STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225525	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Harwich	111 Headwaters Drive Harwich, MA 02645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on interview and record review, the facility failed to ensure a [NAME] Treatment Plan (court approved treatment plan for the administration of antipsychotic medications) was obtained prior to the administration of an antipsychotic medication for one Resident (#24), in a total sample of 20 residents. Findings include: Review of the website (www.mass.gov/[NAME]-guardianships) indicated but was not limited to the following: -A guardian for an adult is a person appointed by a judge in the Probate and Family Court who is responsible for making decisions for an individual after a judge has decided they aren't competent to make their own informed choices. Some guardians can make decisions about medical treatment for a person with mental illness that is considered extraordinary. These are called [NAME] guardianships. -At a [NAME] guardianship hearing, the person asking for the [NAME] guardianship asks the court to approve extraordinary medical treatment for an incapacitated person. This usually refers to treatment with antipsychotic medication . -If an incapacitated person is prescribed antipsychotic medications, the incapacitated person will need a guardian who has been given [NAME] authority by the court. Resident #24 was admitted to the facility in November 2023 with diagnoses which included traumatic subdural hemorrhage, traumatic brain injury, strange inexplicable behavior, and dementia with behavioral disturbances. Review of the medical record indicated Resident #24 was transferred to the facility from another nursing facility without Guardianship documents. The medical record indicated a Health Care Proxy was in effect upon admission in November 2023. Review of a progress note, dated 6/27/24, indicated the facility was notified that Resident #24 had a Guardian and the Guardian was unaware Resident #24 was residing in the facility. Additionally, the note indicated the Guardian had very little paperwork regarding the Guardianship and Treatment Plan. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record included the letter, dated 6/26/24, which indicated the legal Guardian hereby revoked any and all past and/or current Health Care Proxies previously signed by Resident #24. Review of the medical record indicated Resident #24 was appointed a Guardian by the Commonwealth of Massachusetts Probate and Family Court on 1/25/23. The document further indicated that the legal guardian had authority to authorize treatment of the incapacitated person with antipsychotic medication in accordance with the treatment plan dated 1/25/23 which shall be reviewed on or before 1/23/24 and if not sooner extended, shall expire on 1/23/24. The document failed to include the Treatment Plan for the administration of antipsychotic medication and failed to include any subsequent review of the authorization. Review of the Physician's Orders indicated the following: -Risperidone 1 milligram (mg). Give 0.5 mg one time a day (11/1/23) (antipsychotic medication) -Risperidone 1mg two times a day (11/1/23) Review of the Medication Administration Records (MAR) for June, July, and August 2024 indicated the Risperidone was administered as ordered by the physician. Review of the Informed Consent for Psychotropic Administration Form for administration of the medication Risperidone, dated 7/1/23, indicated the consent form was signed by the legal guardian. Additional information on the consent form indicated the legal guardian checked off the box which attested to being the guardian with substituted judgement authority and the [NAME] Monitor has been informed and authorized this medication. Further review of the Informed Consent indicated if the proposed medication is an antipsychotic, and the resident has a guardian, evidence of [NAME] substituted judgement is required. The surveyor had requested a copy of the [NAME] Treatment Plan on 8/8/24 at 2:00 P.M and the facility was unable to provide the document. Further review of the medical record failed to indicate a current Court Ordered [NAME] Treatment Plan and failed to indicate the facility had tried to obtain such documentation since 6/27/24 when they were notified of the Guardianship (>40 days). On 8/13/24, the facility provided the surveyor with a copy of a fax transmittal timestamped 8/8/24 at 4:02 P. M. The fax indicated the facility was requesting authorization to treat with antipsychotic medication. During an interview on 8/13/24 at 12:00 P.M, Nurse #1 said every psychotropic medication needed consent and he was unsure of the process if a resident had a Guardian in place and deferred further questions to the Director of Nurses (DON). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/24 at 1:52 P.M., the DON said Resident #24 was on Risperidone, an antipsychotic, and had a Guardian. Additionally, she said there should be a [NAME] Treatment Plan in the record for the use of the antipsychotic and he/she did not have one in the medical record. The DON said they did not find out Resident #24 had a Guardian until June 2024; the Administrator was dealing with it and deferred further questions to the Administrator. During an interview on 8/13/24 at 2:21 P.M., the Administrator said there should be a [NAME] Treatment Plan in place for the Risperidone. She said when the Guardian surfaced in June, they should have submitted the documents requesting the Treatment Plan, but they did not. She said the form was faxed over last week (8/8/24) after the Treatment Plan was requested by the surveyor and she had no further information regarding the Treatment Plan at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49424 Based on observation and interview, the facility failed to ensure the residents' environment was clean, comfortable, and homelike. Specifically, the facility failed to ensure the residents' rooms and environment were maintained in good repair and homelike on two (Bayview and Cranview) of three resident care units. Findings include: Review of the facility's policy titled Accommodation of Needs and Preferences and Homelike Environment, dated as last revised 4/20/22, indicated but was not limited to the following: -Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas. -Orderly is defined as an uncluttered physical environment that is neat and well-kept. -The resident's environment will be maintained in a homelike manner to ensure appropriate housekeeping, clean linens in good repair, private closet space for each resident. Between 8/7/24-8/8/24, the surveyor observed the following on the Bayview unit: -The entrance to the Bayview unit had unpainted areas near the baseboard and the door and molding were chipped and discolored. -The breakfast dining room on Bayview had pieces of wood floor approximately eight to ten inches chipped and missing, the baseboard heating unit was missing the top cover, was bent and appeared in disrepair. The wall had an approximately four-foot scuff visible on the wall. -room [ROOM NUMBER]: The television cable and power plug were hanging from the television unplugged on the floor. The walls had oily drip marks over the walls on both resident sides, in addition to scuff marks and chipped paint. -room [ROOM NUMBER]: The thermostat was broken with internal wires exposed; the bathroom had a soap dispenser sized area unpainted with multiple layers of wall exposed. The heating unit in the room was observed to be dirty and discolored. -room [ROOM NUMBER]: The blinds for the window were broken, the corner of the wall was dented with parts of the molding lifting. -room [ROOM NUMBER]: The molding on the floor connecting the hallway and the resident room was broken and exposed cracked tiles. The blind on the window was broken. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER]: Five ceiling tiles were discolored from water stains, there was a crack in the window glass. -room [ROOM NUMBER]: The wall had holes, scuffs, and a large unpainted area. -room [ROOM NUMBER]: The ceiling tile had a discolored water stain visible. -room [ROOM NUMBER]: The thermostat was broken exposing the internal parts including wires. The closet was missing doors. -room [ROOM NUMBER]: The heating unit was discolored and cracked. The closet was missing doors. -room [ROOM NUMBER]: The room had a large black scuff on the wall about four feet in width. The closet doors were not attached and leaning against the closet. -room [ROOM NUMBER]: The ceiling tile had a discolored water stain visible. -room [ROOM NUMBER]: The bottom of the wall near the bathroom was missing molding, scratched, and discolored. -room [ROOM NUMBER]: The ceiling tile had two discolored water stains visible. -room [ROOM NUMBER]: The wall had multiple areas of unpainted areas visible, missing molding, and the heating unit appeared dirty, and the cover was on the ground. -room [ROOM NUMBER]: The wall had broken molding on the bottom of the wall exposing wood. -room [ROOM NUMBER]: The wall had holes visible and broken molding that was lifting from the wall. -room [ROOM NUMBER]: The wall had an area visible where the painting was cracked and peeling. The ceiling tiles had two discolored water stains. There was an area of the wall that was peeling. There was an area of molding missing and plaster was crumbled at the bottom of the wall with an unpainted area and wood exposed. On 8/12/24 at 1:00 P.M., the surveyor observed the following on the Cranview Unit: -The residents' shower room had a hole of approximately 12 inches wide on the corner of the wall with pieces of the inner plaster crumbled and a wood stud being exposed. -room [ROOM NUMBER]: The room was dirty with dozens of pieces of trash on the floor, the blind was broken, the headboard and footboard were broken. The dresser drawer was also broken. -The hallway window was cracked, and the screen frayed with a five-inch hole in the screen exposed. During an interview on 8/7/24 at 12:14 P.M., Resident #56's Representative said she wished the building looked better. She said the rooms were in disrepair and the bathrooms were gross. She said there are holes and scratches in the rooms and dining areas. She said the appearance of the unit's upstairs is depressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225525	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Harwich	111 Headwaters Drive Harwich, MA 02645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/7/24 at 2:43 P.M., the family member of a resident on Bayview said she was surprised by the environment and how much work was needed compared to the first floor. During an interview on 8/12/24 at 2:56 PM., Resident #75's Representative said the place has not had a lot of attention cosmetically since she had been visiting the Resident for a few months. During an observation with an interview on 8/12/24 at 3:12 P.M., the Regional Plant Manager said there was a gap of about three weeks where the building did not have a full time Maintenance Director. He said at that time he and another building's maintenance director were covering and attending to emergent issues that arose. He said the issues appeared to have been neglected for more than three weeks and his expectation is that all the issues identified would be fixed and walls painted. He said he would expect the wall to be repaired and paint to match. During an interview on 8/12/24 at 3:20 P.M., the Administrator said she has hired a maintenance director, and her expectation is that all these identified concerns are fixed and that he is rounding to ensure issues are identified quickly and responded to. She said during her lapse in coverage preventative maintenance was not being done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed for one Resident (#3), in a sample of 20 residents, and one Resident (#91), in a sample of three closed record reviews. Specifically, the facility failed: 1. To ensure the accurate admitted was reflected on three MDSs and limited range of motion was reflected on two MDSs for Resident #3; and 2. To ensure the accurate discharge location was reflected on the MDS for Resident #91. Findings include: 1. Resident #3 was admitted to the facility in October 2018 and developed a contracture. Review of the MDSs, dated 2/5/24, 5/2/24, and 8/1/24, indicated Resident #3 had an admitted [DATE]. During an interview on 8/13/24 at 10:15 A.M., MDS Nurse #1 said the MDSs inaccurately reflected the admitted for Resident #3 and would be updated to indicate the Resident was admitted in 2018. On 08/07/24 at 2:53 P.M., the surveyor observed Resident #3 wearing bilateral hand splints. Review of the Occupational Therapy Discharge Summary indicated services initiated 4/22/24 indicated the prior level of function of Resident #3's bilateral hands were fisted with a gauze roll in the left hand and a baseline of significant contractures to bilateral hands/wrists on 4/22/24. Review of the MDSs, dated 5/2/24 and 8/1/24, indicated Resident #3 had no functional impairment to range of motion on the upper extremities. During an interview on 8/13/24 at 1:14 P.M., MDS Nurse #2 said she had not seen the Occupational Therapy notes, did not know the Resident had a contracture, and the MDSs were inaccurate. 46862 2. Resident #91 was admitted to the facility in July 2024 with diagnoses including hypertension, heart failure, chronic kidney disease, and dementia. Review of Resident #91's clinical record indicated a Physician's Order, dated 7/23/24, may discharge to [Name of local skilled nursing facility (SNF)]. Review of the Transfer/Discharge Evaluation-V7, dated 7/23/24, indicated Resident #91 was transferred to a SNF. Family requested for transfer to [Name of local SNF] to be close to family. Review of the Discharge MDS assessment section A, dated 7/23/24, indicated Resident #91 was discharged to acute care hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225525	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Harwich	111 Headwaters Drive Harwich, MA 02645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 8/9/24 at 11:08 A.M., MDS Nurse #2 said the discharge status of Resident #91 was incorrectly coded and should have been coded as discharged to a skilled nursing facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46862 Based on observations, interviews, and record review, the facility failed to ensure one Resident's comprehensive and individualized plan of care was implemented, for one Resident (#60), out of a total sample of 20 residents. Specifically, for Resident #60, the facility failed to place a padded floor mat to the left side of his/her bed. Findings include: Review of the facility's policy titled Comprehensive Person-Centered Care Plan, dated 4/17, included but was not limited to: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. -The Interdisciplinary Team must review and update the care plan when there has been a significant change in the resident's condition. Resident #60 was admitted to the facility in March 2022 with diagnoses including history of falling and fracture of the right femur. Review of the Minimum Data Set (MDS) assessment, dated 6/20/24, indicated Resident #60 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Review of the care plan, initiated 3/8/22, indicated Resident #60 was at high risk for falls. The goal identified was that Resident #60 will be free of falls through the review date. Interventions included but were not limited to the following: -4/2/24 Padded floor mat to left side of bed. On 8/7/24 at 10:11 A.M., the surveyor observed Resident #60 lying in bed. There was a blue padded floor mat standing straight up against the wall opposite the foot of the bed. During an interview on 8/7/24 at 10:30 A.M., Nurse #2 and the surveyor observed the blue padded floor mat standing straight up against the wall. Nurse #2 said the mat should have been on the floor on the left side of the Resident's bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Harwich	111 Headwaters Drive Harwich, MA 02645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 11:09 A.M., the surveyor observed Resident #60 lying in bed. There was a blue padded floor mat standing straight up against the wall opposite the foot of the bed. During an interview on 8/8/24 at 11:15 A.M., Certified Nursing Assistant (CNA) #1 and the surveyor observed the blue padded floor mat standing straight up against the wall. CNA #1 said she had put Resident #60 in bed for a nap. CNA #1 said the blue mat was used because the resident falls, and she should have put the mat on the floor before she left the room. On 8/9/24 at 7:43 A.M., the surveyor observed Resident #60 lying in bed sleeping. There was a blue padded floor mat standing straight up against the wall opposite the foot of the bed. During an interview on 8/9/24 at 7:55 A.M., Unit Manager #1 (UM) and the surveyor observed the blue padded floor mat standing straight up against the wall. UM #1 said, I see they are not in use. UM #1 said the mat should have been on the floor on the left side of the Resident's bed. UM #1 said staff had not followed Resident #60's fall care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 15214 Based on record review and staff interview, the facility failed to ensure that for one Resident (#2), of a total sample of 20 residents, the pharmacy's monthly medication regimen review with recommendations for the Resident was reported to the attending physician and director of nursing and acted upon timely. Findings include: Review of the facility's policy titled Medication Regimen Review, dated November 2021, included but was not limited to the following: Policy: The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. The MRR also involves a thorough review of the resident records, and may include collaboration with the resident, family members or other resident representatives. MRR also involves reporting of findings with recommendations for improvement. All findings and recommendations are reported to the director of nursing and the attending physician, the medical director and the administrator. Resident #2 was admitted with diagnoses which included Type 2 diabetes mellitus and chronic systolic heart failure. Review of a Pharmacy Consultant Note, dated 6/2/24, indicated Resident #2's medications were reviewed and Please see the Consultant Pharmacist report for the recommendations. Review of the Consultant pharmacist's recommendations on 6/2/24 indicated to decrease the potassium chloride from 40 milliequivalents (meq) total per day, to 20 meq per day. During an interview on 08/09/24 at 12:57 P.M., the Director of Nurses (DON) said the facility missed it, in reference to the consultant pharmacist's recommendation on 6/2/24 to decrease the potassium chloride. Review of a separate report submitted by the consultant pharmacist on 7/4/24, titled Recommendations With No Response-DNS, the pharmacist indicated the resident currently receives potassium 20 meq ER (extended release) tablets twice daily. The K (potassium) lab most recent noted K-4.6 (potassium blood level) suggests decrease to 20 meq daily since this formulation is a 24-hour medication. The recommendation status from the physician was listed as no response and the Resident continued to receive potassium chloride 20 meq twice daily, for a total of 40 meq until the omission was discovered and the potassium chloride was decreased to 20 meq daily on 7/12/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36542 Based on observation, record review, and staff interview, the facility failed to ensure food was stored, in accordance with professional standards. Specifically, the facility failed to ensure 2 out of 3 kitchenettes were maintained in a sanitary manner to store food. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: -A permanent temperature measuring device is required in any unit storing time/temperature control for safety food because of the potential growth of pathogenic microorganisms should the temperature of the unit exceed Code requirements. In order to facilitate routine monitoring of the unit, the device must be clearly visible. 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; On 8/8/24 at 11:25 A.M., the surveyor observed the following in the Bayview kitchenette with the Unit Manager: -August 2024 refrigerator temperature log did not include a place to document temperatures for the freezer and none had been recorded between 8/1/24 and 8/8/24. The surveyor and Unit Manager observed the freezer full of small individual ice creams. The Unit Manager had to move multiple ice creams to find the thermometer which was observed covered in ice particles. -the surveyor and Unit Manager observed the counter drawers in the kitchenette to have a sticky substance when attempting to open them. One of the drawers had a brown sticky substance inside the drawer and on condiment packets. -the surveyor observed a baseball sized tin foil in the cabinet. The Unit Manager opened the tin foil and revealed a hamburger on a bun. The Unit Manager said she did not know who this belonged to and it was not made by the facility. - the surveyor observed an open, undated when opened, bottle of ranch dressing in a cabinet. The bottle indicated it should be refrigerated after opening. The expiration year on the bottle had been torn on the label and unable to read. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225525	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Harwich	111 Headwaters Drive Harwich, MA 02645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 11:25 A.M., Unit Manager #2 said she was not sure who was responsible for cleaning the cabinets, drawers or handles in the kitchenette. She said the cheeseburger and the ranch dressing should not have been kept in the cabinets. 15214 On 8/8/24 at 8:43 A.M., the surveyor observed the following in the Cranview Unit nourishment kitchen: - The freezer had a significant amount of frost built up throughout all surfaces. The freezer contained multiple individual portion sized cups of ice cream. The ice cream containers were coated with frost and soft when squeezed. Additionally, there was a half-gallon sized container of ice cream that was also soft. - There was no thermometer in the freezer, and no log for monitoring freezer temperatures. During an interview on 8/8/24 at 2:00 P.M., the Food Service Director (FSD) said that frozen items in the freezer should not be soft. She also said that the freezer temperatures should be monitored/recorded and acknowledged that there was no thermometer in the Cranview Unit freezer. The FSD said that food quality and safety can be affected by improper temperatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46862 Based on record review and staff interview, the facility failed to maintain medical records that are complete, accurate, and systemically organized within accepted professional standards and practice for one Resident (#91), out of a total sample of three closed records. Specifically, the facility failed to ensure the physician's order for destination of discharge was accurate. Findings include: Resident #91 was admitted to the facility in July 2024 with diagnoses including hypertension, heart failure, chronic kidney disease, and dementia. Review of a nurse's progress note, dated 7/22/24, indicated the Healthcare Proxy requested that referral be sent to Local skilled nursing facility (SNF) A for transfer as it was closer to family. Documents were sent to Local SNF A. Review of a Social Service's progress note, dated 7/23/24, indicated the social worker had reached out to Local SNF A who confirmed a bed offer had been approved for Resident #91. Resident #91 was transferring to Local SNF A by stretcher . by Ambulance company. Review of the Transfer/Discharge Evaluation-V7, dated 7/23/24, indicated Resident #91 was transferred to a SNF. Family request for transfer to Local SNF A to be close to family. Review of the July 2024 Physician's orders included but was not limited to: May discharge to Local SNF B During an interview on 8/13/24 at 10:44 A.M., Unit Manager (UM) #1 reviewed the Physician's order for discharge. UM #1 said Resident #91 had been discharged to Local SNF A not to Local SNF B. UM #1 said that was her error, in transcribing the order, as she had a few residents being discharged that week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48084 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and potential transmission of communicable diseases and infections for five Residents (#24, #19, #82, #16, and #57). Specifically, the facility failed: 1. For Resident #24, to ensure staff wore personal protective equipment (PPE) as required for Isolation/Droplet Precautions (infection control precautions used for residents who are infected with certain infectious agents including COVID-19 for which additional precautions are needed to prevent infection transmission) while entering the room for medication administration; 2. For Residents #19 and #82, to ensure staff wore PPE as required for Isolation/Droplet Precautions while entering the room and providing morning coffee/snack and daily activity Chronicle; 3. For Resident #16, to ensure staff wore PPE as required for Contact Precautions (infection control precautions used for patients who may be infected with certain infectious agents for which additional precautions are needed to prevent infection transmission) while entering the room to provide housekeeping services; and 4. For Resident #57, to ensure staff wore PPE as required for Contact Precautions while entering the room to provide housekeeping services. Findings include: Review of the facility's policy titled Isolation: Categories of Transmission Based Precautions, dated as last revised 2/2024, indicated but was not limited to the following: -Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. -Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection. -Based on Center for Disease Control (CDC) definitions, three types of Transmission-Based Precautions (airborne, droplet, and contact) have been established. DROPLET PRECAUTIONS: -In addition to Standard Precautions, implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large particles (larger than 5 microns) that can be generated by the individual coughing, sneezing, and talking). -Examples of infections requiring Droplet Precautions include but are not limited to COVID-19. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident Placement: private room if possible, residents with the same infection may be cohorted, if private room is not achievable, use a curtain and maintain at least three feet of space between the infected resident and other residents. -Masks to be used when entering the room. -Eye protection to be used when entering the room. -Resident Care Equipment: when possible, dedicate the use of equipment to avoid sharing between residents. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. -Signs: The facility will implement a system to alert staff and visitors to the type of precaution the resident requires. -The facility will also ensure that the resident's care plan and care specialist communication system indicated the type of precautions implemented for the resident. Review of the RED Isolation/Droplet Precaution signage posted indicated but was not limited to the following: STOP: ISOLATION-In addition to Standard Precautions Staff and Providers MUST: -Clean Hands when entering and exiting -Gown: Change between each Resident -N 95 Respirator (respiratory protective device designed to achieve a very close facial fit to filtrate airborne particles; the edges form a seal around the nose and mouth) -Eye Protection (goggles or face shield) -Gloves: Change between each Resident 1. Resident #24 was admitted to the facility in November 2023. Review of the medical record including progress notes, physician orders, and care plan indicated but were not limited to the following: -He/she tested positive for COVID-19 on 8/7/24 and COVID protocol was implemented. -Droplet Precautions for COVID-19 every shift. -Resident has an active infection and is being treated in an attempt to prevent the spread, Droplet Precautions. On 8/8/24 at 9:05 A.M. the surveyor observed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was a RED ISOLATION SIGN Posted on the doorway outside Resident #24's room and a plastic cart containing PPE outside the doorway. -Nurse #3 poured the morning medications for Resident #24. -Nurse #3 had a surgical mask on (being used on the unit by all staff for source control). -Nurse #3 put gloves on, opened the Lidoderm Patch (adhesive pain patch). -Nurse #3 picked up the medication cup, Lidoderm Patch, a cup of water and entered the room. -Resident #24 was observed coughing. -Nurse #3 administered the cup of medications to Resident #24, put the Lidoderm Patch on the overbed table and exited the room. -Nurse #3 removed gloves, performed hand hygiene, looked at her report sheet and said Resident #24 is positive for COVID-19. -Nurse #3 walked down the hallway to wash her hands. -Upon returning to the medication cart, Nurse #3 opened the plastic cart to get PPE. She put a gown on, put an N-95 over the surgical mask she had on, and put gloves on. -Nurse #3 entered the room and applied the Lidoderm Patch to Resident #24's back. -Nurse #3 removed the PPE, exited the room, performed hand hygiene, and put a new surgical mask on. Nurse #3 failed to put on a gown, N-95, or eye protection prior to entering the room with the medications. (The surveyor stood at the doorway and did not enter the room.) Nurse #3 failed to ensure the N95 had a close facial fit and failed to put on eye protection when she entered the room the second time. During an interview on 8/8/24 at 9:17 A.M., Nurse #3 said she should have had full PPE (gown, gloves, eye protection, and N-95) on to enter the room and to administer medications. During an interview on 8/8/24 at 9:20 A.M., Nurse #3 said she always put the N-95 over her surgical mask for extra protection because she does not want COVID again. Additionally, she said the eye protection/face shield is optional. She said she usually wears one if the resident is coughing a lot, but you do not have to wear it. During an interview on 8/8/24 at 9:55 A.M., Minimum Data Set (MDS) Nurse #2 said there are three residents positive for COVID, there is a Red Sign outside the door, and everyone needs to wear full PPE to enter the room. She said they had been fit tested and the N-95 does not go over the surgical mask, she said it must be fitted to your face to work properly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 1:30 P.M., the Director of Nurse (DON) said if there is a Red Sign at the door everyone needs full PPE to enter the room regardless of which resident they are providing care for. Additionally, she said the N-95 does not go over the surgical mask, it needs to be fitted directly to the face or it is ineffective, and the eye protection/ face shield is not optional. She said everyone should have eye protection on to enter the room. 2. Resident #19 was admitted to the facility in August 2016. Review of the medical record including progress notes and physician's orders indicated but were not limited to the following: -He/she tested positive for COVID-19 on 7/30/24 and was on droplet precautions. -Droplet Precautions for COVID-19 every shift. Resident #82 was admitted to the facility in July 2023. Review of the medical record including progress notes and physician's orders indicated but were not limited to the following: -He/she tested positive for COVID-19 on 7/26/24 and was on droplet precautions through 8/5/24 During an interview on 8/7/24 at 10:00 A.M., Nurse #1 and MDS Nurse #2 said Resident #19 and #82's room had a red sign on it and everyone needed to wear full PPE to enter the room. On 8/7/24 at 10:50 A.M., the surveyor observed the following: -There was a RED ISOLATION SIGN Posted on the doorway to Resident #19 and #82's room and a plastic cart containing PPE outside the doorway. -Activity Assistant #2 was standing at the doorway to the room with a coffee cart. -Activity Assistant #2 entered the room without putting PPE on and was observed delivering coffee, a snack, and the Daily Chronicle to Residents #19 and #82. The Activity Assistant failed to put on PPE to enter the room and failed to perform hand hygiene between resident interaction. During an interview on 8/7/24 at 10:52 A.M., Activity Assistant #2 said she did not need PPE for either Resident and she did not know why the sign was still up, as they were both negative now. During an interview on 8/7/24 at 10:53 A.M., Nurse #1 said Resident #19 is still positive and everyone needs to wear full PPE to enter the room to provide care or see either resident in the room while the red sign is still up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 2:55 P.M., the DON said if there is a Red Isolation Sign at the doorway everyone needs full PPE to enter the room regardless of which resident they are going to see or providing care for. Additionally, she said if staff are unsure why a sign is posted they should be checking with the nurse prior to entering the room. 46862 3. Resident #16 was admitted to the facility in July 2024 with diagnoses including Extended Spectrum Beta Lactamase (ESBL a Multidrug Resistant Organism) and urinary tract infection (UTI). Review of the Centers for Disease Control and Prevention (CDC) guidance titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 8/1/23, indicated but was not limited to: -Contact Precautions are one type of Transmission-Based Precaution that are used when pathogen transmission is not completely interrupted by Standard Precautions alone. Contact Precautions are intended to prevent transmission of infectious agents, like MDROs, that are spread by direct or indirect contact with the resident or the resident's environment. -Contact Precautions require the use of gown and gloves on every entry into a resident's room. Review of Resident #16's current care plan indicated but was not limited to: -Resident has active infection and is being treated in attempt to prevent the spread. Is symptomatic and/or has a positive test indicating contagious stage urine: ESBL UTI, dated 8/5/24 -Transmission based precautions of contact, dated 8/5/24 The surveyor observed a contact precaution sign posted on the door entrance of Resident #16's room on: -8/7/24 at 10:20 A.M. -8/8/24 at 7:54 A.M. Further review of the facility posted contact precautions sign indicated but was not limited to: -Everyone must: -Clean their hands, including before entering and when leaving the room Providers and Staff must also: -Put on gloves before room entry. Discard gloves before room exit. -Put on gown before room entry. Discard gown before room exit. -Do not wear the same gown and gloves for the care of more than one person. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Regalcare at Harwich		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Headwaters Drive Harwich, MA 02645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/24 at 10:20 A.M., the surveyor observed a contact precaution sign posted on Resident #16's doorway. Housekeeper #2 was in the room and was observed emptying Resident #16's trash. Housekeeper #2 was not wearing a gown. Housekeeper #2 exited the room and placed trash in a large bin. Housekeeper #2 removed her gloves and did not wash her hands. On 8/7/24 at 10:28 A.M., Nurse #2 said any staff entering Resident #16's room needed to wash their hands and put on gloves and a gown. Nurse #2 said Housekeeper #2 needed to wear a gown in the room and wash her hands when she left the room. 4. Resident #57 was admitted to the facility in July 2024 with diagnoses including Enterocolitis due to Clostridium Difficile (C-diff an infection that can be spread by direct contact with an infected person's bowel movements. The infection can also spread through contact with equipment or surfaces that have been contaminated by the germs). The surveyor observed a contact precaution sign posted on the door entrance of Resident #57's room on: -8/7/24 at 10:20 A.M. -8/8/24 at 7:54 A.M. On 8/8/24 at 7:54 A.M., the surveyor observed a contact precaution sign posted on Resident #16's and Resident #57's doorway. Housekeeper #2 was observed putting on gloves and entering Resident #16's room. Housekeeper #2 did not put on a gown. Housekeeper #2 emptied the trash and exited Resident #16's room. Housekeeper #2 placed the trash in a large bin. Housekeeper #2 then was observed to enter Resident #57's room without washing her hands and replacing her gloves. Housekeeper #2 emptied the trash and exited the room. During an interview on 8/8/24 at 8:10 A.M., Housekeeper #2 said she did not need a gown. Housekeeper #2 said she forgot to wash her hands and change her gloves. During an interview on 8/8/24 at 9:49 A.M., the Unit Manager (UM) #1 said Resident #16 was on contact precautions for ESBL and Resident #57 was on contact precautions for C-diff. UM #1 said staff entering a contact precaution room need to wash their hands and use appropriate PPE. Staff need to remove their PPE when leaving the room and wash their hands. UM #1 said Housekeeper #2 should have been wearing a gown and washed her hands when she exited Resident #16's room. The UM #1 said Housekeeper #2 should not have entered Resident #57's room wearing the same gloves. UM #1 said Housekeeper #2 did not follow the proper procedure for contact precautions. During an interview on 8/9/24 at 1:00 P.M., the Director of Nurses (DON) said Resident #16 had ESBL and Resident #57 had C-diff. The DON said she was aware Housekeeper #2 did not follow the contact precaution signage on either room. The DNS said Housekeeper #2 should have followed the signage for contact precautions.