STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225516	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eliot Center for Health and Rehabilitation	168 West Central Street Natick, MA 01760

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50138 Based on observation, record review, and interview, the facility failed to maintain a clean, comfortable, and homelike environment for one Resident (#7) out of a total sample size of 19 residents. Specifically, the facility failed to maintain the Resident's enteral feeding pump pole in a clean and sanitary manner when the base of the pole stand was visibly soiled with spilled substances. Findings include: Review of the facility's policy titled Resident Care Equipment Processing Between Resident Use and Transport, undated, indicated the following: -The employee will wear appropriate personal protective equipment when handling, cleaning or transporting soiled material. -Enteral feeding poles will be cleaned if visibly soiled and routinely. -Each department will determine accountability within their area. Resident #7 was admitted to the facility in February 2017 with diagnoses including Dysphagia and Gastrostomy Status. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #7: -had severely impaired cognitive skills for daily decision making. -rarely understood others or was understood by others. Review of Resident #7's medical record included but was not limited to the following: -A Physician's order for enteral feeding (also referred to as G-tube feeding) of Jevity 1.5 at 30 ml/hr (milliliters per hour) continuous, effective 11/4/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225516	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Eliot Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 168 West Central Street Natick, MA 01760	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Person-Centered Care Plan for Nutritional Concerns included but was not limited to: -Nutritional Concerns related to chewing and swallowing difficulty with interventions including but not limited to a need for enteral feeding, effective 12/23/20. On 1/13/25 at 8:32 A.M., the surveyor observed Resident #7 lying in bed with enteral feeding running as ordered from a pump that was connected to a pole. The surveyor also observed a large quantity of dried, milky colored substance covering the base of the enteral pole stand. On 1/14/25 at 7:30 A.M., the surveyor observed Resident #7 lying in bed, with enteral feeding running as ordered from a pump that was connected to a pole. The surveyor observed that a large quantity of dried, milky colored substance remained covering the base of the enteral pole stand. On 1/15/25 at 10:41 A.M., the surveyor observed Resident #7 lying in bed, with enteral feeding running from a pump as ordered, and the base of the enteral pole stand remained covered with a large quantity of dried, milky colored substance. During an observation and interview on 1/15/25 at 10:52 A.M., the surveyor and Certified Nurses Aide #1 (CNA #1) observed the Resident's enteral feeding pole. CNA #1 said that the base of the pole was dirty and should have been cleaned up when the spills were made. CNA #1 said that she was assigned to Resident #7 at the time. CNA #1 said the housekeeping department never cleans the enteral pumps or poles. CNA #1 said that the nursing staff who spilled the liquid should have wiped the enteral feeding pole off as soon as it happened because the staff have wipes that could be used on the enteral pump pole. CNA #1 said that she could have also cleaned the dirty enteral pump pole. On 1/15/25 at 11:02 A.M., the surveyor and the Assistant Director of Nurses (ADON) observed the enteral feeding pole and the ADON said the pole was dirty. The ADON said that housekeeping and nursing were responsible to maintain cleanliness on the unit. The ADON said that spills should be wiped up immediately to prevent attraction of pests and to maintain a proper environment because nobody would want to have dirty things in their home.

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50138

Based on record review, and interview, the facility failed to ensure prompt efforts to resolve a grievance for one Resident (#84) out of a total sample size of 19 residents.

Specifically, for Resident #84, the facility failed to investigate and resolve a grievance for missing personal property when the Resident's electronic communication tablet that was used to communicate with staff was reported missing.

Findings Include:

Review of the facility policy titled, Administration: Grievance Policy, revised November 2016, indicated the following:

-The facility will support the resident/responsible party to voice grievances/concerns regarding .lost articles or any violation of resident's rights.

-Upon receipt of the grievance/concern the facility will take appropriate measures to seek a resolution to the concern. -The Administrator will appoint a Grievance Officer.

-The Grievance Officer will be responsible to ensure that all grievances are responded to in a timely manner.

-Facility staff is encouraged to attempt to resolve the verbal grievance/concern at the time it is brought forward whenever possible. In the case that the grievance/concern cannot be resolved promptly, the staff member will complete the grievance form or give it to the person with the concern to complete.

-Once the form is complete it will be forwarded to the Social Service Department.

-During the absence of the social worker, the forms will be forwarded to the Administrator. The grievance/concern book will be kept in the Administrators office.

-The Social Worker will review the grievance/concern and forward a copy to the appropriate department head. The Social worker will keep the original and document the receipt of the grievance/concern form on the grievance log.

-The Department head is responsible for investigating the concern and developing a plan to resolve it.

-The Administrator is responsible for reviewing grievances/concerns weekly to ensure that they have been investigated and resolved to the residents/responsible party satisfaction.

(continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #84 was admitted to the facility in February 2024 with diagnoses including Aphasia, Hemiplegia and Hemiparesis following Nontraumatic Intracerebral Hemorrhage affecting right dominant side, and Major Depressive Disorder. Review of Resident #84's Minimum Data Set (MDS) assessment dated [DATE] indicated the following: -Resident had no speech (absence of spoken words) -Resident was sometimes understood (ability limited to making concrete requests) -Resident was able to understand others usually (misses some part/intent of message but comprehends most conversation responds adequately to simple, direct communication only). -A Brief Interview for Mental Status (BIMS) assessment had not been attempted. Review of Resident #84's complete medical record indicated: >A Legal Guardianship was established on 7/10/24. Review of Resident #84's Care Plan for Communication, created on 5/22/24 and last revised on 5/22/24, indicated: >Resident #84 had a communication problem related to Aphasia. >Goal was for the Resident to maintain a current level of communication by using a communication device, gestures, pointing, responding to yes/no questions as indicated/need. >Interventions included to use alternative communication tools as needed. Review of the Speech Therapy Discharge Summary dated 9/6/24, indicated: -Resident and caregivers were to utilize compensatory strategies to repair communication breakdown (cues, gestures and ACC (Augmentative and Alternative Communication- a communication device tablet) system. -Interventions included: >modification of the Resident's ACC communication device. >addition of functional icons and included addition of home exercises to patient's AAC device for both practice and communication. >modification of patient's AAC device were made to place more frequently used icons in easier to access locations. Review of the Nursing Progress Note dated 11/30/24 at 9:02 A.M. indicated: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-client trying to communicate. Nursing staff explained to this Nurse that pt's (patient's/ Resident) tablet is missing. -Also, client refusing medications today and wants to leave that room. Supervisor notified. Review of the Nursing Progress Note dated 11/30/24 at 1:50 P.M. indicated: -client, I've been told, has a tablet to communicate. The tablet hasn't been found. -PT (Physical Therapy) looked in rehab. -I searched pt. room. I did not locate the tablet and how many days it's been missing, this Nurse does not know. During an interview on 1/15/25 at 2:38 P.M., Certified Nurses Aide (CNA) #2 said that Resident #84 had an electronic communication tablet that was used to talk to the staff. CNA #2 said that the communication tablet had pictures on the screen that the Resident could point at to make his/her needs known. CNA #2 said that he had not seen the communication tablet in a long time so it must be missing. CNA #2 said that he had not communicated the missing communication tablet to anyone because he was pretty sure they all knew it was missing a few months ago. During an interview on 1/15/25 at 2:41 P.M., the Administrator said that he was the Grievance Officer in the facility and keeps the grievance binder in his office. The Administrator said that he was unaware that the communication device belonging to Resident #84 had been missing and did not have a grievance form related to the missing communication tablet. During an interview on 1/15/25 at 3:01 P.M., the Speech Therapist (ST) said the ACC tablet had been purchased though the Resident's insurance and therefore was Resident #84's personal property. The ST said the ACC tablet, in addition to hand gestures as well as yes and no questions, was a communication method used by Resident #84 to make his/her needs known. The ST said that she was aware that the communication tablet had been missing but the tablet was not removed from the Care Plan for Communication at any time nor was she asked to perform an evaluation once the communication device was no longer available for the Resident to use. During an interview and record review on 1/21/25 at 8:51 A.M., the Assistant Director of Nurses (ADON) said she had located the original grievance form which had been completed by the Supervising Nurse on 11/30/24. Review of the Grievance Form dated 11/30/24, provided by the ADON indicated: -Tablet of Resident #84 used for communication was missing and the Guardian had been notified by the nursing supervisor. -Evidence of an action taken to resolve grievance was blank (on the form). -Evidence of person responsible for resolution was blank. -Evidence of follow-up on completion was blank. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Social Worker signature and date were blank. -Administrator signature and date were blank. The ADON said that the grievance form dated 11/30/24, had been located in the Contracted Social Worker's binder, but the Contracted Social Worker was no longer in the facility. The ADON said that she was able to recall that the missing AAC tablet had been discussed at the morning staff meeting a few times but was unsure what happened thereafter. The ADON said the grievance process should have been addressed sooner but had not been.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 44222 Based on observation, interview, and record review, the facility failed to ensure that the Minimum Data Set (MDS) Assessment was coded accurately for one Resident (#79) out of a total sample of 19 residents. Specifically, the facility failed to ensure that the most recent MDS Assessment was coded accurately relative to dental status for Resident #79. Findings include: Resident #79 was admitted to the facility in November 2023 with diagnoses including Unspecified Dementia, Insomnia, Anxiety, and high cholesterol. Review of the most recent MDS Assessment completed on 11/8/24, indicated that the Resident: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15 possible points. -had no obvious or likely cavity or broken natural teeth, no difficulty noted to examine the Resident's teeth. On 1/13/25 at 11:03 A.M., the surveyor observed that Resident #79 had no teeth on the top gum line, and had three teeth on the bottom gum line, two of which were dark in color and broken. On 1/21/25 at 9:23 A.M., the surveyor and the Director of Nursing (DON) observed the Resident's teeth and observed no teeth on the top gum, and three teeth on the bottom gum, two of which were dark in color and broken. During an interview at the time, the Resident said my other teeth are at home. During an interview on 1/21/25 at 9:35 A.M., with the DON and the MDS Nurse, the DON said that the most recent comprehensive MDS assessment completed on 11/8/24 was completed by an off-site MDS Nurse and she could not provide evidence that any staff member or the MDS Nurse completing the MDS actually examined the Resident's mouth for dental status. The DON said the MDS coding for the Resident's dental status was inaccurate. The MDS Nurse said that the MDS responses for dental status came from the previous MDS assessment completed on 11/13/23, and were just kept the same for the MDS assessment completed on 11/8/24. Please Refer to F791

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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 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on record review, and interview, the facility failed to accurately complete a Level I Preadmission Screening and Resident Review (PASARR- screen to determine if a resident had an intellectual or developmental disability (ID or DD) and/or serious mental illness (SMI) and needed further evaluation) for two Residents (#57 and #58), out of a total sample of 19 residents. Specifically, the facility failed to: 1. for Resident #57, accurately complete a Level I PASRR when the Resident's admission PASRR indicated no SMI, and the Resident was admitted to the facility with SMI diagnoses and a recent hospitalization where psychiatric services were provided resulting in a Level II PASRR Evaluation (an evaluation conducted to determine if an individual who screened positive for an SMI or ID/DD requires specialized services) not being completed as required. 2. for Resident #58, the facility failed to accurately complete a Level I PASRR indicating that the Resident had received psychiatric services while hospitalized within the last two years in the community, resulting in a Level II PASRR Evaluation not being completed as required. Findings include: Review of the facility policy titled Preadmission Screening and Resident Review (PASSR), effective 4/18, included: -It is the policy to screen all potential admissions on an individual basis. As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review (PASRR) screening process (Level I) .for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder. -The facility will report any changes as identified via the screen to the state mental health authority . -The PASARR will be evaluated annually and upon any significant change for those individuals identified. 1. Resident #57 was admitted to the facility in February 2024 with diagnoses including Major Depressive Disorder Recurrent Unspecified, Unspecified Psychosis Not Due to a Substance or Known Physiological Condition, Post Traumatic Stress Disorder (PTSD), and Anxiety. Review of the PASRR Level I Screening dated 2/13/24, indicated that the Resident had no Serious Mental Illnesses (SMI). Review of the Resident's Facility Admission Record indicated the following diagnoses were present upon admission: -Unspecified Psychosis Not Due to a Substance or Known Physiological Condition (continued on next page)

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	-Major Depressive Disorder Recurrent Unspecified -Post Traumatic Stress Disorder (PTSD) Review of the Physician Admission Note dated 2/17/24 included: -The patient with multiple medical issues who was hospitalized with confusion and agitation and mental status changes. -now admitted to the .rehab center for skilled nursing rehab and psychiatry evaluation and management -past medical history includes depression, anxiety, insomnia, psychosis . -Olanzapine (anti-psychotic medication) 5 milligrams (mg) for psychosis is in place. -Depression is treated with Cymbalta (anti-depressant medication) extended release 30 mg a day, and we will follow. Review of the Psychiatric Evaluation and Consultation dated 2/19/24 included: -Post Traumatic Stress Disorder (PTSD) - chronic illness -Anxiety Disorder - chronic illness Review of Resident #57's Minimum Data Set (MDS) assessment dated [DATE], included a diagnosis of Post Traumatic Stress Disorder. Review of the Resident's MDS dated [DATE], included diagnoses of: -Psychotic Disorder -Anxiety -Depression -Post Traumatic Stress Disorder (PTSD) During an interview on 1/21/25 at 11:05 A.M., with the MDS Nurse and the Director of Nursing (DON), the MDS Nurse said that she had added the psychiatric diagnoses to the Resident's clinical record and MDS when she identified them in the hospital and provider notes from the Resident's admission to the facility. The MDS Nurse said that all of the psychiatric/mood diagnoses listed on the Resident's MDS Assessment were from the Resident's records before or on admission to the facility. The DON reviewed the admission PASRR that indicated no SMI, and said that the PASRR should have been reviewed upon admission and then resubmitted to include the Resident's SMI diagnoses and determination for a Level II evaluation, but it had not been. 45429 (continued on next page)

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Resident #58 was admitted to the facility in April 2024, with diagnoses including Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder. Review of Resident #58's PASRR Level I Screening, dated 4/1/24, indicated No to the following questions: -Within the past two years, is the applicant known to have required one of the treatments or interventions listed below, that is, or may be due to a mental illness or mental disorder (MI/MD) < inpatient psychiatric hospitalization s <psychiatric day treatment <partial hospitalization program <intensive outpatient treatment <residential treatment <admission to a nursing facility <substance abuse disorder treatment <DMH involvement/case management <outpatient/community mental health treatment <other: -Within the past two years, did the applicant receive or would the applicant have benefited from one of the interventions listed below? <legal involvement <housing intervention <emergency mental health intervention (e.g., section 12 [transportation order to a hospital for individuals in crisis to see a Physician or Psychiatrist], crisis team involvement, suicide attempt, overdose) <other significant disruption to living situation for which supportive services were required -Currently or within the past six months, has the applicant had any limitation in major life activities in one of the areas listed below that is, or may be, due to mental illness or disorder? Major Life Activity Areas/Functional Impairments (continued on next page)

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	<Interpersonal functioning- serious difficulty interacting and or communicating effectively with others: illogical comments, fear of strangers, frequently isolating or avoiding others, excessive irritability, easily upset or anxious, hallucinations, or a possible history of eviction, altercations or unstable employment. <Concentration, persistence and pace- difficulty completing age-appropriate tasks and or/concentrating, completion timeliness, serious loss of interest, makes frequent errors, or requires assistance with activities/tasks that the applicant should be capable of accomplishing <Adaptation to change- significant difficulty adapting to typical change associated with employment, home, family, or social interactions, agitation, withdrawal due to adaptation difficulties, self-injurious behavior, self-mutilation, suicidal talks/ideations, physically violent or threatening, judicial intervention, severe appetite disturbance, excessive tearfulness. Review of the Referral Admission Information dated 4/1/24, indicated Resident #58 was referred to the psychiatric team while hospitalized for : -Failure to Thrive -agitation -mood lability (rapid exaggerated changes in mood) -pseudobulbar affect symptoms (a condition characterized by episodes of sudden uncontrolled and inappropriate laughter and crying). Further review of the Referral Admission Information indicated that Resident #58 was prescribed Zyprexa (anti-psychotic medication) and Prozac (anti-depressant) for treatment of these symptoms. Review of the facility policy titled PASRR, effective April 2018, indicated the following: -the facility will participate in a Level I screen for all potential admission regardless of payer source to determine if the individual meets the criterion for mental disorder (SMI), intellectual disability (ID) or related condition. During an interview on 1/16/25 at 11:52 A.M., the Admissions Liaison said that she did not feel that Resident #58 should have been referred to the PASRR office for receiving psychiatric treatment while in the hospital for Failure to Thrive, Depression, pseudobulbar effect and ongoing Depression that prompted the Resident to be started on new psychotropic medications. During an interview on 1/16/25 at 12:35 P.M., Social Worker (SW) #1 said that based on the hospital discharge summary, the Level I PASRR should have been completed to indicate Resident #58 had a positive SMI screen and that the Resident should have been referred to the PASRR Office for a Level II PASRR evaluation to determine whether the Resident met criteria for SMI and to determine whether the Resident required specialized services for SMI.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50320 Based on interview, and record review, the facility failed to ensure that the Resident and/or Resident Representative was provided the right to participate in the care planning process for four Residents (#40, #89, #57 and #22) out of a total sample of 19 residents. Specifically, for Resident #40, #89, #57 and #22, the facility failed to ensure that: -quarterly care plan meetings were conducted as required -the Resident/Resident Representative were invited to participate in the care planning process. -the Interdisciplinary Team (IDT) met quarterly in 2024 to review the plan of care as required. Findings include: Review of the facility policy titled Care Planning-Interdisciplinary Team (IDT), undated, included the following: -the IDT include but is not limited to: <the resident's attending physician; <registered nurse with responsibility for the resident; <nursing assistant with responsibility for the resident; <a member of the food and nutrition services staff; <the resident or the resident's representative. -the resident, the resident's family and or legal representative . are encouraged to participate in the development of and revisions to the resident's care plan. -care plan meetings are held at the best time of the day for the resident and family when possible. -if it is determined that participation of the resident or representative is not practicable for the development of the care plan, an explanation is documented in the medical record. Review of the facility policy for Care Plans- Comprehensive, last revised July 2023, indicated: -the Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans .at least quarterly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies. 1. Resident #40 was admitted to the facility in February 2024 with diagnoses including Adjustment Disorder and Dementia. Review of the Resident's most recent Minimum Data Set (MDS) assessment completed 11/21/24 indicated the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15 points. Review of Resident #40's clinical record included MDS assessments completed on 5/24/24 and 9/3/24. Further review of the Resident's record indicated no documented evidence Resident #40's care plan was reviewed by the IDT to include the Resident and/or a Resident Representative following the completion of the May 2024 and September 2024 MDS assessments. During an interview on 1/21/25 at 10:42 A.M., the MDS Nurse said the facility could provide no evidence any care plan meetings involving the Resident/ Resident Representative were held for the May 2024 or September 2024 MDS assessments. The MDS Nurse said the care plan meetings should have been held. 2. Resident #89 was admitted to the facility in August 2024 with diagnoses including Malignant Neoplasm of the Prostate, Dementia with Mild Anxiety and Adult Failure to Thrive. Review of the Resident's most recent MDS completed on 11/7/24 indicated the Resident was moderately cognitively impaired as evidenced by a BIMS score of 8 out of 15. Review of the clinical record indicated no documented evidence that Resident #89's care plan was reviewed by the IDT to include the input of the Resident and/or their Representative for the MDS assessment completed on 11/7/24. During an interview on 1/16/25 at 9:43 A.M., the Director of Nursing (DON) provided the surveyor with the facility's November 2024 care plan meeting schedule which included the Resident's name but no other information regarding completion of an IDT care plan meeting. The DON said she could not provide any evidence a care plan meeting was held that involved the Resident and/or a Resident Representative. 44222 3. Resident #57 was admitted to the facility in February 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, Major Depressive Disorder, and Unspecified Psychosis. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], included a BIMS score of 10 out of 15 points indicating the Resident was moderately cognitively impaired. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eliot Center for Health and Rehabilitation	168 West Central Street Natick, MA 01760

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated no evidence that the Resident and/or their Representative were invited to, or that a care plan meeting was held after completion of the MDS Assessment. During an interview on 1/13/25 at 10:49 A.M., Resident #57 said that he/she never goes to care plan meetings. During an interview on 1/16/25 at 9:38 A.M., the DON said the facility could provide no evidence a care plan meeting involving the Resident and/or their Representative was held following the 8/20/24 MDS assessment. The DON said the Resident and/or their Representative should have been invited to, and a care plan meeting held after completion of the MDS Assessment on 8/20/24 but it had not been. 45429 4. Resident #22 was admitted to the facility in September 2022 with diagnoses including Malignant Neoplasm of the Brain (brain cancer) and Multiple Sclerosis. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #22 was cognitively impaired as evidenced by a BIMS score of 3 out of 15. Review of the MDS schedule for Resident #22 indicated that the Resident had care plan meetings scheduled for April 2024 and July 2024. Review of Resident #22's clinical record indicated no documented evidence that the Resident and/or the Resident Representative participated in the care planning process or that the IDT met quarterly as required for April 2024 or July 2024, to review the plan of care. Further review of the clinical record indicated there were no meetings or refusals to participate in the meetings by the Resident and/or the Resident Representative documented for April 2024 or July 2024. During an interview on 1/13/25 at 12:03 P.M., Resident #22's invoked (activated) Health Care Proxy (HCP- a legal document that allows you to nominate someone to make health care decisions on your behalf should you become unable to communicate or make decisions for yourself) said that he/she had not been invited to attend or involved in care plans meetings at the facility. During an interview on 1/16/25 at 12:01 P.M., the MDS Nurse and the Regional MDS Nurse said that they were unable to provide evidence that Resident #22 or their Resident Representative had been invited to or participated in the care plan meetings in April 2024 or July 2024. The MDS Nurse and the Regional MDS Nurse said that the Resident and/or the Resident Representative should have been invited, the meetings should have been held, and they had not been.

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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** 44222 Based on observation, interview, and record review, the facility failed to provide assistance with personal hygiene care and services for two Residents (#15 and #57) out of a total sample of 19 residents. Specifically, the facility failed to ensure that: 1. Resident #15 was offered and/or provided with grooming assistance for fingernail care and facial hair care when the Resident was dependent on staff for both grooming tasks. 2. Resident #57 was offered and/or provided grooming assistance for fingernail care when the Resident was dependent on staff for this task. Findings include: Review of the facility policy titled Activities of Daily Living (ADL), Supporting, undated, included: -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal oral hygiene. -Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). 1. Resident #15 was admitted to the facility in February 2015 with diagnoses including Unspecified Dementia, Major Depressive Disorder, Dysphagia following Unspecified Cerebrovascular Disease, Type 2 Diabetes, and Atherosclerotic Heart Disease. Review of Resident #15's ADL Care Plan last revised 11/6/24, indicated that the Resident was dependent on one staff for all personal hygiene tasks, including fingernail care and facial hair care. Review of the Resident's most recently completed Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -was severely cognitively impaired. -Brief Interview for Mental Status (BIMS) assessment was not done. -was dependent on staff for personal hygiene tasks including fingernail care and facial hair care. -had no rejection of care noted on the MDS Assessment. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0n 1/13/25 at 11:32 A.M., the surveyor observed Resident #15 to have long facial hair on the chin, and fingernails that were long with debris under the fingernails. The Resident was dressed for the day and had received morning care. On 1/14/25 at 11:40 A.M., the surveyor observed the Resident in the main dining room. The Resident's fingernails were observed to be long with debris under the fingernails, and the Resident had long facial hair on the chin. The Resident was dressed for the day and morning care had been provided. Review of Resident #15's clinical record did not indicate any refusals by the Resident during grooming care provided by staff. Review of the Resident's Certified Nurses Aides (CNA) Daily Care Record indicated that the CNA provided total care for Resident #15's personal hygiene care on 1/13/25 for both morning and evening care, and again on 1/14/25 for morning care. During an observation and interview on 1/14/25 at 11:45 A.M., the surveyor and the Director of Nursing (DON) observed Resident #15's fingernails and facial hair. The DON said that the Resident's fingernails should have been trimmed but had not been, and the Resident's facial hair should have been removed but had not been. The DON said that fingernail care and care for facial hair was part of the grooming task and the Resident's fingernails and facial hair should have been checked and cared for as needed during morning and evening care. During an interview on 1/16/25 at 2:50 P.M., CNA #5 confirmed that the Resident was on his assignment on 1/14/25. CNA #5 said that the Resident was totally dependent on staff for care. He said that he was working with another CNA and did not notice the Resident's fingernails or facial hair. CNA #5 said he did not provide any nail care or facial shaving care to the Resident on the morning of 1/14/25. CNA #5 said that on the afternoon of 1/14/25 the DON requested that he check the Resident's fingernails and facial hair. CNA #5 said that he found the Resident's fingernails long and dirty and the hair on the Resident's chin was long. CNA #5 said that the Resident's nails should have been trimmed/cleaned and the facial hair removed during morning care on 1/14/24 but they had not been. 2. Resident #57 was admitted to the facility in February 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, Major Depression, and unspecified Psychosis. Review of the Resident's most recently completed MDS assessment dated [DATE], indicated the Resident: -was moderately cognitively impaired as evidenced by a score of 10 out of 15 points on the Brief Interview for Mental Status (BIMS) assessment, -was dependent on staff for personal hygiene tasks including fingernail care. -had no rejection of care noted on the MDS Assessment. Review of Resident #57's care plan last revised 11/19/24 indicated that the Resident required the assistance of one staff for personal hygiene with encouragement to participate in the task to his/her fullest ability. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 10:51 A.M., the surveyor observed Resident #57's fingernails to be long and jagged. During an interview at the time, the Resident said he/she needed the fingernails to be trimmed. On 1/14/25 at 9:52 A.M., the surveyor observed Resident #57's fingernails to be long and jagged. The Resident was dressed for the day and morning care had been completed. Review of Resident #57's clinical record did not indicate any refusals by the Resident during grooming care provided by staff. Review of the Resident's Certified Nurses Aide (CNA) Daily Care Record indicated that the CNA provided total care for Resident #57's personal hygiene care on 1/13/25 for both morning and evening care, and again on 1/14/25 for morning care. During an observation and interview on 1/14/25 at 11:45 A.M., the surveyor and the DON observed Resident #57's fingernails and the DON said that the Resident's nails should have been trimmed but had not been. The DON said that fingernail care was part of the grooming task and the Resident's fingernails should be checked and cared for as needed during morning and evening care. During an interview on 1/16/25 at 2:40 P.M., CNA #4 said that she had provided care for Resident #57 on the morning of 1/14/25. CNA #4 said that morning care does include fingernail care but she said that she was rushing and didn't recall seeing that the Resident's fingernails were long and jagged. CNA #4 said that she reviewed the Resident's fingernails later that afternoon on 1/14/25 and provided needed fingernail care. CNA #4 said that the Resident's nails were long and jagged and she should have trimmed the fingernails that morning but had not done so.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45429 Based on observation, record review, and interview, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#252) out of a total sample of 19 residents, who required renal dialysis. Specifically, the facility failed to ensure that an emergency kit including clamps and pressure dressings were kept with the Resident (#252) and the Resident's bedside as ordered, in the event of a medical emergency related to a tunneled hemodialysis catheter (a plastic tube used for exchanging blood between a patient and a hemodialysis machine). Findings include: Review of the facility policy for End-Stage Renal Disease (ESRD), Care of a Resident with, undated, indicated: -staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. -Education and training of staff includes specifically: < .how to recognize and intervene in medical emergencies such as hemorrhages and septic infections; <how to recognize and manage equipment failure or complications (according to the type of equipment used in the facility; <the care of grafts (piece of plastic inserted to connect a vein and an artery; second choice for access) and fistulas (connection between a vein and an artery; generally last longer and has fewer problems); -the residents comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. Resident #252 was admitted to facility in January 2025 with diagnoses including Chronic Kidney Disease (CKD) Stage 5, and dependence on renal dialysis. On 1/13/25 at 12:22 P.M., the surveyor observed Resident #252 resting in bed with his/her family sitting at his/her bedside. During an interview at the time the Resident's family said that Resident #252 had a central venous catheter located in his/her chest. The surveyor and the Resident's family member observed the Resident's room and did not observe any clamps and pressure dressings at the Resident's bedside or in the Resident's room. Review of Resident #252 Physician's orders for January 2025 indicated: -Hemodialysis Emergency Kit at Bedside, start date of 1/5/25 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor Hemodialysis site for signs and symptoms of infection, every shift for dialysis, start date of 1/5/25 -Resident going to dialysis every Saturday, Tuesday, Thursday, at Dialysis Clinic out of the facility, start date of 1/3/25 On 1/14/24 at 7:57 A.M., the surveyor and Nurse #2 observed the Resident resting in bed in his/her room. There was no emergency kit including clamps and pressure dressings observed at the Resident's bedside or in the Resident's room. The surveyor and Nurse #2 observed the inside of Nurse #2's medication cart and there were no clamps available in the cart as well. During an interview on 1/14/25 at 8:28 A.M., Nurse #2 said that if there was an emergency she would utilize a tourniquet (device used to place pressure on a limb or extremity to stop the flow of blood) on the Resident's arm. When the surveyor asked if Nurse #2 was familiar with the Resident's care, Nurse #2 said that she was not aware that the venous catheter access site was not located on the Resident's arm. During an interview on 1/14/25 at 9:26 A.M., the Director of Nursing (DON) said that the clamp should have been at the Resident's bedside, and they were not. The DON also said that facility staff had used the clamp for another resident's wound care and the clamp had not been put back in its place.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 50320 Based on observation, and interview, the facility failed to post the required nurse staffing information daily as required. Specifically, the facility failed to: -post daily nurse staffing information in a prominent place, that was readily accessible to facility residents and visitors. -retain a copy of staffing records for 18 months as required. Findings include: During the facility recertification survey the surveyor observed no daily nursing staff information posted on the following days: -1/13/25 -1/14/25 -1/15/25 During an interview on 1/15/25 at 9:27 A.M., the Administrator said he knew the nurse staffing information should be posted in a prominent area, and he would find out where it was posted. The Administrator failed to provide evidence to the survey team by the survey exit of the nursing staff posting information for 1/13/25, 1/14/25, and 1/15/25. During an interview on 1/16/25 at 1:55 P.M., the [NAME] President (VP) of Operations said he knew staffing should be posted daily in a prominent place. The VP of Operations showed the surveyor the nurse staffing information was posted at the front desk for the date of 1/16/25 and said that was where it should be posted daily. The VP of Operations also said he did not have 18 months of daily nurse staff postings maintained in the facility records as required.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 45429 Based on interview, and record review, the facility failed to ensure that recommendations made by the Consultant Pharmacist during a monthly Medication Regimen Review (MRR) was acted upon as required for one Resident (#20), of five applicable residents reviewed for unnecessary medications, out of a total sample of 19 residents. Specifically, the facility failed to act upon the Consultant Pharmacist recommendation dated 3/18/24, to update the Physician's order for Budesonide (inhaled steroid medication) to instruct the Resident to rinse mouth after use to prevent the development of oral thrush, after it had been approved by the Resident's Physician. Findings include: Review of the facility policy for Consultants, undated, indicated: -our facility uses outside resources to furnish specific services provided by the facility -consultant services may be utilized in the following areas: Pharmacy -consultants provide the Administrator with written, dated, and signed reports of each consultation visit. Such reports contain the consultant's: <recommendations <plans for implementation of his/her or recommendations <findings and <plans for continued assessments -the facility retains the professional and administrative responsibility for all services provided by consultants. Resident #20 was admitted to the facility in September 2023 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #20's Physician's orders indicated: -Budesonide Inhalation Suspension 0.5 Milligrams (MG)/2 Milliliters (ML) Budesonide (Inhalation), one inhalation, inhale orally two times a day for COPD, start date of 10/31/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's Clinical Record indicated a Consultant Pharmacist Recommendation to Nursing dated 3/7/24 that indicated: -Resident is receiving Budesonide. In order to prevent the development of thrush please update order to instruct Resident to rinse mouth after use. -that the Recommendation had been reviewed and agreed to by the Physician. Further review of the Clinical Record did not indicate that the Consultant Pharmacist Recommendations had been added to the Physician's orders as suggested. During an interview on 1/16/25 at 9:34 A.M., the surveyor and the Director of Nursing (DON) reviewed the Consultant Pharmacist Recommendation to Nursing dated 3/7/24 as well as Resident #20's clinical record. The DON said that the recommendation should have been added to the Resident's Physician's orders in order to prevent thrush development but it had not been.

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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. 50138 Based on observation, record review, and interview, the facility failed to ensure that drugs were stored in accordance with accepted professional standards of practice for a medication pass process for Resident #20 out of four medication passes observed. Specifically, the facility nursing staff failed to ensure that medications prepared for Resident #20 were secure and inaccessible to unauthorized staff and residents when Nurse #1 left the prepared medications on the top of the cart, left the cart unattended and unlocked in the hallway outside the Resident's room on multiple occasions, while administering the medications to the Resident in his/her room. Findings include: Review of the facility's policy titled Storage of Medications, last revised April 2007, indicated the following: -The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. -The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -Compartments (including but not limited to drawers .carts and boxes) containing drugs and biologicals shall be locked when not in use . or carts used to transport such items shall not be left unattended if open or potentially available to others. On 1/15/25 at 8:49 A.M., the surveyor observed Nurse #1 complete the following tasks during medication pass for Resident #20: -Medications were prepared by Nurse #1 on top of the medication cart in the hallway, just outside the doorway of Resident #20's bedroom. -Medications prepared included two cups of oral (taken by mouth) medications, one nasal (taken by way of nostrils) spray, and one single dose ampule of inhalation (taken by breathing in) medication. -Nurse #1 then entered Resident #20's room leaving the medication cart in the hallway, unattended and unlocked with the nasal spray, the inhalation medication, and one cup of oral medication on top of the cart. There were two residents, one facility staff member, and the surveyor in the hallway in close proximity of the medication cart when Nurse #1 entered the Resident's room. -Nurse #1 returned to the medication cart and collected the single dose ampule inhalation medication from the top of the medication cart and left the unlocked medication cart with the cup of oral medication and nasal spray on top of the cart in the hallway and re-entered Resident #20's bedroom. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #1 was observed to walk behind Resident #20's privacy curtain and obstructing her view of the medication cart as she collected a nebulizer (electric pump that delivers inhaled medication in an aerosol form). Nurse #1 was further observed with her back to the medication cart which remained in the hallway, as she proceeded to fill the nebulizer with the inhaled medication and left the filled nebulizer container at the Resident's bedside. -Nurse #1 returned to the medication cart in the hallway, collected the nasal spray, and re-entered Resident #20's bedroom leaving the medication cart unlocked and one cup of oral medication on top of the cart. Nurse #1 had the medication cart out of view when she turned her back to the cart to administer the nasal spray to Resident #20. -Nurse #1 then returned to the medication cart. During an interview at the time, the surveyor asked Nurse #1 if leaving the medication cart unlocked and unattended during medication administration was standard practice, Nurse #1 said she always leaves the medication cart unlocked during medication pass so that she didn't have to mess around with all the keys. Nurse #1 said she thought it was easier not to have to find the key every time she returned to the medication cart. -Nurse #1 was observed to walk away from the unlocked, unattended medication cart in the hallway, and one cup of oral medication remained on top of the medication cart. -Nurse #1 re-entered the Resident's bedroom, repositioned Resident #20 in bed, and then administered the inhaled medication from the nebulizer. During an interview on 1/15/25 at 9:04 A.M., the Director of Nursing (DON) said she had concerns with medication carts being left unlocked while unattended during medication pass due to safety for other residents on the unit. The DON said medications should be secured and medication carts locked when not in use or unattended.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 44222 Based on observation, interview, and record review, the facility failed to ensure that dental services were provided for one Resident (#79) out of a total sample of 19 residents. Specifically, the facility failed to provide dental services for Resident #79 after the Resident's Guardian requested dental services. Findings include: Review of the facility policy titled Dental Services, undated, included: -Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. -Routine and 24-hour emergency dental services are provided to our resident's through a contract agreement with a licensed dentist that comes to the facility. Resident #79 was admitted to the facility in November 2023 with diagnoses including Unspecified Dementia, Insomnia, Anxiety, and high cholesterol. Review of the Resident's Care Plan did not include any problems, goals, or interventions for dental care. Review of the Dental Services Contract indicated that the Resident's Guardian requested dental services on 7/18/24. Review of the most recent Minimum Data Set (MDS) Assessment completed on 11/8/24, indicated the Resident: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15 possible points. -had no obvious or likely cavity or broken natural teeth -displayed no difficulty to examine his/her teeth. On 1/13/25 at 11:03 A.M., the surveyor observed the Resident's teeth that there were no teeth on the top gum line and three teeth on the bottom gum line, two of which were dark in color and broken. During an interview on 1/21/25 at 7:41 A.M., the Director of Nursing (DON) reviewed the Resident's record and said she could not find any evidence that the Resident had been offered dental services. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Eliot Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 168 West Central Street Natick, MA 01760	

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/21/25 at 8:19 A.M., the DON said that when a resident or a resident representative signs a request for dental services, the resident was then put on a list to be seen by the dental services vendor. The DON said that the Resident #79 was never referred to the dental services vendor but should have been. On 1/21/25 at 9:23 A.M., the surveyor and the DON observed the Resident's teeth and saw there were no teeth on the top gum line, there were three teeth on the bottom gum line, two of which were dark in color and broken. During an interview at the time, the Resident said my other teeth are at home and it's good that my teeth don't hurt. The DON said that the Resident should have been referred for dental services as requested, but had not been. The DON further said that the on-site dental service had been at the facility multiple times since July 2024 but the Resident had not been seen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50320 Based on observation, and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent foodborne illness to residents. Specifically, the facility failed to: 1. Discard spoiled food and food that was past the use by date, and label and date prepared food. 2. Distribute and serve food in the main dining room under sanitary conditions. Findings include: 1. Review of the facility policy and procedure manual Chapter 3: Food Production and Food Safety, undated, indicated: -Refrigerated food storage, all foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates or frozen (where applicable) or discarded. -All stock must be rotated with each new order received. -Foods should be dated as it is placed on the shelves if required by state regulations. -Date marking will be visible on all high-risk foods to indicate the date by which ready to eat, temperature-controlled food should be consumed, sold, or discarded. Review of the Live Well Healthcare Solutions Policy on Food Storage, undated, provided to the surveyor by the Corporate Food Service Director indicated: -All foods will be held according to manufacturer's guidelines and expiration dates. -All foods not labeled with an expiration date will be discarded according to guidelines outlined in the policy. -All foods will be labeled with a use by date when opened and stored in an appropriate manner. -Fresh fruit or vegetables - whole, should be in the refrigerator stored 37-40 degrees Fahrenheit for one week or until visual decline is noted. During the initial tour of the facility kitchen on 1/13/25 at 7:27 A.M., the surveyor observed the following: -In the walk-in refrigerator: (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

>cucumbers that were individually wrapped and sealed in plastic and stored in a cardboard box with a packed-on date of 12/18/24. The cucumbers had a white moldy film on them under the plastic wrap.

>Sandwiches that were individually wrapped and stacked in a container on the second shelf from the top and were undated and unlabeled.

-In the reach-in refrigerator:

>stored on the bottom shelf in a metal container was a tube of ground beef labeled with a use by date of 1/9/25.

During an interview on 1/13/25 at 7:45 A.M., Dietary Staff #1 said both the cucumbers and the ground beef should have been thrown away and not used. Dietary Staff #1 said the sandwiches should have been dated before they were put in the refrigerator.

During an interview on 1/15/25 at 12:08 P.M., the Corporate Food Service Director (FSD) said the ground beef seen on the initial kitchen tour with a use by date of 1/9/25 was mislabeled and was pulled from the freezer to thaw on 1/9/25, to use for service on 1/13/25. The Corporate FSD said he was not there the morning of the initial kitchen walk through and did not see the only label that the surveyor observed to have a use by date of 1/9/25. The Corporate FSD said the ground beef should have been labeled with a pull and preparation date as well as a use by date. The Corporate FSD said if the cucumbers were moldy, they should have been thrown away and not used. The Corporate FSD further said the sandwiches or the container they were stored in should have been labeled and dated. The Corporate FSD said the staff have a guide for food storage attached to the walk-in refrigerator which tells them how to properly store and discard food and they should have been following those guidelines.

2. Review of the facility policy Assistance with Meals, version 2.0, undated, indicated all employees who provide resident assistance with meals will be trained and shall demonstrate competency in prevention of foodborne illness, including personal hygiene practices and safe food handling.

During a dining observation on 1/16/25 at 11:50 A.M., in the main dining room the surveyor observed the following:

-a drink station including coffee, pitchers of juices and sealed juice cups stored in a metal container on top of ice, and trays with clean cups and mugs alongside the drinks.

-drinks being served to the residents from the drink station by nursing staff.

-A tray on the same drink station was storing dirty cups, dirty silverware, and dirty pitchers. Staff were observed taking used cups from the Resident's tables and placing them on the tray next to the tray with clean items.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Activities Assistant (AA) #1 was observed getting a clean cup from the drink station and with ungloved hands used the clean cup to scoop contaminated ice from the metal container housing the drink pitchers and juice cups. AA #1 poured the ice into a resident's cup on the table and handed the cup to the resident. The Director of Nursing (DON) intervened and stopped the resident from drinking from the contaminated cup. The DON educated AA #1 that she could not use ice from the container that the drinks were stored in. The contaminated ice and the cup were taken from the resident and a clean cup with ice was provided to the resident. -At 12:06 P.M., the tray with the dirty cups and utensils on the drink station had been removed and several staff members were observed leaving dirty cups and utensils directly on the table with the clean drinks and cups. During an interview on 1/16/25 at 12:26 P.M., the Corporate FSD said there should not have been dirty items on the same table with the clean items at the drink station. The Corporate FSD said staff should not have been using the dirty ice from the drink station to serve to the residents. The Corporate FSD said staff should be using the clean ice provided in pitchers on the table. During an interview on 1/16/25 at 4:20 P.M., the DON said the staff member should not have used the dirty ice for resident drinks. The DON said the dirty cups and utensils should be put in a separate container and not on the drink station with the clean cups and drinks being served to the residents. The DON said all the staff should be trained on food safety and infection control if they are assisting with dining program. The DON said she was unsure if AA #1 had been educated on safe food handling.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45429 Based on observation, interview, and record review, the facility failed to adhere to infection control standards to prevent the potential transmission of communicable diseases and infections for one Resident (#12) who had tested positive for COVID-19, out of a total sample of 19 residents. Specifically for Resident #12, the facility failed to ensure that staff: -wore the necessary Personal Protective Equipment (PPE: items such as a gown, gloves, mask, eye protection, etc. to prevent transmission of communicable disease) to maintain isolation contact/droplet precautions (used to prevent transmission of a disease spread by touching a contaminated surface or person). -performed hand hygiene procedure after removing gloves as required. Findings include: Resident #12 was admitted to the facility in April 2004 with diagnoses including Paranoid Schizophrenia. Review of the facility policy titled Isolation - Categories of Transmission-Based Precautions, undated, indicated the following: -Contact Precautions <Staff and visitors will wear gloves (clean, non-sterile) when entering the room <gloves will be removed and hand hygiene performed before leaving the room -Droplet Precautions <masks will be worn when entering the room <gloves, gown and goggles will be worn if there is risk of spraying respiratory secretions Review of the facility policy for Coronavirus Prevention and Control, last revised May 2023, indicated: -The administrator or designee will ensure the following are available at the facility: .<PPE (gloves, gowns, eyewear, facemasks) -Contact and droplet precautions are implemented for any residents with symptoms of respiratory infection and standard precautions will be used as indicated. Review of Resident #12's January 2025 Physician's orders indicated: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-COVID Isolation - Contact Precautions in private room due to positive for COVID, start date of 1/11/25. Review of Resident #12's Care Plan for confirmed COVID-19 dated 1/11/25, indicated: -Isolation Precautions -Contact/Droplet Precautions On 1/13/25 at 9:45 A.M., the surveyor observed: -Isolation/Droplet/Contact Precaution signage posted outside of Resident #12's room which indicated: >for Everyone: -to cleanse hands before entering and when exiting the room. -wear gloves, a gown, N95 Respirator, Eye Protection (face shield or goggles) -use patient dedicated or disposable equipment. -clean and disinfect shared equipment -the PPE bin outside Resident's #12's room did not include goggles or face shields. On 1/13/25 at 11:37 A.M., the surveyor observed Housekeeper #1 enter Resident #12's room with Isolation/Droplet/Contact Precaution signage posted outside the door. Housekeeper #1 was observed to: -don all the PPE indicated on the Precaution sign except for goggles/eyewear. -enter the room and clean all the surfaces. -exit the room and doff all PPE in receptacle. -not perform hand hygiene after doffing her gloves and donning new gloves and proceeding to clean another room. During an observation on 1/14/25 at 8:06 A.M., the surveyor observed CNA #3 enter Resident #12's room with a breakfast tray. CNA #3 was observed to: -don all the PPE indicated on the Precaution sign except for goggles/eyewear. -Provide Resident #12 with his/her breakfast tray in the room, exit the room and doffed his PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/14/25 at 8:10 A.M., CNA #3 said that he did not wear goggles or eye protection when entering Resident #12's room because they were not available. When the surveyor opened the PPE bin to find there were goggles available and showed them to CNA #3, CNA #3 said that he should have worn eye protection. CNA #3 said that the facility had recently given an in-service on PPE use so he knew that he should have worn eye protection prior to entering Resident #12's room and he did not. During an interview on 1/14/25 at 2:39 P.M., the Director of Nursing (DON) said that both Housekeeper #1 and CNA #3 should have worn eye protection before entering the COVID-19 positive room. The DON also said that Housekeeper #1 should have performed hand hygiene after taking off her potentially soiled gloves and putting on another pair of gloves.