STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Rehabilitation & Nursing Center	8 Dana Street Cambridge, MA 02138

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 44095 Based on record review, policy review and interviews, the facility failed to implement their abuse prohibition policy for one Resident (#69) out of a total sample of 19 residents. Specifically, for Resident #69, the facility failed to ensure nursing immediately reported an allegation of potential abuse (bruise of unknown origin) to the Director of Nursing or Administrator, as required. Findings include: Review of the facility policy titled Accident/Incident - Investigating and Reporting, dated as revised 6/2022, indicated to provide the guidelines for the completion, investigation, care plan intervention and regulatory reporting of all Accidents & Incidents; to ensure the timeliness of such reporting, and to ensure the appropriate follow-up and monitoring post-incident occurs. PROCEDURE: Upon the discovery of an accident/incident immediately report the occurrence to the Charge Nurse and/or the Nursing Supervisor. All accidents and incidents require an assessment and an accident/incident report form to be completed in following order: 3. If the incident is an elopement, an alleged physical abuse or any other incident that meets the criteria of a reportable incident per the DPH regulations, the Nursing Supervisor/Nurse Manager will immediately notify the Administrator and Director of Nursing regardless of the time in which the incident was discovered. If the (sic) is not in the building, the Administrator will give the Nursing Supervisor/Nurse Manager direction to initiate the investigation until he/she arrives. The Administrator will conduct the required investigation. Review of the facility policy titled Abuse, Investigating and Reporting, dated as 4/23/19, indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Resident #69 was admitted to the facility in April 2023 with diagnoses including dementia and psychosis. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 1/10/24, indicated that Resident #69 was rarely/never understood. This MDS indicated Resident #69 required total assistance with activities of daily living. Review of Resident #69's alert note, dated 3/3/24 at 8:56 A.M., indicated: This writer was told resident has a bruise on the left side of his/her eyes. I can't recall seeing the bruise and Resident is un unable to explain what happen. During an interview on 7/1/24 at 1:58 P.M., Nurse #4 said she worked the 3:00 P.M. to 11:00 P.M. shift and the 11:00 P.M. to 7:00 A.M. shift on 3/2/24 into 3/3/24, and she was not sure how Resident #69 got a bruise on his/her face. Nurse #4 said she did not notify the Director of Nursing of the new bruise. Review of Resident #69's progress note, dated 3/3/24 at 2:52 P.M., indicated: The assigned resident assistant (RA) to the supervision group reported that this Resident was found with a bruise on the left eye. During an interview on 7/2/24 at 11:19 A.M., Nurse #5 said she worked on 3/3/24 during the 7:00 A.M. to 3:00 P.M. shift, and said she was not sure what caused the bruise on Resident #69's face. Nurse #5 said she notified the Director of Nursing. Review of the health care facility reporting system, dated 3/4/24 at 4:31 P.M., indicated the facility reported the injury of unknown to the state agency, 30 hours after facility staff were first aware of the injury of unknown. During an interview on 7/2/24 at 12:04 P.M., the Director of Nursing (DON) said she became aware of the new bruise while reading the nursing note on 3/4/24. The DON said nursing should have notified administration about the injury of unknown but did not. During an interview on 7/2/24 at 1:08 P.M., the Administrator said that he became aware of the bruise by the Director of Nursing on 3/4/24. The Administrator said that direct care staff should have reported the injury of unknown to the Director of Nursing or Administrator but did not.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on record review and interviews for one Resident (#3) out of a total sample of 19 residents, the facility failed to ensure staff adequately identified a significant change in Resident's status and complete a comprehensive Significant Change of Status Assessment Minimum Data Set (MDS) as required. Specifically, the facility failed to identify and complete a Significant Change of Status MDS when Resident #3 experienced significant weight loss and a decline in his/her ability to transfer in and out of bed. Findings include: Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2023, indicated a Significant Change of Status must be completed by the end of the 14th calendar day following determination that significant change has occurred. It defines a significant change as a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting. 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. Resident #3 was admitted to the facility in February 2019 with diagnoses including chronic obstructive pulmonary disease (COPD), which is a common lung disease causing restricted airflow and breathing problems, stroke, dysphagia (difficulty swallowing), and malnutrition. Review of Resident #3's MDS, dated [DATE], indicated: -a documented weight of 129 pounds. -supervision chair/bed-to-chair transfer. Review of Resident #3's MDS, dated [DATE], indicated: -a documented weight of 109 pounds. -significant weight loss (loss of five percent or more of the Resident's total body weight in the last month or a loss of ten percent or more in six months). -dependent chair/bed-to-chair transfer. Review of Resident #3's dietary progress notes, dated 3/26/24, indicated he/she had significant weight loss (6.5% in 30 days) based on documented weight of 115.5 pounds, and an increase in Med Pass (nutritional supplement) to 120 milliliters (mL) three times a day was ordered. (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident's #3's dietary progress notes, dated 4/4/24, indicated he/she had significant weight loss (12.8% in 30 days) based on documented weight of 109 pounds, and an increase in Med Pass to 120 mL four times a day was ordered. Review of Resident #3's dietary progress notes, dated 4/11/24, indicated he/she had significant weight loss (6% in 30 days) based on documented weight of 108.5 pounds. Review of Resident #3's Certified Nursing Assistant (CNA) documentation, dated 1/18/24 to 1/24/24, indicated he/she required supervision for transfer to and from bed to chair. Review of Resident #3's CNA documentation, dated 4/18/24 to 4/24/24, indicated he/she was totally dependent on staff for transfer to and from bed to chair. The MDS Nurse was unable to be interviewed because she no longer worked at the facility. During an interview on 7/2/24 at 4:01 P.M., the Director of Nursing (DON) said a Significant Change of Status MDS should have been completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44095 Based on observation, record review, and interviews, the facility failed to ensure care plans were reviewed with the interdisciplinary team (IDT) as required for one Resident (#16), out of a total sample of 19 residents. Specifically, the facility failed to revise and update Resident #16's Activities of Daily Living (ADL) care plan. Findings include: Resident #16 was admitted to the facility in November 2022 with diagnoses including irritable bowel syndrome. Review of the Minimum Data Set (MDS) assessment, dated 2/7/24, indicated that Resident #16 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #16 required: B. Oral hygiene: the ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment, coded as independent. C. Toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment, coded as independent. F. Toilet transfer: the ability to get on and off a toilet or commode, coded as independent. Review of Resident #16's plan of care related to activities of daily living, dated as current 6/28/24, indicated the following: - PERSONAL HYGIENE: The resident requires supervision/assist by (1) staff with personal hygiene and oral care, dated as revised 6/23/23. - TOILET USE: The resident is assist with toileting, dated as revised 9/13/23. - TRANSFER: The resident requires supervision by (1) staff with rollator to move between surfaces. Chair/ bed transfer supervision/ touching assist, dated as revised 1/18/24. - BATHING/SHOWERING/GROOMING: The resident requires partial/moderate assistance by (1) staff with bathing/showering/grooming, dated as revised 1/18/24. Further review of this care plan failed to include any revisions were made to the above focus areas after the revision dates stated above. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's Activities of Daily Living (ADLs) flow sheets, dated February 2024, indicated Certified Nursing Assistants consistently coded Resident #16 on the day, evening, and night shifts between 2/4/24 to 2/7/24, the following: - Oral hygiene, coded as independent. - Toileting hygiene, coded as independent. - Toilet transfer, coded as independent. During an interview on 7/2/24 at 12:03 P.M., the Director of Nursing said the interdisciplinary team who completes section GG under the MDS is responsible for updating the care plan after each comprehensive assessment. The DON said that the care plan should have been updated after Resident #16's MDS assessment completed on 2/7/24 but was not.

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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. 49880 Based on observations, record review and interviews, the facility failed to meet professional standards of quality for one Resident (#50) out of a total sample of 19 residents. Specifically, for Resident #50, the facility failed to follow physician's orders to apply offloading booties to bilateral heels while in bed. Findings include: Resident #50 was admitted to the facility in May 2024 with diagnoses that include adult failure to thrive and repeated falls. Review of Resident #50's most recent Minimum Data Set (MDS) Assessment, dated 6/4/24, indicated a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating that Resident #50 had severe cognitive impairment. The MDS further indicated that Resident #50 was at risk for the development of pressure ulcers. The MDS further indicated that rejection of care was not a behavior exhibited by the Resident. Review of Resident #50's physician's orders indicated the following: -Apply booties to bilateral heels while in bed, dated 5/31/24. Review of Resident #50's active skin risk care plan indicated that the resident had potential for skin breakdown related to fragile coccyx areas and left heel with DTI (deep tissue injury, a type of pressure ulcer) as evidenced of observation of eschar, dated 5/31/24. On 6/28/24 at 8:59 A.M., the surveyor observed Resident #50 laying in bed on his/her back with his/her heels directly on the mattress. On 6/28/24 at 11:40 A.M., the surveyor observed Resident #50 laying in bed on his/her back with his/her heels directly on the mattress. On 7/1/24 at 6:44 A.M., the surveyor observed Resident #50 sleeping in bed on his/her back with his/her heels directly on the mattress. The surveyor observed two offloading booties the wheelchair across the room from the Resident. On 7/1/24 at 9:30 A.M., the surveyor observed Resident #50 sleeping in bed on his/her back with his/her heels directly on the mattress. The surveyor observed two offloading booties the wheelchair across the room from the Resident. On 7/2/24 at 9:24 A.M., the surveyor observed Resident #50 laying in bed on his/her back with his/her heels directly on the mattress. The surveyor observed two offloading booties the wheelchair across the room from the Resident. (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 interview on 7/2/24 at 9:32 A.M., the surveyor and Certified Nurse Assistant (CNA) #2 observed Resident #50 in bed without offloading boots on his/her bilateral feet. CNA #2 said Resident #50 should wear offloading booties at all times when he/she is in bed, but somebody must have forgotten to put them on. During an interview on 7/2/24 at 9:36 A.M., Nurse #9 said Resident #50 should have offloading booties on both feet at all times when he/she is in bed. Nurse #9 said Resident #50 never refuses to wear the offloading booties, but if he/she did it would be documented in the Treatment Administration Record (TAR) or in a progress note. Review of Resident #50's Treatment Administration Record (TAR) indicated that Resident #50 had heel booties on in bed as ordered on 6/28/24 and 7/1/24. Further review of TAR and progress notes failed to indicate Resident #50 refused offloading booties in the last month. During an interview on 7/2/24 at 12:07 A.M., the Director of Nursing (DON) said if the booties were refused it would be indicated in TAR or a progress note. The DON said offloading booties should have be worn following the physician order. 48990

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44095 Based on observation, record review, and interview, the facility failed to maintain professional standards in the managing and care for urinary catheter devices for one Resident (#28) out of a total sample of 19 Residents. Specifically, the facility staff failed to ensure the correct size suprapubic indwelling urinary catheter (a flexible tube that passes through the abdomen and into the bladder to drain urine) was in place for Resident #28 as ordered by the physician. Findings include: Review of the facility policy, titled suprapubic catheter insertion, dated as 10/2017, indicated: Purpose: The purpose of this procedure is to ensure the proper and safe insertion of suprapubic catheters to relieve urine retention in residents who require a permanent or long-term catheter. Policy: All nursing staff performing suprapubic catheter insertion must adhere to this policy to ensure safe and effective care for residents. This procedure outlines the steps, preparation, and documentation required for the insertion of suprapubic catheters. 1. Preparation a. verify there is a physician's order for the procedure. 5. Documentation: Record the following information in the resident's medical record f. Type of catheter inserted, balloon size, French size, and composition. Resident #28 was admitted to the facility in February 2019 with diagnoses including Parkinson's disease, urine retention, and legal blindness. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/22/24, indicated that Resident #28 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS indicated Resident #28 required an indwelling catheter (suprapubic catheter). On 7/1/24 at 6:56 A.M., the surveyor and Unit Manager #1 observed Resident #28 bed. Resident #28 had a 16 French (F) with a 5 cubic centimeter (cc) balloon catheter inserted into his/her abdomen. Review of Resident #28's physician's order, dated 3/28/24, indicated: - suprapubic catheter active change suprapubic tube with 16 F/10 cc catheter one time a day every 1 month(s) starting on the 1st for 28 day(s). - suprapubic catheter, change monthly in the facility per physician (MD) and as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's physician's order, dated 6/30/24, indicated: - Change suprapubic tube with 16 French 10 cc catheter monthly, one time a day, every 1 month(s) starting on the 1st for 28 day(s). Review of Resident #28's nursing progress note, dated 6/13/24, indicated: Patient is alert and oriented, suprapubic catheter replaced with 16 F/10 ml (milliliter) and patent. During an interview on 7/2/24 at 3:03 P.M., Nurse #8 said that on 6/13/24, she and Unit Manager #1 changed Resident #28's suprapubic catheter. Nurse #8 said that prior to inserting a suprapubic catheter you need to verify the correct size. Nurse #8 said that Unit Manager #1 replaced the catheter. Review of Resident #28's Treatment Administration Record (TAR), dated June 2024, indicated on 6/28/24 nursing implemented the physician's ordered suprapubic catheter change. During an interview on 7/1/24 at 7:00 A.M., Unit Manager #1 said staff should implement the physician's order for the correct catheter size. During an interview on 7/1/24 at 2:44 P.M., Resident #28 said nursing changed his/her catheter a few weeks ago (6/13/24) because it was leaking. Resident #28 said the catheter was not changed on 6/28/24 and he/she would only allow staff to change it every four to six weeks. During an interview on 7/1/24 at 7:56 A.M., the Director of Nursing said nursing should implement the physician's order and Resident #28 should have a 16 French 10 cc balloon indwelling catheter.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on observation, record review, policy review and interview the facility failed to ensure staff provided appropriate care and services for one Resident (#38) with a Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication), out of a total of 19 sampled residents. Specifically, the amount of tube feeding infused did not correspond with the rate of infusion and the hours infused as ordered by the physician for Resident #38. Findings include: Review of the facility policy titled Gastrostomy Tube Feeding, dated 10/20/22, indicated that the purpose of the policy was intended to administer nourishment into the stomach via gastrostomy (G-tube) and decisions to continue use of tube feeding (TF) will be reviewed quarterly at a minimum and documented through continued care planning for intervention and renewal of physician orders. If any time the tube feeding is not administered per physician order, the physician must be notified for further instruction or orders. Resident #38 was admitted to the facility in February 2024 with diagnoses including stroke, dementia, dysphagia (difficulty swallowing), and post-traumatic stress disorder. Review of Resident #38's most recent Minimum Data Set (MDS), dated [DATE], indicated that Resident #38 had a feeding tube. Review of Resident #38's active physician's orders, dated 6/21/24, indicated the following: -Jevity (calorie dense therapeutic nutrition for tube feeding) 1.5 calorie (cal) administer via pump every shift, 60 mL (milliliters) per hour, hold at 5:00 A.M. and resume at 7:00 A.M. Review of the physician's progress note, dated 6/21/24, indicated: - concern tube feeding (TF) frequently turned off or forgotten to be turned on after providing personal care and at several follow up visits tube feeding have been off or stopped. On 7/1/24 at 7:00 A.M., the surveyor observed a 1500 mL bottle of Jevity 1.5 cal hanging in Resident #38's room. The Jevity 1.5 cal bottle was dated 7/1/24 at 7:00 A.M. and was visibly running through the tubing and was connected to resident at a rate of 60 mL per hour. On 7/1/24 at 1:25 P.M., the surveyor observed the tube feeding (TF) hanging, connected to Resident #38 and the pump read 60 mL per hour. The 1500 mL bottle of Jevity 1.5 cal, dated 7/1/24 at 7:00 A.M., contained 1500 mL of tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/24 at 3:52 P.M., the surveyor observed the tube feeding hanging, connected to Resident #38 and the pump read 60 mL per hour. The 1500 mL bottle of Jevity 1.5 cal, dated 7/1/24 at 7:00 A.M., contained 1500 mL of tube feeding, which remained unchanged since the 7/1/24 at 7:00 A.M. observation. On 7/1/24 at 3:55 P.M., Unit Manager #1 observed the tube feeding infusing for Resident #38 with the surveyors, the tube feeding bottle was dated 7/1/24 and contained 1500 mL of Jevity 1.5 cal tube feeding. Unit Manager #1 said she was unsure why the tube feeding did not infuse all day, but it should have. Review of progress note dated 7/1/24 at 10:34 P.M., Nurse #7 documented Patient not getting full amount of Jevity 1.5 d/t (due to) machine, only got 400 cc (cubic centimeter and mL are different names for the same metric unit of volume). (sic.) Nurse #7 obtained an order from the physican to administer one time order Jevity 1.5 200cc bolus. (sic.) During phone interview at 7/2/24 at 12:57 P.M., Nurse #7 (who worked on 7/1/24 from 7:00 A.M. to 3:00 P.M. and 7/1/24 from 3:00 P.M. to 11:00 P.M.) said that she noticed a defect in the machine on 7/1/24 in the afternoon after 4:00 P.M., she said she tried to flush the tubing and reset the machine. Nurse #7 said that Resident #38 should have received tube feeding at 60 mL per hour but did not. Nurse #7 said that she did not check on enteral feeding routinely during her shift. Nurse #7 said she was not aware of any staff pausing or turning off the tube feeding machine during care. Nurse #7 called the physician and received an order at 6:00 P.M. to deliver a bolus feeding of 200mls. During interview 7/2/24 at 3:56 P.M., the Director of Nursing (DON) said she would expect tube feeding to be assessed and monitored to make sure enteral feed is infusing. The DON said she was aware that the physician had multiple concerns that the tube feeding had been stopped and would expect the physician to have notified her prior to leaving the facility.

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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. 50338 Based on observation, policy review, record review and interview the facility failed to provide necessary respiratory care consistent with professional standards of practice for one Resident (#3) out of a total sample of 19 residents. Specifically, the facility failed to implement Resident #3's physician ordered oxygen flow rate. Findings include: Review of the facility policy titled Oxygen Therapy, dated 2/22/22, indicated that the purpose of the policy was intended to ensure that high quality of care is delivered to residents regarding administration of oxygen to and the appropriate monitoring of resident's receiving oxygen and included the procedure that a physician's order is required to initiate oxygen therapy. Resident #3 was admitted to the facility in February 2019 with diagnoses including chronic obstructive pulmonary disease (COPD-a common lung disease causing restricted airflow and breathing problems), stroke, dysphagia (difficulty swallowing), and malnutrition. Review of the Minimum Data Set (MDS) assessment, dated 4/24/24, indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 which indicated moderate cognitive impairment. This MDS further indicated Resident #3 required oxygen. On 6/28/24 at 7:50 A.M. and 8:04 A.M., the surveyor observed Resident #3 sitting in a wheelchair in his/her room. The Resident was receiving oxygen via nasal cannula at three liters per minute. On 6/28/24 at 2:07 P.M., the surveyor observed Resident #3 in the day room receiving oxygen via nasal cannula at three liters per minute. Review of Resident #3's physician orders indicated: -Oxygen two liters (L) per minute via nasal cannula (NC) continuously every shift, initiated 4/18/21. Review of the Medication Administration Record (MAR) indicated on 6/28/24 during the 7:00 A.M. to 3:00 P. M. shift and on 7/1/24 during the 11:00 P.M. to 7:00 A.M. nursing implemented the physician's order. Review of the plan of care related to oxygen therapy, dated 6/6/24, indicated: -OXYGEN (O2) SETTINGS: O2 continuously as ordered. During a phone interview on 07/02/24 at 10:41 A.M., Nurse #3 who worked the 11 P.M. to 7 A.M. shift on 7/1/24 said Resident #3 should be on continuous oxygen at two liters per minute which he verified by reviewing physician's order, and that Resident #3 does not adjust the settings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Rehabilitation & Nursing Center	8 Dana Street Cambridge, MA 02138

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/02/24 at 3:44 P.M., the Director of Nursing (DON) said nursing should implement the physician's order for oxygen flow rate. The DON said on 7/2/24 she observed Resident #3's oxygen set to three liters per minute and she had to adjust it.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49880 Based on observation, policy review and interview, the facility failed to ensure staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically, the facility failed to properly secure medication/treatment carts on two of two units. Findings Include: Review of facility policy titled Storage- Labeling- Maintenance of Medications, dated 11/8/22, indicated the following: -Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. -1. All drugs and biologicals are to be stored in the locked designated cabinets for this purpose and shall be stored under proper temperature controls. Only Authorized licensed personnel are to have access to the keys and the medications. -4. Medication carts must be locked at all times when not in use, including during medication passes when the nurse steps away from the cart. On 7/1/24 at 8:38 A.M., during a medication storage observation on the first- floor unit, Nurse #1 opened the medication cart for the surveyor, checked that the narcotic draw was locked, and walked away from the medication cart. Nurse #1 was out of site of the surveyor but was observed walking to the other end of the hallway. At 8:41 A.M., Nurse #1 returned to the medication cart. During an interview on 7/1/24 at 8:57 A.M., Nurse #1 said she should not leave her medication cart unlocked and unattended. She said, I had to do something quick, and I knew that you weren't going to take anything. During an interview on 7/1/24 at 10:12 A.M., the Corporate Director said that if a nurse leaves his or her medication cart, they should lock it. During observation of medication pass on the second- floor unit on 7/1/24 at 9:46 A.M., Nurse #2 walked away from her medication cart to administer medications to a resident, leaving it unlocked and unattended. During an interview on 7/1/24 at 9:46 A.M., Nurse #2 said that she should not have left her medication cart unlocked and should have locked it when she walked away. During an interview on 7/1/24 at 10:12 A.M., the Corporate Director said that if a nurse leaves his or her medication cart, they should lock it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48990 On 7/2/24 at 6:48 A.M., the surveyor observed an unlocked treatment cart on the first- floor unit with no licensed nurse within view of the cart. On 7/2/24 at 6:51 A.M., the surveyor opened the unlocked treatment cart, which was filled with prescription creams. During an interview on 7/2/24 at 6:53 A.M., Unit Manager #1 came down the hall and said the treatment cart should always be locked when unattended because a resident could get into it. During an interview on 7/2/24 at 7:01 A.M., Nurse #6 said the treatment cart should be locked when not within view of the nurse. During an interview on 7/2/24 at 9:02 A.M., the Corporate Director said the nurse had forgotten to lock the treatment cart, but should have locked it since it was not within her view. During an interview on 7/2/24 at 12:07 A.M., the Director of Nursing (DON) said treatment carts should be locked if not within view of the nurse.

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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. 48990 Based on observation, interviews, and policy review, the facility failed to ensure transmission-based precautions were followed to prevent the spread of infections. Specifically, the facility failed to ensure a nurse appropriately donned (put on) a precaution gown while caring for a Resident on enhanced barrier precautions (EBP). Findings include: Review of the facility policy titled Enhanced Barrier Precautions - Multidrug-Resistant Organisms (MDROs), dated 4/1/24, indicated the following: -Enhanced Barrier Precautions (EPB) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. -Enhanced barrier precautions should be followed for any resident in the facility with: an open wound requiring a dressing change. -Signage must be posted on the door or wall outside of the resident's room indicating enhanced barrier precautions and required PPE (personal protective equipment). On 7/2/24 at 7:25 A.M., the surveyor observed a pressure ulcer wound with Unit Manager #1. Upon entry into the resident room, there was a sign posted at the doorway that indicated the resident was on EBP and that everyone must wear gloves and gown for high-contact resident care activities including wound care. Unit Manager #1 did not put on a precaution gown, and only put on gloves. Unit Manager #1 removed the dressing on the Resident's right lateral foot revealing an open quarter sized circular wound with a bright red wound bed. Unit Manager #1 placed the dressing in her gloved hand and rested the right lateral foot back into a blue off-loading bootie without a new dressing on it and left the room. During an interview on 7/2/24 at 7:17 A.M., Certified Nurse Assistant (CNA) #1 said a precaution gown and gloves must be worn if the surveyor wanted to look at the foot wound of the resident because he/she was on EBP. During an interview on 7/2/24 at 11:06 A.M., Unit Manager #1 said the resident with the foot wound we observed was on enhanced barrier precautions and a precaution gown and gloves should be worn when changing his/her right foot pressure ulcer wound dressing. Unit Manager #1 said that she did not wear a gown when she removed the resident's dressing from their right foot. During an interview on 7/2/24 9:02 A.M., the Corporate Director said Unit Manager #1 should have worn a precaution gown, in addition to gloves, when removing a dressing from an open wound for the resident because he/she was on EBP. (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 7/2/24 at 12:07 P.M., the Director of Nursing (DON) said a precaution gown, in addition to gloves, should have been worn by Unit Manager #1 for all wound procedures, even if she was just removing the right foot pressure ulcer wound dressing because the resident was on EBP.