STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225514	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Cove Manor Nursing & Rehabilitation Center	288 Washington Street Quincy, MA 02169

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 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. 43935 Based on interview and record review, the facility failed to implement a person-centered care plan intervention of monitoring the behavior of visual hallucinations for Resident #71, out of a total sample of 27 residents. Findings include: Review of the facility's policy titled Care Plans Comprehensive Person Centered, dated 12/1/17, indicated but was not limited to the following: - a comprehensive person-centered care plan that includes measurable objectives and timetables to meet resident's physical, psychosocial and functional needs is developed and implemented - the care plan will: reflect recognized standards of practice, develop interventions that are targeted and meaningful - care plan interventions are chosen with consideration of relationship between problem areas and their causes and relevant clinical decision making Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, dated 12/2018, indicated but was not limited to the following: - the facility will comply with regulatory requirements related to the use of medication to manage behaviors - as part of the assessment the nursing staff and MD will identify individuals with a history of impaired cognition, altered behavior or mental illness - the care plan will incorporate findings from the assessments and be consistent with current standards of practice - interventions will be individualized and a part of an overall care environment that supports physical, functional, and psychosocial needs and strives to understand, prevent, or relieve the resident's distress (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- when medications are prescribed for behavioral symptoms, documentation will include: rational, dosage, duration, monitoring for efficacy and adverse consequences, plans (if applicable) for gradual dose reduction Resident #71 was admitted to the facility in August 2023 with diagnoses including: Severe dementia with mood disturbance, visual hallucinations and adjustment disorder with depressed mood. Review of the Minimum Data Set (MDS) assessment, dated 7/3/24, indicated Resident #71 has severely impaired cognitive skills and his/her healthcare proxy (HCP) was activated. Review of the current active MD orders indicated the Resident was receiving Seroquel (an antipsychotic medication) for the indication of visual hallucinations. Review of the current active care plans for Resident #71 included but were not limited to the following: PROBLEM: Resident is prescribed the following psychotropic medication: Seroquel related to dementia with behavior/visual hallucinations (last revised: 4/3/24) INTERVENTIONS: track target behaviors in order to assess the effect and benefit of the drug use (8/16/23) During an interview on 7/30/24 at 12:57 P.M., Nurse #2 said she was unaware the Resident had visual hallucinations and she does not track, monitor or document that anywhere. She said the Resident does have behaviors of spitting food, yelling, cursing, and resisting care and those are infrequent but monitored on the medication administration record (MAR). Review of the medical record, including nursing progress notes, MAR, and behavior monitoring sheets, failed to indicate the Resident's behavior of visual hallucinations were being tracked or monitored. During an interview on 7/30/24 at 4:51 P.M., Consultant #1 said as part of her job she reviews the medication and behavior monitoring for the residents and the behaviors are monitored and tracked on the facility MAR. She said Resident #71 is taking Seroquel for the targeted behavior of visual hallucinations, per the physician's order, but she could not locate any monitoring of that behavior on the MAR or in the medical record during her most recent review in July. During an interview on 7/31/24 at 7:12 A.M., the Assistant Director of Nurses (ADON) said the Resident was not being monitored for the behavior of visual hallucinations. During an interview on 7/31/24 at 8:38 A.M., Family Member #1 said the Resident does have visual hallucinations very frequently and they are memories of early life, their home country, children playing and seeing friends and family from their past and the memories are happy and positive. He said the Resident is not frightened by the hallucinations and finds joy in them. He said the family does not report these episodes to the facility because they are not bothersome to the Resident or a problem. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 10:04 A.M., Unit Manager #1 said, on review of the care plan, that the Resident was supposed to be monitored and have their behavior of visual hallucinations tracked related to the use of the Seroquel but that was not occurring. Refer to F758

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42742 Based on observation, interview, and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for one Resident (#64), out of a total sample of 27 residents. Specifically, the facility failed to ensure the Resident's Geri-sleeves (sleeves that provide protection to sensitive skin) were consistently applied per physician's orders. Findings include: Resident #64 was admitted to the facility in April 2023 and had diagnoses including type 2 diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 5/8/24, indicated Resident #64 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, had no current skin tears, but had an open lesion other than ulcers, rashes, or cuts. The MDS also indicated Resident #64 required partial to moderate assistance for upper body dressing, showering, and bathing. Review of current Physician's Orders indicated the following: -Geri-sleeves on at bilateral upper extremities every shift for skin protection, 5/19/24 Review of the Weekly Skin Assessments indicated but were not limited to the following: 5/30/24 - bruise left forearm, open lesion, cut, laceration, or skin tear on right forearm 6/6/24 - forearm scab 6/13/24 - bruises bilateral upper extremities, open lesion, cut, laceration, or skin tear on right forearm 6/20/24 - bruises bilateral upper extremities, open lesion, cut, laceration, or skin tear on right forearm scabby 6/27/24 - bruises bilateral upper extremities, open lesion, cut, laceration, or skin tear on right forearm, scabbing 7/4/24 and 7/11/24 - excessively dry or flaky skin bilateral upper extremities 7/25/24 - no areas of concern (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 7/25/24 at 9:49 A.M., the surveyor observed Resident #64 lying in bed with bilateral upper extremity Geri-sleeves applied. Resident #64 said staff recommended the arm sleeves because his/her skin was fragile and got skin tears. The Resident said he/she didn't mind wearing them then pulled the sleeves down from the elbows to the wrists revealing the skin's surface. The surveyor observed an ecchymotic (bruised) area approximately 1.5 centimeters (cm) width x 1.5 cm length x 0.0 cm depth on the right forearm. The Resident's skin was thin, and paper-like with dry flakes of skin. Resident #64 said he/she had a skin tear there that had been bleeding and hurt when it happened but was now healing. During an observation with interview on 7/29/24 at 8:26 A.M., the surveyor observed Resident #64 lying in bed. The Geri-sleeves were not applied. The Resident's skin on the bilateral upper extremities was thin, and paper-like with dry flakes of skin. The Resident said his/her skin tear healed so he/she didn't need the sleeves anymore. During an observation with interview on 7/29/24 at 1:54 P.M. and 7/30/24 at 7:49 A.M., the surveyor observed Resident #64 lying in bed. The Resident's sleeves were not applied and observed resting on top of the dresser out of reach of the Resident. The Resident's skin on the bilateral upper extremities was thin, and paper-like with dry flakes of skin. Resident #64 said his/her skin was very fragile and dry and he/she was supposed to be wearing the sleeves. During an observation with interview on 7/30/24 at 2:28 P.M., Nurse #4 entered the Resident's room with the surveyor. The Resident's Geri-sleeves were not applied and observed resting on top of the dresser out of reach of the Resident. Nurse #4 said the Resident's skin was fragile and bruised easily and that's why the sleeves had been on him/her. Nurse #4 said the Resident refused to wear them sometimes and did not put them on that day. During an interview on 7/30/24 at 2:36 P.M. with Nurse #4 and the Assistant Director of Nursing (ADON), Nurse #4 said there was no documented evidence of the Resident's refusal to wear the Geri-sleeves and was not care planned for it. The ADON said the sleeves should be applied per physician's orders or care planned if the Resident refused them but was not. During an interview on 7/31/24 at 12:03 P.M., the Director of Nursing (DON) said the Resident got skin tears because his/her skin was fragile and was susceptible to bruising. He said physician's orders should have been consistently followed for the Resident's use of the Geri-sleeves unless there was a rationale for them to not be that is documented in the medical record. He said he couldn't find any evidence of this or a care plan for the Resident's refusal to wear them.

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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. 31830 Based on observation, interview, and record review, the facility failed to ensure an assessment for wander risk was completed for one Resident (#100), out of a total sample of 27 residents. Findings include: Review of the facility's policy titled Wandering/Missing Resident, dated as revised 6/24/23, indicated but was not limited to: - Purpose: to provide a safe and secure environment to protect residents from elopement. - It is the policy of the facility that the safety and well-being of all residents with the potential for wandering are ensured. - If it is determined, through assessment, that a resident has a potential for wandering, the Resident Care Plan will reflect this behavior with all disciplines aware of the need for his/her monitoring - Residents will be assessed quarterly, annually, and with significant changes. Resident #100 was admitted to the facility in May 2022 with diagnoses which included dementia. Review of the Minimum Data Set (MDS) assessment, dated 5/22/24, indicated Resident #100 had severe cognitive impairment, and had wandering behaviors which occurred daily. Review of the care plan for behaviors, initiated 5/25/23, indicated but was not limited to: - Resident #100 displays the following behavioral symptoms: wandering/intrusive behaviors disrupting others. Goal: Resident's safety will be maintained through next survey, dated as revised, 6/3/24. Interventions: Apply wanderguard. Review of current Physician's Orders indicated the following: - Check wanderguard placement every shift to left ankle. - Document the number of episodes Resident exhibited wandering along with interventions used. Review of the current Medication Administration Record, dated 7/1/24 through 7/31/24 indicated documented daily episodes of Resident wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 1:38 P.M., and 7/30/24 at 12:10 P.M., the surveyor observed Resident #100 wandering throughout the unit with a wanderguard on his/her left ankle. Subsequent review of the clinical record indicated the last Wander Risk Assessment for Resident #100 was completed on 2/22/24 and indicated the Resident exhibited wandering behavior and had a wanderguard in place. During an interview on 7/31/24 at 10:52 A.M., Unit Manager #2 said Resident #100 had behaviors which included wandering and had a wanderguard in place. Unit Manager #2 reviewed the clinical record and was unable to locate the most current quarterly assessment. Unit Manager #2 said an elopement assessment needed to be completed quarterly and was not completed this quarter for the Resident. During an interview on 7/31/24 at 11:51 A.M., the Director of Nurses said it was the expectation that all residents at risk for elopement be assessed quarterly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42742 Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care and services for one Resident (#64), out of a total sample of 27 residents. Specifically, the facility failed to ensure oxygen (O2) equipment was maintained to ensure sanitary conditions to help decrease the risk of potential contamination and infection. Findings include: 1. Review of the facility's policy titled Equipment Change/Disinfection, undated, indicated but was not limited to the following: -Thoroughly clean all exterior surfaces of equipment. -In addition to disinfecting the surfaces, please maintain the following: Oxygen Concentrators: -Rinse and dry the external filter weekly and prn (as needed) when visibly dusty. Wipe down concentrator prn when visibly dusty or soiled. Resident #64 was admitted to the facility in April 2023 with diagnoses including chronic obstructive pulmonary disease (COPD) (group of lung diseases that block airflow and make it difficult to breathe), pulmonary hypertension, and chronic congestive heart failure. Review of the Minimum Data Set (MDS) assessment, dated 5/8/24, indicated Resident #64 was receiving oxygen therapy. Review of current Physician's Orders indicated the following: -may give Oxygen up to 3 liters/minute via nasal cannula continuously for O2 saturation level of 89% or less and for shortness of breath every shift, 1/26/24 On 7/25/24 at 9:47 A.M., 7/29/24 at 8:21 A.M., and 7/30/24 at 7:47 A.M., the surveyor observed Resident #64 lying in bed with a nasal cannula (NC) (lightweight tube which one end splits into two prongs which are placed in the nostrils from which a mixture of oxygen (O2) and air flows) in place attached to an O2 concentrator delivering 2 Liters (L) of Oxygen. The exterior of the concentrator was laden with dust. The external filter (sponge-like filter that captures dust and other airborne pollutants that can clog the machine and get transferred into the oxygen supply you breathe) was 100% laden with dusty gray matter. Resident #64 said he/she used Oxygen continuously for his/her COPD. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 7/30/24 at 2:10 P.M., Nurse #4 entered Resident #64's room with the surveyor and observed Resident #64 lying in bed with a NC in place attached to an O2 concentrator delivering 2 L of Oxygen. The exterior of the concentrator was laden with dust. The external filter was 100% laden with dusty gray matter. Nurse #4 said the Resident used Oxygen continuously for shortness of breath and had a history of congestive heart failure. She said the O2 concentrator and filter are cleaned every week by the night nurse but there was no order for that and no documentation of it being done. Nurse #4 said she could not determine when the concentrator and filter were last cleaned if it wasn't documented anywhere. She said the filter needed to be clean for air purity. During an interview on 7/30/24 at 2:37 P.M., the Assistant Director of Nursing said she wasn't sure if there was a specific order set to clean the concentrator and filter, but they should be clean. During an interview on 7/31/24 at 12:05 P.M., the Director of Nursing (DON) said he didn't have a policy for maintenance of respiratory equipment and there was no order set for it that he knew of. He said the second and third floor units had a written schedule where staff documented wiping down respiratory equipment and cleaning of the filters but the first floor unit where Resident #64 resided did not do this. He said there is no process to clean respiratory equipment on that floor. The DON said if the filter is laden with dust the Resident could be breathing it in. He further said he wasn't sure how often the concentrators and filters should be cleaned but should be cleaned per the manufacturer and on an as needed basis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43935 Based on interview and document review the facility failed to develop and maintain a policy and procedure for monthly drug regimen review. Findings include: On 7/30/24 at 12:21 P.M., the survey team requested a copy of the monthly medication regimen review (MRR) policy from the Director of Nurses (DON) for review. During an interview on 7/30/24 at 1:37 P.M., the DON said the facility does not have a MRR policy. Since MRR's are completed by consultants, they use the facility's policy titled: Follow Up on Recommendations of Consulting Physicians or Other Practitioners. He said he did not have any policies that outlined the steps or the process the pharmacist should use when completing a MRR or the timeline in which the MRR should be completed or followed up on but thought by the next pharmacy review seemed reasonable. Review of the policy in use by the facility titled: Follow Up on Recommendations of Consulting Physicians or Other Practitioners, dated as revised 7/2022, indicated but was not limited to the following: POLICY: - To ensure that consulting physician's or practitioner orders are followed through in and [sic] accurate and timely manner PROCEDURE: - Review the recommendation of the consultation for any new orders or follow up appointment - Notify resident's attending physician for all new recommendations - Document in resident's chart, physician notification and response The policy failed to identify any process for pharmacy to complete required monthly drug regimen reviews or a timeline for recommendations to be reviewed. During a follow up interview on 7/31/24 at 12:36 P.M., the DON confirmed the facility did not have a policy or procedure for the completion of monthly drug regimen reviews and said he understood that it was a concern since there was no process for the pharmacist or facility to follow and said he would have to contact the pharmacy consultant to make one for the facility. At the time of survey exit, a monthly medication regimen review policy was not provided to the survey team. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/2/24, the Assistant Director of Nurses emailed the survey team a policy titled Medication Monitoring and Management and indicated it was from the facility's pharmacy policy book. Review of the policy failed to identify any process for pharmacy to complete required monthly drug regimen reviews or a timeline for recommendations to be reviewed. Refer to F758

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 43935 Based on observation, interview, and record review, the facility failed to monitor the targeted behavior of an antipsychotic medication and attempt two antipsychotic gradual dose reduction (GDR) for one Resident (#71) who had a new antipsychotic medication initiated within the last year, out of a total sample of 27 residents. Findings include: Review of the facility's policy titled: Behavioral Assessment, Intervention and Monitoring, dated 12/2018, indicated but was not limited to the following: - the facility will comply with regulatory requirements related to the use of medication to manage behaviors - the care plan will incorporate findings from the assessments and be consistent with current standards of practice - interventions will be individualized and a part of an overall care environment that supports physical, functional, and psychosocial needs and strives to understand, prevent, or relieve the residents distress - when medications are prescribed for behavioral symptoms, documentation will include: rational, dosage, duration, monitoring for efficacy and adverse consequences, plans (if applicable) for gradual dose reduction Monitoring: - document any improvements or worsening of the individual's mood, behavior, and function - the interdisciplinary team (IDT) will monitor the progress of the individual with impaired cognition and behavior until stable - if antipsychotic medication is used to treat behavioral symptoms the IDT will monitor their indication and implement gradual dose reduction or document why this cannot or should not be done Review of the facility's policy titled Psychoactive Drug Monitoring, dated 7/2020, indicated but was not limited to the following: - residents who receive antipsychotic medications are monitored to evaluate the effectiveness of the medication - need for psychoactive medications are reassessed regularly by the prescriber and care planning team; effects of the medication are documented as part of the care planning process (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the need for and response to the psychoactive medication therapy is monitored and documented in the medical record - for deviation from the dosage reduction criteria, the clinical record contains evidence to support justification for the use of the drug including: medical or psychiatric consultations, health care professional documentation that previous dose reductions have been unsuccessful, documentation of residents improvement or maintenance of function - psychoactive drug therapy guidelines include: residents receive antipsychotic medications only for behaviors that are qualitatively and objectively documented through the behavior monitoring chart or similar mechanism - residents receive gradual dose reductions of the antipsychotic medications unless clinically contraindicated, in an effort to reduce these drugs; a clinical contraindication means: (a) resident has a specific condition and history of recurrent psychotic symptoms that are stabilized on a maintenance dose, the resident has an organic mental syndrome (dementia, delirium and other cognitive disorders with associated psychotic or agitated symptoms) and has had a GDR attempted twice in one year that resulted in the return of symptoms for which the drug was prescribed and a return to the previous dose or an increase of the current dose was required; (b) resident's physician has provided justification for the continued drug use and dose in the medical record that includes: a diagnosis with description of symptoms, discussion with psychiatric and medical differential diagnosis, description of the rationale for the choice of the particular treatment, a discussion as to why the present dose is necessary to manage the symptoms - residents who are receiving antipsychotic drug therapy are evaluated by the consultant pharmacist and medical doctor (MD) for a possible GDR minimally quarterly Resident #71 was admitted to the facility in August 2023 with diagnoses including: severe dementia with mood disturbance, visual hallucinations and adjustment disorder with depressed mood. Review of the Minimum Data Set (MDS) assessment, dated 7/3/24, indicated Resident #71 has severely impaired cognitive skills. Further record review indicated the Resident's healthcare proxy (HCP) was activated. Review of the current Physician's Orders for Resident #71, as of 7/30/24, indicated but were not limited to the following: - Seroquel (an antipsychotic) give 25 milligrams (mg) by mouth one time a day related to visual hallucinations (9/28/23) Review of the Psych Nurse Practitioner's (NP) behavioral health progress notes from 8/2023 through 7/29/24 indicated but were not limited to the following: - the Resident was seen for an initial evaluation and assessed as irritable with behaviors of hitting staff, cursing and spitting out meds and targeted behaviors of agitation, confusion and hallucinations and Seroquel was initiated 8/15/23 (continued on next page)

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South Cove Manor Nursing & Rehabilitation Center	288 Washington Street Quincy, MA 02169

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- behaviors of yelling, cursing, combative with care, yelling out and refusing medications were worse and could not be consistently redirected and Seroquel was increased; the targeted behaviors were agitation, confusion, yelling out, combativeness and hallucinations (9/26/23) - psych progress notes fail to indicate the Resident's behavior of visual hallucinations, which is the indication for the Seroquel per the physician's order, was being monitored or reported as a concern by the nursing staff during visits/evaluations - Resident #71 was seen and evaluated by psych services four additional times since the Seroquel increase in September 2023; those psych progress notes failed to indicate the Resident was offered a GDR of the antipsychotic or that one was considered or recommended During an interview on 7/30/24 at 12:57 P.M., Nurse #2 said she is the regular nurse for the Resident and she was unaware the Resident had visual hallucinations and she does not track, monitor or document those anywhere. She said the Resident does have behaviors of spitting food, yelling, cursing and resisting care and those are rare, occurring only probably a few times a month and are monitored on the medication administration record (MAR) by the nurses. She said she does not know anything about a GDR for the Resident's Seroquel. Review of the Certified Nurse Assistant care card, last updated 7/24/24, indicated behaviors of spitting and cursing at staff. The document failed to indicate the Resident had behaviors of visual hallucinations. Review of the current active care plans for Resident #71 included but were not limited to the following: PROBLEM: Resident is prescribed the following psychotropic medication: Seroquel related to dementia with behavior/visual hallucinations (last revised: 4/3/24) INTERVENTIONS: track target behaviors in order to assess the effect and benefit of the drug use (8/16/23) Review of the MARs for Resident #71 from 8/2023 through 7/30/24 failed to indicate the Resident's behavior of visual hallucinations was being tracked or monitored for the use of Seroquel. Review of the monthly medication regimen reviews (MRR) conducted by the pharmacist from October 2023 through June 2024 failed to indicate a recommendation for the potential GDR of the Seroquel. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/24 at 4:51 P.M., Consultant #1 said the guideline the pharmacy follows is in line with the regulation and indicated a recommendation be left for a GDR of a newly initiated antipsychotic medication twice within the first year after its initiation if there is no documented evidence of it being clinically contraindicated. She said as part of her job she reviews the medication and behavior monitoring for the Resident and verifies the target behaviors are monitored and tracked on the facility MAR. She said this will provide documented evidence of whether or not a medication is effective for its targeted behavior and if a GDR could be attempted and recommended. She said Resident #71 is taking Seroquel for the targeted behavior of visual hallucinations, per the physician order, and she could not locate any monitoring of that behavior on the MAR or in the medical record during her most recent review in July. She said upon reviewing Resident #71's medical record that she should have previously left a recommendation for the facility to monitor the targeted behavior of visual hallucinations and also for a GDR of the Seroquel, since it is unmonitored and new within the last year. She said she did leave a recommendation for a GDR of the Seroquel this month but had missed doing so previously in error. Review of the MRR, dated 7/3/24, in Resident #71's medical record indicated but was not limited to the following: This Resident is currently receiving Seroquel 25 mg daily since 9/2023 Within the first year a patient is admitted on an antipsychotic or after an antipsychotic medication has been initiated in the facility, a GDR must be attempted in two separate quarters (with at least one month between attempts), unless clinically contraindicated. RECOMMENDATION: Please consider a trial dose reduction If a GDR is clinically contraindicated at this time, please document the clinical rationale below. This must address the reason(s) why an attempted dose reduction would likely impair the patient's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. During an interview on 7/31/24 at 8:38 A.M., Family member #1 said the Resident does have visual hallucinations very frequently and they are memories of early life, their home country, children playing and seeing friends and family from their past and the memories are happy and positive. He said the Resident is not frightened by the hallucinations and finds joy in them. He said the family does not report these episodes to the facility because they are not bothersome to the Resident or a problem. He said he was unaware that the Seroquel was to prevent the hallucinations and he would be agreeable to a dose reduction, but one has not been offered. Further review of the MRR left for the physician by the pharmacist on 7/3/24 was found completed by the MD on 7/25/24 and indicated the following: Two prepopulated boxes were checked off by the physician and the physician signed the recommendation 1. Disagree with recommendation (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Condition is not well controlled/stable and a reduction is likely to impair the patient's function and/or cause psychiatric instability. No other information was documented During an interview on 7/31/24 at 9:08 A.M., Physician #1 said he recently saw the Resident and addressed the GDR recommendation left by the pharmacist. He said this was the first time the pharmacy had recommended a GDR of this Resident's Seroquel. He said he did not review the record when making the decision to not complete the GDR and that he received report from the nursing staff that the behaviors had continued and they felt the Resident needed the medication and based on that conversation he declined the recommendation. He said he was not aware the Resident was not being monitored for the behavior of hallucinations, which was the indication on the order for the Seroquel. During an interview on 7/31/24 at 10:04 A.M., Unit Manager #1 said she was the one who gave report to the physician when they were discussing the GDR for the Resident. She said the staff had told her they felt the Resident still had behaviors of yelling, cursing and being resistive to care at times and they did not want the medication taken away so she told the physician the Resident was still behavioral and needed the Seroquel. She said she did not think to review the medical record to see if the Resident was having any behaviors of visual hallucinations, which is what the medication is ordered for. She said that the facility was not monitoring Resident #71 for visual hallucinations until yesterday (7/30/24) after it was brought to the facility's attention by the surveyor. She said the Resident should have been monitored for visual hallucinations the entire time he/she was on the drug to determine if it was effective, but they have not been. During an interview on 7/31/24 at 12:36 P.M., the Director of Nurses said the expectation and process is for the staff to document and monitor the targeted behavior for the use of the antipsychotic to determine whether or not it is effective and a GDR could be completed. He said he is aware that the Resident has not had a GDR as required and had not had their target behavior monitored. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 3:06 P.M., Consultant #2 said she evaluated Resident #71 in the last few days for psych stability and medication management follow up. She said in general, once a resident is stable on their medication regimen, they are seen every one to three months and not every few weeks and one to three months is for routine monitoring and care. She said when she saw the Resident they appeared stable and the staff informed her the Resident's behaviors were stable at baseline and the Resident was compliant with all medications and care at that time. She said she was not aware the facility had recently received a recommendation from the pharmacy for a GDR of the Seroquel or that a GDR had not previously been attempted on the Resident. She said, had she been informed of that, she would have recommended a GDR for the Resident at the time of her visit since the Resident appears to have been stable for visual hallucinations long term and should have one attempted twice in the first year. She said the progress notes in use by the psych team are a template note and the sections of the progress notes for psych that say No GDR required at this time, follow up in one to three months, continue to monitor for changes and concerns and notify healthdrive behavioral health, continue with current treatment plan and encourage compliance, continue with supportive care/redirection, continue to monitor and document behaviors every shift to guide treatment (tx) plan is part of the template and is only changed if the psych provider is alerted to the need for a GDR once they are stabilized or goes in and physically makes changes to those sections. She said Resident #71 should be monitored for their targeted behavior of visual hallucinations to determine if the Seroquel is effective and should have already had an attempted GDR as they are required to have two attempts in the first year and that had not occurred.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43935 Based on document review and interview, the facility failed to ensure residents who were eligible to receive the recommended pneumococcal vaccine (PCV-20), were offered the vaccination and they or their legal representatives were educated on the benefits and potential side effects of the vaccine in a timely manner for one Resident (#36), out of a total sample of five residents reviewed for immunizations. Findings include: Review of the Centers for Disease Control and Prevention (CDC) document titled Pneumococcal Vaccine Timing for Adults, dated March 2023, indicated the following: Make sure your patients are up to date with pneumococcal vaccination. Adults >= [AGE] years Old, Complete Pneumococcal Vaccine Schedules: -PPSV23 only at any age - give PCV20 or PCV15 (pneumococcal 15-valent conjugate) >= 1 year later Review of the facility's policy titled Immunizations and Vaccines - Residents, dated as revised 1/2024, indicated but was not limited to the following: - each resident is offered pneumococcal vaccine as soon as possible, unless the immunization is medically contraindicated, or the resident has already been immunized according to the CDC - CDC recommends pneumococcal vaccination for all adults [AGE] years or older, in accordance with the vaccine timing table Resident #36 was readmitted to the facility January 2021 and is currently [AGE] years old. During an interview on 7/25/24 at 10:36 A.M., the Infection Preventionist (IP) said the process for pneumococcal vaccination is the facility addresses it with residents and their families at the time of admission to ensure the residents will receive the completed series of pneumococcal vaccinations in accordance with CDC recommendations. She said if residents have not received the complete series, they have their immunizations tracked to ensure they receive all required pneumococcal vaccines once they consent and receive the vaccine information sheet in their primary language to ensure they are up to date with their vaccines in accordance with the CDC pneumococcal vaccine timing guidelines. Review of the immunization history for Resident #36 indicated, but was not limited to the following: - PPSV23 pneumococcal vaccination received 5/11/2010 - PCV 13 pneumococcal vaccination declined 5/8/2019 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #36 indicated but was not limited to the following: - MD order that reads: May have annual flu vaccine. May have Mantoux 2-step. May have Pneumovax (pneumococcal vaccinations) (9/25/2019) - Flu/Pneumococcal vaccine consent form, dated and signed by Resident 10/5/23, with no decision documented for pneumococcal vaccinations The record failed to indicate the Resident was ever offered the PCV20 pneumococcal vaccination in accordance with CDC guidance. During an interview on 7/26/24 at 8:46 A.M., the IP said the Resident had declined the PCV 13 vaccination in 2019 and had not been offered the PCV20 vaccination as of this time, even though it had been [AGE] years since his/her last pneumococcal vaccination. The Resident had not completed the pneumococcal series in accordance with the CDC guidance. She said the Resident should have been offered the PCV20 vaccination and was not. It was an error.