STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225523	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Glen Ridge	120 Murray Street Medford, MA 02155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review and interview the facility failed to provide a dignified existence for three Residents (#50, #30 and #86) out of a total sample of 46 residents. Specifically: 1. For Resident #50 and #30 the facility failed to provide a dignified dining experience. 2. The facility failed to serve meals in a homelike atmosphere evidenced by meals served on institutional trays on the [NAME] Unit. 3. For Resident #86 the facility failed to provide privacy while toileting. Findings include: Review of the facility policy titled Dignity, dated April 2022, indicated that residents are treated with respect and dignity at all times. Further review indicated that residents are provided a dignified dining experience including while assisting at meal time. Further review indicated that staff are to promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care. 1a. Resident #50 was admitted to the facility in March 2022 with diagnoses including stroke, vision loss and diabetes. Review of the Minimum Data set assessment dated [DATE], indicated that resident #50 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderately impaired cognition. On 8/6/24, at 12:30 P.M. the surveyor observed Resident #50 sitting in the dining room with 3 other residents at a table. The surveyor then observed one of the residents at the table served their meal at 12:30 P.M. The surveyor then observed two of the residents served their meals at 12:43 P.M At 1:02 P.M., the surveyor then observed Resident #50 exit the dining room and asked the unit manager if she had a tray for him/her. The Unit Manager then delivered the tray to the Resident; 32 minutes after his/her tablemate was deliver their tray. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/6/24, at 12:48 P.M., Resident #50 said he/she was very hungry. Resident #50 then said he/she hates to watch his/her tablemate's eat while sitting and watching them. Resident #50 said that by the time he/she gets his/her meal, his/her tablemate's are done eating and he/she hates to eat alone. Resident #50 then said that the kitchen should put his/her tray on the cart with his/her tablemate's so they could all eat together. During an interview on 8/6/24, at 1:10 P.M., Nurse #6 said that the staff should serve all the residents sitting at one table at the same time. 1b. Resident #30 was admitted to the facility in June 2024 and has diagnoses that include dysphagia (difficulty chewing and swallowing), dementia, type two diabetes mellitus and protein calorie malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated that on the Brief Interview for Mental Status exam Resident #30 scored a 11 out of a possible 15, indicating moderate cognitive impairment. The MDS further indicated that Resident #30 requires supervision or touching assistance with eating. (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently). Review of the Nursing admission assessment dated [DATE] indicated the following: Supervision or touching assistance. Review of the current Activity of Daily Living (ADL) care plan, dated as created 6/26/24, was blank and did not indicate interventions or level of assistance needed. Review of the current nutrition care plan, dated as revised 8/3/24, indicated the following interventions: Observe diet texture tolerance and refer to SLP (speech) prn (as needed). Review of Resident #30's speech evaluation dated 6/12/24, indicated the following: -Dysphagia Advanced Soft + Bite Size -Supervision for Oral Intake = Occasional supervision -Standard aspiration precautions Review of Resident #30's current Resident ADL Guide/Kardex failed to indicate the level of care needed and was blank for all ADL care areas with no instructions for Resident #30. During an observation on 8/6/24 1:01 P.M., the surveyor observed Resident #30 sitting in the dining room with the lunch on a tray table directly in front of him/her. Certified Nursing Assistant (CNA) #2 walked up to Resident #30, while standing and picked up the grilled cheese sandwich and placed it up to Resident #30's mouth then turned around and walked across the dining room to another Resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:12 P.M., CNA #2 returned to Resident #30, picked up a cup of milk and without speaking to the Resident she placed the cup on Resident #30's lip to take a drink. Resident #30 took a sip from the cup and CNA #2 the placed the cup on the table and walked away from the Resident. During an interview on 8/6/24 at 1:37 P.M., CNA #2 said she is supposed to be seated at eye level when feeding residents and talking with him/her while providing assistance. During an interview on 8/7/24 at 12:46 P.M., Unit Manager #1 said staff should be seated at eye level when feeding residents and engaging with the residents. During an interview on 8/12/24 at 10:17 A.M., Corporate Nurse #1 said staff should not be standing while assisting with meals and should not walk away from residents. 2. On 8/6/24, at 8:45 A.M., and 12:24 P.M., the surveyor observed all residents in the dining room on the [NAME] unit being served on institutional trays. On 8/7/24, at 8:50 A.M., the surveyor observed all residents in the dining room on the [NAME] unit being served on institutional trays. On 8/8/24, at 9:00 A.M. the surveyor observed all residents in the dining room on the [NAME] unit being served on institutional trays. During an interview on 8/8/24, at 9:05 A.M., Certified Nurse's Aide #3 said that she was not aware that she was supposed to place the contents of the meal trays onto the table and remove the tray. 48671 3. Resident #86 was admitted to the facility in April 2021 and had diagnoses that include prostatic hyperplasia with lower urinary tract symptoms and anxiety. Review of the most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that on the Brief Interview for Mental Status exam Resident #62 scored a 5 out of possible 15, indicating severely impaired cognition. The MDS further indicated Resident #86 is incontinent of bowel and bladder and is dependent for toileting hygiene. Review of Resident #86's current Activity of Daily Living (ADL) care plan indicated the following interventions: Toilet use: assist. Grooming: assist to dependent Review of Resident #86's current incontinence care plan indicated the following interventions: Provide access to the bathroom. Provide verbal cues and physical assistance as needed. Assist (Resident) to the toilet at scheduled times i.e. upon rising, before meals, at HS (hour of sleep) and as needed. Review of Resident #86's current falls care plan indicated the following interventions: Provide verbal cures for safety and sequencing when needed. Monitor for and assist toileting needs. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/6/24 at 9:09 A.M., the surveyor observed Resident #86 say I need to pee pee now, to Certified Nursing Assistant (CNA) #2 in the hallway. CNA #2 was observed pushing Resident #86's wheelchair into his/her bathroom and stopped the wheelchair in front of the bathroom sink and walk out of the room. Resident #86 could be seen and heard from the hallway saying, Look at me I am all wet now how they hell can I do this? From 9:09 A.M., to 9:14 A.M., the surveyor observed CNA #2 walk in and out of Resident #86's room to obtain towels from the hall and return to the bathroom where Resident #86 was getting cleaned up and transferred to the toilet. Other Residents and staff were in the hallway and Resident #86 was visible with his/her pants down. During an interview on 8/8/24 at 11:45 A.M., Unit Manager #1, said staff should close the door and privacy curtain when proving care to ensure privacy and treat Residents with dignity. During an interview on 8/12/24 at 10:48 A.M., the Director of Nurses (DON) said staff should not be providing incontinence care without privacy because it is a dignity issue. During an interview 8/12/24 at 10:50 A.M., Corporate Nurse #1 said she expects all residents to have privacy when care is being provided.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interviews, the facility failed to obtain informed consents for psychotropic medications explaining the risks and benefits of treatment, prior to administering psychotropic medication for one Resident (#3) out of a sample of 46 residents. Findings include: Review of the facility policy titled Psychotropic Medication, revised 4/22, indicated an informed consent from the resident (or legally authorized individual in the case of resident incompetence) is required for administration of psychoactive medication. Resident #3 was admitted to the facility in January 2024 with diagnoses that included Alzheimer's disease, depression, and lymphedema. Review of Resident #3's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS indicated the Resident receives an antipsychotic medication and an antidepressant medication. Review of Resident #3's physician order, dated 2/22/24, indicated Sertraline (antidepressant medication) tablet 50 MG (milligrams) give one tab once a day. Review of Resident #3's physician order, dated 7/17/24, indicated Lorazepam (antianxiety medication) 2 mg/ml (milligrams per milliliter) Give 0.25 milliliter by mouth every 4 hours as needed. Review of Resident #3's physician order, dated 7/22/24, indicated Olanzapine (antipsychotic medication) 5 MG give one tab once a day. Review of Resident #3's medical record failed to indicate consent for the Sertraline, Lorazepam and Olanzapine was obtained. Review of Resident #3's August 2024 Medication Administration Record (MAR), indicated that the Sertraline 50 mg and Olanzapine 5 mg was given daily as ordered. During an interview on 8/9/24 at 1:05 P.M., Nurse #6 said if a resident is admitted on or has an new order for a psychotropic medication then the staff need to obtain consent prior to administering those medications. During an interview on 8/12/24 at 10:22 A.M., the Director of Nurses (DON) said the nursing staff must obtain written consent prior to administering any psychotropic medication.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observation, record review and interview, the facility failed to accommodate the needs of one Resident (#63) out of a total of 46 sampled residents. Specifically, the facility failed to provide a shower chair able to fit Resident #63, resulting in Resident #63 not receiving a shower since his/her admission. Findings include: Resident #63 was admitted to the facility in May 2024 with diagnoses including morbid severe obesity, type two diabetes, congestive heart failure, muscle weakness, localized edema, anemia in chronic kidney disease, and hereditary and idiopathic neuropathy. Review of Resident #63's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #19 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated the Resident had intact cognition. The MDS also indicated Resident #63 is dependent on staff for all functional tasks. Review of Resident #63's current Activity of Daily Living (ADL) care plan, last revised 6/4/24, indicated Resident #63 required assistance with toilet use, bed mobility, personal hygiene and turning/repositioning. During an interview on 8/7/24 at 8:02 A.M., Resident #63 told the surveyor that he/she has not had a shower in months, because the facility does not have a big enough shower chair and would like a shower. He/she said she has told numerous staff members including the Ombudsman and community care worker who has tried to talk with the staff. During an interview on 8/8/24 at 12:50 A.M., the Ombudsman approached the surveyor during a visit and reported that she has expressed her concerns regarding the need for a shower chair to accommodate Resident #63 and Resident #63 not having a shower in months, to the nursing staff and director of nursing numerous times with not resolution. Review of the social services progress note dated, 7/24/24, indicated the following: SW (social worker) f/u (follow up) Call from (community center contact) to discuss Resident's ongoing concerns regarding his/her care. SW was able to speak with (contact) and discuss a number of concerns that this Resident has, and IDT (interdisciplinary team) is aware, SW made (contact) aware that SW had already spoken with this Resident and IDT discussed plan of intervention in place in order to accommodate resident needs, IDT interventions currently in process at this time. No f/u (follow up) needed from SS. During an interview on 8/07/24 at 10:13 A.M. Nurse #2 said Resident #63 does not get out of bed and gets washed up by the staff in bed. During an interview on 8/7/24, at 10:15 A.M., Unit Manager #1 said he is not sure how the Resident takes a shower and said the facility should have a shower chair available for use if needed to shower. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 2:30 P.M., Corporate Nurse #1 said Resident #63 does not get out of bed but is unaware of how the Resident gets into the shower. Corporate Nurse #1 said the Resident has the right to have a shower and the facility needs to accommodate all residents. During an interview on 8/12/24 at 10:22 A.M., the Director of Nurses (DON) said she is not aware of any issues with the Resident not taking a shower and that she is unaware of any conversations with the Ombudsman regarding the issue. The DON said she does not know if the facility has a shower chair to accommodate Resident #63 because the Resident does not get out of bed. During an interview on 8/14/24 at 3:35 P.M., Occupational Therapist #1 (OT) said Resident #63 requires a large shower chair and accommodations due to his/her size and that she has never assessed him/her for a shower and does not know if the facility has a shower chair to accommodate the Resident. OT #1 said the Resident is able to transfer with the use of a hoyer lift into a chair and he/she should be able to have a shower. During an interview with on 8/14/24 at 4:58 P.M. with Additional Staff #4, she said she has worked with Resident #63 in the community for a long time and has ongoing concerns regarding the facility not meeting the Residents' needs with no shower and no shower chair. She also said she has voiced her concerns to the facility social worker multiple times without any follow up and with the prior administrator. She also said she has not heard back from the DON regarding the reported concerns.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review, policy review, and interview, the facility failed to ensure Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were consistently documented in the medical record for one Resident (#3), out of a total sample of 46 residents. Findings include: Review of the facility policy titled Advance Directives, revised April 1022, indicated: advanced directives will be respected in accordance with state law and facility policy. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The plan of care of each resident will be consistent with his or her documented treatment preferences and/or advance directive. Resident #3 was admitted to the facility in January 2024 with diagnoses that included Alzheimer's disease, depression, and lymphedema. Review of Resident #3's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS). The MDS further indicated that the Residents' advanced directives are a full code. Review of Resident #3's advanced directives care plan, dated 1/30/24, indicated code status: Full Code. Review of Resident #3's physician order, dated 4/11/24, indicated: Full Code. Review of Resident #3's Medical Orders for Life-Sustaining Treatment (MOLST), dated 2/28/24, indicated Do Not Resuscitate (DNR) and Do Not Intubate (DNI). Review of Resident #3's care plan meeting note, dated 4/22/24, indicated the Resident's family was unable to attend the meeting and advanced directives for the Resident are Full Code. During an interview on 8/9/24 at 1:06 P.M., Nurse #6 observed Resident #3's MOLST with the surveyor, Nurse #6 said that the MOLST says Resident #3 should be a DNR and a DNI. Nurse #6 then reviewed Resident #3's active physician orders with the surveyor, Nurse #6 said Resident #3 currently has a full code order in place. During an interview on 8/12/24 at 10:30 A.M., the Director of Nurses (DON) said if a MOLST is filled out reflecting a DNR and DNI then the doctors order should read the same as a DNR and DNI.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review, interview, and observation, the facility failed to notify the physician of changes in medical status for five Residents (#81, #42, #30, #99 and #78) of 46 sampled Residents. Specifically: 1. For Resident #78 the facility failed to ensure the physician was notified when: a.) pain medication was unavailable upon admission to the facility, and for the 19 hours following admission, resulting in worsening pain; and b.) when Resident #78's scheduled pain medication ran out, resulting in worsening pain. 2. For Resident #42 the facility failed to ensure the physician was notified when they were unable to fulfill an order to obtain a culture and sensitivity of a new wound for over a week from when the order was given. 3. For Resident #81, the facility failed to notify the physician or nurse practitioner that Resident #81 had a Stage 2 pressure wound on the left calf. 4. For Resident #30, the facility failed to notify the physician or nurse practitioner of deteriorating wounds and the recommendations of the wound nurse practitioner in a timely manner. 5. For Resident #99, the facility failed to ensure the physician was alerted to a skin injury. Findings include: According to the National Pressure Injury Advisory Panel, a Stage 2 Pressure Injury is defined as a partial-thickness skin loss with exposed dermis and may present as an intact or ruptured serum-filled blister. A Deep Tissue Injury (DTI) is defined as a persistent non-blanchable deep red, maroon or purple discoloration, intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. Resident #78 was admitted to the facility in May 2024 and has diagnoses that include contracture of muscle of right upper arm and Marfan Syndrome with Skeletal Manifestation. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/28/24, indicated that on the Brief Interview for Mental Status exam Resident #78 scored a 15 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #78 requires pain management on a scheduled basis as well as PRN (as needed), and that his/her pain was coded as almost constantly. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/6/24 at 9:01 A.M., with Resident #78 he/she said that he/she has had a terrible experience at the facility. Resident #78 explained that he/she has a diagnosis that causes significant pain and that the pain has not been managed by the facility. Resident #78 said I made a complaint to DPH after here a week (of being at the facility) and things have gotten progressively worse. Review of Resident #78's current Pain care plan indicated initiated on 6/4/24 indicated: Focus: Chronic pain due to contractures and Marfan's syndrome. Interventions include: Administer and monitor for effectiveness and possible side effects from: Routine pain medication. PRN (as needed) pain medication. See [Medication Administration Record] (MAR). Monitor and report to nurse: Signs and symptoms of pain. Worsening of pain. Report changes in pain location /type frequency intensity to physician. a.) Review of the Emergency Department documentation one day prior to Resident #78's admission to the facility indicated: Patient states that he/she has a history of Marfan's and with this does have chronic pain for which he/she uses a patch. The documentation also indicated that the patch was removed at the hospital on the date of transfer to the facility. The discharge orders from the hospital to the facility included the following orders for pain management: Fentanyl 100 Mcg/hr, apply 2 patches every 72 hours. Review of the May 2024 MAR indicated that Resident #78 first had the Fentanyl 100 mcg/hr patch applied on 5/25/24 at 4:15 P.M.; nearly 19 hours after admission to the facility. Review of the record indicated a progress note dated 5/25/24 at 8:45 A.M., approximately 12 hours after the Resident's admission to the facility: Writer this morning found a resident agitated, crying and stated he/she does not feel good because since yesterday he/she came haven't received any medication, sated (sic) that in pain and requesting to be transferred back to hospital, writer called pharmacy to request start orders of Dilaudid and Fentanyl patch because patient stated that he/she is in pain, Pharmacy phones goes to voice mail for 4 times, On call supervisor notified the situation, in about 30 minutes resident called 911 and taken back to hospital. (sic) Review of the Narcotic book indicated that all of Resident #78's admission medications, including the Fentanyl 100 mcg/hl patch were received from the pharmacy on 5/25/24 at 3:20 P.M.; nearly 18 hours after Resident #78's admission to the facility. Review of the facility's MedWiz (an emergency medication supply system for medications not in stock) report failed to indicate the system was accessed to provide any pain medication for Resident #78 on 5/24/24 or 5/25/24. The record failed to indicate that the Physician was notified that the pain medication was unavailable. During an interview on 8/12/24 at 8:35 A.M., with the Director of Nursing (DON) and Corporate Nurse #1, Corporate Nurse #1 said that the admitting nurse should have discussed with the MD what they should provide the resident for pain management coverage until the Resident's medication is available and that this should be documented in the clinical record. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	b.) Review of the August 2024 Physician orders included the following orders: Fentanyl Transdermal Patch 72 hours 100 MCG/HR (Fentanyl) Apply 2 patch transdermally every 72 hours for pain and remove per schedule. Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) Apply 1 patch transdermally every 72 hours for chronic pain Apply together with the two 100 mcg/hr patches. For total dose of 212 mcg/hour of Fentanyl and remove per schedule. Pain assessment Q (each) shift using pain scale 1-3 Mild Pain, 4-6 Moderate pain, 7-9 Severe Pain, 10 Very severe pain During an observation and interview on 8/7/24 at 12:06 P.M., Resident #78 was observed in bed with his/her right upper arm exposed. 2 patches were applied to the right upper arm that were dated 8/6/24, 7-3. Resident #78 voiced being upset and in pain and presented with significant facial grimacing. Resident #78 said that he/she is supposed to have three pain patches applied but that the facility ran out of one of them yesterday. Resident #78 said that last night the nurses said they had to order more patches from the pharmacy and that they should be in by midnight last night. Resident #78 said that the patches never came in last night and that the nurse today said they are still waiting for the pain patches to come in from the pharmacy. Review of the August 2024 Medication Administration Record (MAR) indicated the following: -The order for Fentanyl Transdermal Patch 72 hours 100 MCG/HR (Fentanyl) Apply 2 patch transdermally every 72 hours for pain was administered on 8/6/24. -The order for Fentanyl Transdermal Patch 72 hours 100 MCG/HR (Fentanyl) Apply 1 patch transdermally every 72 hours was blank. There was no progress note to indicate why the medication was not administered as ordered. -The most recent pain assessed on the 7-3 shift on 8/7/24 indicated Resident #78 reported a pain level of 5. Review of the clinical progress notes failed to indicate the Physician was notified that the Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) patch was not administered as ordered on 8/6/24 or that alternate pain management was provided. During an interview with Nurse #1 on 8/7/24 at 1:00 P.M., she verified that the facility had run out of Resident #78's Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) patch and that it was not available for application as ordered on 8/6/24. Nurse #1 said the following: -The nurse on each shift is responsible to monitor their medication supply and when they are low to reorder it through the computer system. -If it is a narcotic that needs to be refilled it is the nurse's responsibility to notify the MD who will send a prescription directly through the system to the pharmacy and that the Physician's at the facility were very good about doing this. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	-If a medication is not available the nurse must notify the MD and write a note. In Resident #78's case she said the note should indicate the MD's plan for pain management while waiting for the needed medication to come in from the pharmacy. -Resident #78's Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) patch came in last night (8/6/24) but that the night nurse didn't give it and she did not know why. -Nurse #1 said that she did not apply the Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) patch that day and planned to ask the Director of Nursing if it was okay to apply it late, but had not yet had a chance to try to speak with her that day. Nurse #1 said she did not notify the physician. -Resident #78 reported to her that his/her was a 5 on a scale of 1-10 that day. Nurse #1 said that Resident #78 is probably reporting that his/her pain level is a 10 now because of the patch not being on. During an Interview on 8/7/24 at 1:24 P.M., with the facility's Corporate Nurse #1 she would have expected the MD to notified yesterday when the pain patch was not available, a progress note written about the medication not being applies and what the MD wanted to do to address pain pending receipt of the patch. 2. For Resident #42 the facility failed to ensure the physician was notified when they were unable to fulfill an order to obtain a culture and sensitivity of a new wound for over a week from when the order was given. Resident #42 was admitted to the facility in July 2022 and has diagnoses that include Multiple Sclerosis and chronic venous hypertension (Idiopathic) with ulcer of right lower extremity. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/10/24, indicated that on the Brief Interview for Mental Status exam Resident #42 scored a 15 out of 15, indicating intact cognition. The MDS further indicated Resident #42 had no wounds or skin issues. Review of the clinical record indicated the following: -A nurses note dated 7/26/24: Area skin flaking and moist with pus filled skin to RLE (history of areas). New order to obtain wound C&S, NSW, pat dry, apply Bacitracin and cover with DPD until healed. -A Nurse Practitioner Progress note, dated 7/30/24, indicated: Chronic venous ulceration on right lower extremity, protein-calorie malnutrition, generalized muscle weakness. Noted on the patient's right lower extremity are multiple scattered shallow ulcerations with irregular borders. Some areas are reddened with granulation tissue and others are with slough, none tunneling, with large amounts of serous drainage, mild odor (a deterioration from 7/26/24). Wound culture ordered, Venous Doppler Ultrasound. Continue health supplements. Continue daily dressing changes with NS and wrap with kerlix. We will order topical after results of wound culture is available. Review of the July 2024 Medication Administration Record (MAR) indicated the following order: Obtain wound C & S RLE wound. Start date 7/26/24 at 15:00. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	-A nurses note dated 8/4/24 indicated the C&S was obtained on 8/04/24, 10 days after the order was initially ordered. -A nurses note dated 8/8/24: Wound C&S results had come back and Resident #42 was positive for the following infection in the wound: + Proteus Mirabilis and Staphylococcus. During an interview with the Nurse #4 on 8/12/24 11:42 A.M., she said that she was the nurse that initially obtained the order to get a C&S but that the facility had run out of the kits that are provided by the lab. Nurse #4 said that the kits were delivered the end of the next week. She said that she should have notified the MD and written a progress note when she was unable to fulfill the MD order, but did not. The record failed to indicate that the MD/NP were notified that the kits were unavailable and that therefore the facility was unable to obtain the C&S for Resident #42's new wound. During an interview on 8/12/24 at 12:21 P.M., the Director of Nursing (DON) said that the MD should have been notified they could not fulfill an order when they were unable to obtain the C&S of a new wound as ordered by the MD. 15016 3. Resident #81 was admitted to the facility in May 2021 and had a primary diagnosis of stroke. Review of Resident #81's Minimum Data Set Assessment (MDS) dated [DATE], indicated a Brief Interview for Mental Status score of 1 of 15 points, indicating severe cognitive impairment. The MDS indicated that Resident #81 is dependent on staff for all bed mobility and requires substantial assistance for all other activities of daily living. The MDS also indicated was at-risk for pressure injuries but had no skin wounds. The Resident required pressure relieving devices for the bed and chair. Review of the facility's policy Pressure Ulcer/Injury Risk assessment dated as revised 3/20/22, indicated the following information should be recorded in the resident's medical record utilizing facility forms. This included but was not limited to: Notify attending MD if new skin alteration noted. Documentation in the medical record addressing MD notification if new skin alteration noted with change of plan of care, if indicated. According to the National Pressure Injury Advisory Panel, a Stage 2 Pressure Injury is defined as a partial-thickness skin loss with exposed dermis and may present as an intact or ruptured serum-filled blister. A Deep Tissue Injury (DTI) is defined as a persistent non-blanchable deep red, maroon or purple discoloration, intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. Resident #81's care plan dated as revised 6/19/24, indicated: Focus: He/she was at-risk for skin breakdown due to decreased mobility and incontinence, staying in his chair for longer periods and refusing to go to bed. The care plan indicated, 3/23/24 multiple scabs to both legs- open to air. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Goal: The resident will not show signs of skin breakdown x 90 days. Interventions: - Independent bed mobility. - Monitor scabs on bilateral lower extremities and report changes to MD. - Pat (do not rub) skin when drying. - Provide preventative skin care i.e. lotions, barrier creams as ordered. - Apply barrier cream with each cleansing. - Resident at-risk for skin breakdown due to decreased mobility and incontinence, staying in his/her chair for longer periods and refusing to go to bed. Review of Resident #81's skin observation tool record dated 7/18/24, indicated he/she had no wounds or pressure areas. Review of Resident #81's physician orders and notes and nursing notes dated prior to 8/8/24, did not indicate he/she had a skin wound. On 8/8/24 at 2:10 P.M., the surveyor and Nurse #9 observed that Resident #81 had a 1 centimeter (cm) x 1 cm open wound located on the left calf. There was a small amount of serosanguinous drainage. A dressing or other treatment was absent. Nurse #9 said this was a Stage 2 pressure ulcer because of its depth and the skin around the wound was erythematous. Nurse #9 said she would contact the physician to report the wound and obtain treatment orders. On 8/8/24 at approximately 2:20 P.M., Corporate Nurse #1 accompanied the surveyor and observed Resident #81's calf wound. Corporate Nurse #1 said this was only a scab and it did not need to be reported to the physician because no treatment was required. On 8/8/24 at 2:35 P.M., two surveyors, accompanied by Unit Manager #1, observed Resident #81's calf wound. Unit Manager #1 said the wound was a Stage 2 pressure injury due to its depth and surrounding erythema. Unit Manager #1 said he was unaware of the wound until now. Unit Manager #1 said he would notify NP #2 about the wound and obtain treatment orders. Review of Resident #81's skin assessment dated [DATE] and completed at 11:02 P.M. by Corporate Nurse #1 indicated: Wound 1 x 1 cm to the rear left lower leg, treatment applied. The assessment did not indicate the depth of the wound, type of treatment or if the physician or NP #2 was notified about the wound. On 8/9/24 at approximately 8:15 A.M., 8:57 A.M. and 10:50 A.M., the surveyor observed Resident #81 in the dining room sitting in a chair and his/her calf wound was exposed without a dressing. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #81's medical record on 8/9/24 at approximately 8:50 A.M., indicated there was no documentation to indicate Nurse #9, Unit Manager #1, Corporate Nurse #1, or any other staff notified the physician or NP #2 about the Resident's calf wound. On 8/9/24 at 12:50 P.M., the surveyor telephoned NP #2 to determine if she was aware of Resident #81's calf wound. A voice mail message was left but as of 8/15/24 there was no call back. On 8/9/24 at 1:00 P.M., the surveyor observed Resident #81 in the dining area, sitting in a chair. The Resident's left calf was exposed and there was no dressing covering the open wound. During an interview with the DON and Corporate Nurse #1 on 8/9/24 at 1:15 PM., the surveyor told them that Resident #81's skin assessment dated [DATE] indicated a 1 cm x 1 cm wound on the left lower leg and that a treatment was applied. The surveyor told them there was no documentation in the record to indicate staff notified the physician or NP #2 about Resident #81's calf wound. Corporate Nurse #1 said she telephoned the physician during the night of 8/8/24 and notified him that Resident #81 had a scab on the left calf. Corporate Nurse #1 said the physician told her to only apply skin prep because it was not an open wound. Corporate Nurse #1 said she forgot to document the conversation and treatment order. On 8/9/24 at 1:20 P.M., the DON and surveyor observed Resident #81's calf wound. The DON said this was either a Stage 2 or an unstageable wound and not a scab. The DON said the skin surrounding the wound was purple and the wound had signs of drainage. The DON said skin prep was not an appropriate treatment for the wound and that it should be covered with a medicated dressing to encourage healing and prevent infection. The DON said staff had not made her aware of the wound. She said she would immediately notify NP #2 about the wound and obtain treatment orders. 36797 4. Resident #30 was admitted to the facility in June 2024 with diagnoses including schizoaffective disorder bipolar type, dementia and heart failure. Review of the Minimum Data Set Assessment (MDS) dated [DATE], indicated that Resident #30 scored a 10 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. Further review indicated that Resident #30 requires substantial to maximal assistance with all activities of daily living. Review of the facility document titled SKIN OBSERVATION TOOL - (Licensed Nurse) - V 4 dated 7/2/24, indicated that Resident #30's skin was intact. Review of the Nurse Practitioner (NP) #1 note dated 7/9/24, indicated a new stage one pressure area to right lateral heel measuring 2.0 CM x 1.5 CM (centimeters). Further review indicated a new order for skin prep to heels, Prevalon boots and to off load both heels. Review of the facility document titled SKIN OBSERVATION TOOL - (Licensed Nurse) - V 4 dated 7/10/24, indicated that Resident #30's right heel now has an intact blister. (stage 2 pressure ulcer, a deterioration) (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Review of NP #1's notes dated 7/11/24 failed to indicate she had been notified of the wound deteriorating or that she assessed Resident #30's wound. There is no documentation to support she is aware the stage one is now a blister. Review of Physician #1's notes dated 7/12/24, failed to indicate he was aware of the pressure area on the right heel. There is no documentation to support he is aware of the blister on Resident #30's right heel. On 8/8/24 at 9:26 A.M., the Director of Nursing (DON) said that it is the expectation for the nurse practitioner or doctor to be notified of a deteriorated pressure area. 36876 5. Resident #99 was admitted to the facility in August 2023 with diagnoses including Alzheimer's disease, dysphagia and legal blindness. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #99 scored 3 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating severe cognitive impaired. The MDS also indicated Resident #99 requires assistance with bathing, dressing and transfers. Review of the nurse progress note dated 6/30/2024 indicated: CNA (Certified Nursing Assistant) informed this nurse of an old scab on the left upper extremity discovered not intact and opened. Area cleansed, bacitracin antibiotic ointment applied, and covered with bordered dressing. The clinical record failed to indicate the physician was notified and orders were obtained to provide treatment to Resident #99's skin injury. Review of the physicians note dated 7/11/24 indicated: Skin tear of left elbow without complication Unclear when this initially occurred, however old steri strips present on two locations of L (left) elbow removed. Some pain on palpation, no signs of infection. Wound care orders placed: QOD dleanse (sic) with normal saline, pat dry, apply bacitracin, cover with bordered gauze. During an interview on 8/8/24 at 11:26 A.M., Physician #2 said he was not aware of a skin injury to Resident #99's arm until he observed it on 7/11/24. Unit Manager #2 was unavailable for interview. During an interview on 8/8/24 at 12:15 P.M., Nurse #7 said on 6/30/24, a CNA alerted her that Resident #99 had an injury on his/her arm so she provided treatment. Nurse #7 said she is a new nurse and did not call the physician to alert him about Resident #99's arm because she didn't know she needed to. During an interview on 8/12/24 at approximately 12:30 P.M., the Director of Nursing (DON) said that the expectation is for nurses to communicate with the physician regarding changes in resident skin condition. Ref. F658, F684, F686, F697

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 36797 Based on record review and interview the facility staff failed to inform two out of three residents reviewed, or their representatives, with potential liability for payment for non-covered services including estimated cost of services received while accessing their Medicare benefit. Findings include: The Advanced Beneficiary Notice (SNFABN) is a form which provides information to Residents and/or their beneficiaries to decide if they wish to continue receiving the skilled services they are receiving at the facility that may not be paid for by Medicare and assume financial responsibility for these services. Review of the facilities' SNFABN form failed to include the cost of rehab services for two of three applicable residents. During an interview on 8/7/24, at 2:40 P.M., The Minimum Data Set Nurse said the cost indicated on the form was for room and board and did not include skilled services, such as rehab.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observation, record review, and interview, the facility failed to protect three Residents (#5, #63, and #10) from abuse and neglect out of a total sample of 46 residents. Specifically: 1. For Resident #5, (who is cognitively impaired), the facility failed to ensure he/she was free from abuse, when the surveyor witnessed a staff member squeeze Resident #5 cheeks and force feed medications. Using the reasonable person concept, this would result in emotional distress. 2. For Resident #63 and #10, the facility failed to ensure they were free from neglect after staff failed to provide incontinence care for 17 hours, resulting in the development of a new pressure ulcers. Findings include: Review of the facility's policy titled Abuse Prohibition dated 7/1/13, and revised 10/24/22, indicated the following: To ensure that center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients. Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injury of unknown origin, or misappropriation of patient property, must also report to outside agencies, if required. Injuries of unknown origin will be investigated. If abuse or neglect is suspected, report allegations to the appropriate state and local authorities involving neglect, exploitation, or mistreatment, including injuries of unknown source, suspected criminal activity, and misappropriation of patient property, no later than two hours after the allegation is made if the event results in serious bodily injury. Report allegations to the appropriate state and local authorities involving neglect, exploitation, or mistreatment, including injuries of unknown source, suspected criminal activity, and misappropriation of patient property within 24 hours, if the event does not result and serious bodily injury. Provide subsequent reports to the department as often as necessary to inform the department of significant changes in the status of affected individuals or changes in material facts originally reported. Initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse or neglect occurred, and to what extent. Interventions implemented to prevent further injury. The investigation will be thoroughly documented within risk management portal. Failure to report in the required time frames may result in disciplinary action up to and including termination. 1. Resident #5 was admitted to the facility in March 2023 with diagnoses including dementia, selective mutism, heart failure, diabetes, and major depressive disorder. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #5's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #5 was unable to complete a Brief Interview for Mental Status (BIMS) assessment due to impaired cognition. The MDS also indicated Resident #5 requires assistance with Activities of Daily Living tasks. During an observation on 8/7/24 at 8:30 A.M., the surveyor observed Nurse #3 attempting to administer oral medications to Resident #5 in the dining room during the breakfast meal while other residents were present in the dining room. The surveyor observed Nurse #3 holding a plastic spoon containing whole pills and attempting to place them into Resident #5's mouth. Nurse #3 was not engaging with the Resident and at no time during the observation did Nurse #3 explain what she was doing or attempt to communicate with Resident #5. Nurse #3 was observed squeezing Resident 5's cheeks and attempting to pry open his/her lips with the plastic spoon. The Resident continued to keep his/her mouth closed and the Nurse continued to push the spoon into his/her mouth while squeezing the Resident's cheeks in an attempt to force open his/her mouth. The Resident was pulling back and Nurse #3 continued to squeeze the Residents cheeks. The Resident was observed with one large white oval pill hanging out of his/her mouth, the pill then fell out of the Residents' mouth and back on to the spoon. Review of Resident #5's medical record failed to indicate any nursing notes prior to 8/7/24 that indicated this was typical behavior during medication administration for Resident #5 and there were no documented refusals of medication or care. Review of Resident #5's behavior care plan dated as revised on 8/6/24, indicated the following interventions: Explain care to resident in advanced, in terms resident understands. Review of Resident #5's communication care plan dated as revised on 10/25/23, indicated the following interventions: Speak in normal tone voice clearly and slowly. Provide preferred (aka, primary) language interpreter services such as language line as indicated. Gain attention and eye contact before speaking to the resident/patient. Break tasks down into smaller steps. Review of Resident #5's activities care plan dated as revised on 1/19/24, indicated the following: (The Resident) is Italina (sic) speaking. I would benefit from accommodation for cognitive limitation by using demonstration, reminders, physical prompts, single step activity, time limited, verbal prompts and/or personalized/individual engagement. During an interview on 8/7/24 at 8:30 A.M., Nurse #3 said she was not familiar with the Resident and she was unsure if the Resident requires medication crushed or whole. Nurse #3 said the Resident was refusing to take the medication and that he/she has an appointment at 9:00 A.M. Nurse #3 said that the Resident needed to take the medication, so she squeezed his/her cheeks open. Nurse #3 said she should have asked the Resident if she could administer the medication and said she should not have squeezed the Residents cheeks to make him/her open his/her mouth. During an interview on 8/7/24 at 9:28 A.M., Unit Manager #1 said Nurse #3 should not squeeze the Residents cheeks or try to open the Residents mouth with the spoon during medication administration and that Nurse #3 should communicate with the Resident appropriately. Unit Manager #1 said forcing a resident to take medications is abuse and that he was going to report this to administration right away. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/7/24 at 10:50 A.M., Corporate Nurse #1 said Nurse #3 should not be squeezing any Residents cheeks or forcing a resident to take oral medications. Corporate Nurse #1 said Nurse #3 was removed immediately from the unit. During an interview on 8/12/24 at 10:27 A.M., The Director of Nursing (DON) said Nurse #3 was removed from the schedule and that the nurse should not have squeezed the residents' cheeks to try to force medications into his or her mouth. Based on the reasonable person concept, a person who is cognitively impaired and unable to understand or verbalize refusal, would experience emotional distress being physically forced to accept medications. 2. Resident #63 was admitted to the facility in May 2024 with diagnoses including morbid severe obesity, type two diabetes, congestive heart failure, muscle weakness, localized edema, anemia in chronic kidney disease, and hereditary and idiopathic neuropathy. Review of Resident #63's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #19 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated the Resident had intact cognition. The MDS also indicated Resident #63 is dependent on staff for all functional tasks. Review of the current care plan, included the following focuses: a. Skin Integrity- with interventions including; -Protective skin care with incontinent care. -Turn and reposition every 2-3 hours and PRN. b. Activity of Daily Living (ADL) care plan- with interventions including; -Assistance with toilet use, bed mobility, personal hygiene, and turning/repositioning. c. Incontinence care plan, last revised 5/30/24, indicated the following interventions: -Brief worn, change every 2-3 hours and PRN. Review of Resident #63's current Activity of Daily Living (ADL) care plan, last revised 6/4/24, indicated Resident #63 required assistance with toilet use, bed mobility, personal hygiene and turning/repositioning. Review of Resident #63's Kardex (a form indicating the level of assistance a resident requires) indicated Resident #63 is always incontinent. The Kardex failed to indicate the level of assistance required. On 8/8/24, at 1:50 P.M., the surveyor observed Resident #63 lying in bed. The Resident said his/her incontinent brief had not been changed since 9:00 P.M. the night before, (a total of 17 hours since his/her brief was change), and that he/she was wet and uncomfortable. (continued on next page)

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Regalcare at Glen Ridge	120 Murray Street Medford, MA 02155

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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 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/8/24 at 1:58 P.M., Corporate Nurse #1, Corporate Nurse #2 and Nurse #9 observed the Resident laying in bed. Corporate Nurse #1 removed the blankets to provide incontinence care. The Resident was observed wearing two incontinent briefs. Corporate Nurse #1 asked the Resident why he/she was wearing two incontinent briefs and the Residents said, I ask them to put two on me because no one comes and changes me. Resident #63 said the last time he/she was provided incontinence care or was repositioned occurred the night before at 9:00 P.M. Corporate Nurse #2 and Nurse #9 turned the Resident on to his/her left side and removed the two incontinence briefs. The two incontinence briefs were soaking wet with dark yellow, foul-smelling urine and contained pink, red, and brownish spots of discoloration throughout the brief, along the coccyx and buttocks area. The Resident had dried feces on his/her skin along the coccyx and buttocks area as well with excoriation throughout the buttock. The surveyor also observed a shallow open ulcer with red wound bed, bloody drainage and slough on the left buttock, a shallow open ulcer with red wound bed, bloody drainage and slough on the posterior thigh, and intact skin with localized area of persistent non-blanchable erythema and maroon discoloration on the coccyx. Corporate Nurse #1 said the Resident has three Stage II wounds. (In spite of slough being present in the wounds indicating wounds are a stage III). During an interview on 8/8/24, at 2:00 P.M., CNA #4 said that Resident #63 had not been provided incontinent care because Resident #63 required an assist of two people to turn and reposition and there was not enough staff to care for all 24 residents on the unit. Review of the facility document titled Documentation Survey Report v2 (Activities of Daily Living (ADL) documentation sheet), dated August 2024, indicated Resident #63 was dependent on staff for toileting, and incontinent of bowel and bladder. Further review failed to indicate that ADL care was provided during the following shifts: On 8/7/24, 7:00 A.M. to 3:00 P.M. On 8/7/24, 11:00 P.M. to 7:00 A.M. On 8/8/24, 7:00 A.M. to 3:00 P.M. On 8/8/24, 3:00 P.M. to 11:00 P.M. During an interview on 8/8/24 at 2:30 P.M., Corporate Nurse #1 said the expectation of the facility is that incontinent residents be toileted every two hours and as needed. During an interview on 8/8/24 at 2:48 P.M., Unit Manager #1 said Residents who require incontinence care and turning and repositioning are at risk for skin breakdown and should not be left sitting in urine without care. During an interview on 8/12/24 at 10:19 A.M., the Director of Nurses (DON) said it is her expectation that staff reposition residents and provide incontinence care every two hours. 36797 3. Resident #10 was admitted to the facility in July 2024 with diagnoses including pain, spinal stenosis and osteoarthritis. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #10 scored a 15 out of 15 on the Brief Interview for Mental Status, indicating intact cognition. Further review indicated that Resident #10 is totally dependent on staff for toileting needs and is always incontinent of bowel and bladder. Review of the care plan dated 7/31/24, indicated that Resident #10 is dependent on staff for toileting needs. During an observation on 8/8/24, at 2:00 P.M., Resident #10 said that his/her incontinent brief had not been changed since 9:00 P.M. the night before, (a total of 17 hours without receiving incontinence care.) The surveyor and Unit Manager #1 observed Resident #10 laying in bed in a saturated incontinent brief. The surveyor and Unit Manager #1 observed the incontinent brief to be saturated and the color of the contents to be a dark reddish brown, with a strong smell of stale urine. Unit Manager #1 said that he could tell that there was no feces present but was concerned about the dark color of the urine. Unit Manager #1 said that Resident #10 should have had his/her incontinent brief checked and changed as needed but at least every two to three hours. He then said that he could tell that it had been many hours since the incontinent brief had been changed. Unit Manager #1 said that with the number of residents on the unit that require an assist of two staff members to provide care, one Certified Nurse's Aide (CNA) and one nurse is not enough to get the job done. The surveyor and Unit Manager #1 then observed a non-blanchable area on the coccyx measuring 7L cm x 2W cm (centimeters). Unit Manager #1 said that the non-blanchable area on the coccyx was a stage one pressure area and was new. Unit Manager #1 said that leaving a resident in a saturated incontinent brief for an extended period of time could lead to skin breakdown. During an interview on 8/8/24, at 2:00 P.M., CNA #4 said that Resident #10 had not been provided incontinent care because Resident #10 required an assist of two people to turn and reposition and there was not enough staff to care for all 24 residents on the unit. During an interview on 8/12/24, at 12:40 P.M., the Corporate Nurse said that not providing incontinent care to an incontinent resident for 17 hours is considered neglect. Ref. F609, F610, F677, F725

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, interviews and records reviewed, the facility failed to identify and assess the use of pillows under the fitted sheet as a potential restraint for one Resident (#23) out of a total of 46 sampled residents. Findings include: Review of the facility policy titled, Use of Restraints dated as revised April 2022, indicated the following: -Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. -Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience or for the prevention of falls. -Physical restraints are defined as any manual method or physical or medical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove, which restricts freedom of movement or restricts normal access to one's body. -Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. -Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). Resident #23 was admitted to the facility in April, 2019 with diagnoses including Alzheimer's disease, dementia, aphasia, peripheral vascular disease, and depression. Review of the Minimum Data Set Assessment (MDS) dated [DATE], indicated Resident #23 was unable to complete a Brief Interview for Mental Status (BIMS) assessment due to impaired cognition. On 8/6/24 at 8:03 A.M., Resident #23 was observed sleeping in bed, two pillows were stuffed and built up under the fitted sheet going the length of the mattress on both sides of the Resident. On 8/6/24 at 8:35 A.M., Resident #23 was observed sleeping in bed, two pillows were stuffed and built up under the fitted sheet going the length of the mattress on both sides of the Resident. Review of the care plan evaluation progress note dated 9/22/23 indicated the following: Resident no longer use pillows as restraint (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's medical record failed to indicate a restraint assessment had been completed, failed to indicate a physician order for use of restraint, failed to indicate consent for restraint use and failed to indicate a care plan for a restraint. During an interview on 8/7/24 at 8:37 A.M., Nurse #2 and the surveyor observed Resident #23 sleeping in bed, two pillows were stuffed and built up under the fitted sheet going the length of the mattress on both sides of the Resident. Nurse #2 observed the pillows and lifted the sheet up exposing the pillows and said the pillows are there because the Resident can pull his/her legs over the sides. Nurse #2 said if the pillows are not in place, he/she will get out of bed and fall. Nurse #2 said the pillows are not a restraint because the Resident will try to put his/her legs over the edge and it prevents her from falling. During an interview on 8/7/24 at 10:01 A.M., Unit Manager #1 and the surveyor observed Resident #23 sleeping in bed, two pillows were stuffed and built up under the fitted sheet going the length of the mattress on both sides of the Resident. The Unit Manager said the pillows are a restraint and we do not put pillows under residents, we get proper mattresses and complete side rails assessments. Unit Manager #1 said, the pillows should not be under the sheet, because it prevents the Resident from putting his/her legs over the edge. During an interview on 8/7/24 at 12:38 P.M., the Corporate Nurse #1 said Residents require a restraint assessment and pillows or blankets should not be placed under the fitted sheet. During an interview on 8/12/24 at 10:17 A.M., the Director of Nursing (DON) said blankets and pillows should not be placed under fitted sheets because it is a restraint. The DON said residents should be assessed for restraints and blankets and pillows could be considered a restraint if they prevent a resident from getting out of bed by restricting movement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to effectively carry out their abuse policy related to the reporting of an alleged abuse for one Resident (#78) out of a total sample of 25 residents. Findings include: Review of the facility policy titled Abuse: Investigation, dated March 2022, indicated the following: - The facility will investigate all alleged/potential incidents of resident abuse, neglect, mistreatment, injuries of unknown etiology, and misappropriation of property. Resident #78 was admitted in May 2024 with diagnoses including depression and anxiety. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #78 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the progress note, dated 9/17/24, indicated the following: Resident #78 reported to this nurse that she is going to go home and kill herself by taking all of his/her medicine. He/She said that the conditions of this place make him/her want to kill him/herself every day and that he/she is getting beaten up by staff everyday when he/she gets changed. notified DON, admin and NP, awaiting orders. During an interview on 9/24/24 at 11:46 A.M., the Director of Nursing said that she was not made aware of the alleged abuse and would have expected to be notified so she could initiate an investigation and report the incident to the state agency.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview, the facility failed to report allegations of neglect related to the provision of incontinence care to the state agency as required for two Residents (#10 and #63) out of a total of 46 sampled residents. Findings include: Review of the facility's policy titled Abuse Prohibition dated 7/1/13, and revised 10/24/22, indicated the following: To ensure that center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients. Report allegations to the appropriate state and local authorities involving neglect, exploitation, or mistreatment, including injuries of unknown source, suspected criminal activity, and misappropriation of patient property within 24 hours, if the event does not result in serious bodily injury. Provide subsequent reports to the department as often as necessary to inform the department of significant changes in the status of affected individuals or changes in material facts originally reported. 1. Resident #10 was admitted to the facility in July 2024 with diagnoses including pain, spinal stenosis and osteoarthritis. Review of the Minimum Data Set Assessment (MDS) dated [DATE], indicated that Resident #10 scored a 15 out of 15 on the Brief Interview for Mental Status, indicating intact cognition. Further review indicated that Resident #10 is totally dependent on staff for toileting needs and is always incontinent of bowel and bladder. Review of the care plan dated 7/31/24, indicated that Resident #10 is dependent on staff for toileting needs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/8/24, at 2:00 P.M., Resident #10 said that his/her incontinent brief had not been changed since 9:00 P.M. the night before; (a total of 17 hours of not receiving incontinence care). The surveyor and Unit Manager #1 observed Resident #10 laying in bed in a saturated incontinent brief. The surveyor and Unit Manager #1 observed the incontinent brief to be saturated and the color of the contents to be a dark reddish brown, with a strong smell of stale urine. Unit Manager #1 said that he could tell that there was no feces present but was concerned about the dark color of the urine. Unit Manager #1 said that Resident #10 should have had his/her incontinent brief checked and changed as needed but at least every two to three hours. He then said that he could tell that it had been many hours since the incontinent brief had been changed. Unit Manager #1 said that with the number of residents on the unit that require an assist of two staff members to provide care, one Certified Nurse's Aide (CNA) and one nurse is not enough to get the job done. The surveyor and Unit Manager #1 then observed a non-blanchable area on the coccyx measuring 7L cm x 2W cm (centimeters). Unit Manager #1 said that the non-blanchable area on the coccyx was a stage one pressure area and was new. Unit Manager #1 said that leaving a resident in a saturated incontinent brief for an extended period of time could lead to skin breakdown. During an interview on 8/8/24, at 2:00 P.M., CNA #4 said that Resident #10 had not been provided incontinent care because Resident #10 required an assist of two people to turn and reposition and there was not enough staff to care for all 24 residents on the unit. During an interview on 8/12/24, at 12:40 P.M., the Corporate Nurse said that not providing incontinent care to an incontinent resident for 17 hours is considered neglect. She said that she did not report the neglect to the state agency. 48671 2. Resident #63 was admitted to the facility in May 2024 with diagnoses including morbid severe obesity, type two diabetes, congestive heart failure, muscle weakness, localized edema, anemia in chronic kidney disease, and hereditary and idiopathic neuropathy. Review of Resident #63's most recent Minimum Data Set Assessment, dated 5/29/24, indicated Resident #63 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated the Resident had intact cognition. The MDS also indicated Resident #63 is dependent on staff for all functional tasks. During an observation on 8/8/24, at 1:50 P.M., Resident #63 was observed laying in bed. The Resident said his/her incontinent brief had not been changed since 9:00 P.M. the night before, (a total of 17 hours without incontinence care) and that he/she was wet and uncomfortable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 1:58 P.M., Corporate Nurse #1, Corporate Nurse #2 and Nurse #9 observed the Resident laying in bed. Corporate Nurse #1 removed the blankets to provide incontinence care. The Resident was observed wearing two incontinent briefs. Corporate Nurse #1 asked the Resident why he/she was wearing two incontinent briefs and the Residents said, I ask them to put two on me because no one comes and changes me. Resident #63 said the last time he/she was provided incontinence care or was repositioned occurred the night before at 9:00 P.M. Corporate Nurse #2 and Nurse #9 turned the Resident on to his/her left side and removed the two incontinence briefs. The two incontinence briefs were soaking wet with dark yellow, foul-smelling urine and contained pink, red, and brownish spots of discoloration throughout the brief, along the coccyx and buttocks area. The Resident had dried feces on his/her skin along the coccyx and buttocks area as well with excoriation throughout the buttock. The surveyor also observed a shallow open ulcer with red wound bed, bloody drainage and slough on the left buttock, a shallow open ulcer with red wound bed, bloody drainage and slough on the posterior thigh, and intact skin with localized area of persistent non-blanchable erythema and maroon discoloration on the coccyx. Corporate Nurse #1 said the Resident has three Stage II wounds. (In spite of slough being present in the wounds indicating wounds are a stage III). During an interview on 8/8/24 at 2:24 P.M., Corporate Nurse #2 said Residents should be turned and repositioned, and provided incontinence care every two hours. Corporate Nurse #2 said open skin areas require recommendation for wound consultation and to notify the physician due to a change in condition. During an interview on 8/8/24 at 2:30 P.M., Corporate Nurse #1 said the expectation of the facility is that incontinent residents be toileted and repositioned every two hours and as needed. During an interview on 8/8/24 at 2:48 P.M., Unit Manager #1 said Residents who require incontinence care and turning and repositioning are at risk for skin breakdown and should not be left sitting in urine without care. During an interview on 8/12/24 at 10:19 A.M., the Director of Nurses (DON) said it is her expectation that staff reposition residents and provide incontinence care every two hours. During an interview on 8/12/24, at 12:40 P.M., Corporate Nurse #1 said that not providing incontinent care to an incontinent resident for 17 hours is considered neglect. She then said that she did not report the neglect to the state agency. Review of the Department of Public Health (DPH) Health Care Facility Reporting System (HCFRS) system indicated on 8/13/24 at 2:23 P.M., the facility submitted a report that Resident #63 did not receive incontinence care; approximately 6 days after the facility was notified of the allegation. Ref. F677, F725

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview, the facility failed to investigate allegations of neglect to the state agency as required for for two Residents (#10 and #63) out of a total of 46 sampled residents. Findings include: Review of the facility policy titled Abuse Investigation dated as revised March 2022 indicated that the facility will investigate all alleged/potential incidents of resident abuse, neglect, mistreatment, injuries of unknown etiology and misappropriation of property. Further review indicated that the facility administrator will coordinate and/or delegate the gathering of information and implementation of actions for purposes of investigation. Further review indicated that the nursing supervisor will complete an Abuse Prohibition Investigation Report which includes event identification details, notification of appropriate persons, confirmation of resident examination, interviews of appropriate individuals including the alleged victim and complete a medical record review. 1. Resident #10 was admitted to the facility in July 2024 with diagnoses including pain, spinal stenosis and osteoarthritis. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #10 scored a 15 out of 15 on the Brief Interview for Mental Status, indicating intact cognition. Further review indicated that Resident #10 is totally dependent on staff for toileting needs and is always incontinent of bowel and bladder. Review of the care plan dated 7/31/24, indicated that Resident #10 is dependent on staff for toileting needs. During an observation on 8/8/24, at 2:00 P.M., Resident #10 said that his/her incontinent brief had not been changed since 9:00 P.M. the night before. On 8/8/24, at 2:00 P.M., the surveyor and Unit Manager #1 observed Resident #10 lying in bed in a saturated incontinent brief. The surveyor and Unit Manager #1 observed the incontinent brief to be saturated and the color of the contents to be a dark reddish brown, with a strong smell of stale urine. Unit Manager #1 said that he could tell that there was no feces present but was concerned about the dark color of the urine. Unit Manager #1 said that Resident #10 should have had his/her incontinent brief checked and changed as needed but at least every 2 to 3 hours. The surveyor and Unit Manager #1 then observed a non-blanchable area on the coccyx measuring 7L cm x 2W cm (centimeters). Unit Manager #1 said that the non-blanchable area on the coccyx was a stage one pressure area and was new. Unit Manager #1 said that leaving a resident in a saturated incontinent brief for an extended period of time could lead to skin breakdown. During an interview on 8/12/24, at 11:10 A.M., Unit Manager #1 said that he had not initiated the Abuse Prohibition Investigation Report. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/12/24 at 12:30 P.M., the Corporate Nurse #1 said that she was made aware by the surveyor on 8/8/24 at 2:00 P.M., that Resident #10 had reported the he/she had not been provided incontinent care from 9:00 P.M. 8/7/24, to 2:00 P.M., on 8/8/24. Corporate Nurse #1 said that an investigation had not been initiated. During an interview on 8/12/24, at 12:40 P.M., the Corporate Nurse said that not providing incontinent care to an incontinent resident for 17 hours is considered neglect. The surveyor requested the facility investigation for the alleged neglect and by the time of the survey exit (four days after the facility was notified of the neglect) the facility had not produced an investigation. 48671 2. Resident #63 was admitted to the facility in May 2024 with diagnoses including morbid severe obesity, type two diabetes, congestive heart failure, muscle weakness, localized edema, anemia in chronic kidney disease, and hereditary and idiopathic neuropathy. Review of Resident #63's most recent Minimum Data Set Assessment, dated 5/29/24, indicated Resident #63 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated the Resident had intact cognition. The MDS also indicated Resident #63 is dependent on staff for all functional tasks. During an observation on 8/8/24, at 1:50 P.M., Resident #63 was observed laying in bed. The Resident said his/her incontinent brief had not been changed since 9:00 P.M. the night before, (a total of 17 hours without incontinence care) and that he/she was wet and uncomfortable. On 8/8/24 at 1:58 P.M., Corporate Nurse #1, Corporate Nurse #2 and Nurse #9 observed the Resident laying in bed. Corporate Nurse #1 removed the blankets to provide incontinence care. The Resident was observed wearing two incontinent briefs. Corporate Nurse #1 asked the Resident why he/she was wearing two incontinent briefs and the Residents said, I ask them to put two on me because no one comes and changes me. Resident #63 said the last time he/she was provided incontinence care or was repositioned occurred the night before at 9:00 P.M. Corporate Nurse #2 and Nurse #9 turned the Resident on to his/her left side and removed the two incontinence briefs. The two incontinence briefs were soaking wet with dark yellow, foul-smelling urine and contained pink, red, and brownish spots of discoloration throughout the brief, along the coccyx and buttocks area. The Resident had dried feces on his/her skin along the coccyx and buttocks area as well with excoriation throughout the buttock. The surveyor also observed a shallow open ulcer with red wound bed, bloody drainage and slough on the left buttock, a shallow open ulcer with red wound bed, bloody drainage and slough on the posterior thigh, and intact skin with localized area of persistent non-blanchable erythema and maroon discoloration on the coccyx. Corporate Nurse #1 said the Resident has three Stage II wounds. (In spite of slough being present in the wounds indicating wounds are a stage III). During an interview on 8/8/24 at 2:24 P.M., Corporate Nurse #2 said Residents should be turned and repositioned, and provided incontinence care every two hours. Corporate Nurse #2 said open skin areas require recommendation for wound consultation and to notify the physician due to a change in condition (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 2:30 P.M., Corporate Nurse #1 said the expectation of the facility is that incontinent residents be toileted and repositioned every two hours and as needed. During an interview on 8/8/24 at 2:48 P.M., Unit Manager #1 said Residents who require incontinence care and turning and repositioning are at risk for skin breakdown and should not be left sitting in urine without care. During an interview on 8/12/24 at 10:19 A.M., the Director of Nurses (DON) said it is her expectation that staff reposition residents and provide incontinence care every two hours. During an interview on 8/12/24, at 12:40 P.M., the Corporate Nurse #1 said that not providing incontinent care to an incontinent resident for 17 hours is considered neglect. The surveyor requested the facility investigation for the alleged neglect and by the time of the survey exit the facility had not produced an investigation. Ref. F677, F725

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Regalcare at Glen Ridge	120 Murray Street Medford, MA 02155

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on interview and record review, the facility failed to accurately code in the Minimum Data Set (MDS) for three Residents (#28, #100 and #112) of 46 sampled residents. Specifically; 1. For Resident #28, the use of non-invasive mechanical ventilation was inaccurately coded in the MDS. 2. For Resident #100 a significant weight loss was inaccurately coded in the MDS. 3. For Resident #112 the discharge status was inaccurately documented on the MDS. Findings include: 1. Resident #28 was admitted to the facility in July 2023 with diagnoses that included vascular dementia, chronic kidney disease, obstructive sleep apnea, heart failure and asthma. Review of Resident #28's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. Further review of the MDS indicated the Resident utilizes non-invasive mechanical ventilation. Review of Resident #28's nursing progress note, dated 4/25/24, indicated that the CPAP machine (is a device that delivers pressurized air to your nose and mouth to treat sleep apnea) was refused by the Resident and was reported to MD (physician) who stated it is ok to discontinue the CPAP machine since the Resident has been refusing it. Review of Resident #28's active physician orders failed to indicate an order for the use of his/her CPAP machine. During an interview on 8/9/24 at 6:58 A.M., Nurse #10 said Resident #28 does have a CPAP machine but there are no doctors orders for it to be used. During an interview on 8/12/24 at 10:11 A.M. the MDS Nurse reviewed the MDS that was completed on 7/24/24 with the surveyor and said the non-invasive mechanical ventilation was coded incorrectly because the CPAP order had been discontinued in April 2024. During a interview on 8/12/24 at 10:38 A.M., the Director of Nurses (DON) said the MDS that was completed on 7/24/24 should reflect Resident #28's status. The DON said non-invasive mechanical ventilation should not have been coded on the 7/24/24 MDS if the sleep apnea CPAP machine was discontinued in the end of April 2024. 36797 2. Resident #100 was admitted to the facility in June 2024 with diagnoses including paranoid schizophrenia, seizure disorder and traumatic compartment syndrome of abdomen. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated the following weights: 6/1/2024: 202.0 Lbs (pounds) 6/15/2024: 202.0 Lbs 6/24/2024: 203.4 Lbs 6/29/2024: 171.0 Lbs 7/8/2024: 170.1 Lbs 8/2/2024: 176.0 Lbs The weight list above indicated that on 6/24/24, Resident #100 weighed 203.4 lbs (pounds). Further review indicated that on 6/29/24 Resident #100 weighed 171.0 lbs.; a 32.4 lb or a 15.93% weight loss in two months. Review of the Minimum Data Set (MDS) dated [DATE], indicated that Resident #100 had not had a significant weight loss. During an interview on 8/8/24, at 2:15 P.M., the MDS Nurse said that she inaccurately documented the MDS for Resident #100. 3. Resident #112 was admitted to the facility in April 2024 with diagnoses including compression fractures of lumbar vertebra, traumatic shock sequela and alcoholic cirrhosis. Review of the nurse's note dated 5/22/24, indicated that Resident #112 was sent to the hospital for evaluation post fall. Review of the Minimum Data Set, dated dated dated [DATE], indicated Resident #112 was discharged home. During an interview on 8/8/24, at 2:15 P.M., the MDS Nurse said that she inaccurately documented the MDS for Resident #112.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 41105 Based on record review and interview the facility failed to develop a baseline care plan that includes the instructions needed to provide effective and person-centered care for one Resident (#16) out of a total sample of 46 residents. Specifically, the facility failed to develop a baseline care plan including resident specific interventions for a Resident who requires Dialysis three times a week. Findings include: Resident #16 was admitted to the facility in February 2024 and has diagnoses that include Type II diabetes mellitus with diabetic chronic kidney disease, End Stage Renal Disease (ESRD) and dependence of renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/10/24, indicated that on the Brief Interview for Mental Status exam Resident #16 scored a 3 out of a possible 15, indicating severely impaired cognition. Review of the Resident #16's Physician orders from his/her admission in February 2024 indicated Resident #16 required dialysis 3 times a week. Review of the medical record failed to indicate a baseline care plan for dialysis was created for Resident #16. The dialysis care plan, was dated as created 7/03/24, five months after the Resident's admission to the facility. During an interview on 8/12/24 at 8:41 A.M., with the Director of Nursing and Corporate Nurse (#1) they said that for Resident #16 a dialysis care plan, with Resident specific interventions, should have been created as a part of the baseline care plan because Resident #16 admitted with a plan to require dialysis three times a week.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, record review and interview the facility failed to implement a person centered care plan for six Residents (#3, #28, #30, #99, #100, and #90) out of a total sample of 46 residents. Specifically, 1. For Resident #3, the facility failed to off load his/her heels per the plan of care. 2. For Resident #28, the facility failed to don (apply) heel boots per the plan of care. 3. For Resident #30 the facility failed to don (apply) heel boots per the plan of care. 4. For Resident #99 the facility failed to apply a pillow between legs and place floor mats per the plan of care. 5. For Resident #100 the facility failed to obtain weights weekly per plan of care. 6 a. For Resident #90 the facility failed to implement Geri sleeves (skin protector sleeves). 6 b. For Resident #90 the facility failed to implement pressure relieving booties, per the plan of care. Findings include: 1. Resident #3 was admitted to the facility in January 2024 with diagnoses that included Alzheimer's disease, depression, and lymphedema. Review of Resident #3's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS indicated the Resident is at risk for developing pressure ulcers. On 8/6/24 at 8:52 A.M., 12:28 P.M., the surveyor observed Resident #3 in bed with his/her heels directly on the mattress. On 8/7/24 at 6:57 A.M., 7:59 A.M., 8:41 A.M., and 12:52 P.M., the surveyor observed Resident #3 in bed with his/her heels directly on the mattress. On 8/8/24 at 8:45 A.M. and 12:45 P.M., the surveyor observed Resident #3 in bed with his/her heels directly on the mattress. During an interview and observation on 8/9/24 at 1:04 P.M., Certified Nurse Aide (CNA) #4 said she was not sure if Resident #3 needed to have his/her heels offloaded but said the Resident's heels are not currently off loaded because his/her heels are flat on the mattress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's at risk for skin breakdown care plan, dated 1/30/24, indicated Off Load/Float heels while in bed. Review of Resident #3's Norton Plus Pressure Ulcer Scale, dated 7/30/24, indicated a score of seven indicating the Resident is at high risk for developing pressure ulcers. During an interview on 8/9/24 at 1:07 P.M., Nurse #6 said Resident #3 should have his/her heels offloaded as care planned. During an interview on 8/12/24 at 10:36 A.M., the Director of Nurses (DON) said Resident #28 should have heel boots on as ordered. The DON said if the Resident refuses a treatment then there should be a nursing progress note. 2. Resident #28 was admitted to the facility in July 2023 with diagnoses that included vascular dementia, chronic kidney disease, obstructive sleep apnea, heart failure and asthma. Review of Resident #28's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. Further review of the MDS indicated the Resident is at risk for pressure ulcers. On 8/6/24 at 8:16 A.M. and 8:54 A.M., the surveyor observed Resident #28 in bed with out heel boots on his/her feet. On 8/7/24 at 6:58 A.M. and 8:49 A.M., the surveyor observed Resident #28 in bed with out heel boots on his/her feet. On 8/8/24 at 7:51 A.M. and 8:55 A.M., the surveyor observed Resident #28 in bed with out heel boots on his/her feet. Review of Resident #28's physician order, dated 12/12/23, indicated Prevalon heel boots on when in bed to prevent skin pressure. May remove for skin care. Review of Resident #28's skin breakdown care plan, dated 3/2/24, indicated Prevalon heel boots on when in bed to prevent skin pressure. May remove for skin care. Review of Resident #28's Norton Plus Pressure Ulcer Scale, dated 7/23/24, indicated the Resident was at high risk for developing pressure ulcers scoring an 8. Review of Resident #28's nursing progress notes failed to indicate that the Resident refused the heel boots during survey. During an interview on 8/9/24 at 1:07 P.M., Nurse #6 said Resident #28 should have heel boots on in bed as ordered. During an interview on 8/12/24 at 10:36 A.M., the Director of Nurses (DON) said Resident #28 should have heel boots on as ordered. The DON said if the Resident refuses a treatment then there should be a nursing progress note. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	36797 3. Resident #30 was admitted to the facility in June 2024 with diagnoses including dementia, acute respiratory failure and cancer. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #30 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderately impaired cognition. Further review indicated Resident #30 has three pressure areas and is at risk for the development of pressure areas. Review of the facility document titled RC Norton Plus Pressure Ulcer Scale and dated 7/9/24, indicated that Resident #30 scored a 10 indicating high risk for pressure ulcer development, Review of the doctor's orders dated August 2024 indicated an order dated 6/11/24 for Pressure relief heel boots to Bilat feet when in bed remove as needed for skin checks or patient tolerance. Further review of the doctor's indicated an order, with an initiation date of 7/9/24 at 11:00 P.M., for Prevalon boot to R heel, offload R heel every shift for R heel pressure ulcer. Review of the care plan indicated a focus problem for alteration in skin integrity dated 8/6/24, with an intervention for Prevalon Boots to the right heel. Further review failed to indicate that Resident #30 refused to wear the Prevalon boot. On 8/6/24 at 8:58 A.M., and 12:44 P.M., the surveyor observed Resident #30 lying in bed with both heels flat on the mattress. No Prevalon boots were in the Resident's room. On 8/7/24, at 12:50 P.M., the surveyor observed Resident #30 lying in bed with his/her heels directly on the mattress. The surveyor observed that Resident #30 was not wearing a Prevalon boot to the right heel, nor were his/her feet off loaded. The surveyor was unable to locate a Prevalon boot in the Resident's room. Review of Resident #30's nursing progress notes failed to indicate that the Resident refused the heel boots during survey. On 8/8/24 at 9:26 A.M., the Director of Nursing (DON) said that it is the expectation that the doctor's orders and care plan are to be followed. During an interview on 8/8/24, at 11:25 P.M., Unit Manager (UM) #1 said that he would expect that the heels would be off loaded as ordered. 4. Resident #99 was admitted to the facility in August 2023 with diagnoses including dementia, malnutrition and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #99 scored a 3 our of a possible 15 on the Brief Interview for Mental Status exam indicating severely impaired cognition. Further review of the MDS indicated Resident #99 is a risk for pressure ulcer development. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the doctor's orders dated August 2024 indicated an order dated 9/15/23 for floor matt to both sides of the bed. Further review indicated an order dated 3/12/24, for place pillow between legs when in bed to prevent rubbing and skin tears. Review of the care plan with an intervention dated 3/12/24, indicated a focus problem of; at risk for skin breakdown related to decreased activity, with an intervention of; Place pillow between Resident #99's legs when he/she is in bed. Further review indicated an intervention dated 9/13/23 for floor [NAME] to both side of the bed, monitor for placement every shift. Further review failed to indicate Resident #99 refuses care. On 8/6/24, at 12:27 P.M., the surveyor observed Resident #99 without a pillow between his/her legs, and a floor matt on right side of bed only. No other floor mats were observed in the room. On 8/7/24, at 8:50 A.M., the surveyor observed Resident #99 without a pillow between his/her legs, and a floor matt on right side of bed only. No other floor mats were observed in the room. On 8/8/24, at 7:26 A.M., and 10:06 A.M., the surveyor observed Resident #99 without a pillow between his/her legs, and a floor matt on right side of bed only. No other floor mats were observed in the room. Review of Resident #99's nursing progress notes failed to indicate that the Resident refused the pillow or floor mats during survey. During an interview on 8/8/24, at 10:12 A.M. Certified Nurse's Aide (CNA) #3 said that she was not aware that Resident #99 required floor mats on both sides of the bed or that a pillow was supposed to be placed between Resident #99's legs when in bed. 5. Resident #100 was admitted to the facility in June 2024 with diagnoses including paranoid schizophrenia, seizure disorder and traumatic compartment syndrome of abdomen. Review of the care plan dated 7/2/24, indicated a focus of; at risk for nutritional decline related to: CHF, DM, AFIB. Diuretic therapy may cause weight to fluctuate. Further review indicated an intervention of; Weight loss noted, Weekly Weight. Review of the weights indicated the following: 8/2/2024 08:36 176.0 Lbs 7/8/2024 13:03 170.1 Lbs 6/29/2024 23:42 171.0 Lbs 6/24/2024 08:50 203.4 Lbs 6/15/2024 09:04 202.0 Lbs 6/1/2024 15:08 202.0 Lbs (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review indicated that no weights were obtained between 7/8/24 and 8/2/24. Review of Resident #100's nursing progress notes failed to indicate that the Resident refused to be weighed. 45343 6 a. Resident #90 was admitted to the facility in July 2021 with diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and vascular dementia Review of Resident #90's most recent Minimum Data Set (MDS) assessment, dated 7/31/24, indicated Resident #90 scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Further review of the MDS indicated Resident #90 requires substantial/maximal to dependent assistance for all self-care activities and has skin tears. On 8/6/24 at 8:18 A.M., and 12:25 P.M., on 8/7/24 at 7:40 A.M. and 12:16 P.M., on 8/8/24 at 11:26 A.M., and on 8/12/24 at 7:42 A.M., the surveyor observed Resident #90 lying in bed. Resident #90 was not wearing his/her Geri Sleeves on his/her arms. Review of Resident #90's active physician order, dated 6/27/24, indicated Geri sleeves the BUE (bilateral upper extremities), every shift for skin tears. Review of Resident #90's Nursing note, dated 7/2/14, indicated Left upper arm skin tear observed by her daughter and reported to [NAME] NP (Nurse Practitioner) who was sitting at the nurses, station. NP in the facility assessed the resident with new order to clean the area with normal saline and cover with 4x4 gauze. Apply geri-sleeves on both arms. Review of Resident #90's nursing progress notes from 6/27/24 to 8/7/24 failed to indicate that the Resident refused to wear the Geri sleeves. During an interview on 8/12/24 at 8:35 A.M., Certified Nursing Assistant (CNA) #8 said she was not aware if Resident #90 is required to wear anything on his/her arms to protect his/her skin. During an interview on 8/12/24 at 9:51 A.M., Nurse #14 said she was per diem and was not aware if Resident #90 is required to wear geri sleeves on his/her arms. During an interview on 8/12/24 at 1:14 P.M., Corporate Nurse #1 said nurses should be following each resident's physician orders. Corporate Nurse #1 said if the Resident refuses anything it should be documented in a nursing note. 6 b. Resident #90 was admitted to the facility in July 2021 with diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and vascular dementia Review of Resident #90's most recent Minimum Data Set (MDS) assessment, dated 7/31/24, indicated Resident #90 scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Further review of the MDS indicated Resident #90 is at risk for pressure ulcers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/24 at 8:18 A.M., 8/7/24 at 7:41 A.M., and 12:17 P.M., and 8/8/24 7:47 A.M. and 9:04 A.M., Resident #90 was observed lying in his/her bed. Resident #90 was not wearing his her Prevalon boots on his/her feet. Review of Resident #90's physician order, dated 12/4/23, indicated Prevalon boots while in bed, may remove for hygiene every shift. Review of Resident #90's nursing progress notes for the past 90 days failed to indicate that the Resident refused pressure relieving boots to his/her feet. Review of Resident #90's [NAME] Pressure Ulcer Risk Scale, dated 7/29/22, indicated Resident #90 scored a 10, indicating the Resident was at high risk for developing pressure ulcers. During an interview on 8/12/24 at 8:35 A.M., Certified Nursing Assistant (CNA) #8 said Resident #90 should be wearing booties, but he/she does not like them. CNA #8 was asked if she put on the Residents booties today, she said no. During an interview on 8/12/24 at 9:51 A.M., Nurse #14 said Resident #90 should have booties on his/her feet and it should be documented if the resident refuses. During an interview on 8/12/24 at 1:14 P.M., Corporate Nurse #1 said she expects the booties to be worn as ordered and documented in the nurses note if the resident refuses care. Ref. F725

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observation, record review, and interviews, the facility failed to ensure care plans were reviewed and revised with the interdisciplinary team (IDT) as required for three Residents (#28, #16 and #77), out of a total sample of 46 residents. Specifically: 1. For Resident #28, the facility failed to ensure his/her sleep apnea care plan was revised. 2. For Resident #16, the facility failed to ensure his/her care plan was revised in May 2024 to include the dialysis plan of care, when it was not developed upon admission or with the initial comprehensive plan of care in February 2024. 3. For Resident #77 the facility failed to ensure his/her activities of daily living care plan was revised. Findings include: 1. Resident #28 was admitted to the facility in July 2023 with diagnoses that included vascular dementia, chronic kidney disease, obstructive sleep apnea, heart failure and asthma. Review of Resident #28's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. Further review of the MDS indicated the Resident utilizes non-invasive mechanical ventilation. Review of Resident #28's nursing note, dated 4/25/24, indicated that the CPAP machine (a device that delivers pressurized air to your nose and mouth to treat sleep apnea) was refused and was reported to MD (physician) who stated it is ok to discontinue the CPAP machine since resident has been refusing it. Review of Resident #28's sleep apnea care plan, dated 5/13/24, indicated CPAP as ordered. During an interview on 8/9/24 at 6:58 A.M., Nurse #10 said Resident #28 does have a CPAP machine but he/she has not used it in a long time. On 8/12/24 at 10:11 A.M., MDS Nurse #1 reviewed the MDS dated [DATE] with the surveyor, the MDS Nurse said that the sleep apnea care plan should have been revised with the MDS that was completed on 7/24/24 and said it was not. During an interview on 8/12/24 at 10:38 A.M., the Director of Nurses (DON) said Resident #28's sleep apnea care plan should have been revised at the time of the last MDS was completed because the CPAP machine has been discontinued. 41105 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #16, the facility failed to ensure his/her care plan was revised in May 2024 to include the dialysis plan of care, when it was not developed upon admission or with the initial comprehensive plan of care in February 2024. Resident #16 was admitted to the facility in February 2024 and has diagnoses that include Type II diabetes mellitus with diabetic chronic kidney disease, End Stage Renal Disease (ESRD) and dependence of renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/10/24, indicated that on the Brief Interview for Mental Status exam Resident #16 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #16 requires dialysis. Review of the Resident #16's current Physician orders indicate Resident #16 requires dialysis 3 times a week. Review of the medical record further indicated Resident #16' Dialysis care plan, was dated as created 7/3/24, five months after the Resident's admission and not at the time of the comprehensive admission assessments or in May 2024 at the time of a comprehensive quarterly assessment. Further review of the Dialysis care plan indicated the care plan was incomplete and indicated the following interventions: -Administer/monitor effectiveness of medications as ordered-(see physician's orders/MAR) (start date 7/3/24); -Avoid constriction on affected arm, such as carrying purse and constrictive clothing (start date 7/3/24); -Dialysis days: _____ (start date 7/3/24); -Monitor shunt site by palpating for thrill and auscultating for bruit daily. Notify physician of absence of thrill or bruit. (Note: No thrill/bruit present with Tessio or CV dialysis catheters) (start date 7/3/24); -Monitor shunt site for s/s infection, pain, or bleeding daily and PRN (start date 7/3/24) -No b/p on limb with shunt/CV dialysis catheter (start date 7/3/24); -Protect access site from injury. Site: _____ (start date 7/3/24; The incomplete dialysis care plan, was dated as created 7/03/24, five months after the Resident's admission to the facility. During an interview on 8/12/24 at 8:41 A.M., with the Director of Nursing and Corporate Nurse (#1), they said that Resident #16's care plan should have been revised to include dialysis at the time the last MDS was completed in May 2024. Corporate Nurse #1 said that the care plan should include interventions specific to Resident #16's dialysis treatment plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36797 3. Resident #77 was admitted to the facility in March 2022 with diagnoses including Alzheimer's disease, stroke and anxiety disorder. Review of the Minimum data Set (MDS) dated [DATE], indicated Resident #77 was unable to complete the Brief Interview for Mental Status exam and is moderately cognitively impaired. Further review indicated that Resident #77 is independent for eating. On 8/6/24, at 9:00 A.M., the surveyor observed Resident #77 in bed with a breakfast tray on the over the bed table, eating alone in his/her room. On 8/6/24, at 12:59 P.M., the surveyor observed Resident #77 in bed with a breakfast tray on the over the bed table, eating alone in his/her room. Review of the care plan dated 3/2/24, indicated a focus of; Resident #77 is at risk for decreased ability to perform ADL(s) in: bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Limited mobility. Further review indicated a revised an intervention dated 10/25/23, of; Resident #77 requires assist to total care for eating. The care plan had not been revised to indicate Resident #77 is currently independent for eating. During an interview on 8/6/24, at 1:02 P.M. Certified Nurse's Aide #4 said that Resident #77 is a set up help only for eating and does not require supervision.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review, observations and interviews, the facility failed to ensure a physician's order was implemented for two Residents (#263, #81) out of a total sample of 46 residents. Specifically, 1. For Resident #263, the facility failed to ensure his/her weight was reported to the Nurse Practitioner (NP) or Medical Doctor (MD) as ordered; 2. For Resident #81, the facility failed to treat and accurately report a Stage 2 wound to the physician. Findings include: 1. Resident #263 was admitted to the facility in August 2023 with diagnoses that included acute and chronic respiratory failure, dementia, hypertensive heart and chronic kidney disease. Review of Resident #263's Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has a moderate cognitive impairment. Review of Resident #263's medical record indicated a weight on 8/6/24 was 123 lbs (pounds) and on 8/7/24 his/her weight was 143.6 lbs. Review of Resident #263's nutrition care plan, dated 5/13/24, indicated monitor weights, intakes, skin, labs, med's a/o (as ordered). Notify RD/MD/HCP (registered dietitian/medical doctor/health care proxy) of significant weight changes. Review of Resident #263's physician order, dated 8/5/24, indicated daily weight one time a day for call MD or NP if change > (greater) 3 lbs. Review of Resident #263's nursing progress notes failed to indicate they called the NP/MD for the weight change of > 3 lbs. During an interview 8/8/24 at 11:40 A.M., MD #2 said he and his team were not notified of the weight changes of Resident #263. MD #2 said if there was a three pound gain he would have expected the nursing staff to update him or his NP but was not. During an interview on 8/9/24 at 1:08 P.M., Nurse # 6 said if a resident has a doctors order to update the MD or NP for greater than a 3 lb gain then the nurses are expected to call and update the MD or NP when a resident has a > 3 lb gain and write a nurses note. During an interview and review of Resident #263's medical record on 8/12/24 at 10:32 A.M., the Director of Nurses (DON) said the Resident's weight was 123 lbs on 8/6/24 and on 8/7/24 it was 143.6 lbs. The DON said the MD and NP should have been made aware and a nursing progress note should have been written. The DON said the Resident should have been re-weighed but was not. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15016 2. Resident #81 was admitted to the facility in May 2021 and had a primary diagnosis of stroke. Review of Resident #81's Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status score of 1 of 15 points, indicating severe cognitive impairment. Resident #81 was completely dependent on staff for all bed mobility and required substantial assistance for all other activities of daily living. The Resident was at risk for pressure injuries but had no skin wounds, and required pressure relieving devices for the bed and chair. Resident #81's care plan dated as revised 6/19/24, indicated: - Resident at risk for skin breakdown due to decreased mobility and incontinence, staying in his/her chair for longer periods and refusing to go to bed. - Goals included the use of pressure relieving devices. - Interventions included showing no signs of skin breakdown x 90 days. Review of Resident #81's skin observation tool dated 7/18/24, indicated he/she had no wounds or pressure areas. Review of Resident #81's physician orders and notes and nursing notes dated prior to 8/8/24, did not indicate he/she had a skin wound. On 8/8/24 at 2:10 P.M., the surveyor and Nurse #9 observed that Resident #81 had a 1 centimeter (cm) x 1 cm wound located on the left calf. A dressing or other treatment was absent. Nurse #9 said this was a Stage 2 wound because of its depth and drainage, and the skin around the wound was erythematous. Nurse #9 said she was unaware of the wound until now. Nurse #9 said she would report the wound to the physician to obtain a treatment. On 8/8/24 at approximately 2:20 P.M., Corporate Nurse #1 accompanied the surveyor and observed Resident #81's calf wound. Corporate Nurse #1 said this was only a scab and it did not need to be reported to the physician because treatment was not required. On 8/8/24 at 2:35 P.M., Unit Manager #1, accompanied by two surveyors, observed Resident #81's calf wound. Unit Manager #1 said the wound was a Stage 2 pressure injury due to its depth and surrounding erythema. Unit Manager #1 said he was unaware of the wound until now. Unit Manager #1 said he would report the wound the the physician and obtain an order for treatment. Review of Resident #81's skin observation tool dated 8/8/24 and completed at 11:02 P.M. by Corporate Nurse #1, indicated a treatment was applied to a 1 cm x 1 cm wound located on the left calf. The assessment did not indicate the depth of the wound, or the type of treatment. Review of the Resident's nursing and physician progress notes and orders failed to indicate any reference to the Resident's wound, if staff notified the physician or NP #2 about the calf wound or reference a treatment. On 8/9/24 at approximately 8:15 A.M., 8:57 A.M. and 10:50 A.M., the surveyor observed Resident #81 in the dining room and that no dressing covered his/her exposed calf wound. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #81's medical record on 8/9/24 at approximately 8:50 A.M., indicated there was no documentation to indicate Nurse #9, Unit Manager #2, Corporate Nurse #1, or any other staff notified the physician or NP #2 about his/her calf wound or attempt to seek wound treatment. On 8/9/24 at 12:50 P.M., the surveyor telephoned NP #2 to determine if she was aware of Resident #81's calf wound or orders for treatment. A voice mail message was left but as of 8/15/24 there was no call back. On 8/9/24 at 1:00 P.M., the surveyor observed Resident #81 in the dining area, sitting in a chair. The Resident's left calf wound was exposed and there was no dressing covering it. During an interview with the DON and Corporate Nurse #1 on 8/9/24 at 1:15 PM., the surveyor told them that Resident #81's skin assessment dated [DATE] and completed after the surveyor's observations of the wound earlier in the day, indicated a 1 cm x 1 cm wound on the left lower leg and that a treatment was applied. The surveyor told them there was no documentation in the record to indicate staff notified the physician or NP #2 about Resident #81's calf wound or obtained a physician's order for wound treatment. The surveyor informed them that, despite the assessment indicating a treatment was applied, as of this time Resident #81 did not have a dressing over the open wound. Corporate Nurse #1 said she telephoned the physician during the night of 8/8/24 and notified him that Resident #81 had a scab on the left calf. Corporate Nurse #1 said the physician told her to only apply skin prep because it was not an open wound. Corporate Nurse #1 said she forgot to document the conversation and treatment order. The surveyor told Corporate Nurse #1 that Unit Manager #1, a staff nurse and two surveyors observed the wound on 8/8/24 and determined it was an open wound, not a scab. On 8/9/24 at 1:20 P.M., the DON and surveyor observed Resident #81's calf wound. The DON said it was either a Stage 2 or an unstageable wound and not a scab. The DON said the skin surrounding the wound was purple and the wound had signs of drainage. The DON said skin prep was not an appropriate treatment for the wound and that it should be covered with a medicated dressing to encourage healing and prevent infection. The DON said staff had not made her aware of the wound. She said she would immediately notify NP #2 about the wound and obtain treatment orders.

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F 0677 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** 48671 Based on observations, record review, policy review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs), for six Residents (#63, #10, #3, #37, #94, and #2) out of a total sample of 46 residents. Specifically: 1a. For Resident #63, the facility failed to ensure incontinence care was provided for 17 hours resulting in the development of new pressure ulcers. 1b. For Resident #10, the facility failed to ensure incontinence care was provided for 17 hours resulting in the development of new pressure ulcers. 2. For Resident #3, the facility failed to provide assistance with meals as per the plan of care. 3. For Resident #37 and #94, the facility failed to provide assistance with nail care. 4. For Resident #2, the facility failed to provide assistance with facial hair removal. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs), dated 3/22, indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary for activities of daily living. Appropriate care and services will be provided for residents who are unable to carry out ADLs including appropriate support and assistance with: Dining (meals and snacks). Hygiene (bathing, dressing, grooming and oral care). Elimination (toileting). 1 a. Resident #63 was admitted to the facility in May 2024 with diagnoses including morbid severe obesity, type two diabetes, congestive heart failure, muscle weakness, localized edema, anemia in chronic kidney disease, and hereditary and idiopathic neuropathy. Review of Resident #63's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #63 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated the Resident had intact cognition. The MDS also indicated Resident #63 is dependent on staff for all functional tasks. Review of Resident #63's current Activity of Daily Living (ADL) care plan, last revised 6/4/24, indicated Resident #63 required assistance with toilet use, bed mobility, personal hygiene and turning/repositioning. Review of Resident #63's current incontinence care plan, last revised 5/30/24, indicated the following interventions: Brief worn, change every 2-3 hours and PRN (as needed). Review of Resident #63's Kardex (a form indicating the level of assistance a resident requires) indicated Resident #63 is always incontinent. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an observation on 8/8/24, at 1:50 P.M., Resident #63 was observed laying in bed. The Resident said his/her incontinent brief had not been changed since 9:00 P.M. the night before, (a total of 17 hours since his/her brief was change), and that he/she was wet and uncomfortable. On 8/8/24 at 1:58 P.M., Corporate Nurse #1, Corporate Nurse #2 and Nurse #9 observed the Resident laying in bed. Corporate Nurse #1 removed the blankets to provide incontinence care. The Resident was observed wearing two incontinent briefs. Corporate Nurse #1 asked the Resident why he/she was wearing two incontinent briefs and the Residents said, I ask them to put two on me because no one comes and changes me. Resident #63 said the last time he/she was provided incontinence care or was repositioned occurred the night before at 9:00 P.M. Corporate Nurse #2 and Nurse #9 turned the Resident on to his/her left side and removed the two incontinence briefs. The two incontinence briefs were soaking wet with dark yellow, foul-smelling urine and contained pink, red, and brownish spots of discoloration throughout the brief, along the coccyx and buttocks area. The Resident had dried feces on his/her skin along the coccyx and buttocks area as well with excoriation throughout the buttock. The surveyor also observed a shallow open ulcer with red wound bed, bloody drainage and slough on the left buttock, a shallow open ulcer with red wound bed, bloody drainage and slough on the posterior thigh, and intact skin with localized area of persistent non-blanchable erythema and maroon discoloration on the coccyx. Corporate Nurse #1 said the Resident has three Stage II wounds. (In spite of slough being present in the wounds indicating wounds are a stage III). During an interview on 8/8/24, at 2:00 P.M., CNA #4 said that Resident #63 had not been provided incontinent care because Resident #63 required an assist of two people to turn and reposition and there was not enough staff to care for all 24 residents on the unit. During an interview on 8/8/24 at 2:30 P.M., Corporate Nurse #1 said the expectation of the facility is that incontinent residents be toileted every two hours and as needed. During an interview on 8/8/24 at 2:48 P.M., Unit Manager #1 said Residents who require incontinence care and turning an repositioning are at risk for skin breakdown and should not be left sitting in urine without care. Review of the facility document titled Documentation Survey Report v2 (Activities of Daily Living (ADL) documentation sheet), dated August 2024, indicated Resident #63 was dependent on staff for toileting, and incontinent of bowel and bladder. Further review failed to indicate that ADL care was provided during the following shifts: On 8/7/24, 7:00 A.M. to 3:00 P.M. On 8/7/24, 11:00 P.M. to 7:00 A.M. On 8/8/24, 7:00 A.M. to 3:00 P.M. On 8/8/24, 3:00 P.M. to 11:00 P.M. During an interview on 8/12/24 at 10:19 A.M., the Director of Nurses (DON) said it is her expectation that staff reposition residents and provide incontinence care every two hours. 36797 (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	1 b. Resident #10 was admitted to the facility in July 2024 with diagnoses including pain, spinal stenosis and osteoarthritis. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #10 scored a 15 out of 15 on the Brief Interview for Mental Status, indicating intact cognition. Further review indicated that Resident #10 is totally dependent on staff for toileting needs and is always incontinent of bowel and bladder. Review of the care plan dated 7/31/24, indicated that Resident #10 is dependent on staff for toileting needs. During an observation on 8/8/24, at 2:00 P.M., Resident #10 said that his/her incontinent brief had not been changed since 9:00 P.M. the night before; a total of 17 hours without incontinence care. The surveyor and Unit Manager #1 observed Resident #10 lying in bed in a saturated incontinent brief. The surveyor and Unit Manager #1 observed the incontinent brief to be saturated and the color of the contents to be a dark reddish brown, with a strong smell of stale urine. Unit Manager #1 said that he could tell that there was no feces present but was concerned about the dark color of the urine. Unit Manager #1 said that Resident #10 should have had his/her incontinent brief checked and changed as needed but at least every 2 to 3 hours. He then said that he could tell that it had been many hours since the incontinent brief had been changed. Unit Manager #1 said that with the number of residents on the unit that require an assist of two staff members to provide care, one Certified Nurse's Aide (CNA) and one nurse is not enough to get the job done. The surveyor and Unit Manager #1 then observed a non-blanchable area on the coccyx measuring 7L cm x 2W cm (centimeters). Unit Manager #1 said that the non-blanchable area on the coccyx was a stage one pressure area and was new. Unit Manager #1 said that leaving a resident in a saturated incontinent brief for an extended period of time could lead to skin breakdown. During an interview on 8/8/24, at 2:00 P.M., CNA #4 said that Resident #10 had not been provided incontinent care because Resident #10 required an assist of two people to turn and reposition and there was not enough staff to care for all 24 residents on the unit. During an interview on 8/12/24 at 10:19 A.M., the Director of Nurses (DON) said it is her expectation that staff reposition residents and provide incontinence care every two hours. 43846 2. Resident #3 was admitted to the facility in January 2024 with diagnoses that included Alzheimer's disease, depression, and lymphedema. Review of Resident #3's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS indicated the Resident required supervision or touching assistance for eating. On 8/6/24 at 8:44 A.M. to 8:53 A.M., the surveyor observed Resident #3 in bed with their breakfast tray in front of them on the over the bed table not set up. The surveyor observed the Resident struggle to uncover their food and drinks. No staff were present in the room. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 8/6/24 at 8:53 A.M., Resident #3 said he/she needs help to eat and cannot uncover her meal and drinks with out help. On 8/6/24 from 12:19 P.M. to 12:28 P.M., the surveyor observed Resident #3 in bed with their lunch tray, the Resident was not initiating eating. No staff were present in the room. On 8/7/24 from 8:39 A.M. to 8:46 A.M., the surveyor observed Resident #3 in bed asleep with their breakfast tray on their over the bed table. The Resident was behind the privacy curtain and unable to be visualized from the hallway. No staff were present in the room. On 8/7/24 from 12:40 P.M. to 12:48 P.M., the surveyor observed Resident #3 in bed with their lunch tray, the Resident was not initiating eating. The Resident was behind the privacy curtain and unable to be visualized from the hallway. No staff were present in the room. On 8/8/24 from 8:46 A.M. to 8:56 A.M., the surveyor observed Resident #3 in bed asleep with their breakfast tray on their over the bed table. The Resident was behind the privacy curtain and unable to be visualized from the hallway. No staff were present in the room. On 8/9/24 at 8:54 A.M. to 8:58 A.M., the surveyor observed Resident #3 in bed with their breakfast tray in front of them on the over the bed table not set up. The surveyor observed the Resident asleep behind the privacy curtain. No staff were present in the room. Review of Resident #3's Activity of Daily Living (ADL) care plan failed to indicate the level assist the Resident requires for eating. Review of Resident #3's nursing progress note, dated 7/17/24, indicated downgrade diet to puree d/t (due to) difficulty swallowing. During an interview on 8/9/24 at 8:57 A.M., Nurse #5 said if a resident's plan of care is supervised or assist at meals then a staff member should be present in the room with the resident. During an interview on 8/9/24 at 8:58 A.M., CNA #5 said Resident #3 needs assistance to eat and said no one is in the room currently with the Resident. During an interview on 8/12/24 at 10:17 A.M., the Director of Nurses (DON) said if a resident is coded on the MDS as needing supervision or assistance with meal then the expectation is that staff are in the room assisting that resident. 45343 3 a. Resident #37 was admitted to the facility in August 2021, with diagnoses including atrial fibrillation, cerebral infarction, and hemiplegia and hemiparesis affecting the right dominant side. Review of Resident #37's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, indicating he/she has severe cognitive impairments. The MDS also indicated Resident #37 requires substantial/maximal to dependent assistance for all self-care activities. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 8/6/24 at 8:13 A.M., and 12:16 P.M., 8/7/24 at 12:27 P.M., 8/8/24 at 8:59 A.M., and 8/12/24 at 8:28 A.M., Resident #37 was observed lying in bed with long dirty fingernails. Resident #37 said he/she always kept his/her fingernails clean and would like his/her fingernails cut and cleaned. Resident said he/she has not been offered to have his/her fingernail cut or cleaned. Record review on 8/8/24 at 8:32 A.M., Resident #37's care plan last updated on 3/2/24 indicated the following: Grooming: x 1 assist, dependent at times due to fatigue. Further review of Resident #37's Kardex (a form indicating level of assistance a resident requires) indicated the following: Grooming: x 1 assist, dependent at times due to fatigue. During an interview on 8/12/24 at 9:53 A.M., Nurse #14 said nail care is part of a resident's morning care and if she notices long nails, she will ask the Resident if they would like their nails to be cut. Nurse #14 said she was not aware that Resident #37 had long dirty nails but said she will ask the CNA to go back and clean his/her nails as it was not done during this morning's care. During an interview on 8/12/24 at 12:59 A.M., Corporate Nurse #1 said she would expect Resident's nails to be cleaned and cut as needed during morning care and if a resident refuses care, it should be documented. Review of Resident #37's medical record failed to indicate he/she refused care. 3 b. Resident #94 was admitted to the facility in June 2022, with diagnoses including hemiplegia and hemiparesis affecting left non-dominant side and hypertension. Review of Resident #94's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicating he/she is cognitively intact. The MDS also indicated Resident # 94 requires supervision to touch assistance for self-care activities. On 8/6/24 at 8:07 A.M., 8/7/24 at 12:26 P.M., and 8/8/24 at 9:03 A.M., Resident #94 was observed lying in bed with long fingernails on his/her left hand. Resident #94 said he/she normally keeps his/her nails short, but said you have to practically beg to get your nails cut. Resident #94 was asked if he/she was offered to have his/her fingernails cut today, he/she said no. Record review on 8/7/24 at 12:26 P.M., Resident #94's care plan last updated on 7/12/24 indicated the following: Grooming: x 1 assist. Further review of Resident #94's Kardex (a form indicating level of assistance a resident requires) indicated the following: Grooming: x 1 assist. During an interview on 8/12/24 at 9:53 A.M., Nurse #14 said nail care is part of a resident's morning care and if she notices long nails, she will ask the Resident if they would like their nails to be cut. Nurse #14 said she was not aware that Resident #94 needed his/her fingernails cut. During an interview on 8/12/24 at 12:59 A.M., Corporate Nurse #1 said she would expect Resident's nails to be cut as needed during morning care and if a resident refuses care, it should be documented. Review of Resident #94's medical record failed to indicate he/she refused care. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	4. Resident #2 was admitted to the facility in May 2018, with diagnoses including Neurocognitive disorder with Lewy body, paranoid schizophrenia, and anxiety disorder. Review of Resident #2's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15, indicating he/she has severe cognitive impairments. The MDS also indicated Resident #2 requires partial/moderate assistance for personal hygiene and does not display any behaviors impacting care. On 8/6/24 at 8:37 A.M., 8/7/24 at 9:30 A.M., 8/8/24 at 8:04 A.M., 8:34 A.M., and 12:42 P.M., and 8/12/24 at 7:56 A.M., Resident #2 was observed with long chin and upper lip hair. Resident #2 said he/she normally does not have facial hair. Record review on 8/6/24 at 3:33 P.M., Resident #2's care plan last updated 3/2/24 indicated the following: assist of 1 to independent for personal hygiene (grooming). During an interview on 8/12/24 at 10:10 A.M., Nurse #13 said we normally shave Resident #2 after asking his/her permission. Nurse #13 said she has not heard that the Resident is refusing care as the staff will normally come find me to assist with his/her care. During an interview on 8/12/24 at 12:59 P.M., Corporate Nurse #1 said she would expect facial hair to be removed with the residents permission during routine care and any refusals should be documented in the medical record. Ref. F684, F686, F725

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review, and interview, the facility failed to ensure residents received treatment and care to maintain the highest practicable well-being for six Residents (#99, #42, #81, #41, #49, and #263) out of a total of 46 sampled residents. Specifically, 1. For Resident #99, the facility failed to ensure staff identified and address a deteriorating skin injury. 2. For Resident #42 the facility failed to obtain a culture and sensitivity (C&S) as ordered by the MD for 10 days after the order was initially given and failed to notify the MD that they were unable to fulfill the order. 3. For Resident #81, the facility failed to ensure it monitored or identified a Stage 2 calf wound or seek treatment to promote healing and prevent infection. 4. For Resident #41, the facility failed to ensure nursing staff completed his/her physician ordered wound treatment. 5. For Resident #49, the facility failed to ensure nursing staff completed his/her physician ordered wound treatment. 6. For Resident #263, the facility failed to ensure physician orders were implemented for his/her wound. Findings include: 1. Review of the facility's Care of Skin Tears - Abrasions and Minor Breaks, dated April 2022 indicated: Obtain a physicians order as needed. Document physician notification in the medical record. Report other information in accordance with facility policy/guideline and professional standards of practice. Resident #99 was admitted to the facility in August 2023 with diagnoses including Alzheimer's disease, dysphagia and legal blindness. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #99 scored 3 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating severe cognitive impaired. The MDS also indicated Resident #99 requires assistance with bathing, dressing and transfers. Review of Resident #99's Activities of Daily Living (ADL) care plan indicated the following interventions: Provide resident/patient with assist of one for dressing. Provide resident/patient with assist of two for bed mobility. Provide resident/patient with assist for ambulation, toileting. (3/2/24). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #99's clinical record indicated the following progress note written by Nurse #8 : 6/19/2024, at 11:37 A.M., while nurse was passing meds, CNA (Certified Nursing Assistant) assign (sic) to resident reported to the nurse, she noted blood on resident leg, and when she looks (sic), resident has a skin tear on the left leg shin area. Nurse assess resident for pain, resident denies any pain or discomfort. assess the skin tear, clean with normal saline and apply sterile strip and sterile border gauze applied. Nurse notified unit manager, HCP and resident physician. Review of the physicians note dated 7/11/24 indicated: [Resident #99] was seen at the facility for follow up where he/she is a long term care resident. [Resident #99] was seen to follow up a skin tear on his/her RLE (right lower extremity).Wound was cleaned with wound spray cleaner by RN (Registered Nurse), old dressing removed, and new dressing placed with santyl (an ointment used to treat wounds). Skin: RLE wound: 10 cm linear skin tear with some scar tissue formed at wound edges. Minimal erythema of the edges of the wound bed where it appears to be attempting to heal. No tenderness to palpation. Minimal warmth as compared to the adjacent leg, no surrounding erythema, some slough (dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material), upon removal of dressing unclear amount of time present on leg. Neurological: At baseline. Responds with inconsistently intelligible speech. States that it hurts when dressings were changed. Assessment/Plan: Open wound of right lower extremity. Skin tear initially noted 6/2024. Unclear if dressing was changed, removed at visit with some slough present, minimal warmth compared to L (left) leg, minimal edema, no pain on palpation, no fevers. Skin tear RLE with delayed healing, no signs of infection at this time. Wound care orders placed: Cleanse with normal saline, pat dry, apply bacitracin, cover with bordered gauze. Change daily - NP (Nurse Practitioner) follow up next week, will initiate antibiotics at that time if signs of cellulitis. Review of the physicians orders failed to indicate any orders for treatments were implemented for Resident #99's skin tear until 7/11/24; after the physician documented the wound had deteriorated evidenced by the presence of slough. During an interview on 8/8/24 at 11:26 A.M., Physician #2 said he had seen Resident #99's skin tear on his/her leg in June 2024 and a dressing was applied, but he did not write a note. Physician #2 said he spoke with nursing staff regarding caring for Resident #99's skin tear but he did not input orders to treat Resident #99's in the clinical record. Physician #2 said he came in to see Resident #99 again (on 7/11/24) and saw that he/she had a dressing on that was undated, saturated and visibly soiled. Physician #2 said that it appeared that the dressing had not been changed for an unknown period of time and was at risk for infection. Physician #2 said that Resident #99 is dependent for care and staff should have noticed that Resident #99's skin tear and dressing needed attention. Physician #2 said that Resident #99's skin tear had deteriorated since he had seen it in June 2024. Multiple calls were placed to Nurse #8 for interview which were unanswered. Unit Manager #2 was unavailable for interview. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 8/9/24 at 11:27 A.M., Corporate Nurse #1 said that attending physicians have access to the electronic record and will input treatment orders for residents which nurses are supposed to confirm. During an interview on 8/9/24 at 11:27 A.M. and 8/12/24 at approximately 12:30 P.M., The Director of Nursing (DON) said that nurses are to monitor and alert the physician with changes in resident skin condition and change dressings when they are visibly soiled. 41105 2. For Resident #42 the facility failed to obtain a culture and sensitivity (C&S) as ordered by the physician for 10 days after the order was initially given, and failed to notify the physician that they were unable to fulfill the order. Resident #42 was admitted to the facility in July 2022 and has diagnoses that include Multiple Sclerosis and chronic venous hypertension (Idiopathic) with ulcer of right lower extremity. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/10/24, indicated that on the Brief Interview for Mental Status exam Resident #42 scored a 15 out of 15, indicating intact cognition. The MDS further indicated Resident #42 had no wounds or skin issues. Review of the clinical record indicated the following: -A skin assessment, dated 7/22/24, indicated Resident #42 had no skin issues. -A nurses note dated 7/26/24: Area skin flaking and moist with pus filled skin to RLE (history of areas). New order to obtain wound C&S, NSW, pat dry, apply Bacitracin and cover with DPD until healed. -A skin assessment, dated 7/29/24, indicated Resident Resident #42's skin was not intact and had the following area to the front of his/her right lower leg: open areas present with purulent and serosanguineous drainage. -A Nurse Practitioner (NP) Progress note, dated 7/30/24, indicated: Chronic venous ulceration on right lower extremity, protein-calorie malnutrition, generalized muscle weakness. Noted on the patient's right lower extremity are multiple scattered shallow ulcerations with irregular borders. Some areas are reddened with granulation tissue and others are with slough, none tunneling, with large amounts of serous drainage, mild odor. (a deterioration from 7/6/24). Wound culture ordered, Venous Doppler Ultrasound. Continue health supplements. Continue daily dressing changes with NS (normal saline) and wrap with kerlix. We will order topical after results of wound culture is available. Review of the July 2024 Medication Administration Record (MAR) indicated the following order: Obtain wound C & S RLE wound. Start date 7/26/24 at 15:00. The MAR further indicates that after the order was obtained nursing failed to follow the order: -7/26/24 evening shift was left blank (not completed); -7/26/24 night shift was left blank; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-7/27/24 day shift was left blank; -7/27/24 evening shift was left blank; -7/27/54 night shift was left blank; -7/28/24 day shift was left blank; -7/28/24 evening shift was left blank; -7/28/24 night shift was left blank; -7/29/24 day shift was coded 9=other/see progress notes. The record indicated a progress note Unable to obtain d/t (due to) no culture swab. -7/29/24 evening shift was coded 2=drug refused; -7/29/24 night shift was left blank; -7/30/24 day shift was coded 9. The record failed to indicate a progress note; -7/30/24 evening shift was left blank; -7/30/24 night shift was coded 9. The record indicated a progress note unavailable. -7/31/24 day shift was coded 9. The record indicated a progress note having technical difficulties. -7/31/24 evening shift was coded with a check mark=drug administered; -7/31/24 night shift was coded with a check mark; -8/01/24 day shift was coded 9. The record indicated a progress note refused. -8/01/24 evening shift was coded 9. The record failed to indicate a progress note; -8/01/24 night shift was coded with a check mark; -8/02/24 day shift was coded 2=drug refused; -8/02/24 evening shift was coded 9. The record failed to indicate a progress note; -8/02/24 night shift was coded 9. The record failed to indicate a progress note; -8/03/24 day shift was coded with a check mark; -8/03/24 evening shift was coded with a check mark; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-8/03/24 night shift was coded with a check mark; -8/04/24 night shift was coded with a check mark; -A nurses note dated 8/4/24 indicated the C&S was obtained on 8/4/24; 10 days after the order was initially ordered. -A nurses note dated 8/8/24: Wound C&S results had come back and Resident #42 was positive for the following infection in the wound: + Proteus Mirabilis and Staphylococcus. During an interview on 8/12/24 11:42 A.M., Nurse #4 said that she was the nurse that initially obtained the order to get a C&S. Nurse #4 said that when the change to Resident #42's leg was noted the new orders should have been implemented on that day, however, the facility had no culture kits available, (which are provided by the lab) for a period of time. Nurse #4 said that she called the lab and the kits were delivered the end of the next week. She said that she should have notified the physician and written a progress note but that she has been very busy and must have forgotten. The record failed to indicate that the physician or Nurse Practitioner were notified that the kits were unavailable and that therefore the facility was unable to obtain the C&S for Resident #42's new wound. During an interview on 8/12/24 at 12:21 P.M., the Director of Nursing (DON) said that there was an issue with running out of kits and it took about a week to get them from the lab. The DON said that the physician should have been notified they could not fulfill an order. 15016 3. Resident #81 was admitted to the facility in May 2021 and had a primary diagnosis of stroke. Review of Resident #81's Norton Plus Pressure Ulcer Scale dated 7/30/24, indicated a score of 15, signifying a moderate risk for the development of pressure ulcers. Review of Resident #81's Minimum Data Set Assessment (MDS) dated [DATE], indicated a Brief Interview for Mental Status score of 1 out of 15; signifying severe cognitive impairment. The MDS indicated the Resident is completely dependent on staff for all bed mobility and required substantial assistance for all other activities of daily living. The MDS indicated the Resident was at-risk for pressure injuries but had no skin wounds and required pressure relieving devices for the bed and chair. Resident #81's care plan dated as revised 6/19/24, indicated: Focus: He/she was at-risk for skin breakdown due to decreased mobility and incontinence, staying in his chair for longer periods and refusing to go to bed. The care plan indicated, 3/23/24 multiple scabs to both legs - open to air. Goal: The resident will not show signs of skin breakdown x 90 days. Interventions included: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	- Monitor scabs on bilateral lower extremities and report changes to MD. - Resident at-risk for skin breakdown due to decreased mobility and incontinence, staying in his/her chair for longer periods and refusing to go to bed. - Independent bed mobility. - Pat (do not rub) skin when drying. - Provide preventative skin care i.e. lotions, barrier creams as ordered. - Apply barrier cream with each cleansing. Review of Resident #81's skin observation tool dated 7/18/24, indicated he/she had no wounds or pressure areas. Review of Resident #81's physician orders and notes and nursing notes dated prior to 8/8/24, did not indicate he/she had a skin wound. On 8/8/24 at 2:10 P.M., the surveyor and Nurse #9 observed that Resident #81 had a 1 centimeter (cm) x 1 cm wound located on the left calf. A dressing or other treatment was absent. Nurse #9 said this was a Stage 2 wound because of its depth and drainage, and the skin around the wound was erythematous. Nurse #9 said she would contact the physician to report the wound and obtain treatment orders. On 8/8/24 at approximately 2:20 P.M., Corporate Nurse #1 accompanied the surveyor and observed Resident #81's calf wound. Corporate Nurse #1 said this was only a scab and it did not need to be reported to the physician because treatment was not required. On 8/8/24 at 2:35 P.M., Unit Manager #1, accompanied by two surveyors, observed Resident #81's calf wound. Unit Manager #1 said the wound was a Stage 2 pressure injury due to its depth and surrounding erythema. Unit Manager #1 said none of the Certified Nurses Aides or nurses who provide care to the Resident and who are supposed to monitor the Resident for skin wounds, told him about this wound. Unit Manager #1 said he would notify Nurse Practitioner (NP) #2 about the wound and obtain treatment orders. Review of Resident #81's skin observation tool dated 8/8/24 and completed at 11:02 P.M. by Corporate Nurse #1, indicated a treatment was applied to a 1 cm x 1 cm wound located on the left calf. The assessment did not indicate the depth of the wound, or the type of treatment. Review of the Resident's nursing and physician progress notes and orders failed to indicate any reference to the Resident's wound or that staff notified the physician or NP #2 about the calf wound, or reference to a treatment. Review of Resident #81's medical record on 8/9/24 at approximately 8:50 A, M., indicated there was no documentation to indicate Nurse #9, Unit Manager #2, Corporate Nurse #1, or any other staff notified the physician or NP #2 about his/her calf wound. On 8/9/24 at approximately 8:15 A. M., 8:57 A.M. and 10:50 A.M., the surveyor observed Resident #81 in the dining room and that no dressing covered his/her exposed calf wound. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview with Certified Nurse Aide (CNA) #9 on 8/9/24 at 8:59 A.M., she said she regularly provides care to Resident #81 because he/she is dependent on staff for activities of daily living. CNA #9 said she was unaware the Resident had an open wound on his/her calf. The surveyor observed that the skin surrounding the Resident's calf wound was now purple. On 8/9/24 at 12:50 P.M., the surveyor telephoned NP #2 to determine if she was aware of Resident #81's calf wound. A voice mail message was left but as of 8/15/24 there was no call back. On 8/9/24 at 1:00 P.M., the surveyor observed Resident #81 in the dining area, sitting in a chair. The Resident's left calf wound was exposed and there was no dressing covering it. During an interview with the DON and Corporate Nurse #1 on 8/9/24 at 1:15 PM., the surveyor told them that Resident #81's skin assessment dated [DATE] and completed after the surveyor's observations of the wound earlier in the day, indicated a 1 cm x 1 cm wound on the left lower leg and that a treatment was applied. The surveyor told them there was no documentation in the record to indicate staff notified the physician or NP #2 about Resident #81's calf wound or obtained a physician's order for wound treatment. The surveyor informed them that, despite the assessment indicating a treatment was applied, as of this time Resident #81 did not have a dressing over the open wound. Corporate Nurse #1 said she telephoned the physician during the night of 8/8/24 and notified him that Resident #81 had a scab on the left calf. Corporate Nurse #1 said the physician told her to only apply skin prep because it was not an open wound. Corporate Nurse #1 said she forgot to document the conversation and treatment order. The surveyor told Corporate Nurse #1 that Unit Manager #1, a staff nurse and two surveyors observed the wound on 8/8/24 and determined it was an open wound, not a scab. On 8/9/24 at 1:20 P.M., the DON and surveyor observed Resident #81's calf wound. The DON said it was either a Stage 2 or an unstageable wound and not a scab. The DON said the skin surrounding the wound was purple and the wound had signs of drainage. The DON said skin prep was not an appropriate treatment for the wound and that it should be covered with a medicated dressing to encourage healing and prevent infection. The DON said staff had not made her aware of the wound. 43846 4. Resident #41 was admitted to the facility in April 2022 with diagnoses that included type 2 diabetes, chronic venous hypertension, and chronic kidney disease. Review of Resident #41's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. On 8/6/24 at 8:15 A. M., the surveyor observed Resident #41 in bed with exposed wounds on the left lower leg, no dressing was in place. During an interview on 8/6/24 at 8:16 A. M., Resident #41 said that the nurses are busy and do not do his/her leg treatment daily. Review of Resident #41's physician order, dated 7/2/24, indicated Left front calf: Wash with WC (wound cleanser), pat/dry, skin prep, cover the open area with collagen, puracol plus, and silicone border dressing QD/prn (daily/as needed). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #41's skin breakdown care plan, dated 3/2/24, indicated: Treatment as ordered. Review of Resident #41's nursing progress notes failed to indicate the Resident refused the left leg treatment. During an interview on 8/9/24 at 1:05 P.M., Nurse #6 said treatments should be completed as ordered and if a resident refuses a treatment, the doctor should be called and a nurses note should be written. During an interview on 8/12/24 at 10:37 A.M., the Director of Nurses (DON) said the expectation is the nurses complete their treatments as ordered. 5. Resident #49 was admitted to the facility in June 2016 with diagnoses that included multiple sclerosis, type 2 diabetes, dementia and legally blind. Review of Resident #49's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she scored a 7 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. The MDS further indicated the Resident is at risk for developing pressure ulcers and has a skin tear. The MDS also indicated that the Resident does not reject care. On 8/6/24 at 8:06 A.M., the surveyor observed Resident #49 in bed with wounds exposed on the right shin, no dressing was in place. Review of Resident #49's skin breakdown care plan, dated 3/2/24, indicated: Treatment as ordered. Review of Resident #49's physician order, dated 7/30/24, indicated: Right LE (lower extremity) wound care; Cleanse with NS (normal saline) and pat dry. Apply woundgel/ hydrogel, DPD (dry protective dressing) and kling daily. Review of Resident #49's skin observation tool, dated 7/31/24, indicated the Resident has right lower leg abrasions. Review of Resident #49's nursing progress notes did not indicate that the Resident refused the right lower extremity treatment. During an interview on 8/9/24 at 1:05 P.M., Nurse #6 said treatments should be completed as ordered and if a resident refuses a treatment the doctor should be called and a nurses note should be written. During an interview on 8/12/24 at 10:37 A.M., the Director of Nurses (DON) said the expectation is the nurses complete their treatments as ordered. 6. Resident #263 was admitted to the facility in August 2023 with diagnoses that included acute and chronic respiratory failure, dementia, hypertensive heart and chronic kidney disease. Review of Resident #263's Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has a moderate cognitive impairment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 8/6/24 at 8:01 A.M. and 12:18 P.M., the surveyor observed Resident #263 with a dressing on their right forearm with a date of 8/2/24. During an interview on 8/6/24 at 8:02 A.M., Resident #263 said he/she was not sure why they has a dressing on their forearm. Resident #263 said he/she has had it on their arm since being in the hospital. On 8/7/24 at 6:56 A.M., the surveyor observed Resident #263 with a dressing on their right forearm with a date of 8/6/24. Review of Resident #263's Comprehensive Nutritional Evaluation, dated 8/6/24, indicated a forearm skin tear. Review of Resident #263's active physician orders did not indicate a treatment order for the right forearm. During an interview on 8/9/24 at 1:05 P.M., Nurse #6 said there needs to be a doctors order in place for dressings to be done on any resident. During an interview on 8/12/24 at 10:25 A.M., the Director of Nurses (DON) said there should be a doctors order in place for any dressing treatment. Ref. F686, F725

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45343 Based on interview and record review, the facility failed to provide routine vision services to obtain new eyeglasses for one Resident (#20) out of a total sample of 46 residents. Findings include: Review of the facility's policy titled, Ancillary Physician, revised April 2022, indicated: Policy: -Routine and emergency optometry, podiatry and audiology services are available to meet the resident's health services by the resident's assessment and plan of care. Guidelines: -All services provided are recorded in the resident's medical record and a copy of the resident's record is provided to any facility to which the resident is transferred. Resident #20 was admitted to the facility in November 2023 with diagnoses that included hemiplegia affecting the left non-dominant side, and Type Diabetes Mellitus. Review of Resident #20's most recent Minimum Data Set (MDS) 5/22/24 indicated Resident #20 has a Brief Interview for Mental Status (BIMS) exam score of 8 out of a possible 15 which indicated he/she has moderate cognitive deficits. The MDS assessment also indicated Resident #20 requires partial/moderate to substantial/maximal assistance from staff for all self-care activities and has adequate vision with use of corrective lenses. During an interview on 8/16/24 at 8:00 A.M., Resident #20 was observed seated in his/her bed watching television and looking at his/her cell phone wearing one pair of glasses over another. Resident #20 said he/she wears both pairs of glasses when he/she wants to read text on his/her cell phone and watch tv at the same time. He/she said one pair is for reading and the other is so I can see the tv. Resident #20 was asked if he/she has been seen by the eye doctor, he/she said they have not seen an eye doctor since they were admitted to the facility in November. Review of Resident #20's medical record on 8/6/24 at 3:45 P.M., indicated Resident #20 signed a consent to see optometry on 11/14/23 and a doctor's order on 11/14/23 to consult ophthalmology as needed/indicated and treatment for patient health and comfort. A review of the facilities vision services records provided by the Administrator on 8/12/24 at 6:57 A.M., indicated no record of Resident #20 being seen by an eye doctor. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/12/24 at 9:55 A.M., Nurse #4 said if a resident needs to see the eye doctor the nurse will reach out to the consultant service and initiate the appointment and the unit manager ensures the resident is on the appointment list for the next scheduled facility visit by the eye doctor. Nurse #4 said she was not aware the Resident was wearing two pairs of glasses in order to be able to read and watch tv at the same time. During an interview on 8/12/24 at 1:09 P.M., Corporate Nurse #1 said it is the responsibility of the whole team and she would expect a referral to be made to the eye doctor if a resident needs new glasses.

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, interviews, policy review, and record review, the facility failed to provide care and treatment to prevent the development and worsening of pressure ulcers (wounds that occur when the skin and tissue are damaged by prolonged pressure, usually on bony areas like the coccyx, hips, heels, or elbows) for six Residents (#30, #14, #63, #10, #81, #3) out of a total sample of 46 residents. Specifically: 1. For Resident #30 the facility failed to implement interventions to prevent pressure ulcer development for a resident who is dependent on staff. The Resident developed an unstageable deep tissue injury on the right heel. 2. For Resident #14, the facility failed to implement treatments recommended by the Wound Nurse Practitioner resulting in the deterioration of a stage II pressure ulcer to an Unstageable pressure ulcer. 3. For Resident #63 and Resident #10, the facility failed to provide incontinence care resulting in the development of pressure ulcers. 4. For Resident #81, the facility failed to treat and promote the healing of a pressure injury. 5. For Resident #3, the facility failed to implement treatment recommendations made by the Wound Nurse Practitioner. Findings include: According to the National Pressure Injury Advisory Panel, a Stage 2 Pressure Injury is defined as a partial-thickness skin loss with exposed dermis and may present as an intact or ruptured serum-filled blister. A Deep Tissue Injury (DTI) is defined as a persistent non-blanchable deep red, maroon or purple discoloration, intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. Review of the facility's policy Pressure Ulcer/Injury Risk assessment dated as revised 3/20/22, indicated Notify attending MD if new skin alteration noted. Documentation in the medical record addressing MD notification if new skin alteration noted with change of plan of care, if indicated. 1. Resident #30 was admitted to the facility in June 2024 with diagnoses including schizoaffective disorder bipolar type, dementia and heart failure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Minimum Data Assessment (MDS) dated [DATE], indicated that Resident #30 scored a 10 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. Further review indicated that Resident #30 requires substantial to maximal assistance with all activities of daily living. Further review indicated that Resident #30 was at risk for developing pressure ulcers. Review of the care plan dated 6/19/24, with a focus of Potential alteration in skin integrity included the following interventions: -dietary interention/evaluation as indicated -Protective skin care with incontinent care -Rehab screen for positioning/seating as needed -Skin assessments weekly Further reveiw failed to indicate that pressure ulcer prevention interventions were implemented. Review of the facility document titled SKIN OBSERVATION TOOL - (Licensed Nurse) - V 4 dated 7/2/24, indicated that Resident #30's skin is intact. Review of the facility document titled RC Norton Plus Pressure Ulcer Scale and dated 7/9/24, indicated that Resident #30 scored a 10, indicating high risk for pressure ulcer development, (completed one month after Resident #30 was admitted to the facility and only after the development of a pressure ulcer on the right heel on 7/9/24). Review of the doctor's orders with an initiation date of 7/9/24 at 11:00 P.M., indicated an order for Prevalon boot to R (right) heel, off-load R heel every shift for R heel pressure ulcer. Review of the facility document titled SKIN OBSERVATION TOOL - (Licensed Nurse) - V 4 dated 7/10/24, indicated that Resident #30's right heel now has an intact blister. Review of the medical record indicated that Resident #30 was admitted to the hospital on 7/16/24 with pneumonia. Further review of the medical record failed to indicate the condition of the right heel since 7/10/24. Review of the facility document titled SKIN OBSERVATION TOOL - (Licensed Nurse) - V 4 dated 7/28/24, indicated that Resident #30 had a deep tissue injury (DTI) to the right heel and was readmitted from the hospital with a new open area on the Sacrum and a new DTI to L (left) heel. No measurements or staging were included in assessment. Review of the hospital discharge summary dated 7/28/24, failed to indicate Resident #30 had pressure ulcers or non-intact skin. Review of the care plan indicated a focus problem for alteration in skin integrity dated 8/6/24, with an intervention for Prevalon Boots to the right heel. Further review of the care plan failed to indicate that Resident #30 refused to wear the Prevalon boot. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 8/6/24 8:58 A.M., and 12:44 P.M., the surveyor observed Resident #30 laying in bed with both heels flat on the mattress. On 8/7/24, at 12:50 P.M., the surveyor observed Resident #30 laying in bed with his/her heels directly on the mattress. The surveyor observed that Resident #30 was not wearing a Prevalon boot to the right heel. The surveyor observed multiple reddish/brown spots of blood on the sheet under the right heel. The surveyor observed a dark maroon area, approximately the size of a half dollar, on the right heel that had sanguineous drainage. The surveyor was unable to locate a Prevalon boot in the Resident's room. Review of Nurse Practitioner (NP) #1 note dated 7/9/24, indicated a new pressure area to right lateral heel measuring 2.0 x 1.5 CM (centimeters). Further review indicated new order for skin prep to heel and Prevalon boots and off load both heels. Review of NP #1's notes dated 7/11/24 and 7/30/24 failed to indicate she had been notified of the wounds deteriorating. Further review failed to indicate that NP #1 evaluated the deteriorating wounds. Review of Physician #1's notes dated 7/12/24 and 8/2/24, failed to indicate he was aware of the pressure area on the right heel, left heel and sacrum. Review of the medical record failed to indicate any measurements or any process in place to monitor the progression of the wounds. During an interview on 8/8/24, at 9:38 A.M., the Director of Operations said that Resident #30 had not been seen by the wound doctor. On 8/8/24 at 9:26 A.M., the Director of Nursing (DON) said that it is the expectation for the nurse practitioner to be notified of a new pressure area and the wound doctor to see the resident within one week of the development of a new pressure area. The DON then said that she expects that the doctor's orders are followed. During an interview on 8/8/24, at 11:25 A.M., Unit Manager (UM) #1 said that he was not aware of Resident #30's wounds and would expect that a draining wound would be covered, and that the heels should be off loaded as ordered. UM #1 said that he would expect that wounds would be measured at least weekly to determine if treatments were effective. UM #1 then measured the wounds on both heels and said they each measured 3 CM x 3 CM, a deterioration since the 7/9/24, measurements taken by NP #1. UM #1 said that he was not aware that Resident #30 was supposed to have Prevalon boots on and was unable to locate them in the room. During an interview on 8/8/24, at 11:25 A.M., Certified Nurse's Aide (CNA) #4 said that she was not aware that Resident #30 was supposed to have Prevalon boots on. She then said that she had never seen the Resident with the boots on and could not find them in his/her room. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 8/12/24 at 8:50 A.M., the Wound Nurse Practitioner (NP) said that she was made aware of the Resident #30's wounds on the heels and sacrum today. The Wound NP then said that the wounds are significant. She also said that the wounds have been in place for more than a week based on their severity. The Wound NP then said that she comes in to the building once a week and said she would have expected to be have been notified of the wounds. Review of the Wound NP's note dated 8/8/24, indicated that Resident #30 has the following wounds: Pressure ulcer buttock left; stage 3, 5.4 x 3.6 x 0.3 cm (centimeters) 40% slough, 60% granulation. Pressure ulcer heel left; unstageable, 2.6 x 1.6 x 0 cm intact, boggy to touch, non-blanching maroon. Pressure ulcer heel right; unstageable, 3.7 x 2.4 x 0 cm boggy to touch, non-blanching maroon, small tear in tissue that produces drainage. Further review indicated that the Wound NP wrote and discussed with staff the following treatment recommendations: Pressure ulcers to left and right heel- skin prep to wounds, cover with ABD and wrap in Kerlex, Qday/PRN (every day and as needed). Off-loading in bed at all times, frequent repositioning, avoid pressure and trauma. Monitor for changes. Air Mattress recommended. Pressure ulcer buttock left- Wash with wound cleanser, pat dry, and skin prep to peri skin. Santyl to the area of the slough. Calcium alginate to entire wound with sacral dressing QD and PRN. Prompt pericare, frequent repositioning. Air mattress recommended. Review of the progress notes dated 8/8/24 through 8/12/24 failed to indicate that the doctor had been notified of the Wound NP recommendations. During an interview on 8/12/24, at 11:37 A.M., Unit Manager #1 said that it is the expectation that the nurse taking the recommendation from the Wound NP would call the primary doctor to review the recommendations and obtain the orders. During an interview on 8/12/24 at 11:44 A.M., the DON said that it is the expectation that the nurse taking the recommendation from the Wound NP would call the primary doctor to review the recommendations and obtain the orders. The DON also said that the facility has the nurse complete rounds with the Wound NP so that the nurse is aware of the recommendations at the time of the evaluation of the Wound NP and can then notify the primary doctor and obtain orders because sometimes it takes 24 hours to obtain the Wound NP's written evaluation. 36876 2. Resident #14 was admitted to the facility in May 2023 with diagnoses including peripheral vascular disease and type 2 diabetes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #14 is cognitively intact as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated he/she had pressure injuries and required assistance with bathing, dressing and transfers. Review of the clinical record indicated Resident #14 was readmitted to the facility after a hospitalization on [DATE] with closed unstageable pressure ulcer to his/her right heel. Review of Resident #14's Skin Integrity care plan dated as revised 3/25/24 indicated: Focus: Resident is at risk for skin breakdown related to diabetes, decreased mobility. Actual wounds; wound to right heel. (Interventions: pressure re-distribution surfaces to chair as per guidelines. Provide wound treatment as ordered. Provide supplements as ordered. Weekly skin check by license nurse. Weekly wound assessment to include measurements an description of wound status. Review of the Wound Nurse Practitioner visit note dated 5/16/24 indicated: Unstageable: 1 centimeters (CM) x 0.9 CM x 0 0.9 CM Exudate: None. 100% Closed. Note: Dry. Instruction: Skin prep Q shift (every shift) and prn (as needed). Avoid trauma and pressure. Boots in bed QD (every day) and prn. Monitor for changes . Review of the May 2024 Treatment Administration Record (TAR) indicated the following: Right heel pressure ulcer: Wash with soap and water pat dry apply skin prep, every shift and as needed. Review of the Wound Nurse Practitioner visit note dated 5/23/24 indicated: Pressure ulcer to right heel has opened up. Patient denies pain. Subsequent progress: Deteriorating Stage II, Exudate (fluid released through wounds): Light Serosanguinous (drainage that is typically thin and watery with a light red or pink hue) Note: 1 CM (centimeter) x 0.9 CM x 0.1 CM total area non-blanchable erythema and maroon. Instruction: Clean with wound cleanser open area pat dry, skin prep to peri skin and closed area of wound. Cover open area with collagen matrix, (a dressing for use on partial and full thickness wounds) silicone foam dressing, offload pressure booties in bed QD and prn. The May 2024 TAR indicated the Wound Nurse Practitioner's recommendations for the use of wound cleanser and collagen sheet were never implemented. 5/30/24: Pressure ulcer to right heel continues to open. No new complaints reported. Stage II, 3.5 CM x 4 CM x 0.1 CM. Exudate: Light Serosanguinous. Subsequent progress Deteriorating: Instruction: Cleanse with wound cleanser pat dry, skin prep to peri skin and closed non-blanchable area. Medi honey, (a treatment that supports the removal of necrotic tissue and aids in wound healing), to open area with necrotic tissue (tissue that is dead and indicative of a deterioration and is present on Stage III, Stage IV or Unstageable wounds.) Cover with collagen sheet. ABD (abdominal dressing) wrap in kerlix, booties in bed and frequent reposition. Q day/PRN. The presence of necrotic tissue and the increase in wound size on 5/30/24 indicated a deterioration from the previous visit on 5/23/24. The May 2024 TAR indicated the Wound Nurse Practitioner's recommendations for the use of wound cleanser, medi-honey, and collagen sheet were never implemented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 8/13/24 at 12:56 P.M., the Wound Nurse Practitioner said that she documented Resident #14's wound a Stage II on 5/30/24 because the necrotic tissue was on the edges of the wound and not the wound bed. Review of the Wound Nurse Practitioner visit note dated 6/13/24 indicated: Stage II, 2 CM x 2 CM x 0.1 CM. Exudate: Moderate Serosanguinous. Instruction: Cleanse with wound cleanser pat dry, skin prep to peri skin and closed non-blanchable area. Cover with a collagen sheet, ABD, wrap in kerlix, booties in bed and frequent reposition. Q day/PRN. Review of the June 2024 TAR indicated: Right heel pressure ulcer: Wash with soap and water pat dry apply skin prep, every shift and as needed. The June 2024 TAR indicated that the recommendations for the use of wound cleanser and collagen were not implemented. Review of the Wound Nurse Practitioner visit note dated 6/20/24 indicated: Stage II, 2.2 CM X 2 CM X 0 CM. Exudate: Light Serosanguinous Note: hard non-blanching eschar (a type of necrotic tissue that can develop on severe wounds which typically dry, black, firm, and usually adhered to the wound bed and edges). Instruction: Cleanse with wound cleanser pat dry, cover hard eschar with Santyl, and cover whole wound with collagen, ABD, and wrap in kerlix, offload, and pressure booties in bed QD and prn. The June 2024 TAR indicated that the recommendations for the use of wound cleanser, Santyl and collagen were not implemented. Review of the Wound Nurse Practitioner visit note dated 6/27/24 indicated: Unstageable, 2.5 CM x 2 CM x 0 CM. Exudate: None. Tissue Type: 100% Eschar. Instruction: Cleanse with wound cleanser pat dry, cover hard eschar with Santyl, and cover whole wound with collagen, ABD, and wrap in kerlix, offload, and pressure booties in bed QD and prn The June 2024 TAR indicated that the recommendations for the use of wound cleanser, Santyl and collagen were not implemented. Review of the Wound Nurse Practitioner visit note dated 7/4/24 indicated: Unstageable, 2.4 CM x 1.8 CM x 0 CM. Exudate: None. Tissue Type 100% Eschar. Note: Hard necrotic tissue. Peri skin fragile Instruction: Cleanse with wound cleanser pat dry, cover hard eschar with Santyl, and cover whole wound with collagen, ABD, and wrap in kerlix, offload, and pressure booties in bed QD and prn. Review of the July 2024 TAR indicated: Right heel pressure ulcer: Wash with soap and water pat dry apply skin prep every shift, 5/15/24 through 7/15/24. Right heel pressure ulcer: Cleanse with wound cleanser pat dry, Santyl to eschar, collagen to wound bed, ABD and wrap in kerlix, daily & prn. Document on wound bed, odor, drainage, surrounding skin, wound outcome, initiated 7/16/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The July 2024 TAR indicated that the treatment recommendations for collagen and Santyl were not implemented until 7/16/24. Review of the Wound Nurse Practitioner visit note dated 7/11/24 indicated: Unstageable, 2.5 CM x 1.8 CM x 0 CM. Exudate: None. Tissue Type: 100% Eschar. Note: Hard eschar. Instruction: Cleanse with wound cleanser pat dry, cover hard eschar with Santyl, and cover whole wound with collagen, ABD, and wrap in kerlix, offload, and pressure booties in bed QD and prn. The July 2024 TAR indicated that the treatment recommendations for collagen and Santyl were not implemented until 7/16/24. During an interview on 8/9/24 at 9:21 A.M., Resident #14 said that he/she does not like wearing booties as they irritate his/her heel, then said: I told them I am okay with using a pillow. Resident #14 showed the surveyor his/her right heel offloaded on a pillow in the bed. Resident #14 said that the Wound Nurse Practitioner comes in weekly to look at his/her wound and facility staff had been using Santyl on his/her heel wound for about a month. Resident #14 said that before using Santyl, staff would wash his/her wound and use lotion (skin prep). During an interview on 8/9/24 at 9:33 A.M., Nurse #9 said that when the wound nurse or attending physician makes recommendations or treatment orders, they input the orders themselves into the resident record and the nurse staff has to confirm them. During an interview on 8/9/24 at 9:50 A.M., Unit Manager #1 said that the wound nurse or physician puts orders into the computer as pending orders which are then confirmed by nursing staff. During an interview on 8/9/24 at 11:27 A.M., Corporate Nurse #1 said that the Wound Nurse Practitioner and attending physicians have access to the clinical record and they input orders and pending orders that nursing staff then confirms. During an interview on 8/9/24 at 12:13 P.M., the Wound Nurse Practitioner said that she rounds the facility weekly and does not input orders into the resident's electronic medical record. The Wound Nurse Practitioner said that she will write her note which is then uploaded individual medical record with the treatment recommendations. The Wound Nurse Practitioner said Resident #14 was non-compliant with wearing his/her bootie but she was not aware Resident #14's treatment recommendations were not implemented until July 2024. During an interviews on 8/12/24 at 11:44 A.M. and approximately 12:30 P.M., the Director of Nursing (DON) said she was not aware that Resident #14's treatment recommendations made by the Wound Nurse Practitioner were not implemented. 48671 3. Resident #63 was admitted to the facility in May 2024 with diagnoses including morbid severe obesity, type two diabetes, congestive heart failure, muscle weakness, localized edema, anemia in chronic kidney disease, and hereditary and idiopathic neuropathy. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #63's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #63 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated the Resident had intact cognition. The MDS further indicated Resident #63 is high risk for pressure ulcers, always incontinent of bowel and bladder and dependent on staff for toileting. Further review of the MDS indicated use of a pressure reducing device for his/her bed. Review of Resident #63's medical record indicated he/she scored a 10.0 on the Norton Plus Pressure Ulcer Scale, dated 6/14/24, indicating Resident #63 is high risk for pressure ulcers. Review of the physicians orders indicated: -Skin Assessment Weekly on Tuesday evening every evening shift every Tuesday. Dated 5/28/24. -Diabetic foot care daily. Check feet, toes, heels, report any redness or discolored area to the MD. Every evening shift. Dated 5/25/24. -Barrier Cream: Apply House Barrier Cream to bony prominences ever shift and as needed to prevent skin breakdown. Every shift for Preventative Measures. Dated 5/24/24. Review of the current care plan, included the following focuses: a. Skin Integrity- with interventions including; -Protective skin care with incontinent care. -Turn and reposition every 2-3 hours and PRN (as needed). b. Activity of Daily Living (ADL) care plan- with interventions including; -Assistance with toilet use, bed mobility, personal hygiene, and turning/repositioning. c. Incontinence care plan- with interventions including; -Brief worn, change every 2-3 hours and PRN. Review of the facility document titled Skin Observation Tool - (Licensed Nurse) - V4, indicated the following: -An assessment dated [DATE]: Rash, Right Scapula. Skin is intact otherwise. -An assessment, dated 6/8/24: Refused -An assessment, dated 7/10/24: Skin intact -An assessment, dated 7/17/24: Skin intact -An assessment, dated 7/31/24: Skin intact (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #63's nurse practitioner progress note dated 8/1/24 indicated the following: -Skin: No skin lesions or rashes noted in b/l UE or LE (bilateral upper extremities or lower extremities). Further review of the progress note indicated Resident #63 is at high risk for developing pressure ulcers. During an observation on 8/8/24, at 1:50 P.M., the surveyor observed Resident #63 laying in bed. Resident #63 said his/her incontinent brief had not been changed since 9:00 P.M. the night before, (for a total of 17 hours without incontinence care) and that he/she was wet and uncomfortable. During an interview on 8/8/24, at 1:55 P.M., CNA #4 said that Resident #63 had not been provided incontinent care because Resident #63 required an assist of two people to turn and reposition and there was not enough staff to care for all 24 residents on the unit. On 8/8/24 at 1:58 P.M., Corporate Nurse #1, Corporate Nurse #2 and Nurse #9 observed the Resident laying in bed. Corporate Nurse #1 removed the blankets to provide incontinence care. The Resident was observed wearing two incontinent briefs. Corporate Nurse #1 asked the Resident why he/she was wearing two incontinent briefs and the Residents said, I ask them to put two on me because no one comes and changes me. Resident #63 said the last time he/she was provided incontinence care or was repositioned occurred the night before at 9:00 P.M. Corporate Nurse #2 and Nurse #9 turned the Resident on to his/her left side and removed the two incontinence briefs. The two incontinence briefs were soaking wet with dark yellow, foul-smelling urine and contained pink, red, and brownish spots of discoloration throughout the brief, along the coccyx and buttocks area. The Resident had dried feces on his/her skin along the coccyx and buttocks area as well with excoriation throughout the buttock. The surveyor also observed a shallow open ulcer with red wound bed, bloody drainage and slough on the left buttock, a shallow open ulcer with red wound bed, bloody drainage and slough on the posterior thigh, and intact skin with localized area of persistent non-blanchable erythema and maroon discoloration on the coccyx. Corporate Nurse #1 said the Resident has three Stage II wounds. (In spite of slough being present in the wounds indicating wounds are a stage III). During an interview on 8/8/24 at 2:24 P.M., Corporate Nurse #2 said any open areas require recommendation for wound consultation and to notify the physician due to a change in condition. During an interview on 8/8/24 at 2:30 P.M., Corporate Nurse #1 said the expectation of the facility is that incontinent residents be toileted every two hours and as needed. During an interview on 8/8/24 at 2:48 P.M., Unit Manager #1 said Residents who require incontinence care and turning and repositioning are at risk for skin breakdown and should not be left sitting in urine without care. Review of the facility document titled Documentation Survey Report v2 (Activities of Daily Living (ADL) documentation sheet), dated August 2024, indicated Resident #63 was dependent on staff for toileting, and incontinent of bowel and bladder. Further review failed to indicate that ADL care was provided during the following shifts: On 8/7/24, 7:00 A.M. to 3:00 P.M. On 8/7/24, 11:00 P.M. to 7:00 A.M. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 8/8/24, 7:00 A.M. to 3:00 P.M. On 8/8/24, 3:00 P.M. to 11:00 P.M. Further review of the ADL Documentation Sheet indicated there were no documented refusals of care during the month of August 2024. During an interview on 8/12/24 at 8:39 A.M., the Wound Nurse Practitioner said best practice interventions in place include skin prep, floating his/her heels, an air mattress and said not following preventative measures can cause skin breakdown. During an interview on 8/12/24 at 10:19 A.M., the Director of Nurses (DON) said it is her expectation that staff reposition residents and provide incontinence care every two hours and said preventative measures upon admission should have been implemented and reviewed weekly to prevent skin breakdown. The DON said preventative measures include offloading heels, applying booties and an air mattress. The DON said weekly skin checks include assessment and documentation in the medical record. The DON said wound rounds are scheduled weekly and wounds are measured and documented by the Wound Nurse Practitioner. During an interview on 8/12/24 at 11:15 A.M., the Corporate Nurse #1 said, Nurses will describe open skin areas, but they would not measure them because they measure them wrong. We follow the facility policy, and the nurses notify the DON to add the resident to the wound rounds for the following Thursday. The wound nurse does the measuring and puts in orders. Corporate Nurse #1 said the physician would be notified and treatment orders would be adjusted after the wound nurse sees the residents the following Thursday. Corporate Nurse #1 said she expects staff to document care provided and document refusals of care in the chart. 15016 4. Resident #81 was admitted to the facility in May 2021 and had a primary diagnosis of stroke. Review of Resident #81's Norton Plus Pressure Ulcer scale dated 7/30/24, indicated a score of 15, signifying a moderate risk for the development of pressure ulcers. Review of Resident #81's Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status score out 1 of 15 signifying severe cognitive impairment. Resident #81's MDS indicated he/she is completely dependent on staff for all bed mobility and required substantial assistance for all other activities of daily living. The MDS also indicated Resident #81 was at-risk for pressure injuries but had no skin wounds and required pressure relieving devices for the bed and chair. Resident #81's care plan dated as revised 6/19/24, indicated: Focus: He/she was at-risk for skin breakdown due to decreased mobility and incontinence, staying in his chair for longer periods and refusing to go to bed. The care plan indicated, 3/23/24 multiple scabs to both legs- open to air. Goal: The resident will not show signs of skin breakdown x 90 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interventions included: - Independent bed mobility. - Monitor scabs on bilateral lower extremities and report changes to MD. - Pat (do not rub) skin when drying. - Provide preventative skin care i.e. lotions, barrier creams as ordered. - Apply barrier cream with each cleansing. - Resident at-risk for skin breakdown due to decreased mobility and incontinence, staying in his/her chair for longer periods and refusing to go to bed. Review of Resident #81's skin observation tool dated 7/18/24, indicated he/she had no wounds or pressure areas. Review of Resident #81's physician orders and notes and nursing notes dated prior to 8/8/24, did not indicate he/she had a skin wound on the left calf. On 8/8/24 at 2:10 P.M., the surveyor and Nurse #9 observed that Resident #81 had a 1 centimeter (cm) x 1 cm wound located on the left calf. A dressing or other treatment was absent. Nurse #9 said this was a Stage 2 wound because of its depth and drainage, and the skin around the wound was erythematous. A pressure-redistribution mattress was in use. On 8/8/24 at approximately 2:20 P.M., Corporate Nurse #1 accompanied the surveyor and observed Resident #81's calf wound. Corporate Nurse #1 said this was only a scab and it did not need to be reported to the physician because treatment was not required. On 8/8/24 at 2:35 P.M., Unit Manager #1, accompanied by two surveyors, observed Resident #81's calf wound. Unit Manager #1 said the wound was a Stage 2 pressure injury due to its depth and surrounding erythema. Review of Resident #81's skin observation tool dated 8/8/24 and completed at 11:02 P.M. by Corporate Nurse #1, indicated a treatment was applied to a 1 cm x 1 cm wound located on the left calf. The assessment did not indicate the depth of the wound, or other description, or the type of treatment. Review of the Resident's nursing and physician progress notes and orders failed to indicate any reference to the Resident's wound or that staff notified the physician or NP #2 about the calf wound, or reference to a treatment. Review of Resident #81's medical record on 8/9/24 at approximately 8:50 A.M., indicated there was no documentation to indicate Nurse #9, Unit Manager #2, Corporate Nurse #1, or any other staff notified the physician or NP #2 about Resident #81's calf wound. On 8/9/24 at approximately 8:15 A.M., 8:57 A.M. and 10:50 A.M., the surveyor observed Resident #81 in the dining room and that no dressing covered his/her exposed calf wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 8/9/24 at 12:50 P.M., the surveyor telephoned NP #2 to determine if she was aware of Resident #81's calf wound. A voice mail message was left but as of 8/15/24 there was no call back. On 8/9/24 at 1:00 P.M., the surveyor observed Resident #81 in the dining area, sitting in a chair. The Resident's left calf wound was exposed and there was no dressing covering it. During an interview with the DON and Corporate Nurse #1 on 8/9/24 at 1:15 PM., the surveyor told them that Resident #81's skin assessment dated [DATE] and completed after the surveyor's observations of the wound earlier in the day, indicated a 1 cm x 1 cm wound on the left lower leg and that a treatment was applied. The surveyor told them there was no further description of the wound or documentation in the record to indicate staff notified the physician or NP #2 about Resident #81's calf wound or obtained a physician's order for wound treatment. The surveyor informed them that, despite the assessment indicating a treatment was applied, as of this time Resident #81 did not have a dressing covering the open wound. Corporate Nurse #1 said she telephoned the physician during the night of 8/8/24 and notified him that Resident #81 had a scab on the left calf. Corporate Nurse #1 said the physician told her to only apply skin prep because she told him it was a scab and not an open wound. Corporate Nurse #1 said she forgot to document the conversation and treatment order. The surveyor told Corporate Nurse #1 that Unit Manager #1, a staff nurse and two surveyors observed the wound on 8/8/24 and determined it was an open wound, not a scab. On 8/9/24 at 1:20 P.M., the DON and surveyor observed Resident #81's open calf wound. The DON said it was either a Stage 2 or an unstageable wound and not a scab. The DON said the skin surrounding the wound was purple and the wound had signs of drainage. The DON said skin prep was not an appropriate treatment for the wound and that it should be covered with a medicated dressing to encourage healing and prevent infection. 43846 5. Resident #3 was admitted to the facility in January 2024 with diagnoses that included Alzheimer's disease, depression, and lymphedema. Review of Resident #3's most recent Minimu [TRUNCATED]

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, record review, policy review and interviews, the facility failed to identify and address a newly developed contracture for one Resident (#63) out of a total sample of 46 residents. Findings include: Resident #63 was admitted to the facility in May 2024 with diagnoses including morbid severe obesity, type two diabetes, congestive heart failure, muscle weakness, localized edema, anemia in chronic kidney disease, and hereditary and idiopathic neuropathy. Review of Resident #63's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #63 had a Brief Interview for Mental Status exam score of 15 out of a possible 15, which indicated the Resident had intact cognition. The MDS also indicated Resident #63 was dependent on staff for all functional tasks. Section GG of the MDS indicated the Resident did not have any impairments in range of motion. On 8/7/24 at 8:41 A.M., Resident #63 was observed laying in bed with both feet on the bed. The Resident said he/she was unable to turn or get up unassisted because of loss of feeling in his/her feet. Review of the discharge summary from the hospital, dated 5/23/24, failed to indicate contractures of the Resident #63's lower extremities were present. Review of Resident #63's admission nursing assessment dated [DATE], failed to indicate the Resident had an impairment of range of motion to his/her extremities. Review of Resident # 63's podiatry visit note dated, 7/2/24, indicated the following: - Patient was seen bedside at nursing facility today for consult for podiatric evaluation and at-risk foot care. -There is dry skin and severe fissuring left, right foot, which does not show any cardinal signs of cutaneous malignancy or significant irritation. - skin temp cool to touch skin thin, atrophic, dry, cracked, scaly feet. -Monitor pressure areas and continue offloading modalities as needed for OA (osteoarthritis)/foot deformities. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	- Pedal joints bilaterally are noted to have limited passive ROM (range of motion), there is atrophy of the fat pad noted with flexion of the PIPJs (Proximal Interphalangeal joint, is the first joint of the small toes) of the lesser toes and contracture noted at the corresponding MTPJs (the joints between the metatarsal bones of the foot and the proximal bones (proximal phalanges) of the toes, there are no gross obvious deformities present. Muscle strength is noted to be diminished in all 4 quadrants bilaterally. -Recommend Vitamin A&D/barrier cream as needed for xerosis/skin protection. Follow up 2-3 months or as needed Review of the Occupational Therapy evaluation dated 7/11/24 indicated Resident #63's failed to indicate the Resident had a lower extremity contracture. Calls placed to the physical therapy department for interview were not returned during the time of the survey. During an interview on 8/14/24 at 3:45 P.M., Occupational Therapist (OT) #1 said she was never told about a decline in Resident #63's range of motion or that a contracture was reported. OT #1 said Resident #63 has no physical therapy evaluation on file since admission. OT #1 said the facility does not have a Director of Rehabilitation and that they are running short staffed. During an interview on 8/15/24 at 2:02 P.M., Corporate Nurse #1 said new recommendation, or new contractures required notification to the physician and a change in condition protocol is to be followed. The Corporate Nurse #1 said the expectation is that the unit manager and Director of Nurses review all recommendations and notify the interdisciplinary team, obtain new orders, and update the plan of care. Corporate Nurse #1said she was unaware that the resident had a contracture, and all new contractures need follow up. Corporate Nurse #1said she expects recommendations to be reviewed the next day and expects notes in the medical record for recommendations as reviewed and or declined and said she would expect communication of any changes in range of motion to the therapy department so an evaluation could be completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41105 Based on record review and interview the facility failed to ensure a falls assessment and falls investigation were initiated timely following a fall with injury for one Resident (#103) out of a total sample of 46 residents. Findings include: Review of the policy titled Accidents, dated as revised 4/2022, indicated the following: -All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. Resident #103 was admitted to the facility in March 2024 and has diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and legal blindness. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/19/24, indicated that on the Brief Interview for Mental Status exam Resident #103 scored a 9 out of a possible 15, indicating moderately impaired cognition. Review of the falls care plan for Resident #103 indicates that Resident #103 is at high risk for falls. Interventions on the care plan include: -Follow facility fall protocol (date initiated: 3/20/24); -Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs (date initiated 3/20/24); -Ensure that Resident #103 is wearing appropriate footwear (SPECIFY and describe correct client footwear i. e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating or mobilizing in w/c (wheelchair) (date initiated 3/20/24, revision on 6/22/24); -PT evaluate and treat as ordered PRN (as needed) (date initiated 3/20/24). Review of the medical record indicated a progress note dated 8/12/24: During 6 AM rounds CNA reported red area to patients back, 2 abrasions noted to mid back along spine. Upper abrasion 4 x 1, lower abrasion 5 x 1 darker red in color. no drainage noted. When I asked patient if back hurt or if he/she knew what happened he/she stated he/she (sic) fell after dinner on Sunday. Patient stated he/she stood up from wheel chair to pick up container of cheese balls, he/she stated he/she lost his/her balance while holding the container and fell on his/her buttocks hitting his/her back against his/her belongings or dresser. Patient stated a staff member came into room to collect his/her tray and that is how he/she was found. (Resident name redacted) stated that the staff member help him/her off the floor and into bed. Patient denies hitting his/her head. Patient states he/she could not locate his/her call light to call for help to get cheese balls. Area to back washed with normal saline, no drainage noted. skin barrier applied. neuros at baseline. Pupils reactive. Hand grasps equal. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/12/24 at 10:49 A.M., Resident #103 said that he/she fell the previous evening. Resident #103 said that someone had pushed his/her snacks out of reach and that when he/she stood up to try to reach them, he/she fell back and landed on the floor beside his/her bed. Resident #103 said that when the aide came to pick up his/her supper tray they found him/her on the floor. Resident #103 said that the aide got him/her up and back in his/her chair. Resident #103 said that a nurse never came in to assess him/her following the fall. Review of the medical record failed to indicate that Resident #103 was evaluated by a nurse following the fall or that a falls investigation was initiated. During an interview on 8/12/24 at 12:45 P.M., with the Director of Nursing and Corporate Nurse #1 they said that they did not have a falls investigation for the surveyor to review as they only found out about the fall that morning at 6:00 A.M., when the CNA (Certified Nurse's Aide) saw the marks on Resident #103's back. Corporate Nurse #1 said that the expectation is that if a resident sustains a fall, the staff person that found him/her should have notified the nurse. The Nurse needs to assess the patient prior to getting him/her up off the floor The Nurse then should have initiated a falls investigation which would include getting statements from all staff that were working and from the resident. In this case, she said that did not happen.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on record review, policy review and interview the facility failed to maintain acceptable parameters of nutrition status for two Residents (#103 and #45) out of a total sample of 46 residents. Specifically: 1. For Resident #103, the facility failed to a.) obtain weekly weights as ordered and b.) address a significant weight loss timely. 2. For Resident #45, the facility failed to obtain a Registered Dietitian (RD) consult. Findings include: Review of the facility policy titled Weight Measurement, revised 4/17, indicated the frequency of weights will be determined by the IDT post-admission based on the resident's individual needs. All residents will be weighed at a minimum monthly. Monthly weights should be completed by the 10th of the month. Residents with a weight variance of 5 lbs more or less than the previous month will be re-weighed. The RN supervisor will notify the physician, responsible party and dietitian when a 5 lb more or less variance is noted. The resident plan of care will be updated accordingly. 1. Resident #103 was admitted to the facility in March 2024 and has diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and legal blindness. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/19/24, indicated that on the Brief Interview for Mental Status exam Resident #103 scored a 9 out of a possible 15, indicating moderately impaired cognition. During an interview on 8/06/24 at 8:00 A.M., Resident #103 said that the food here is absolutely terrible, at best it is warm, not hot and the taste is not good. Resident #103 said that he/she has lost a lot of weight, I think I am 120 now, but I was always around 200 pounds. Resident #103 said that because of this he/she barely eats. The record indicates Resident #103 had a significant weight loss of 23.98% since admission to the facility 5 months prior. Review of the current Nutrition care plan for Resident #103 indicated the following interventions: -Appetite stimulant a/o (as ordered). (Date initiated: 6/26/24); -Diet consult PRN (as needed). (Date initiated: 3/30/24); -Diet, supplements, fortified foods as ordered. (Date initiated: 3/20/24, Revision on: 6/26/24); -Honor food preferences as able. (Date initiated: 4/14/24); (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Glen Ridge	120 Murray Street Medford, MA 02155

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medications as ordered, observe for s.e. (side effects) and efficacy. (Date initiated: 3/20/24); -Monitor labs, weights, intakes, skin as ordered. Notify RD/MD/HCP of significant weight changes. (Date initiated: 3/20/24, Revision on: 6/26/24); -Observe diet texture tolerance and refer to SLP (Speech Language Pathologist) PRN (as needed). (Date initiated: 3/20/24); -Ok to eat all food brought in by family/friends, even if it is not pureed or soft. Is on pureed diet due to lack of teeth not dysphagia. (Date initiated: 8/06/24); -SLP as needed. (Date initiated: 4/14/24). Review of progress notes in clinical record indicated the following: -A Nurse's note, dated 4/9/24, that included: Poor appetite d/t (due to) dislike of facility's food -A Nurse Practitioner note, dated 4/17/23, that included the following : *Pt reports that sometimes he/she is hungry/thirsty but does not use his/her call light to ask for snacks/fluids - emphasized the importance of doing so, this writer brings him/her juice and crackers from the facility nutrition room which pt is appreciative of. He/she reports he/she has not been receiving his/her glucerna for the past few days while his/her regular RN (registered nurse) has been out, he/she is not sure why. -A Nurse practitioner note, dated 4/22/24, that included the following: -Some cramping discomfort in his/her toes while walking - may be d/t dehydration as PO intake continues to be poor. He/she does not like the food served at [the facility] so he/she tries to supplement his/her meals with snacks such as crackers, Glucerna (he/she is on Glucerna supplements TID). Review of the current Physician orders indicated the following order: -Obtain weight once a week Wednesday during day shift (start date 3/31/24). a.) Review of the Resident #103's weights taken since admission to the facility indicated: 8/06/2024 122.4 Lbs (Sitting) 8/05/2024 122.4 Lbs (Wheelchair) 7/03/2024 120.8 Lbs (Standing) 5/08/2024 128.4 Lbs (Wheelchair) 4/17/2024 128.6 Lbs (Sitting) 4/10/2024 159.0 Lbs (Sitting) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/19/2024 161.0 Lbs (Sitting) The record failed to indicate weekly weights have been obtained as ordered since 3/31/24. Of the 18 weights that should have been obtained weekly on Wednesdays, Resident #103's weight was obtained 5 times. The record failed to indicate Resident #103 refused to be weighed. b.) Review of the Hospital Discharge Summary exam weight indicated that on the date that Resident #103 transferred to the facility he/she weighed 161 Lb 2.5 oz. with a BMI of 26.82 kg/m. The discharge summary further indicated Resident #103 was evaluated by the Dietitian while in the hospital who indicated that weight running 150-160# range over past couple years. Review of the record indicated Resident #103 was evaluated by the facility's Dietitian twice since admission. The evaluations were on 4/14/24 and 6/26/24 and indicate the following: -An Admission Assessment, dated 4/14/24, which remains In Progress, summary indicated: Resident #103 is at risk of nutrition decline r/t advanced age, skin breakdown, CI, CHF, CKD, DM, HTN, HLD, MDD. Diet is therapeutic r/t DM and mechanically altered d/t dysphagia. Intakes at meals are variable at 25-100%. No food allergies are noted. Food preferences are honored as able. MVI and vitamin D help to meet micronutrient needs. Remeron 15mg stimulates appetite. Metformin, glargine and diet manage diabetes. Skin has a stage 2 area on the left foot. Recommend starting Prosource BID for extra protein. Mentation is moderately impaired. Code status is DNR, DNI. Goals are safe swallow, wound healing, A1C less than 7.0, maintain nutrition status and have stable weight. -A Comprehensive Nutritional Evaluation, dated 6/26/24, summary indicated: Resident #103 is at risk of nutrition decline r/t significant weight loss, CHF, CI, DM, GERD, HLD, CKD, MDD, legal blindness, advanced age. Diet is therapeutic r/t diabetes and mechanically altered d/t dysphagia. Intakes at meals are variable at 25-100%. Diet is supplemented with Prosource and Glucerna. No food allergies are noted. Food preferences are honored as able. MVI and ergocalciferol help to meet micronutrient needs. Remeron 15mg stimulates appetite. Glargine, Metformin and diet manage diabetes. BMI of 21.4 is WNL's. Weight loss is significant and may be partly d/t fluid shifts of CHF, CKD. Will start super cereal daily. Weekly weights requested. Skin is intact. Mentation is moderately impaired. Goals are to maintain nutrition status and have stable weight. Review of the medical record failed to indicate Resident #103 was evaluated by the facility's dietitian when a significant weight loss of 19.12 % was recorded on 4/17/24. The first evaluation occurred over 2 months later on 6/26/24. The only Nutrition note in the medical record, dated 7/18/24, indicated: Weight continues to decline. Clarified house supplement TID as 237 ml. Changed diet ginger ale at L & D to regular ginger ale. Question if Resident #103 is hospice appropriate. On 8/07/24 at 8:36 A.M., Resident #103 was observed seated in his/her room with a breakfast tray table in front of him/her consisting of oatmeal, diced potatoes and toast. Resident #103 said that he/she was only going to eat the oatmeal because he/she didn't like what the kitchen sent. During an interview on 8/08/24 at 9:47 A.M., the [NAME] President (VP) of Operations said that the facility's only Registered Dietitian (RD) is fully remote and does no come to the building. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/12/24 at 9:45 A.M., the RD said that weights should be taken as ordered and that if a significant weight loss is noted she would expect the resident to be reweighed. If the weight loss is validated she would expect to be notified of the weight loss as soon as possible and she would evaluate the resident within a few days, not two months. The RD said that if nursing and the Nurse Practitioner are aware that Resident #103 does not like the food at the facility, the Food Service Director (FSD) should meet with the resident and discuss food preferences, then update the tray card. The RD said that she only recently started following the long term care residents and that she saw Resident #103 in July for continued weight loss and questioned if the resident was appropriate for hospice. During an interview on 8/12/24 at 10:48 A.M., with Resident #103's Certified Nursing Assistant (CNA) #7 she said that she weighs the resident when the nurses ask her to, but isn't sure how often Resident #103 is supposed to get weighed. CNA #7 said that Resident #103 does not refuse to be weighed. During an interview on 8/12/24 at 12:15 P.M., with the Director of Nursing and Corporate Nurse (#1) they said residents with an order for weekly weights should be weighed weekly and that if the resident refused to be weighed it would be documented in the record. As well, they indicated that if a weight loss is recorded the resident should be reweighed to confirm accuracy. Corporate Nurse #1 said that the Physician and RD should be notified if weight loss is validated through a reweigh. As well, she said that the FSD should review preferences with a resident if the staff are aware that he/she does not like the food. Corporate Nurse #1 said that if there is a weight loss she would expect the RD to see the resident sooner than 2 months. During an interview on 8/12/24, at approximately 12:30 P.M., the FSD said that she met with Resident #103 upon admission to discuss food preferences, but has never met with him/her again because no one has asked her too and she is not aware that the Resident has any concerns with food. 43846 2. Resident #45 was admitted to the facility in April 2024 with diagnoses that included cerebral infarction, aphasia, and traumatic subdural hemorrhage. Review of Resident #45's most recent Minimum Data Set (MDS), dated [DATE], indicated that he/she scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. Further review of the MDS indicated that the Resident received nutrition via a feeding tube (a tube surgically inserted through the abdomin into the stomach). Review of Resident #45's medical record indicated the following weights; - 4/5/24 137 lbs (pounds). - 5/8/24 133.2 lbs. - no weight recorded for the month of June 2024. - 7/8/24 130.1 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #45's nutrition care plan, dated 4/21/24, indicated Monitor labs, weights, intakes, skin as ordered. Notify RD/MD/HCP of significant weight changes. Review of Resident #45's physician orders failed to indicate a weight order. Review of Resident #45's Nutrition Assessment, dated 7/5/2024, indicated: Recent weight requested. Goal is stable weight. Further review of Resident #45's assessment failed to indicate the dietitian followed up after Resident #45's weight loss was documented on 7/8/24. Review of Resident #45's physician order, dated 8/1/24, indicated refer to RD (registered dietitian) for consult. Review of Resident #45's medical record failed to indicate that a dietitian consult was obtained as ordered. During an interview on 8/12/24 at 9:34 A.M., Nurse #4 said when there is a new doctors order for a RD consult for a resident it should be completed within a few days. During an interview on 8/12/24 at 9:42 A.M., the Dietitian said when a doctor orders a RD consult that the Director of Nurses (DON) alerts her via email. The Dietitian said she never received an email to alert her that the Resident required a consult as she works only remotely. The Dietitian said it is unusual for a Resident who receives nutrition via a feeding tube to loose weight. The Dietitian said she should have followed up in July 2024 after his/her weight was obtained because the Resident had lost weight. The Dietitian said she would have put in more interventions like weekly weights if she had done the assessment. During an interview on 8/12/24 at 10:27 A.M., the DON said if a resident has a doctors order to have a RD consult then the Dietitian should be altered and the consult should be done within a few days of the doctors order. The DON said the Resident should have a doctors order to obtain weights at a certain frequency especially a resident who is loosing weight.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, interviews, policy review, and record review, the facility failed to provide respiratory care services in accordance with professional standards of practice two Residents (#6, and #30) out of a total sample of 46 residents. Specifically: 1. For Resident #6, the facility failed to ensure his/her oxygen (02) tubing was changed; 2. For Resident #30, the facility failed to ensure oxygen tubing was changed as ordered by the physician. Findings include: 1. Resident #6 was admitted to the facility in March 2023 with diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia and heart failure. Review of Resident #6's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating a moderate cognitive impairment. On 8/6/24 at 8:13 A.M. and 12:16 P.M., the surveyor observed Resident #6 in bed receiving oxygen via nasal cannula, the 02 tubing was dated for 5/15/24. On 8/7/24 at 6:59 A.M. and 12:45 P.M. ,the surveyor observed Resident #6 in bed receiving oxygen via nasal cannula, the 02 tubing was dated for 5/15/24. On 8/8/24 at 7:52 A.M., the surveyor observed Resident #6 in bed receiving oxygen via nasal cannula, the 02 tubing was dated for 5/15/24. On 8/9/24 at 6:57 A.M., the surveyor and Nurse #10 observed Resident #6 in bed receiving oxygen via nasal cannula, the 02 tubing was dated for 5/15/24. Review of Resident #6's physician order, dated 5/1/24, indicated 02 (oxygen) at 2 Liters prn (as needed) for 02 sat< (greater) 90% or SOB (shortness of breath). Further review of Resident #6's physician orders failed to indicate an order to change the oxygen tubing. During an interview on 8/9/24 at 6:59 A.M., Nurse #4 said 02 tubing should be changed weekly and as needed. Nurse #4 said there should be a doctors order in place to change the tubing. During an interview on 8/12/24 at 10:24 A.M., the Director of Nurses (DON) said the expectation is that the nurses change 02 tubing weekly and as needed. The DON said there should be a doctors order in place to change the 02 tubing and 02 filter. 48671 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #30 was admitted to the facility in June 2024 and has diagnoses that include dysphagia (difficulty chewing and swallowing), dementia, type two diabetes mellitus and protein calorie malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated that on the Brief Interview for Mental Status exam Resident #30 scored a 11 out of a possible 15, indicating moderate cognitive impairment. During an observation on 8/6/24 at 8:58 A.M., Resident #30 was observed lying in bed receiving 1.5 L (liters)of oxygen via nasal cannula. The oxygen tubing was not dated. During an observation on 8/6/24 at 12:44 P.M., Resident #30 was observed sitting in the dining room without oxygen. During an observation on 8/7/24 at 7:54 A.M., Resident #30 was observed sleeping in bed receiving 2.5 L of oxygen via nasal cannula. The oxygen tubing was now dated 8/5/24. During an observation on 8/7/24 at 12:18 P.M., Resident #30 was observed sitting up in bed receiving 2.5 L of oxygen via nasal cannula. The oxygen tubing was dated 8/5/24. Review of Resident #30's physician's orders indicated the following: -Oxygen at 2 L/min via nasal cannula continuously to maintain sat equal or greater than 90%. Every shift for shortness of breath, dated 6/13/23. -Oxygen at 2 lpm (liters per minute) to maintain O2 sat above 92%. Check O2 sat, and effectiveness every shift. Dated 7/29/24. Review of Resident #30's respiratory care plan dated as revised 6/12/24, indicated the following interventions: -Administer/monitor effectiveness of drugs affecting respiratory status (see MD orders and MAR). During an interview on 8/7/24 at 11:02 A.M., Unit Manager #1 said Resident #30 has an order for oxygen for 2 L and he/she should not be receiving 2.5 L. The Unit Manager said oxygen tubing must be changed weekly and dated. During an interview on 8/7/24 at 12:58 P.M. the Corporate Nurse #1 oxygen tubing should be changed weekly, and orders are expected to be followed as ordered by physician.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 41105 Based on interview, observation, record review and policy review, the facility failed to ensure that pain management, consistent with professional standards of practice, the comprehensive person-centered care plan, and the Resident's goals and preferences was provided for one Resident (#78) out of a total sample of 46 residents. Specifically the facility failed to: a.) ensure pain management was provided upon admission to the facility resulting in worsening pain after 19 hours without any medication available or administered and b.) provide effective pain management when Resident #78's scheduled pain medication ran out resulting in worsening pain. Findings include: The facility policy titled Pain Management, dated as revised April 2022, indicated the following: General Guidelines: 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. Pain Management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain Management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. 4. Cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain are considered when assessing and treating pain. Comprehensive pain assessments are conducted upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	5. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. 6. For stable chronic pain, the resident's pain and consequences of pain are assessed at least weekly. Reporting: -Report the following information to the physician or practitioner: 1. Significant changes in the level of the resident's pain; Resident #78 was admitted to the facility in May 2024 and has diagnoses that include contracture of muscle of right upper arm and Marfan Syndrome with Skeletal Manifestation. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/28/24, indicated that on the Brief Interview for Mental Status exam Resident #78 scored a 15 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #78 requires pain management on a scheduled basis as well as PRN (as needed), and that his/her pain was coded as almost constantly. During an interview on 8/06/24 at 9:01 A.M. Resident #78 said that he/she has had a terrible experience at the facility. Resident #78 explained that he/she has a diagnosis that causes significant pain and that the pain has not been managed by the facility. Resident #78 said I made a complaint to DPH after a week (of being at the facility) and things have gotten progressively worse. Review of Resident #78's current Pain care plan, initiated on 6/4/24, indicated: Focus: Chronic pain due to contractures and Marfan's syndrome. Interventions include: Administer and monitor for effectiveness and possible side effects from: Routine pain medication. PRN (as needed) pain medication. See [Medication Administration Record] (MAR). Monitor and report to nurse: Signs and symptoms of pain. Worsening of pain. Report changes in pain location /type frequency intensity to physician a.) Review of the Emergency Department documentation one day prior to Resident #78's admission to the facility indicated: Patient states that he/she has a history of Marfan's and with this does have chronic pain for which he/she uses a patch. The documentation also indicated that the patch was removed at the hospital on the date of transfer to the facility. The discharge orders from the hospital to the facility included the following pain management orders: Fentanyl 100 Mcg/hr (micrograms/hour), apply 2 patches every 72 hours Review of the May 2024 Medication Administration Record (MAR) indicated that Resident first had the Fentanyl 100 mcg/hr patch applied on 5/25/24 at 4:15 P.M.; nearly 19 hours after admission to the facility. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record indicated a progress note dated 5/25/24, in the morning, approximately 12 hours after the resident's admission to the facility: Writer this morning found a resident agitated, crying and stated he/she does not feel good because since yesterday when he/she came, haven't received any medication, sated (sic) that in pain and requesting to be transferred back to hospital, writer called pharmacy to request start orders of Dilaudid and Fentanyl patch because patient stated that he/she is in pain, Pharmacy phones goes to voice mail for 4 times, On call supervisor notified the situation, in about 30 minutes resident called 911 and taken back to hospital. Review of the Narcotic book indicated that all of Resident #78's admission medications, including the Fentanyl 100 mcg/hl patch were received from the pharmacy nearly 18 hours after Resident #78's admission to the facility. Review of the facility's MedWiz (an emergency medication supply system for medications not in stock) report failed to indicate the system was accessed to provide any pain medication for Resident #78 on 5/24/24 or 5/25/24. During an interview on 8/12/24 at 8:35 A.M., with the Director of Nursing (DON) and Corporate Nurse #1, Corporate Nurse #1 said that medication cannot be ordered from the pharmacy until a new admission is physically in the building. The admitting nurse should call the physician to get an order to order the resident's medication from the pharmacy upon the resident's admission. If the resident requires a narcotic, Corporate Nurse #1 said that the the physician will send a prescription directly to the pharmacy through the computer system. Corporate Nurse #1 said in the meantime, the nurse should either obtain the medication from the MedWiz system and if it is not available in the MedWiz, discuss with the MD what they should provide the resident for pain management coverage until the Resident's medication is available. The DON said that Resident #78 should not have had to wait 19 hours after admission to the facility to be medicated or have his/her pain addressed. b.) Review of the August 2024 Physician orders included the following orders: Fentanyl Transdermal Patch 72 hours 100 MCG/HR (Fentanyl) Apply 2 patch transdermally every 72 hours for pain and remove per schedule. Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) Apply 1 patch transdermally every 72 hours for chronic pain Apply together with the two 100 mcg/hr patches. For total dose of 212 mcg/hour of Fentanyl and remove per schedule. Pain assessment Q (each) shift using pain scale 1-3 Mild Pain, 4-6 Moderate pain, 7-9 Severe Pain, 10 Very severe pain During an observation and interview on 8/07/24 at 12:06 P.M., Resident #78 was observed in bed with his/her right upper arm exposed. 2 patches were applied to the right upper arm that were dated 8/6/24, 7-3. Resident #78 voiced being upset and in pain and presented with significant facial grimacing. Resident #78 said that he/she is supposed to have three pain patches applied but that the facility ran out of one of them yesterday. Resident #78 said that last night the nurses said they had to order more patches from the pharmacy and that they should be in by midnight last night. Resident #78 said that the patches never came in last night and that the nurse today said they are still waiting for the pain patches to come in from the pharmacy. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the August 2024 Medication Administration Record (MAR) indicated the following: -The order for Fentanyl Transdermal Patch 72 hours 100 MCG/HR (Fentanyl) Apply 2 patch transdermally every 72 hours for pain was administered on 8/6/24. -The order for Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) Apply 1 patch transdermally every 72 hours was blank. There was no progress note to indicate why the medication was not administered as ordered. -The most recent pain assessed on the 7-3 shift on 8/7/24 indicated Resident #78 reported a pain level of 5 Review of the clinical progress notes failed to indicate the Physician was notified that the Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) patch was not administered as ordered on 8/6/24 or that alternate pain management was provided. During a follow-up interview on 8/7/24 at 12:53 P.M., Resident #78 was grimacing and said that her pain level was a 10 out of 10 and has been all day. The surveyor asked Resident #78 if he/she had reported this to the Nurse (#1) and he/she said she didn't ask me, they never ask me. Review of the facility's MedWiz report failed to indicate the system was accessed to provide any pain medication for Resident #78 on 8/06/24 or 8/7/24. During an interview with Resident #78's Nurse #1 on 8/07/24 at 1:00 P.M., she verified that the facility had run out of Resident #78's Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) patch and that it was not available for application as ordered on 8/6/24. Nurse #1 said the following: -The nurse on each shift is responsible to monitor their medication supply and when they are low to reorder it through the computer system. -If it is a narcotic that needs to be refilled it is the nurse's responsibility to notify the MD who will send a prescription directly through the system to the pharmacy and that the Physician's at the facility were very good about doing this. -If a medication is not available the nurse must notify the MD and write a note. In Resident #78's case she said the note should indicate the MD's plan for pain management while waiting for the needed medication to come in from the pharmacy. -Resident #78's Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) patch came in last night but that the night nurse didn't give it and she does not know why. -Nurse #1 said that she did not apply the Fentanyl Transdermal Patch 72 hours 12 MCG/HR (Fentanyl) patch that day and planned to ask the Director of Nursing if it was okay to apply it late, but had not yet had a chance to try to speak with her that day. Nurse #1 said she did not notify the physician. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Resident #78 reported to her that his/her was a 5 on a scale of 1-10 that day. Nurse #1 said that Resident #78 is probably reporting that his/her pain level is a 10 now because of the patch not being on. On 8/8/24 at 1:49 P.M., Nurse #1 and the surveyor reviewed the narcotic book together. The Fentanyl 12 mg patch was logged in as received 8/7/24 but the nurse who received the medication failed to indicate what time it was received; rather in the section where the time was supposed to be written the nurse wrote received. During an Interview on 8/07/24 at 1:24 P.M., with the facility's Corporate Nurse #1 she would have expected the MD to notified yesterday when the pain patch was not available, a progress note written about the medication not being applies and what the MD wanted to do to address pain pending receipt of the patch. Corporate Nurse #1 said that the patch should have been applied when it came in last night, and that the nurse today should have told someone in administration and the MD that it had not been applied so that the pain could be addressed and possibly a PRN ordered obtained to cover the pain while waiting for the patch.

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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. 41105 Based on observations, record review, policy review and interviews, the facility failed to ensure for one Resident (#16), who required dialysis, that they received services consistent with professional standards of practice, out of a total sample of 46 residents. Specifically for Resident #16 the facility failed to ensure: a.) nursing consistently obtained the Resident's blood pressure from the correct arm to prevent harm or injury; b.) create a complete and resident specific care plan regarding Resident #16's dialysis care; and c.) nurses consistently followed the Physician orders regarding dialysis care. Findings include: Resident #16 was admitted to the facility in February 2024 with diagnoses including Type II diabetes mellitus with diabetic chronic kidney disease, End Stage Renal Disease (ESRD) and dependence of renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/10/24, indicated that on the Brief Interview for Mental Status exam Resident #16 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #16 requires dialysis. Review of the Resident #16's current Physician orders indicate Resident #16 requires dialysis 3 times a week. Additional orders include: -Dialysis access Type: Fistula to LUE and dialysis cath to right upper chest wall. Observe access sites for s/s of infection, bleeding or drainage. If areas appear compromised update NP/MD. Every shift for dialysis access sites. Start date 3/19/24. -Monitor AV fistula to Left forearm fot (sic) Bruit/Thrill every shift for AV fistula. Start date 3/19/24. -Monitor Dialysis access site dressing every shift fir AV fistula. Start date 3/19/24. -Monitor the Hemodialysis site for signs and symptoms of complications (e.g. bleeding, swelling, pain, drainage, odor, hardness or redness of site). Notify the Physician and Dialysis Center are notified immediately with any urgent medical problems. Start date 2/3/24. Review of the current dialysis care plan included the following interventions: -No b/p (blood pressure) on limb with shunt/CV dialysis catheter. -Avoid constriction on affected arm, such as carrying purse and constrictive clothing. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review indicated Resident #16's Dialysis care plan, was dated as created 7/3/24, five months after the Resident's admission and not at the time of the comprehensive admission assessments or in May 2024 at the time of a comprehensive quarterly assessment. Further review of the Dialysis care plan indicated the care plan was incomplete and indicated the following interventions: -Administer/monitor effectiveness of medications as ordered-(see physician's orders/MAR) (start date 7/3/24); -Avoid constriction on affected arm, such as carrying purse and constrictive clothing (start date 7/3/24); -Dialysis days: _____ (start date 7/3/24); -Monitor shunt site by palpating for thrill and auscultating for bruit daily. Notify physician of absence of thrill or bruit. (Note: No thrill/bruit present with Tessio or CV dialysis catheters) (start date 7/3/24); -Monitor shunt site for s/s infection, pain, or bleeding daily and PRN (start date 7/3/24) -No b/p on limb with shunt/CV dialysis catheter (start date 7/3/24); -Protect access site from injury. Site: _____ (start date 7/3/24) Review of the current Blood Pressure Summary report indicated that in the past 30 days Resident #16's blood pressure was obtained in his/her left arm 9 times. Review of the August 2024 Treatment Administration Record (TAR) included the following orders: 1. Dialysis access Type: Fistula to LUE and dialysis cath to right upper chest wall. Observe access sites for s/s of infection, bleeding or drainage. If areas appear compromised update NP/MD. Every shift for dialysis access sites. Start date 3/19/24. Review of the August 2024 TAR documentation failed to indicate a Nurse checked/documented the sites were observed on the following dates: -8/3/24 day shift -8/4/24 day shift -8/4/24 evening shift -8/5/24 evening shift -8/6/24 day shift -8/6/24 evening shift (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Monitor AV fistula to Left forearm fot (sic) Bruit/Thrill every shift for AV fistula. Start date 3/19/24. Review of the August 2024 TAR documentation failed to indicate a Nurse checked/documented the AV fistula site was monitored on the following dates: -8/3/24 day shift -8/4/24 day shift -8/4/24 evening shift -8/5/24 evening shift -8/6/24 day shift -8/6/24 evening shift 3. Monitor Dialysis access site dressing every shift for AV fistula. Start date 3/19/24. Review of the August 2024 TAR documentation failed to indicate a Nurse checked/documented the dialysis access site dressing was monitored on the following dates: -8/3/24 day shift -8/4/24 day shift -8/4/24 evening shift -8/5/24 evening shift -8/6/24 day shift -8/6/24 evening shift 4. Monitor the Hemodialysis site for signs and symptoms of complications (e.g. bleeding, swelling, pain, drainage, odor, hardness or redness of site). Notify the Physician and Dialysis Center are notified immediately with any urgent medical problems. Start date 2/3/24. Review of the August 2024 TAR documentation failed to indicate a Nurse checked/documented that they monitored the Hemodialysis site for signs and symptoms of complications on the following dates: -8/3/24 day shift -8/4/24 day shift -8/4/24 evening shift (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/5/24 evening shift -8/6/24 day shift -8/6/24 evening shift Further review of the medical record failed to indicate Resident #16 refused care on those dates. During an interview on 8/8/24 at 2:06 P.M., Nurse (#1) said Resident #16's blood pressure should never be taken from his/her left arm because that is the arm his/her dialysis fistula is in and it would be dangerous. Nurse #1 said that the expectation is that after a nurse takes Resident #16's blood pressure, they accurately document in the record which arm the blood pressure is taken from. Nurse #1 reviewed the blood pressure summary report and said she does not know why the blood pressure was taken from the left arm. Nurse (#1) reviewed the August TAR and said that there is no indication the orders were followed on the above dates, because they are not signed off. Nurse #1 said it is the expectation that nurses follow physician orders daily on all shifts and that they document that the order has been followed on the TAR. Nurse #1 said that if it is left blank on the TAR that means it was not completed. During an interview on 8/09/24 at 1:22 P.M., Nurse #4 said that blood pressure should never be taken from the arm where the fistula is located as it could cause bleeding, a blockage or some other complication. During an interview on 8/12/24 at 8:41 A.M., with both the Director of Nursing and Corporate Nurse (#1) they said that a dialysis patient's blood pressure should never be taken from the arm that the fistula is in. Corporate Nurse #1 said that it is her expectation that staff follow Physician orders and complete documentation for each order in the TAR and that the documentation should be accurate. She said that Resident #16's Dialysis care plan should be complete and include Resident #16's specific dialysis information. -

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 45343 Based on record review, policy review and interview the facility failed to ensure a plan of care was developed for Trauma Informed Care, with individualized interventions, for one Resident (#58) who had a history of trauma out of a total sample of 46 residents. Specifically, for Resident #58, the facility failed to develop a comprehensive trauma care plan, with individualized triggers. Findings include: Review of the facility policy titled Trauma Informed Care, dated 5/2022, indicated the following: Preparation: -Nursing staff are trained on screening tools trauma assessment and how to identify triggers associated with re-traumatization. General Guidelines: -Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers. Resident #58 was admitted to the facility in March 2024, with diagnoses including traumatic Post-Traumatic Stress Disorder (PTSD), dementia, and major depressive disorder. Review of Resident #58's most recent Minimum Data Set (MDS) assessment, dated 6/12/24, indicated that Resident #58 has severe cognitive deficits. Further review of the MDS indicated Resident #58 has an active diagnosis of PTSD and requires substantial/maximal assistance for daily activities. Review of Resident #58's care plan failed to indicate the development of a comprehensive trauma informed care plan with identified resident specific triggers and interventions for his/her diagnosis of PTSD. During an interview on 8/12/24 at 10:15 A.M., Nurse #13 said if a resident is identified with a PTSD diagnosis, there should be a care plan developed with specific triggers for staff to better care for the resident. During an interview on 8/12/24 at 10:53 A.M., Social Worker #1 said residents with PTSD should be formally assessed and a care plan should be developed with triggers identified. During an interview on 8/12/24 at 12:53 P.M., Corporate Nurse #1 said if PTSD is identified following a trauma informed assessment a patient centered care plan should be developed with triggers identified.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure there was sufficient staffing to provide necessary treatment and care to Residents on one of four nursing units ([NAME]). Subsequently, multiple residents were not provided incontinent care for 17 hours and skin checks revealed newly developed pressure areas for two Residents (#10 and #63). Findings include: Review of the Facility Assessment Tool, dated, 7/29/24, indicated: The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Staffing plan: Licensed nurses providing direct care: 16-18 per day; Nurse aides: 20-28 per day. Direct care staff Nurses 1:21 ratio (days and evenings) 1:41 nights. CNA: 1:13 ratio days. 1:14 ratio evenings. 1:21 ratio nights. Staff assignments are based on resident and need and census. The goal is to maintain consistent assignments for continuity of care. Review of of the facility's HPPD (Hours Per Patient Day) Report indicated that the facility budgeted 3.30 hours of direct patient care. Additional review of the HPPD report indicated that for 12 out of 30 the previous days the facility was below budget. During an interview with the Scheduling coordinator on 8/12/24 at 9:38 A.M., she said that it can be difficult to staff the units and that there are often call outs. The Scheduling Coordinator said that it is very difficult to staff the 7:00 A.M. - 3:00 P.M. shift when there is a call out. The Scheduling coordinator said that the [NAME] Unit goals for staffing on the 7:00 A.M. - 3:00 P.M. shift are for one nurse and two Certified Nursing Assistants (CNAs). On 8/8/24, the surveyor observed one nurse and one Certified Nurse's Aide (CNA) on the [NAME] unit to care for 24 residents until approximately 11:00 A.M., when another CNA was asked to float to the floor. During an interview on 8/8/24, at 8:30 A.M., Nurse #9 said that there is only her and one CNA on the unit and she cannot pass medication, complete treatments, pass food trays, supervise dining and help the CNA provide care. Nurse #9 said that it was too much and the residents on the unit are the ones that are suffering because of the low staffing. During an interview on 8/8/24, at 11:00 A.M., Unit Manager #1 said that there is not enough staff on the unit to care for 24 residents. During an interview on 8/8/24, at 11:30 A.M., CNA #4 said that she is not capable of providing care for 24 residents with only one nurse to help. CNA #4 then said that she had not provided care to some of the residents, had not changed their soiled briefs and had not repositioned those that needed assist. She then said that some of the residents require an assist of two people and several of those residents had not received care this morning. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/8/24 at 12:34 P.M., the Director of Nursing (DON) said that she was aware of the the staffing on [NAME] unit and believed that there were 22 total residents on the unit, (there were 24). Corporate Nurse #1 said that a CNA did not show up for work and another CNA from another unit was asked to float to the [NAME] unit. Corporate Nurse #1 was made aware that the CNA did not go to the [NAME] unit until approximately 11:00 A.M The Corporate Nurse said that staff would begin rounding to perform skin checks on Residents who had still not received morning care. On 8/8/24 the surveyors joined staff nurses in performing skin checks and the following was observed: On 8/8/24 at 1:58 P.M., Corporate Nurse #1, Corporate Nurse #2 and Nurse #9 observed the Resident laying in bed. Corporate Nurse #1 removed the blankets to provide incontinence care. The Resident was observed wearing two incontinent briefs. Corporate Nurse #1 asked the Resident why he/she was wearing two incontinent briefs and the Residents said, I ask them to put two on me because no one comes and changes me. Resident #63 said the last time he/she was provided incontinence care or was repositioned occurred the night before at 9:00 P.M. Corporate Nurse #2 and Nurse #9 turned the Resident on to his/her left side and removed the two incontinence briefs. The two incontinence briefs were soaking wet with dark yellow, foul-smelling urine and contained pink, red, and brownish spots of discoloration throughout the brief, along the coccyx and buttocks area. The Resident had dried feces on his/her skin along the coccyx and buttocks area as well with excoriation throughout the buttock. The surveyor also observed a shallow open ulcer with red wound bed, bloody drainage and slough on the left buttock, a shallow open ulcer with red wound bed, bloody drainage and slough on the posterior thigh, and intact skin with localized area of persistent non-blanchable erythema and maroon discoloration on the coccyx. Corporate Nurse #1 said the Resident has three Stage II wounds. (In spite of slough being present in the wounds indicating wounds are a stage III). During an interview on 8/8/24, at 1:55 P.M., CNA #4 said that Resident #63 had not been provided incontinent care because Resident #63 required an assist of two people to turn and reposition and there was not enough staff to care for all 24 residents on the unit. At 2:00 P.M., the surveyor and Unit Manager #1 observed Resident #10 lying in bed in a saturated incontinent brief. The surveyor and Unit Manager #1 observed the incontinent brief to be saturated and the color of the contents to be a dark reddish brown, with a strong smell of stale urine. Unit Manager #1 said that he could tell that there was no feces present but was concerned about the dark color of the urine. Unit Manager #1 said that Resident #10 should have had his/her incontinent brief checked and changed as needed but at least every two to three hours. Unit Manager #1 said that with the number of residents on the unit that require an assist of two staff members to provide care, one CNA and one nurse is not enough to get the job done. The surveyor and Unit Manager #1 then observed a non-blanchable area on the coccyx measuring 7L cm x 2W cm (centimeters). Unit Manager #1 said that the non-blanchable area on the coccyx was a stage one pressure area and was new. Unit Manager #1 said that leaving a resident in a saturated incontinent brief for an extended period of time could lead to skin breakdown. During an interview on 8/8/24, at 2:00 P.M., CNA #4 said that Resident #10 had not been provided incontinent care because Resident #10 required an assist of two people to turn and reposition and there was not enough staff to care for all 24 residents on the unit (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/9/24 at 9:29 A.M., Nurse #6 said that she typically works on the [NAME] Unit and there is never enough staff. Nurse #6 said staff often call out or do not show up and she then has to work a double. Nurse #6 said that the unit should be staffed with 2 nurses and 3 CNA's. Nurse #6 said that there have been times where it is one nurse and one CNA and it is difficult to pass medications, obtain resident blood sugars, pass trays, assist with resident care, contact physicians and do treatment orders and that on these days, sometimes treatments and tasks do not get done. 36797 During an interview on 8/12/24, at 11:10 A.M., Unit Manager #1 said that he was the only nurse on the unit for the 7:00 A.M. - 3:00 P.M. shift. Unit Manager #1 said that even with one nurse and two CNA's it was hard to provide the needed care for 24 residents when he is responsible for all medications, all treatments, all contact with doctors, dealing with changes to doctor's orders, and checking and passing all meal trays. Unit Manager #1 said that at least 6 of the residents on the unit require an assist of two staff members to provide care and two CNA's and one nurse on the unit is just not enough. Review of the nursing schedules and time sheets from 7/9/24 through 8/9/24 indicated that there was one nurse and one CNA working on 7/9/24, 7/14/24, 7/25/24 and 8/8/24 on the [NAME] Unit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review, policy review and interview, the facility failed to ensure recommendations from the Monthly Medication Reviews (MMRs) conducted by the consultant pharmacist were addressed and acknowledged by the physician in a timely manner for two Residents (#28, and #104) out of a total sample of 46 residents. Findings Include: 1. Resident #28 was admitted to the facility in July 2023 with diagnoses that included vascular dementia, chronic kidney disease, obstructive sleep apnea, heart failure and asthma. Review of Resident #28's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. Review of Resident #28's Medication Record Review, dated 3/7/24 and 5/15/24, indicated that the Resident is currently receiving metoprolol succinate 25 mg (milligrams) twice a day. This formulation is dosed once daily (metoprolol tartrate is dosed every 12 hours). Recommend changing order to metoprolol succinate 50 mg once daily for same total dose of 50 mg. Review of Resident #28's physician orders, start date of 12/5/23 and a discontinued date of 8/9/24, indicated Metoprolol Succinate Oral Tablet Extended Release (ER) 24 Hour 25 MG Give 1 tablet by mouth two times a day. Review of Resident #28's March, April, May, June, July and August 2024 Medication Administration Records (MARs) indicated the Resident received Metoprolol Succinate (ER) 25 mg as ordered twice a day. During an interview on 8/12/24 at 10:29 A.M., the Director of Nurses said the MMRs for Resident #28 should have been completed by now but have not. 36876 2. Resident #104 was admitted to the facility in November 2023 with diagnoses including coronary artery disease and diabetes. Review of Resident #104's pharmacy recommendations indicated: 3/7/24: Resident appears to have duplicate medication orders for the following medications. Suggest discontinuing one of the orders. Tylenol X2 orders with the following directions: 2 tabs q8h prn pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/15/25: Resident appears to have duplicate medication orders for the following medications. Suggest discontinuing one of the orders. Tylenol X2 orders with the following directions: 2 tabs q8h prn pain. 7/10/24: Resident is receiving ibuprofen. NSAIDS are known to cause GI symptoms that may be reduced if medication is given with food. Please update medication order and MAR (medication administration record) to include give with food or milk. Each pharmacy review had been signed by the physician indicating for staff to implement the recommendation. Review of Resident #104's physicians orders indicated that the pharmacy recommendations from 3/7/24, 5/15/24, and 7/10/24 were not implemented until 8/9/24. During an interview on 8/9/24 at 11:27 A.M. Corporate Nurse #1 said that they were aware of the delay in implementing pharmacy recommendations.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interviews the facility failed to ensure that PRN [as needed] psychotropic drugs were limited to 14 days for one Resident (#3) out of a total sample of 46 residents. Specifically, for Resident #3 the facility failed to ensure his/her Lorazepam had a stop date. Findings include: Resident #3 was admitted to the facility in January 2024 with diagnoses that included Alzheimer's disease, depression, and lymphedema. Review of Resident #3's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. Review of Resident #3's physician order, dated 7/17/24, indicated Lorazepam (anti-anxiety medication) 2 MG/ML (milligram/milliliter) give 0.25 milliliter by mouth every 4 hours as needed for anxiety. During an interview on 8/9/24 at 1:07 P.M., Nurse #6 said the expectation is that if a resident has an order for Lorazepam as needed, it needs to have a stop and re-evaluation date in the order but does not. During an interview on 8/12/24 at 10:06 A.M., the Director of Nurses (DON) said an as needed Lorazepam order needs a stop and re-evaluation date in the doctors order.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observation, policy review and interview, the facility failed to ensure nursing staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically: 1. The facility failed to properly secure medication carts on two of four units, 2. The facility failed to properly secure treatment carts on two of four units, 3. The facility failed to properly secure the medication room on the Oak Grove Unit, 4. The facility failed to ensure opened insulin was labeled with resident's name, the prescription label, or opening and expiration dates for two medication carts on the [NAME] unit, 5a. and b. The facility failed to ensure staff stored medications and biologicals in accordance with State and Federal laws. Findings Include: Review of the facility policy titled Medication Storage, revised 3/22, indicated 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. The facility shall not use discontinued, outdated drugs or biologicals. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 1. On 8/6/24 at 8:01 A.M., the surveyor observed a medication cart on the Oak Grove Unit unlocked and unsupervised in the hallway. No staff were present. On 8/9/24 at 6:59 A.M., the surveyor observed a medication cart on the Oak Grove Unit unlocked and unsupervised in the hallway. No staff were present. During an interview on 8/9/24 at 1:06 P.M., Nurse #6 said if a nurse is not present at the medication cart then it should be locked. During an interview on 8/12/24 at 10:28 A.M., the Director of Nurses (DON) said if a nurse is not present at the medication cart then it should be locked. 2a. On 8/6/24 at 8:58 A.M., the surveyor observed the treatment cart unlocked and unsupervised in the hallway on the [NAME] Unit. No staff were present at the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/24 at 8:58 A.M., the surveyor observed the treatment cart unlocked and unsupervised in the hallway on the [NAME] Unit. No staff were present at the cart. On 8/9/24 at 12:58 P.M., the surveyor observed the treatment cart unlocked and unsupervised in the hallway on the Maplewood Unit. No staff were present at the cart. During an interview on 8/9/24 at 1:06 P.M., Nurse #6 said if a nurse is not present at the treatment cart then it should be locked. During an interview on 8/12/24 at 10:28 A.M., the Director of Nurses (DON) said if a nurse is not present at the treatment cart then it should be locked. 2b. On 8/06/24 at 12:22 P.M., on the Maplewood Unit the surveyor observed the treatment cart was unlocked and unattended. The surveyor was able to open and access the cart and staff were unaware. During an interview on 8/06/24 at 12:23 P.M., Nurse #15 she said that the treatment cart is supposed to be locked when unattended. On 8/09/24 at 1:09 P.M., on the Maplewood Unit the surveyor observed the treatment cart was unlocked and unattended. The surveyor was able to open and access the cart and staff were unaware. During an interview on 8/09/24 at 1:10 P.M., Nurse #4 said that the cart is supposed to be locked and that she must have forgotten to lock it. On 8/12/24 at 10:16 A.M., on the Maplewood Unit the surveyor observed the treatment cart was unlocked and unattended. The surveyor was able to open and access the cart and staff were unaware. During an interview on 8/012/24 at 10:17 A.M., Nurse #12 said that the cart is supposed to be locked when unattended. 3. On 8/9/24 from 10:41 A.M. to 1:04 P.M., the surveyor observed the medication room on the Oak Grove Unit unlocked and unsupervised. No staff were present in the medication room. During an interview and observation on 8/9/24 at 1:04 P.M., Nurse #6 said the medication room is unlocked and should not be. During an interview on 8/12/24 at 10:28 A.M., the Director of Nurses (DON) said if a nurse is not present in the medication room then it should be locked. 15016 4. On 8/9/24 at 8:55 A.M., the surveyor observed the two medications carts (A and B) on the [NAME] unit, accompanied by Nurse #9. Medication cart A contained: - Opened Asparte Kwik pen (a short-acting insulin). The pen did not have a label with a resident's name, a prescription label, or an opening and expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication cart B contained: - Opened Lantus Kwikpen (a long acting insulin). The pen did not have a label indicating the opening or expiration date. - Opened Lispro Kwikpen (a fast-acting insulin). The pen did not have a label indicating the opening or expiration date. - Opened vial of ciprofloxacin ophthalmic solution 0.3% (an antibiotic). The vial did not have label indicating the opening or expiration date. During an interview on 8/8/24 at approximately 9:00 A.M., Nurse #9 said all insulin and antibiotic solutions should have a resident name printed on them, and a label with the opening and expiration date. 48671 5. On 8/7/24 at 8:30 A.M., the surveyor observed a medication cup containing 6 pills, and one insulin syringe containing 10cc of insulin, uncapped with the needle exposed, left on top the medication cart on the [NAME] Unit, and the medication cart was unlocked. The surveyor continued to make the following observations from 8:30 A.M., to 8:59 A.M.: -Nurse #3 was observed drawing up insulin and placing the uncapped syringe on top of the medication cart next to the medication cup of 6 pills. Nurse #3 walked away from her medication cart. The surveyor observed a Resident standing directly in front of the unlocked medication cart. There were no staff present in the area of the unlocked medication cart. -Nurse #3 was observed picking up the medication cup containing the 6 pills and the insulin syringe with the exposed needle and placing them on top of the countertop at the nurse's station and walking away. There were no staff present in the area and Residents were observed walking past the nurse's station. - Nurse #3 was observed picking up the medication cup containing the 6 pills and the insulin syringe with the exposed needle, and walking into the dining room area and placing them on top of a breakfast tray that was placed in front of a resident sitting at the table. The Nurse was then observed walking away from the resident leaving the medication cup containing the 6 pills and the insulin syringe with the exposed needle in front of the Resident. During an interview on 8/7/24, at 8:59 A.M., Nurse #3 saw the surveyor standing next to resident sitting at the table with the medication cup containing the 6 pills and the insulin syringe with the exposed needle. Nurse #3 said she should not have left the medication unattended and should not have an injection needle exposed. Nurse #3 said that the medication cart should be always locked. During an interview on 8/7/24, at 9:30 A.M., Unit Manager #1 said medications should not be left unattended and medication carts must be locked when not in use. The Unit Manager #1 said needles should not be left unattended or placed on the nurses station, medication cart, or left in front of a Resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/7/24 at 10:50 A.M., Corporate Nurse #1 said medications and syringes must never be left unattended and medications must be locked at all times. During an interview on 8/12/24 at 10:27 A.M., The Director of Nursing (DON) said medications and medication carts must be locked and not left open or accessible by residents. 41105

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, interview and observation the facility failed to accurately document in the clinical record for six Residents (#81, #30, #16, #63, #5, #90) of 46 sampled residents. Specifically: 1. For Resident #81 the facility failed to accurately document a Stage 2 pressure injury assessment. 2. For Resident #30 the facility failed to accurately document the wearing of Prevalon boots on the treatment sheet. 3. For Resident #16 the nurse staff failed to consistently follow the Physician's orders regarding dialysis care as indicated in the Treatment Administration Record (TAR). 4. For Resident #63, the facility failed to accurately document a Stage 3 pressure injury assessment 5. For Resident #5 the facility failed to accurately document that medications had been administered when they had not. 6. For Resident #90 the facility failed to accurately document wearing of bilateral upper extremity Geri sleeves. Findings include: 1. Resident #81 was admitted to the facility in May 2021 and had a primary diagnosis of stroke. Review of Resident #81's Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status score of 1 of 15 points, signifying severe cognitive impairment. Resident #81 was completely dependent on staff for all bed mobility and required substantial assistance for all other activities of daily living. The Resident was at-risk for pressure injuries but had no skin wounds. The Resident required pressure relieving devices for the bed and chair. Resident #81's care plan dated as revised 6/19/24, indicated: - Resident at-risk for skin breakdown due to decreased mobility and incontinence, staying in his/her chair for longer periods and refusing to go to bed. - Goals included the use of pressure relieving devices. - Interventions included showing no signs of skin breakdown x 90 days. Review of Resident #81's skin observation tool dated 7/18/24, indicated he/she had no wounds or pressure areas. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #81's physician orders and notes and nursing notes dated prior to 8/8/24, did not indicate he/she had a skin wound. On 8/8/24 at 2:10 P.M., the surveyor and Nurse #9 observed that Resident #81 had a 1 centimeter (cm) x 1 cm wound located on the left calf. A dressing or other treatment was absent. Nurse #9 said this was a Stage 2 wound because of its depth and drainage, and the skin around the wound was erythematous. On 8/8/24 at approximately 2:20 P.M., Corporate Nurse #1 accompanied the surveyor and observed Resident #81's calf wound. Corporate Nurse #1 said this was only a scab and it did not need to be reported to the physician because treatment was not required. On 8/8/24 at 2:35 P.M., Unit Manager #1, accompanied by two surveyors, observed Resident #81's calf wound. Unit Manager #1 said the wound was a Stage 2 pressure injury due to its depth and surrounding erythema. Review of Resident #81's skin observation tool dated 8/8/24 and completed at 11:02 P.M. by Corporate Nurse #1, indicated a treatment was applied to a 1 cm x 1 cm wound located on the left calf. The assessment did not indicate the depth of the wound, or other description, or the type of treatment. Review of the Resident's nursing and physician progress notes and orders failed to indicate any reference to the Resident's wound or that staff notified the physician or NP #2 about the calf wound, or reference to a treatment. Review of Resident #81's medical record on 8/9/24 at approximately 8:50 A.M., indicated there was no documentation to indicate Nurse #9, Unit Manager #2, Corporate Nurse #1, or any other staff notified the physician or NP #2 about Resident #81's calf wound. On 8/9/24 at approximately 8:15 A.M., 8:57 A.M. and 10:50 A.M., the surveyor observed Resident #81 in the dining room and that no dressing covered his/her exposed calf wound. On 8/9/24 at 12:50 P.M., the surveyor telephoned NP #2 to determine if she was aware of Resident #81's calf wound. A voicemail message was left but as of 8/15/24 there was no call back. On 8/9/24 at 1:00 P.M., the surveyor observed Resident #81 in the dining area, sitting in a chair. The Resident's left calf wound was exposed and there was no dressing covering it. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON and Corporate Nurse #1 on 8/9/24 at 1:15 PM., the surveyor told them that Resident #81's skin assessment dated [DATE] and completed after the surveyor's observations of the wound earlier in the day, indicated a 1 cm x 1 cm wound on the left lower leg and that a treatment was applied. The surveyor told them there was no further description of the wound or documentation in the record to indicate staff notified the physician or NP #2 about Resident #81's calf wound or obtained a physician's order for wound treatment. The surveyor informed them that, despite the assessment indicating a treatment was applied, as of this time Resident #81 did not have a dressing over the open wound. Corporate Nurse #1 said she telephoned the physician during the night of 8/8/24 and notified him that Resident #81 had a scab on the left calf. Corporate Nurse #1 said the physician told her to only apply skin prep because she told him it was a scab and not an open wound. Corporate Nurse #1 said she forgot to document the conversation and treatment order. The surveyor told Corporate Nurse #1 that Unit Manager #1, a staff nurse and two surveyors observed the wound on 8/8/24 and determined it was an open wound, not a scab. On 8/9/24 at 1:20 P.M., the DON and surveyor observed Resident #81's calf wound. The DON said it was either a Stage 2 or an unstageable wound and not a scab. The DON said the skin surrounding the wound was purple and the wound had signs of drainage. The DON said skin prep was not an appropriate treatment for the wound and that it should be covered with a medicated dressing to encourage healing and prevent infection. 36797 2. Resident #30 was admitted to the facility in June 2024 with diagnoses including schizoaffective disorder bipolar type, dementia and heart failure. Review of the Minimum Data Set (MDS) dated [DATE], indicated that Resident #30 scored a 10 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. Further review indicated that Resident #30 requires substantial to maximal assistance with all activities of daily living. Review of the doctor's orders with an initiation date of 7/9/24 at 11:00 P.M., indicated an order for Prevalon boot to R (right) heel, off-load R heel every shift for R heel pressure ulcer. Further review indicated an order for Pressure relief heel boots to bilat (bilateral) feet when in bed, remove for skin checks and patient tolerance every shift for preventitive measures. Review of the care plan indicated a focus problem for alteration in skin integrity dated 8/6/24, with an intervention for Prevalon Boots to the right heel. Further review failed to indicate that Resident #30 refused to wear the Prevalon boot. On 8/6/24 8:58 A.M., and 12:44 P.M., the surveyor observed Resident #30 lying in bed with both heels flat on the mattress without Prevalon boots on. On 8/7/24, at 12:50 P.M., the surveyor observed Resident #30 lying in bed with his/her heels directly on the mattress. The surveyor observed that Resident #30 was not wearing a Prevalon boot to the right heel and there were no pressure relief boots in the room. The surveyor observed multiple reddish/brown spots of blood on the sheet under the right heel. The surveyor was unable to locate a Prevalon boot in the Resident's room. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/8/24, at 11:25 P.M., the surveyor and Unit Manager #1 observed Resident #30 to not be wearing Prevalon boots and both heels were flat on the mattress. During an interview on 8/8/24, at 11:25 P.M., Unit Manager (UM) #1 said the heels should be off loaded as ordered. UM #1 said that he was not able to locate the Prevalon boots for the Resident in the room. Unit Manager #1 then said that Resident #30's feet were not off-loaded from the mattress. During an interview on 8/8/24, at 11:25 P.M., Certfied Nurse's Aide (CNA) #4 said that she was not aware that Resident #30 was supposed to wear Prevalon boots. CNA #4 then said that she had not put the boots on and that Resident #30's feet were not off-loaded from the mattress. Review of the treatment sheet dated August 2024 inaccurately indicated that on the day shift of 8/6/24 and 8/7/24 Resident #30 was wearing Prevalon boots to each heel. Further review indicated blank spaces where the nurse is to indicate the Resident is wearing the boots on the night shift of 8/6/24 and the eveing shift of 8/7/24. 41105 3. For Resident #16 the nursing staff failed to consistently follow the Physician's orders regarding dialysis care as indicated in the Treatment Administration Record (TAR). Resident #16 was admitted to the facility in February 2024 and has diagnoses that include Type II diabetes mellitus with diabetic chronic kidney disease, End Stage Renal Disease (ESRD) and dependence of renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/10/24, indicated that on the Brief Interview for Mental Status exam Resident #16 scored a 3 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #16 requires dialysis. Review of the August 2024 Treatment Administration Record (TAR) included the following orders: 1. Dialysis access Type: Fistula to LUE and dialysis cath (sic) to right upper chest wall. Observe access sites for s/s of infection, bleeding or drainage. If areas appear compromised update NP/MD. Every shift for dialysis access sites. Start date 3/19/24. -The August 2024 TAR documentation failed to indicate a Nurse checked/documented the sites were observed on the following dates: -8/3/24 day shift -8/4/24 day shift -8/4/24 evening shift -8/5/24 evening shift -8/6/24 day shift (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/6/24 evening shift 2. Monitor AV fistula to Left forearm fot (sic) Bruit/Thrill every shift for AV fistula. Start date 3/19/24. -The August 2024 TAR documentation failed to indicate a Nurse checked/documented the AV fistula site was monitored on the following dates: -8/3/24 day shift -8/4/24 day shift -8/4/24 evening shift -8/5/24 evening shift -8/6/24 day shift -8/6/24 evening shift 3. Monitor Dialysis access site dressing every shift fir AV fistula. Start date 3/19/24. -The August 2024 TAR documentation failed to indicate a Nurse checked/documented the dialysis access site dressing was monitored on the following dates: -8/3/24 day shift -8/4/24 day shift -8/4/24 evening shift -8/5/24 evening shift -8/6/24 day shift -8/6/24 evening shift 4. Monitor the Hemodialysis site for signs and symptoms of complications (e.g. bleeding, swelling, pain, drainage, odor, hardness or redness of site). Notify the Physician and Dialysis Center are notified immediately with any urgent medical problems. Start date 2/3/24. -The August 2024 TAR documentation failed to indicate a Nurse checked/documented that they monitored the Hemodialysis site for signs and symptoms of complications on the following dates: -8/3/24 day shift -8/4/24 day shift (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/4/24 evening shift -8/5/24 evening shift -8/6/24 day shift -8/6/24 evening shift During an interview on 8/8/24 at 2:07 P.M., with Resident #16's Nurse (#1) she reviewed the TAR with the surveyor and said that there is no indication the orders were followed on the above dates, because they are not signed off. Nurse #1 said it is the expectation that nurses follow physician orders daily on all shifts and that they document that the order has been followed on the TAR. Nurse #1 said that if it is left blank on the TAR that means it was not completed. During an interview on 8/12/24 at 8:41 A.M., with the Director of Nursing and Corporate Nurse (#1), Corporate Nurse #1 said that it is her expectation that staff follow Physician orders and complete documentation for each physician order in the TAR and that the documentation should be accurate. 45343 4 For Resident #90, the facility failed to accurately document the wearing of bilateral upper extremity Geri sleeves. Resident #90 was admitted to the facility in July 2021 with diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and vascular dementia. Review of Resident #90's most recent Minimum Data Set (MDS) assessment, dated 7/31/24, indicated Resident #90 scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Further review of the MDS indicated Resident #90 requires substantial/maximal to dependent assistance for all self-care activities and has skin tears. On 8/6/24 at 8:18 A.M., and 12:25 P.M., 8/7/24 at 7:40 A.M. and 12:16 P.M., 8/8/24 at 11:26 A.M., and 8/12/24 at 7:42 A.M., the surveyor observed Resident #90 lying in bed. Resident #90 was not wearing his/her Geri Sleeves on his/her arms. Review of Resident #90's Treatment Administration Record (TAR) for 8/6/24 through 8/12/24 indicated staff had signed off that he/she was wearing his/her geri sleeves. During an interview on 8/12/24 at 9:51 A.M., Nurse #13 said she was not aware if Resident #90 should be wearing geri sleeves, but if he/she has a physician order it should be followed and documented correctly. During an interview on 8/12/24 at 1:20 P.M., Corporate Nurse #1 said the nurses should be following physician's orders and should not document in the TAR if the geri sleeves are not being worn by the Resident. 48671 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Right buttock: nsw, pat and dry Santyl to base and cover with border gauze daily and PRN. Dated 8/9/24. - Right posterior: nsw apply calcium ag f/b border gauze daily and PRN. Dated 8/9/24. - Sacrum: NSW, apply Santyl to wound cover with border gauze daily and PRN. Dated 8/9/24. During an interview on 8/12/24 at 10:19 A.M., the Director of Nurses (DON) said it is her expectation that staff reposition residents and provide incontinence care every two hours and said preventative measures upon admission should have been implemented and reviewed weekly to prevent skin breakdown. The DON said preventative measures include offloading heels, applying booties and an air mattress. The DON said weekly skin checks include assessment and documentation in the medical record. The DON said wound rounds are scheduled weekly and wounds are measured and documented by the Wound Nurse Practitioner. During an interview on 8/12/24 at 11:15 A.M., the Corporate Nurse #1 said, Nurses will describe open skin areas, but they would not measure them because they measure them wrong. We follow the facility policy, and the nurses notify the DON to add the resident to the wound rounds for the following Thursday. The wound nurse does the measuring and puts in orders. Corporate Nurse #1 said the physician would be notified and treatment orders would be adjusted after the wound nurse sees the residents the following Thursday. Corporate Nurse #1 said she expects staff to document care provided and document refusals of care in the chart. 3. Resident #5 was admitted to the facility in March 2023 with diagnoses including dementia, diabetes, pulmonary edema, atrial fibrillation, chronic kidney disease, urinary retention, hypertension, and heart failure. On 8/7/24 at 8:30 A.M., the surveyor observed Nurse #3 prepare to administer the following medications to Resident #5: -Atorvastatin Calcium Oral Tablet x 1 tab. Not administered. -Cyanocobalamin Oral Tablet 500 mcg x 1 tab. Not administered. -Ferrous Sulfate Tablet 325 (65 Fe) Mg x 1 tab. Not administered. -Irbesartab Oral Tablet 75 mg x 1 tab. Not administered. -Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG x 1 tab. Not administered. -Rivaroxaban Oral Tablet 15 MG x 1 tab. Not administered. -Spironolactone Oral Tablet 25 MG x 1 tab. Not administered. -Glucophage Tablet 1000 MG x 1 tab. Not administered. Review of Resident #5's Medication Administration Record (MAR) dated 8/7/24 indicated Nurse #3 documented the medications were administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/7/24 at 9:54 A.M., Nurse #3 said the nurse should not document medications as given when they were not given, and she should not leave medications blank in the record. Unit Manager #1 said he expects staff to document accurately in the medical record at the time of administration. During an interview on 8/7/24, at 10:05 A.M., Unit Manager #1 said medications should not be documented as given when they were not administered. During an interview on 8/7/24 at 10:50 A.M., Corporate Nurse #1 said medications are not to be documented as given in the MAR when they were not given. During an interview on 8/12/24 at 10:27 A.M., The Director of Nursing (DON) said nurses administering medications must document accurately in the MAR and medication should not be documented as administered if not given.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on observation, interview, record, and policy review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically: 1. The facility failed to ensure the clean laundry room was free from potentially infectious substances. 2a. For Resident #30, the facility failed to ensure that enhanced barrier precautions (EBP) were implemented during treatment of an open wound. 2b. For Resident #45, the facility failed to ensure that EBP was implemented during treatment of his/her feeding tube. 3. The facility failed to ensure nursing staff performed hand hygiene appropriately during the medication administration task. Findings include: 1. On 8/12/24 at 8:20 A.M., the surveyor observed the laundry room, accompanied by the Director of Laundry Services and Laundry Staff #1. A ceiling tile above one of the four dryers was stained brown and black and measured approximately 2' x 3'. A metal air exchange vent situated in the middle of this tile was rusted. Directly under this ceiling tile, a staff person had placed a bin of clean, dried clothing, covered with a sheet. During an interview on 8/12/24 at 8:47 A.M. with the Director of Laundry Services and Laundry Staff #1, they said water sometimes drips from the ceiling tile onto the floor in front of the dryer. They said they were unsure how long water had been leaking from the ceiling. During an interview on 8/12/24 at 9:27 A.M. the Maintenance Director said he was unaware of the leaking ceiling. The Maintenance Director said he did not know the source of the leak. The Maintenance Director then said he was concerned that because of the leak's location in the laundry room and that the tile was black in areas, possibly indicating mold, it could contaminate cleaned clothing in the laundry room. 36797 Review of the facility policy titled Enhanced Barrier Precautions, revised 9/22, indicated enhanced barrier precautions are an infection prevention intervention designed to reduce the transmission of multi-drug resistant organisms (MDROs) in the facility. The precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those with increased risk of contracting an MDRO. Employees must wash their hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions or perform hand hygiene using alcohol-based sanitizer: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Before and after direct contact with residents; - Upon exiting the resident's room. 2a. Resident #30 was admitted to the facility in June 2024 with diagnoses including schizoaffective disorder bipolar type, dementia and heart failure. Review of the Minimum Data Set (MDS) dated [DATE], indicated that Resident #30 scored a 10 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. Further review indicated that Resident #30 requires substantial to maximal assistance with all activities of daily living. On 8/7/24, at 12:50 P.M., the surveyor observed Resident #30 lying in bed with his/her heels directly on the mattress. The surveyor observed multiple reddish/brown spots of blood on the sheet under the right heel indicating that the pressure area was not intact. The surveyor observed that there was no enhanced barrier precautions sign outside Resident #30's room. On 8/8/24, at 11:20 A.M., the surveyor informed Unit Manager #1 that the surveyor had observed Resident #30's right heel flat on the mattress with multiple reddish/brown spots of blood on the sheet under the right heel indicating that the pressure area was not intact for the past two days. On 8/8/24, at 11:25 A.M., The surveyor observed that there was no EBP sign outside Resident #30's room. The surveyor then observed Unit Manager #1 and Certified Nurse's Aide (CNA) #4 to enter Resident #30's room without donning a gown (a requirement for EBP), remove the bedding covering the open heel wound, clean the wound with normal saline and cover the wound with a dry protective dressing. During an interview on 8/8/24, at 11:25 P.M., Unit Manager (UM) #1 said that he and the CNA should have donned a gown before entering the room of a resident with an open wound. 43846 2b. Resident #45 was admitted to the facility in April 2024 with diagnoses that included cerebral infarction, aphasia, and traumatic subdural hemorrhage. On 8/7/24 at 12:45 P.M., the surveyor observed Nurse #4 enter Resident #45's room without PPE (personal protective equipment) on. The surveyor then observed Nurse #4 change the Resident's feeding tube nutrition formula, touching the Resident's skin and feeding tube without PPE on. Throughout the survey period, there was not a sign on Resident #45's door to indicate he/she was on EBP (enhanced barrier precautions) precautions. Review of Resident #45's plan of care indicated the Resident received nutrition via feeding tube directly into the stomach through a surgical opening in the abdomen. Review of Resident #45's EBP care plan, dated 7/4/24, indicated maintain EBP per facility policy. During an interview on 8/12/24 at 9:32 A.M., Nurse #4 said there should be a EBP precaution sign on his/her room to alert staff and if he/she is receiving care then staff should be in PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/12/24 at 10:40 A.M., the Director of Nurses (DON) said she is aware that EBP signs are not fully in place in the facility. The DON said a resident who has a feeding tube should be on EBP and said when a nurse is changing the feeding tube solution the nurse should have a gown and gloves on. 48671 3. Review of the Facility's policy titled, Handwashing/Hand Hygiene, revised April 2022, indicated: This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty. b. Before and after direct contact with residents; c. Before preparing or handling medications; i. After contact with residents skin; k. After handling used dressings, contaminated equipment, etc; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. During medication administration observation on 8/7/24 the surveyor made the following observations on the [NAME] Unit: -Nurse #2 at 7:39 A.M., administered eye drops to a resident in the hall, removed her gloves, and did not perform hand hygiene and proceeded to touch items on top of the medication cart. -Nurse #2 at 7:41 A.M., was observed taking a resident's blood pressure in the hall and did not wipe down the vital sign machine after use on a resident, did not perform hand hygiene and began using the computer located on top the medication cart. During an interview on 8/7/24 at 8:12 A.M., Nurse #2 acknowledged she should have performed hand hygiene before and after resident care, and after removing soiled gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Nurse #3 at 8:35 A.M. was observed touching items on top of the medication cart and then picking up loose pills inside the medication cup on top of the medication cart. The Nurse did not perform hand hygiene and did not have gloves on. Nurse #3 was then observed coughing into her bare hand and then touching the computer monitor and keyboard on top of the nurse's station. Nurse #3 then picked up an open insulin syringe and placed the syringe on top of the nurse's station counter, the Nurse then picked up the medication cup containing pills and placed it on top of the counter. Nurse #3 walked to her medication cart and knocked over drinking cups on to the floor. Nurse #3 was observed picking up the cups off the floor using the hand she coughed into, and stacked the contaminated cups that were on the floor, back on to the cups stacked along the side of her medication cart. Nurse #3 was observed picking up a plastic spoon from the side of the medication cart and placing it directly on top of the counter located at the nurse's station. During an interview on 8/7/24, at 9:07 A.M., Nurse #3 said she should have performed hand hygiene, but she forgot, and she didn't realize she put the dirty cups back on to her medication cart. Nurse #3 said she was sorry for placing the spoon on top of the nurse's station. During an interview on 8/7/24, at 9:30 A.M., Unit Manager #1 said he expects staff to perform hand hygiene prior to giving medications and after. The Unit Manager said the nurse should not have place contaminated items with clean items and should not place utensils or medications on top of the counter because it is contaminated. During an interview on 8/7/24 at 10:50 A.M., Corporate Nurse #1 said she expects all staff to follow infection control procedures and to perform hand hygiene before and after care. During an interview on 8/12/24 at 10:27 A.M., The Director of Nursing (DON) said infection control practices and hand washing policy must be followed at all times.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 15016 Based on interview and observation for two of five sampled Residents (#45, and #90), the facility failed to ensure the pneumonia vaccinations were offered. Findings include: Review of the facility's policy Pneumonia Vaccination dated as revised January 2024, indicated: - All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. - Upon admission, residents will be assessed for eligibility to receive the pneumococcal series, and when indicated, will be offered the vaccine unless medically contraindicated, refusal by the resident or health care representative, or the resident has already been vaccinated. 1. Resident #45 was admitted to the facility in April 2024. Review of Resident #45's electronic medical record indicated there was no documented history of him/her having received or declined the pneumonia vaccine, or any contraindication to receiving the vaccine. Review of Resident #45's Massachusetts Immunization Information System (MIIS) record printed on 8/12/24, indicated the pneumonia vaccine was due, but not given. 2. Resident #90 was admitted to the facility in July 2021. Review of Resident #90's electronic medical record indicated there was no documented history of him/her having received or declined the pneumonia vaccine, or any contraindication to receiving the vaccine. The facility did not provide a copy of Resident #90's MIIS record. During an interview on 8/12/24 at 2:00 P.M., with the Infection Preventionist and Corporate Nurse #1, they said the immunization history for all residents is recorded in the electronic medical record. They said that if Resident #45's and Resident #90's records did not indicate the pneumonia vaccine was offered, given, declined or contraindicated then this information would not be located elsewhere.