 was admitted to the facility in December 2023 with a diagnosis of Malignant Neoplasm (Cancer). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #28 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Assessment of 14 out of a total possible score of 15. Review of the Massachusetts Health Care Proxy Designation Form indicated Resident #28 had appointed a HCP on 9/5/13. Review of the HCP Invocation Form for Resident #28 indicated that the Resident's HCP had been invoked on 2/7/24. Review of the MOLST form for Resident #28 indicated that the MOLST form was signed by someone other than the Resident or appointed HCP and was dated 12/15/23. During an interview on 5/8/24 at 12:09 P.M., the DON said that the Resident's MOLST form was invalid because it had been signed by verbal authorization of a person who was not Resident #28's HCP on 12/15/23. The DON said a new MOLST form should have been signed by Resident #28's designated HCP when the Resident was admitted to the facility.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on interview, record and policy review, the facility failed to provide privacy and confidentiality for one Resident (#27) out of 19 sampled residents. Specifically, for Resident #27, the facility staff failed to ensure that personal privacy of the Resident's own body was provided when he/she was observed to be naked and attempting to get dressed in their bedroom. Findings include: Review of the facility policy titled Resident's Rights, last revised 9/19/23, indicated that Federal and state law guarantee certain basic rights to all residents of this facility including: -a dignified existence -privacy and confidentiality Resident #27 was admitted to the facility in May 2023, with diagnoses including vascular Dementia (problems with reasoning, planning, memory, judgement, and other thought processes caused by brain damage from impaired blood flow to the brain). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #27 was unable to complete the Brief Interview for Mental Status (BIMS) exam and was cognitively impaired. On 5/7/24 at 8:03 A.M., the surveyor observed from the Resident's bedroom doorway that Resident #27 was located in his/her bedroom, was naked, and attempting to dress him/herself while sitting in his/her wheelchair. On 5/7/24 at 8:11 A.M., the surveyor asked Nurse #1, who was in the vicinity of the Resident's doorway, if Resident #27 required assistance with dressing. The surveyor observed that Nurse #1 looked into the room at Resident #27 and said that he/she did not require any assistance with dressing. The surveyor further observed that Nurse #1 continued with the task she was doing and did not attempt to enter the Resident's room to draw the Resident's privacy curtain, close the door, or cover the Resident's body. On 5/7/24 at 8:18 A.M., the surveyor observed Certified Nurses Aide (CNA) #2 enter Resident #27's room to obtain an item for the Resident's roommate. The surveyor observed that the Resident was still naked and sitting in his/her wheelchair. The surveyor observed CNA #2 exiting the room without covering the Resident's body or drawing the privacy curtain and leaving the Resident naked, where he/she could still be seen from the doorway by anyone looking into the bedroom. During an interview on 5/8/24 at 8:15 A.M., Nurse #1 said that Resident #27 should have been covered or a privacy curtain should have been drawn and that was not done. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24 at 8:17 A.M., CNA #1 (who also worked on the Resident's unit) said if she saw a Resident naked from the hallway, she would go and help them by covering them with a sheet, when the surveyor asked what she would do in this situation. During an interview on 5/8/24 at 12:18 P.M., Unit Manager (UM) #1 said that the staff should have covered Resident #27 when he/she was exposed. During an interview on 5/9/24 at 10:01 A.M., CNA #2 said that he saw Resident #27 naked in his/her room. CNA #2 also said that he told the CNA on the Resident's assignment what he had seen, but did not cover the Resident's body or draw the curtain for privacy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interview, record and policy review, the facility failed to ensure that two Residents (#54 and #61), out of a total sample of 20 residents were provided with necessary assistance during dining service to decrease the risk of reduced nutritional intake. Specifically, the facility staff failed to: 1. For Resident #54, offer to provide physical assistance to set up meal trays by opening opening containers and placing meal items in an accessible manner that would enable the Resident to consume his/her meals. 2. For Resident #61, assist the Resident in setting up their meal tray for ease with dining by cutting up food items as needed and ensuring meal items were accessible. Findings include: Review of the facility's Dining Program Policy, undated, indicated the following: -It was the facility's policy to provide an enhancing resident-centered dining service that encourages nutritional intake, resident independence, social relationships, and overall well-being. -Proper assistance and encouragement will be given to residents as needed or care planned. 1. Resident #54 was admitted to the facility in November 2023, with a diagnosis of Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) with agitation (state of anxiety or nervous excitement). Review of Resident #54's Activities of Daily Living (ADL) Care Plan, initiated 11/16/23 and edited 11/29/23, indicated the Resident required setup/clean-up assistance for eating. Review of Resident #54's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was severely cognitively impaired as evidenced by a BIMS score of zero out of 15 total possible points. Review of Resident #54's Functional Abilities for Eating Record for 5/1/24 through 5/6/24 indicated the Resident's functional abilities for eating varied from requiring partial/moderate assistance to independent. On 5/7/24, between 9:10 A.M. and 9:47 A.M., the surveyor observed the following in the Dementia Special Care Unit (DSCU) Dining Room: -Resident #54 was sitting at a dining table with two other residents. -The Resident's meal tray was in front of him/her at the table and included the following items: >One breakfast sandwich, cut in half. One half of the sandwich was off the back of the plate. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>One partially eaten muffin on the plate. >One banana, unpeeled, on the tray, behind the plate and out of view of the Resident. >One covered, unopened plastic cup of water. >One unopened carton of milk. >One uncovered bowl of oatmeal. >One uncovered ice cream cup. >One unopened plastic cup of orange juice with a tin foil cover. -Resident #54 held a spoon and knife and was rubbing them together. -At 9:12 A.M., the surveyor observed Resident #54 pick up the milk carton and attempt to pull on the top of the carton repetitively. -At 9:14 A.M., the surveyor observed Resident #54 holding the unopened milk carton in his/her left hand and the uncovered pudding cup in his/her right hand. -The Resident placed the ice cream cup back on the tray, continued to hold the unopened carton of milk and began pulling at the top of the carton again. -The Resident then placed the unopened milk carton back on the tray, placed the fingers on his/her right hand into the bowl of oatmeal, removed his/her fingers from the bowl and licked them. -Resident #54 picked up the ice cream cup and attempted to drink it, but no pudding came out of the cup. -At this time, the surveyor observed no staff in the immediate dining area. -At 9:18 A.M., the surveyor observed a staff member entered the Dining Room and walked by the Resident, into the adjacent dining area, but did not stop to assist Resident #54. -At 9:19 A.M., the surveyor observed Resident #54 take his/her spoon and repeatedly push it into the side of the unopened milk carton. -At 9:25 A.M., the surveyor observed another resident at the table take Resident #54's unopened milk carton and attempt to open it using a fork. -The surveyor observed the other Resident then stood and reached onto Resident #54's plate, picked up one half of Resident #54's breakfast sandwich, and took a bite, then picked up Resident #54's pudding cup and ate the pudding. -At this time, Resident #54 placed the unopened orange juice and what was left of the breakfast sandwich on his/her plate with the partially eaten muffin, then pushed him/herself away from the table. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24, from 8:32 A.M. through 8:40 A.M., the surveyor observed the following in the DSCU Dining Room: -Resident #54's breakfast tray was on the table where the Resident was sitting. -The breakfast tray included the following items: >One uncovered plate with a muffin and one breakfast sandwich that was cut in half. >One unopened cup of orange juice with a tin foil lid. >One unopened fruit cup with a plastic lid. >One unopened bowl of oatmeal with a plastic lid. >One unopened carton of milk. >One unopened cup of water with a plastic lid. >One unopened ice cream cup. -Resident #54 picked up the unopened fruit cup from the meal tray, attempted to grasp the edge of the lid, then began twisting the lid repeatedly before shaking his/her head side to side, then placing the fruit cup back on the tray. -At 8:35 A.M., Resident #54 pushed him/herself away from the table, then moved him/herself forward in his/her wheelchair, bumping into another resident's chair. -At this time, the other resident began to push Resident #54's wheelchair away from him/her and Resident #54 vocalized an expletive. -No staff were observed to intervene and assist Resident #54 until 8:37 A.M. when the MDS Nurse intervened and asked Resident #54 if she could assist him/her. -At this time, the MDS Nurse assisted Resident #54 back to the table and offered to open the Resident's food items that had not been previously opened. -Resident #54 said yes to allowing the MDS Nurse to open his/her orange juice and oatmeal, and also accepted a plastic cup with a lid and straw containing a soft drink. -Resident #54 then ate some oatmeal and drank all of the soft drink. During an interview on 5/10/24 at 11:15 A.M., the MDS Nurse said Resident #54 would allow staff to assist him/her at times, and would also refuse assistance at times. The MDS Nurse said when staff provide Resident #54 with his/her meal tray, staff should always offer to open the food items, and if the Resident refuses, then staff should wait and re-approach. The MDS Nurse also said if the Resident showed interest in specific food items and was having difficulty accessing or opening the food items, staff would need to intervene and provide assistance for the Resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #61 was admitted to the facility in April 2021, with diagnoses including: Dementia, Parkinson's Disease (chronic and progressive movement disorder that initially causes tremors and impaired muscular coordination), and Insomnia (sleep disorder with trouble falling and/or staying asleep). Review of Resident #61's MDS Assessment, dated 4/3/24, indicated the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) of three out of 15 total possible points. Further review of the MDS Assessment indicated the Resident required setup and clean-up assistance for eating. Review of Resident #61's ADL Care Plan, initiated 10/2/23 and edited 4/15/24, indicated the Resident was independent for eating following setup/clean-up. Review of Resident #61's Functional Abilities for Eating Record for 5/1/24 through 5/7/24 indicated the Resident's functional abilities for eating varied from requiring substantial/maximal assistance to setup or clean-up assistance. On 5/8/24, from 8:45 A.M. through 9:01 A.M., the surveyor observed the following in the DSCU Dining Room: -Resident #61 was sitting at a table with his/her breakfast tray in front of him/her. The breakfast tray included: >Two whole pancakes, stacked. >One uncovered bowl of oatmeal. >One uncovered cup of orange juice. -Resident #61 held a spoon in his/her right hand, pushed it under one of the pancakes and attempted to pick it up several times, but the pancake fell off the spoon. -Resident #61 brought the spoon to his/her mouth after each attempt to pick up the pancake, but the spoon had nothing on it. -The surveyor then observed Resident #61 use the spoon to scoop across the table cloth, then bring the spoon to his/her mouth. -Resident #61 then picked up another spoon and a fork from the table so that he/she was holding two spoons and one fork in his/her hands. -Resident #61 placed the spoons and fork onto the plate and began closing his/her eyes. -No staff were observed to assist Resident #61 with his/her breakfast meal until 9:01 A.M. when the DSCU Program Director intervened. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24 at 10:15 A.M., the DSCU Program Director said Resident #61 normally fed him/her self after being provided setup assistance for meals. The DSCU Program Director said she knew Resident #61 did not sleep well the night before, so the Resident was tired and required more assistance that day with breakfast. When the surveyor asked what staff should do to assist residents when they require more assistance, the DSCU Program Director said that she could not speak to the facility's expectation for the level of assistance staff should provide for residents during meal time, based off the residents' status. The DSCU Program Director said Unit Manager (UM) #2 would know more about how staff provided assistance to residents based on the residents' needs. During an interview on 5/8/24 at 10:45 A.M., UM #2 said when staff provided meal trays to residents on the Unit, all food items were to be cut up and covered/sealed items were to be opened for the residents. UM #2 said if residents' status' varied and they needed more assistance, then staff were expected to provide the assistance needed in a timely manner. UM #2 said staff should have provided assistance to set up breakfast meals for Resident #54 on 5/7/24 and 5/8/24 and for Resident #61 on 5/8/24, by cutting up the food items and ensuring all food and drink items were accessible to the Residents.

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	225513	A. Building B. Wing	05/10/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42761 Based on observation, interview, record and policy review, the facility failed to provide an environment as free of accidental hazards as possible, consistent with the needs of one Resident (#84) out of a total sample of 20 residents. Specifically, the facility staff failed to provide adequate supervision and assistance for Resident #84 during meal time, when the Resident was assessed and ordered for a pureed (food that has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding) diet texture, but was able to obtain and ate regular textured food from another Resident's (#54's) meal tray, increasing the Resident's risk for complications and illnesses. Findings include: Review of the facility's Dining Program Policy, undated, indicated the following: -It was the facility's policy to provide an enhancing resident-centered dining service that encourages nutritional intake, resident independence, social relationships, and overall well-being. -Proper assistance and encouragement will be given to residents as needed or care planned. -Therapeutic diets and consistencies will be adhered to. Review of the American Cancer Society's document titled Living as an Oral Cavity and Oropharyngeal Cancer Survivor, dated 3/23/21, indicated the following: -Cancers of the mouth and throat can sometimes cause problems making it hard to eat. -Some people might need to adjust what they eat during and after treatment . -Surgery . can lead to problems with speech, swallowing, . -Speech Therapists are knowledgeable about speech and swallowing problems and can help one learn to manage them. Resident #84 was admitted to the facility in October 2023 with diagnoses including: Dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and Malignant Neoplasm (cancerous tumor) of the Hard Palate (the roof of the mouth, separating the cavities of the nose and the mouth). Review of Resident #84's Health Care Proxy (HCP: person who makes health care decisions for someone who is not able to make health care decisions for themselves) Invocation Form, dated 10/25/23, indicated the Resident's Physician permanently invoked (made active) the Resident's HCP on 10/25/23 due to progressive Dementia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #84's Speech Therapy Evaluation and Plan of Treatment, dated 10/26/23, indicated the following: -The Resident had a history of Malignant Neoplasm of the Hard Palate. -The Resident was status post palatal resection (portion of the palate removed and presents swallowing difficulty) due to palatal cancer. -The Resident had a prosthesis (artificial body part) for the hard palate, but did not tolerate using it due to Dementia/confusion. -The Resident had been eating pureed foods since the palate resection. -The Resident's HCP reported that the Resident occasionally experienced nasal regurgitation (swallowing disorder that occurs when food or fluid comes up into the nose while eating or drinking)/emission (discharge) of material in the Resident's mouth. -The Resident was expected to remain on a pureed diet unless he/she wore his/her palate prosthesis. Review of Resident #84's Speech Therapy Discharge Summary, dated 1/30/24, indicated: -The Resident's swallow status was stable. -The Resident required a pureed diet. -Attempt use of palatal prosthetic. Review of Resident #84's Physician's order dated 1/18/24, with no stop date, indicated: -The Order was a Dietary Order. -The Resident required a House (regular), Pureed diet. Review of Resident #84's Minimum Data Set (MDS) Assessment, dated 4/24/24, indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) due to the Resident being rarely/never understood. Further review of the MDS Assessment indicated: -The Resident wandered one to three days during the assessment period. -The Resident required a mechanically altered (changed by means of whipping, blending, chopping, or mashing) diet. Review of Resident #84's Behavioral Symptoms Care Plan, edited 5/3/24, indicated: -The Resident had a behavior of wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident's needs would be anticipated to limit behaviors. -Staff were to provide re-direction and re-approach as needed. Review of Resident #84's Nutritional Status Care Plan, edited 4/9/24, indicated: -The Resident presented with nutritional concerns. -The Resident was missing part of his/her hard palate. -The Resident required a mechanically altered diet. -Diet as ordered. On 5/8/24, between 8:32 A.M. and 9:17 A.M., the surveyor observed the following: -Resident #84 was seated at a table in the Dining Room, next to Resident #54. -Staff provided Resident #84 with his/her meal tray which contained pureed texture food items. -Staff provided Resident #54 with his/her meal tray which included one breakfast sandwich and one muffin. -Resident #54 left the table at 8:56 A.M. and staff removed the Resident's breakfast tray which included a partially eaten breakfast sandwich and one whole muffin. -Resident #84 was still sitting at the table and had eaten all of his/her own food. -Resident #54 returned to the table, next to Resident #84, at 9:02 A.M. -Staff returned Resident #54's breakfast tray to him/her which included the partially eaten breakfast sandwich and the muffin. -At this time, the surveyor observed Resident #84 stand up and begin walking through the dining room. -The Activities Assistant (AA) offered to walk out in the hallway with Resident #84. -The Resident began to walk with the AA, but turned back to the dining room and sat down next to Resident #54 while Resident #54 ate a portion of the breakfast sandwich. -The AA remained in the hallway with another resident at this time. -Resident #54 then left the table and Resident #84 remained seated at the table with Resident #54's meal tray next to him/her on the table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225513	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Rehab & Skilled Nursing Ctr - Northboro	238 West Main Street Northborough, MA 01532

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At this time, the surveyor observed the Dementia Special Care Unit (DSCU) Program Director in the dining area assisting another resident. The DSCU Program Director's back was toward Resident #84 and no other staff were present in the immediate area. -At 9:16 A.M., Resident #84 looked at the surveyor and spoke softly, without enunciating any words, and the surveyor was unable to understand what the Resident said. -At 9:17 A.M., the surveyor observed Resident #84 pick up the muffin from Resident #54's meal tray and take a bite. -The surveyor immediately notified the DSCU Program Director when the surveyor observed that Resident #84 was eating the muffin from Resident #54's tray. -The DSCU Program Director made several attempts to instruct Resident #84 to follow her to the Nurse who was in the hallway. The surveyor observed that by the time the Resident followed the DSCU Program Director instructions and reached the Nurse in the hallway, the Resident had already swallowed the piece of muffin. During an interview on 5/8/24 at 10:15 A.M., the DSCU Program Director said Resident #84 often wandered and picked up items that belonged to other residents. The DSCU Program Director said that she could not speak to the level of supervision and assistance provided for residents for meals, and that Unit Manager (UM) #2 could probably speak better to the level of supervision and assistance provided to residents based on the residents' status. The DSCU Program Director said she did not see Resident #84 retrieve the muffin from Resident #54's tray and take a bite, because she was assisting another resident. During an interview on 5/8/24 at 10:45 A.M., UM #2 said she thought Resident #84 was on a House Diet, so the Resident could eat whatever he/she wanted, but that he/she should not be eating from other residents' trays. UM #2 said Resident #84 should not have had access to retrieve food items from Resident #54's meal tray. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/24 at 11:00 A.M., the Speech Language Pathologist (SLP) said she had provided services relative to swallowing for Resident #84. The SLP said Resident #84 previously had a palate resection and had been provided with a palate prosthesis, but the Resident did not tolerate wearing the prosthesis so the prosthesis was not in use. The SLP said that without the use of the prosthesis, there was an opening in the top of the Resident's mouth that made it difficult for the Resident to speak intelligibly and that could impact the Resident's ability to manage food. The SLP said that Resident #84 was admitted to the facility on a pureed diet and SLP had not assessed Resident #84's ability to manage regular diet texture food items, so when the Resident was discharged from Speech Therapy services, it was recommended the Resident remain on a pureed diet. The SLP said that Resident #84 demonstrated sufficient strategies to clear pureed food items from the opening in the top of his/her mouth, but she could not say that the Resident could sufficiently and safely manage regular food textures as this had not been assessed for the Resident. The SLP said since the Resident did not use his/her palate prosthesis, there was no way to close the opening in the top of the Resident's mouth. The SLP said if the Resident accessed and ate regular texture food items for which he/she was not assessed, there was a risk the food items could enter into the opening in the top of the Resident's mouth and a potential the Resident would not be able to clear the food items from the opening. The SLP said if the Resident was unable to clear food items that entered into the opening in the top of the Resident's mouth, there was a risk for the food to remain in that space, which would increase the Resident's risk for bacterial growth and illness. The SLP further said she recommended that Resident #84 remain on a pureed diet at this time as a pureed diet was the safest diet texture for the Resident.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 45429 Based on observation, interview, policy and record review, the facility failed to provide appropriate care, services, and monitoring of a gastrostomy tube (G-tube- a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medication, also referred to as a feeding tube) for one Resident (#242) out of a total sample of 19 residents. Specifically, the facility staff failed to obtain Physician's orders to check for gastric residual volume (amount of fluid remaining in the stomach after enteral [passing through the gastrointestinal (GI) tract] nutritional feeding has been given) of a G-tube to identify and prevent complications associated with enteral feeding. Findings include: Review of the facility policy titled Enteral Feedings, last revised 4/30/24, indicated: -to check for gastric residual. -hold the feeding and notify per Physician's orders. -Checking residuals- the nurse should check for residuals once per shift or per Physician order to minimize the potential complications with vomiting, distention and aspiration. Resident #242 was admitted to the facility in April 2024 with diagnoses including cerebral infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) and dysphagia (difficulty swallowing) and G-tube. Review of Resident #242's Care Plan for Tube Feedings, dated 4/30/24, indicated an intervention for enteral feeding management per Physician's orders. Review of the May 2024 Physician's orders, with start date of 5/7/24, indicated: -an order to check residuals every shift -notify Physician if residual is greater than 500 cubic centimeters (cc's) -follow Physician directions Review of Resident #242's Medication Administration Record (MAR) for April 2024 and May 2024 did not indicate that the Resident had been ordered for and checked for gastric residuals until 5/7/24. Review of Resident #242's clinical record did not indicate that the Resident had been checked for gastric residuals from the time of admission to 5/7/24 (the first day of DPH survey). (continued on next page)

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	225513	A. Building B. Wing	05/10/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24 at 12:18 P.M., Unit Manager (UM) #1 said that the Physician's order to check for gastric residuals should have been in place per the facility policy upon the Resident's admission and it had not been. UM #1 said that the facility was not following their policy.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on record review and interview, the facility failed to provide pain management consistent with professional standards for one Resident (#28) out of a total sample of 19 residents. Specifically, the facility staff failed to appropriately assess Resident #28 for the presence of pain and intensity of pain on each shift. Findings include: Review of the facility policy titled Pain Management last revised April 2017, indicated the following: -Purpose: to provide each resident who is experiencing acute or chronic pain effective assessment and management of symptoms . -The resident will be screened for the presence and intensity of pain on each shift using the Medication Administration Record (MAR) to record the results. -Resident's self-report of pain is to be used as the single most reliable indicator of the existence and intensity of pain. -Pain scale tools which are appropriate for the resident's developmental, physical, emotional, and cognitive status are used to evaluate and assess the effectiveness of a pain management plan. They are: Numerical (0-10), Verbal or Non- Verbal for the cognitively impaired. -Consistent documentation of the effectiveness of pain management is done in the Electronic Medication Administration Record (eMAR) and at intervals on the care plan. Resident #28 was admitted to the facility in December 2023, with diagnoses including malignant neoplasm of reproductive system (Cancer) and Mild Cognitive Impairment (trouble with memory, language or judgement) of unknown cause. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #28: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 14 out of a possible score of 15. Review of the Physician's orders dated 4/8/24 to 5/8/24 indicated the following: -Pain Assessment Every Shift, assess for level of comfort via Verbal Pain Scale: -0 = no pain -1-2 = slight pain (continued on next page)

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	225513	A. Building B. Wing	05/10/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-3-4 = mild pain -5-6 = moderate pain -7-8 = severe pain -9-10 = very severe pain. Check off pain three times a day. Start date 12/20/23. -Dilaudid (Hydromorphone: opioid pain medicine) Schedule II, oral liquid, 1 milligram (mg) per milliliter (ml), give 2 mg per 2 ml orally as needed for moderate pain every four hours. Start date 4/4/24 -Dilaudid, Schedule II oral liquid, 1 mg per 1 ml, give 4 mg/4 ml orally as needed for severe pain. Start date 4/4/24. -Dilaudid, Schedule II oral liquid 1 mg per 1 ml, give 2 mg orally twice a day at 6:00 A.M. and 8:00 P.M. for pain. Start date 4/9/24. During an interview on 5/7/24 at 11:51 A.M., Resident #28 said he/she had terminal cancer and is supposed to get pain medicine around the clock for the pain in his/her stomach. Resident #28 said that one night the Nurse only gave him/her half of the pain medication that was ordered. Resident #28 said that if he/she did not keep on top of the pain then he/she is in too much pain to do anything. On 5/8/24 at 8:58 A.M., the surveyor observed Resident #28 sitting a wheelchair, dressed and eating breakfast. Resident #28 said the pain was in his/her stomach and his/her pain level was a four out of 10. Resident #28 also said he/she just received his/her pain medication. On 5/8/24 at 1:44 P.M., the surveyor observed Resident #28 sitting in a recliner. Resident #28 said his/her pain level was a six out of 10 and he/she has not asked for any additional pain medication. During an interview on 5/8/24 at 1:49 P.M., Nurse #2 said that Resident #28 received scheduled doses of Dilaudid twice a day and as needed doses of Dilaudid if he/she has additional pain and asks for the medication. Nurse #2 said that she used the 1-10 numeric pain scale to assess Resident 28's pain and documented the pain level on the Treatment Administration Record (TAR). Review of the December 2023, January 2024, February 2024, March 2024, April 2024 and May 2024 MARs and TARs for Resident #28 indicated no evidence that a numeric pain scale assessment tool had been implemented to assess the presence and intensity of Resident #28's pain level. During an interview on 5/8/24 at 2:02 P.M., Charge Nurse #3 said that pain levels were assessed using the 1-10 numerical pain scale and the numerical pain level was documented on the TAR in the spaces corresponding to the order. The surveyor and Charge Nurse #3 reviewed the clinical record and Charge Nurse #3 said there was no evidence that Resident #28's pain levels had been assessed every shift as ordered, because there were no numerical pain levels documented for the Resident. (continued on next page)

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	225513	A. Building B. Wing	05/10/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 5/8/24 at 2:11 P.M., Unit Manager (UM) #1 reviewed the clinical record and said that she could not provide any documentation that Resident #28's pain level had been assessed every shift as ordered. UM #1 said the numeric pain assessment should have been documented on the TAR but the numeric pain assessment had not been documented because the Physician's order had been entered into the computer incorrectly.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 44337 Based on interview, record and policy review, the facility failed to perform trauma assessments at the time of admission to the facility for two Residents (#45 and #79) out of a total sample of 19 residents. Specifically, the facility staff failed to: 1. For Resident #45, complete a trauma assessment to determine whether the Resident had any history of trauma (emotional response to a deeply distressing or disturbing experience), and/or determine any triggers which may cause re-traumatization. 2. For Resident #79, screen the Resident for a history of trauma since his/her admission to the facility, to recognize and respond to any signs and symptoms of trauma. Findings include: Review of the facility policy titled Trauma Informed Care, effective October 2022, indicated the following: -It is recognized that residents may have experienced trauma in their past that could potentially impact their care or response to care. -All residents are assessed upon admission, as part of their social service history and asked if they have experienced any trauma in their life. 1. Resident #45 was admitted to the facility in June 2023, with a diagnosis of Dementia (a group of symptoms that affect memory, thinking and interferes with daily life) and Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of Resident #45's clinical record included no evidence that the facility staff assessed the Resident for a history of trauma (emotional response to a terrible or threatening event). During an interview on 5/9/24 at 10:25 A.M., the Social Worker (SW) said that she interviewed families and residents upon admission and would ask them about any history of trauma. The SW said that a trauma assessment would not have been completed if a history of trauma had not been identified. 42761 2. Resident #79 was admitted to the facility in May 2023, with diagnoses including: Dementia and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident #79's clinical record included no evidence that the facility staff assessed the Resident for a history of trauma. (continued on next page)

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	225513	A. Building B. Wing	05/10/2024

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/24 at 10:57 A.M., the Social Worker (SW) said she was responsible for screening all residents for a history of trauma when the residents were admitted to the facility. The SW said that there was no evidence that Resident #45 and Resident #79 had ever been screened for a history of trauma since their admission to the facility.

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	225513	A. Building B. Wing	05/10/2024

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47901 Based on record review and interview, the facility failed to utilize the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week, as required. Specifically, the facility failed to have an RN working at least eight consecutive hours for four days between 10/1/23 to 12/31/23, placing all residents at risk for not having their clinical needs met either directly by the RN or indirectly by the Licensed Practical Nurse (LPN) or Certified Nurses Aides (CNA) that the RN was responsible for overseeing with provision of resident care. Findings include: Review of the Fiscal Year Quarter One (dated 10/1/23 through 12/31/23) Payroll Based Journal (PBJ: reporting system to which nursing facilities report on staffing data) Report indicated that the facility reported No RN in the facility for eight consecutive hours on the following dates: -10/1/23 -10/29/23 -11/12/23 -12/3/23 During an interview on 5/7/24 at 8:36 A.M., the facility Administrator said the facility had no Nurse staffing waivers. During an interview on 5/9/24 at 11:12 A.M., the surveyor and the Facility Scheduler reviewed the staffing schedule and the Facility Scheduler said that there was no RN scheduled for eight consecutive hours on 10/1/23, 10/29/23, 11/12/23 and 12/3/23. During an interview on 5/9/24 at 12:04 P.M., the Director of Nurses (DON) reviewed the staffing schedule and said there was no RN scheduled for the identified days reported on the PBJ report. During an interview on 5/9/24 at 1:07 P.M., the facility Administrator said there was no RN in the facility for the required eight consecutive hours on the dates reported on the PBJ report.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, interview, and record review, the facility failed to ensure that medications were stored and administered in a secure and safe manner, according to professional standards for one Resident (#47), out of a total sample of 19 residents. Specifically, the facility staff failed to adhere to safe medication administration practices when medications were left unattended in a medication cup at Resident #47's bedside. Findings include: Resident #47 was admitted to the facility in July 2023 with diagnoses including Arthrosclerosis (a buildup of plaque and fat inside arteries) of arteries in both legs, Atrial Fibrillation (quivering or irregular heartbeat), mild cognitive impairment of unknown cause, and Dysphagia (difficulty or discomfort in swallowing). Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a possible score of 15. Review of the facility policy titled Storage of Medications, last revised August 2020, indicated the following: -Medications are stored safely, securely, and properly . -Only licensed nurses, pharmacy personnel and those lawfully authorized are permitted to access medications. -Medication rooms, carts and medication supplies are locked when they are not attended to by persons with authorized access. Review of the facility policy titled Administration Procedure for All Medications, last revised August 2020, indicated the following: -Medications will be administered in a safe and effective manner. -After administration, return to (medication) cart, and document administration in the Medication Administration Record (MAR) or Treatment Administration Record (TAR). Review of the facility Self-Administration of Medication assessment dated [DATE], indicated that due to Resident 47's cognitive, physical or visual ability, the interdisciplinary team (IDT) feels that Resident #47 was not a candidate for self-administration of medications. (continued on next page)

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	225513	A. Building B. Wing	05/10/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 10:53 A.M., the surveyor observed a small plastic cup containing multiple pills on the bedside table next to Resident #47. During an interview at the time, Resident #47 said that the staff trust him/her to take the medications so they usually leave his/her medications on the bedside table. Resident #47 said it takes a while for him to take all the medications because he/she takes the pills one at a time. During an interview on 5/7/24 at 11:00 A.M., Nurse #2 said she left Resident #47's medications on the table next to the bed because Resident #47 likes to take the medications independently. Nurse #2 said that she should have watched Resident #47 take the medications and should not have left Resident #47's medications at the bedside. During an interview on 5/7/24 at 11:53 A.M., Unit Manager (UM) #1 said that Resident #47 had not been assessed to safely administer his/her own medications and Nurse #2 should not have left any medications at Resident #47's bedside unattended.