STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225532	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mattapan Health & Rehabilitation Center	405 River Street Mattapan, MA 02126

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 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** 41019 Based on observation and interview, the facility failed to provide a dignified existence for one Resident (#3) out of a total sample of 23 residents. Specifically, staff failed to pull the privacy curtain or shut Resident #3's door when he/she was in bed without a top on, which exposed Resident #3 to others passing by in the hallway. Findings include: Review of the facility policy titled Dignity/Quality of Life, dated 12/6/21, indicates the following: - Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with care and treatment procedures. Resident #3 was admitted to the facility in October 2010 with diagnoses including anemia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #3 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Review of the MDS indicated Resident #3 requires assistance to dependence with activities of daily living. Review of Resident #3's current care plan indicates the following: Focus: At times I like to lie naked in bed (initiated 7/3/17). Intervention: Please assist me with the privacy curtain as needed when I want to not wear briefs or clothes (initiated 12/3/19). During an observation on 2/12/25 at 8:47 P.M., Resident #3 was lying in bed topless with his/her privacy curtain open and the bedroom door open to the hallway. Resident #3 had a breakfast tray by his/her bedside that had been dropped off by a staff member. (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: 225532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 8:51 A.M., Nurse #2 said that Resident #3 is very behavioral and will pull open the curtain with a stick. When asked to show the surveyor what stick Resident #3 uses to access the curtain, Nurse #2 could not find it in Resident #3's room. Nurse #2 said he does understand that it is a dignity issue and said it was hard to close the bedroom door because the other roommate likes the door open, but agreed Resident #3's curtain should be closed if he/she is topless. During an interview on 2/12/25 at 11:08 A.M., the Director of Nursing said that if a Resident is exposed, she would expect the privacy curtain to be pulled closed. During an observation on 2/13/25 at 7:38 A.M., Resident #3 was lying in bed topless with the curtain open and the door open, exposing Resident #3 to the hallway.

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F 0580 Level of Harm - Minimal harm or potential for 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** 41019 Based on observation, record review, and interview, the facility failed to notify the physician of a change in condition related to edema for one Resident (#19) out of a total sample of 23 residents. Findings include: Review of the facility policy titled Change of Condition- Physician Notification, dated 1/10/17, indicated the following: - A change in condition is a significant clinical symptom(s) or development, which requires assessment and intervention - It is then the RN supervisor's responsibility to do a follow-up assessment and to ensure that the assessment is documented. - All assessment findings and relevant information should be compiled prior to calling the physician to ensure accuracy of information. - The physician (or alternate) will be contacted to report findings. Resident #19 was admitted in October 2019 with diagnoses including history of an embolism of the lower extremity and hemiplegia of the left side. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #19 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the MDS indicated Resident #19 requires substantial assistance to dependence with activities of daily living. During an observation on 2/11/25 at 8:14 A.M., Resident #19 was lying in bed with his/her left leg exposed. Resident #19's left leg was large and swollen throughout the leg. Resident #19 said that he/she has had increased leg swelling and pain in his/her left calf since last week. Resident #19 said he/she told his/her occupational therapist about it, but no one has done anything about it. Review of the medical record failed to indicate that Resident #19 had any edema or diagnoses that would cause edema of the left leg. During an interview on 2/12/25 at 12:31 P.M., Nurse #2 said that Resident #19's leg has been like that for a while and that it is not pitting edema. Nurse #2 said that he does not think the Nurse Practitioner or Physician had been notified because it is normal for Resident #19. Nurse #2 could not say what was causing the swelling. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 12:46 P.M., Rehab Staff #1 said that she has worked with Resident #19 recently and knows that Resident #19 notified nursing of his/her leg swelling. Rehab Staff #1 said that as far as she knows, the swelling has gotten worse. During an interview on 2/12/25 at 1:27 P.M., Rehab Staff #2 said that she worked with Resident #19 on 2/4/25 and said that Resident #19 told her that his/her leg felt like it had a cramp in it. Rehab staff #2 said she looked at the leg and it was swollen with 2+ edema without redness or warmth. Rehab staff #2 said she notified Nurse #2 and asked Nurse #2 to relay that information to the physician. Rehab staff #2 said she also worked with Resident #19 on 2/11/25 and notified Nurse #2 about the leg swelling again. She said Nurse #2 told her that he's been watching it and it looks the same. Rehab staff #2 was told by Nurse #2 that sometimes Resident #19 can be behavioral. During an interview on 2/12/25 at 1:26 P.M., Nurse Practitioner #1 said she was never notified of the leg swelling, but that Resident #19 has a history of a deep vein thrombosis (occurs when a blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs. Deep vein thrombosis can cause leg pain or swelling.) During an interview on 2/12/25 at 12:18 P.M., Physician #1 said he was never made aware of the leg edema.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation and interview, the facility failed to provide a clean and homelike environment for one Resident (#3) out of a total sample of 23 residents. Findings include: Resident #3 was admitted in October 2010 with diagnoses including anemia. Review of the minimum data set (MDS), dated [DATE], indicated Resident #3 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Review of the MDS indicated Resident #3 requires assistance to dependence with activities of daily living. During an observation on 2/11/25 at 8:17 A.M., Resident #3 was lying in bed with approximately 6-7 dead cockroaches surrounding his/her bed. During an observation on 2/12/25 at 8:47 A.M., Resident #3 was lying in bed with a soiled brief on the floor next to him/her and approximately 6-7 dead cockroaches surrounding his/her bed. During an observation on 2/13/25 at 7:38 A.M., Resident #3 was lying in bed with a soiled brief on the floor next to him/her and approximately 6-7 dead cockroaches surrounding his/her bed. During an interview on 2/12/25 at 11:04 A.M., the Director of Nursing said that housekeeping should be cleaning rooms daily. During an interview on 2/13/25 at 12:09 A.M., the Corporate Nurse said that she expects the rooms to be cleaned daily and as needed if there are pests in the room.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 45343 Based on record review and interviews, the facility failed to investigate a report of drug and alcohol use in the facility, reported by one Resident (#44), out of a total sample of 23 Residents. Findings Include: Review of the facility policy titled, Abuse Prohibition, revised 2/20/23, indicated the following: Policy -Allegations of abuse will be reported and thoroughly investigated. -The Administrator and Director of Nursing are responsible for investigation and reporting. Investigation -The investigation will begin immediately after reporting the actual or suspected incident. -Initiate the investigative process using factual data. The investigation should be thorough with witness statements from staff, residents, visitors, and family members who may be interviewed and have information regarding the allegation. -The results of the investigation will be documented. -Conclusion must include whether the allegation was substantiated or not and what information supported the decision. -Corrective measures will be implemented and documented post incident. Follow-up Measure -The investigation and the findings will be documented and submitted to the facility's Medical Staff for review. Documentation will be retained by the facility for no less than three (3) years. Resident #44 was admitted to the facility in January 2024 with diagnoses including atrial fibrillation, chronic pain, and anxiety disorder. Review of Resident #44's most recent Minimum Data Set (MDS) assessment, dated 12/20/24, indicated a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15, indicating intact cognition. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 2:41 P.M., Resident #44 said he/she reported to the prior social worker that he/she observed his/her roommate doing drugs in the bathroom and drinking alcohol in the room. Resident #44 said he/she was told to submit a grievance but would not be allowed to write his/her account of his/her observations and if he/she did it would stop there and not go any further. Resident #44 was asked if he/she submitted a grievance, he/she said no because there was no point if the staff were not going to investigate his/her report. During an interview on 2/12/25 at 3:39 P.M., the Corporate Nurse and the Director of Nursing said they were not aware of the report of drug and alcohol use. The Corporate Nurse said she would investigate the matter further and report back. During an interview on 2/12/25 at 4:51 P.M., the Corporate Nurse said the prior social worker said Resident #44 did not want to submit a grievance because it would not go anywhere and that the social worker and the Director of Nursing spoke with the Resident and offered him/her a room change, but Resident #44 declined. The Corporate Nurse said an investigation was not completed and said she would expect all reports on alleged drug and alcohol use in the facility to be investigated. Review of the grievance book on 2/13/25 at 8:35 A.M., indicated a grievance on 1/4/25 submitted by the prior social worker regarding Resident #44 not liking his/her roommate and visitors. The grievance form stated the following: Resident #44 was asked by Social Services and the Director of Nursing to write facts not accusations on the roommate. Resident became upset and said never mind I am going to take care of it myself. Resident was offered a room change then refused and said not to bother. Further review of the grievance book failed to indicate an investigation was completed regarding Resident #44's report of his/her roommates' alcohol and drug use in the facility.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on record review and interviews for two Residents (#49 and #67) of 23 sampled residents, the facility failed to ensure staff adequately identified a significant change in the Resident's status and completed a comprehensive Significant Change of Status Assessment Minimum Data Set (MDS) as required. Specifically 1. For Resident #49, the facility failed to identify and complete Significant Change in Status MDS when Resident #49, experienced significant weight loss, had an indwelling urinary catheter removed, and developed a stage 4 pressure wound. 2. For Resident #67, the facility failed to complete a significant change in status MDS when Resident #67 was signed on to hospice care. Findings include: Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2023, indicated a Significant Change in Status Assessment must be completed by the end of the 14th calendar day following determination that a significant change has occurred. It defines a significant change as a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. 1. Resident #49 was admitted to the facility in February 2020 with the diagnoses including stroke and quadriplegia. Review of Resident #49's most recent MDS, dated [DATE], indicated the following: -Weight= 165 pounds, weight loss of 5% or more in the last month or 10% or more in the last six months and not on a physician prescribed weight-loss regime. -Always incontinent of urine, with no use of an indwelling urinary catheter. -One stage four pressure ulcer. Review of Resident #49's previous MDS, dated [DATE], indicated: -Weight= 172 pounds, no weight loss. -Indwelling urinary catheter. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No pressure ulcers. Review of Resident #49's nurses progress notes, dated 11/7/24, indicated the indwelling urinary catheter was discontinued. Review of Resident #49's medical record as of the most recent MDS assessment reference date (ARD) of 12/5/24, indicated that the indwelling urinary catheter was never re-inserted after being removed on 11/7/24 (28 days), thus the change from having an indwelling urinary catheter to being incontinent of urine would not be considered self-limiting. Review of Resident #49's wound physician notes, dated 11/7/24, indicated a new stage 4 pressure wound to the coccyx, full thickness. Review of Resident #49's nurse progress notes, dated 11/8/24, indicated treatment done as ordered to coccyx stage 4. Review of Resident #49's medical record as of the most recent MDS ARD of 12/5/24, indicated that Resident #49 continues to have a stage 4 pressure would to the coccyx, thus the change from having no pressure ulcers to having a stage 4 pressure ulcer to his/her coccyx on 10/21/24 (45 days) would not be considered self-limiting. Review of Resident #49's nurse progress note addressing weights and vitals summary, dated 11/11/24, indicated weight warning: value:161.0 (pounds); 7.5% change in three months (12.5%, 23.0); 10.0% change in six months (12.0%, 22.0). Review of Resident #49's weights and vital summary, dated 2/13/24, indicated his/her weights were the following: -9/10/24- 171.5 pounds (Lbs.): 5% weight change compared to weight on 8/13/24 of 184.0 Lbs. (-6.8%; -12.5 Lbs.). -9/17/24- 167 Lbs.: 5% weight change compared to weight on 8/13/24 of 184.9 Lbs. (-9.2%; 17.0 Lbs.) and 7.5% weight change compared to last weight on 6/25/24 of 183.0 Lbs. (-8.7%; 16 Lbs.). -10/1/24- 163.8 Lbs.: 10% weight change compared to weight on 6/25/24 of 183.0 Lbs. (-10.5%; -19.2 Lbs.) and 7.5 % weight change compared to last weight of 7/22/24 of 179.6 Lbs. (-8.8%; 15.8 Lbs.). -10/21/24- 157.2 Lbs.: 10% weight change compared to weight on 4/30/24 of 175.3 Lbs. (-10.3%; -18.1 Lbs.). -10/29/24- 161 Lbs.: 10% weight change compared to weight on 6/25/24 of 183.0 Lbs. (-12%; -22 Lbs.). -11/12/24- 165.2 Lbs.: 10% weight change compared to weight on 7/23/24 of 185.2 Lbs. (-10.8%; 20 Lbs.). -11/26/24- 161 Lbs.: 10% weight changed compared to weight on 6/25/24 of 183.0 Lbs. (-12%; 22 Lbs.). (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #49's medical record as of the most recent MDS ARD of 12/5/24, indicated that Resident #49 continued to have significant weight loss throughout the quarter (75 days), thus the weight loss would not be considered self-limiting. Although Resident #49 had a documented change in status which indicated he/she had a decline in more than two areas, including a significant weight loss, discontinuation of an indwelling urinary catheter with new urinary incontinence and the development of a new pressure wound, a Significant Change in Status MDS Assessment was not initiated or completed within 14 days as required. During an interview on 2/13/25 at 9:58 A.M., the Director of Nursing (DON) said the MDS nurse monitors residents for the need to complete any Significant Change in Status MDS's. The facility MDS Nurse was not available to interview on 2/13/25. During an interview on 2/13/25 at 11:38 A.M., the MDS trainee, after speaking with the corporate MDS nurse, said Resident #49 was still in acute stages of his/her medical condition and continued to be assessed for changes from his/her baseline, therefore, did not require a significant change of status assessment to be completed according to the RAI (Resident Assessment Instrument) manual guidelines. 46339 2. Resident #67 was admitted to the facility in October 2024 with diagnoses including malignant neoplasm of temporal lobe, depression and dementia. Review of Resident #67's Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 3 out of possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was severely cognitively impaired. Review of a physician progress note dated 10/29/24 indicated the following but not limited to: Glioblastoma multiforme-Decision has been made to make patient comfort measures only and follow up with hospice continue current management. [sic] Review of the physician orders dated 11/11/24 indicated the following: admitted to hospice services as of 11/4/24. Review of the medical record failed to indicate that a significant change MDS was completed within the required time frame following an admission to hospice services. During an interview on 2/13/25 at 10:44 A.M., the Corporate Nurse said a significant change MDS should have been completed for when Resident #67 was admitted to hospice.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49880 Based on observation, record review and interview, the facility failed to accurately reflect the status of one Resident (#42) out of a total sample of 23 residents, when the Minimum Data Set (MDS) assessment failed to indicate that the Resident had an indwelling urinary catheter. Findings include: Resident #42 was admitted to the facility in May 2023 with diagnoses that include neuromuscular dysfunction of the bladder. Review of Resident #42's most recent Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated a Brief Interview for Mental Status score of 15 out of 15 indicating that the Resident is cognitively intact. The MDS failed to indicate the use of an indwelling catheter. On 2/11/25 at 8:00 A.M., Resident #42 was observed lying in bed, a urinary catheter drainage bag was observed hanging from the frame of his/her bed. Review of Resident #42's active Physician's orders indicated the following: -Foley Catheter Order: size: 16 french, 10 balloon Size, dated 5/19/23. -Empty Foley drainage bag and record 24 HOUR output, every night shift for Foley Output (TOTAL OUTPUT), 11/27/24. Review of the January 2025 Treatment Administration Record indicated use of an indwelling urinary catheter for the entire month. Review of Resident #42's active care plan indicated I have a alteration in urinary output r/t (related to) the need for an (specify kind type size balloon size i.e Foley catheter 16 Fr with a 10 ml balloon or Suprapubic) medically justified r/t neurogenic bladder spinal cord disease, dated as revised 8/18/23. [sic] During an interview on 2/12/25 at 12:32 P.M., Nurse #1 said that Resident #42 has an indwelling urinary catheter and had one during the month of January. During an interview on 2/13/25 at 9:47 A.M., the Corporate Nurse said that if a resident had an indwelling urinary catheter, it should be coded accurately on the MDS assessment.

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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 46339 Based on record review and interview the facility failed to create a baseline plan of care within the required 48 hours of admission for one Resident (#373) out of a total sample of 23 residents. Findings include: Resident #373 was admitted to the facility in January 2025 with diagnoses including acute embolism and deep vein thrombosis of the left upper extremity. Review of the medical record failed to indicate a baseline care plan was completed within 48 hours of admission. During an interview on 2/12/25 at 11:44 A.M., Unit Manager #1 said a baseline care plan should be completed within two days of admission, she further said that the care plan is necessary to guide the care givers on the resident's care needs.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, record review and interview the facility failed to develop and implement a comprehensive resident-centered care plan for one Resident (#371) out of a total sample of 23 residents. Specifically, for Resident #371 the facility failed to develop a care plan for dialysis and for an actual skin impairment. Findings include: Resident #371 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease, renal dialysis dependence and osteomyelitis left ankle and foot. Review of Resident #371's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment. The MDS further indicated the Resident was on dialysis, had a surgical wound and infections of the wound. Review of physician orders dated 1/30/25 indicated the following: -Resident to have dialysis on days Monday, Wednesday and Friday. -Dialysis catheter site left chest monitor every shift for signs and symptoms of bleeding. -Left foot daily dressing apply betadine followed by abdominal pad and ace bandage every day shift. Review of Resident #371's care plans failed to indicate a care plan for dialysis and actual skin impairment was developed upon admission to the facility. During an interview on 2/13/25 at 11:56 A.M., Unit Manager #1 said the resident should have a person-centered care plan indicating he/she is on dialysis and that he/she has an actual skin impairment, she said the once the MDS are completed it should trigger what care plans are needed to be completed for the residents.

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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** 41019 Based on observations, record review and interview, the facility failed to meet professional standards of practice for five Residents (#46, #43, #20, #42 and #11) out of a total sample of 23 residents. Specifically: 1. For Resident #46, the facility failed to follow a physician's recommendation to send the resident to an outside clinic. 2. For Resident #43, the facility failed to obtain a physician's orders for air mattress settings 3. For Resident #20, the facility failed to obtain a physician's orders to hold a tube feeding when the Resident was away from the facility. 4. For Resident #42, the facility failed to follow physician's orders regarding air mattress settings. 5. For Resident #11, the facility failed to implement physician's orders for heel booties and elevating heels off the mattress. Findings include: 1. Resident #46 was admitted in October 2024 with diagnoses including methicillin resistant staphylococcus aureus (MRSA) and human immunodeficiency virus (HIV) disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #46 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the physician's note, dated 11/19/24, indicated the following: -Patient needs to follow-up with HIV clinic as per the staff patient question about this diagnosis so if the patient follows up with the HIV clinic will be able to know whether this is an accurate diagnosis and whether the patient needs treatment related there is no signs of opportunistic infections [sic] Review of the medical record failed to indicate if Resident #46 was ever seen by the HIV clinic to determine his/her HIV status. During an interview on 12/12/25 at 12:14 P.M., Physician #1 said that he remembers making that recommendation and believes the facility was trying to get an appointment for an infectious disease clinic, but they can be hard to get. The facility failed to provide any documentation supporting that Resident #46 had an appointment with an HIV clinic. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #43 was admitted in April 2024 with diagnoses including hypertension, hemiplegia, and cerebral infarction. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #43 scored an 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. During an observation on 2/11/25 at 9:20 A.M., Resident #43 was lying in bed on an air mattress set to 150 pounds of pressure. During an observation on 2/12/25 at 8:33 A.M., Resident #43 was lying in bed on an air mattress set to 150 pounds of pressure. Review of the medical record failed to indicate any physician order for the air mattress or supporting care plan for the appropriate air mattress settings. During an interview on 12/12/25 at 11:02 A.M., the Director of Nursing said that she would expect an order or a care plan for the use of an air mattress with the appropriate settings. 46339 3. Resident #20 was admitted to the facility in March 2024 with diagnoses including multiple sclerosis, dysphagia and dependence on tube feeding. Review of Resident #20's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. During an interview on 2/12/25 at 6:45 A.M., Resident #20 was observed lying in his/her bed, the Resident told the surveyor he/she had gone on a leave of absence to his/her apartment the day before at around 12:00 P.M., and returned to the facility around 7:00 P.M. The Resident said he/she does not eat anything by mouth and so he/she goes without food when he/she is away from the facility. Review of the current physician orders indicated the following: -NPO diet (Nothing by Mouth) texture, thin liquids consistency. -Enteral feed order every shift infuse Osmolite 1.5 at 55 ml (milliliter)/ hour x 24 hours. Review of the medical record failed to indicate a physician's order had been obtained for holding the tube feeding when the Resident was away on a leave of absence. During an interview on 2/12/25 at 11:15 A.M., Nurse #1 said the Resident receives the tube feeding continuously. She further said there should be an order to hold the tube feed if the Resident is out of the facility. During an interview on 2/12/25 at 11:33 A.M., Unit Manager #1 said there should be an order to hold the tube feeding when the Resident is out of the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49880 4. Resident #42 was admitted to the facility in May 2023 with diagnoses that include neuromuscular dysfunction of the bladder. Review of Resident #42's most recent Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated a Brief Interview for Mental Status score of 15 out of 15 indicating that the Resident is cognitively intact. The MDS indicated that Resident #42 does not have pressure injuries but is at risk for development of pressure injuries. Review of Resident #42's physician's orders indicated the following order, dated 9/25/23: -Air Mattress to bed at all times set to 325 Alternating. Check placement and functioning every shift. Review of Resident #42's most recent Norton Assessment (an assessment to determine the risk for skin breakdown), dated 1/20/25 indicated a score of 8 indicating that Resident #42 is at high risk for developing pressure ulcers. Review of Resident #42's active activities of daily living care plan indicated an intervention for air mattress for pressure prevention to be set as ordered, dated as initiated 4/10/24. On 2/11/25 at 8:00 A.M., Resident #42 was observed sleeping in bed. An air mattress was in place and set to 150. On 2/12/25 at 7:17 A.M. and 8:39 A.M., Resident #42 was observed lying in bed. An air mattress was in place and set to 150. During an interview on 2/12/25 at 11:02 A.M., the Director of Nursing said that nurses should be checking air mattress orders and settings every shift to ensure that they are at the correct settings. 5. Resident #11 was admitted to the facility in July 2024 with diagnoses including chronic pain syndrome and lack of coordination. Review of Resident #11's most recent Minimum Data Set (MDS) Assessment, dated 1/9/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident is at risk of developing pressure ulcers. Further the MDS indicated rejection of care 1-3 days during the lookback period. Review of Resident #11's most recent Norton Assessment (an assessment utilized to determine a resident's risk for skin breakdown), dated 1/6/25, indicated a score of 12, indicating that the Resident is at high risk for skin breakdown. Review of Resident #11's active risk for skin breakdown care plan, dated 7/23/24, indicated an intervention to Please elevate my heels off the mattress while in bed. Review of Resident #11's active physician orders indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Apply foam booties to bilateral heels when in bed may remove for care, dated 7/11/24. -offload heels whenever in bed, dated 7/11/24. -On 2/11/25 at 8:08 A.M., Resident #11 was observed lying in bed on his/her back. His/her heels were directly on the mattress. Resident #11 said that their left heel often hurts. Heel booties were observed stuffed between the bureau and the wall. -On 2/12/25 at 7:16 A.M. and 8:38 A.M., Resident #11 was observed lying in bed on his/her back. His/her heels were directly on the mattress. Heel booties were observed stuffed between the bureau and the wall in the same place as previously observed. -On 2/13/25 at 6:53 A.M., Resident #11 was observed lying in bed on his/her back. His/her heels were directly on the mattress. Heel booties were observed stuffed between the bureau and the wall in the same place as previously observed. Review of the February 2025 Treatment Administration Record failed to indicate refusal of booties to heels or elevation of heels off the mattress, and during the survey were signed off indicating treatment occurred, and failed to indicate rejection of care. During an interview on 2/13/25 at 9:47 A.M., the Corporate Nurse said that physician's orders should be implemented as written and documented accurately in the medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs), for one Resident (#28) out of a total sample of 23 residents. Specifically, for Resident #28 the facility failed to provide assistance and/or supervision with meals. Findings include: Review of the facility policy titled Activity of Daily Living, dated 12/22, indicated the following: -A resident who is unable to carry out activities of daily living will receive the necessary services to maintain nutrition, grooming, and personal and oral hygiene. -Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that it is unavoidable. -The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. -The facility will provide care and services for following activities of daily living: -Dining- eating, including meals and snacks. Resident #28 was admitted to the facility in December 2024 with diagnoses that included dementia, dysphagia (difficulty swallowing foods and fluids), and schizophrenia. Review of Resident #28's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Review of Resident #28's Activity of Daily Living (ADLs) care plan, dated 8/20/24, indicated Please assist me with eating. I need staff to assist me. Review of Resident #28's Dysphagia care plan, dated 2/12/24, indicated I am to eat with staff assistance/supervision. On 1/11/25 from 8:38 A.M. to 8:52 A.M., the surveyor observed Resident #28 sitting on the edge of the bed with his/her breakfast tray set up without any staff present in his/her room or within view from the hallway. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/12/25 from 9:05 A.M. to 9:21 A.M., the surveyor observed Resident #28 sitting on the edge of the bed with his/her breakfast tray set up without any staff present in his/her room or within view from the hallway. On 1/13/25 from 8:45 A.M. to 9:00 A.M., the surveyor observed Resident #28 sitting on the edge of the bed with his/her breakfast tray set up without any staff present in his/her room or within view from the hallway. During an interview on 2/13/25 at 9:39 A.M., Certified Nursing Assistant (CNA) #2 said she often has Resident #28 on her assignment and that Resident #28 does not need supervision to eat. During an interview on 2/13/25 at 12:07 P.M., Nurse #4 said she works regularly on the second floor and knows Resident #28 very well. Nurse #4 said Resident #28 does not need supervision or assist to eat. Nurse #4 and the surveyor reviewed Resident #28's care plan indicating the need for assistance and supervision. Nurse #4 said that she was unaware that Resident #28's care plan indicated he/she required supervision/assist for eating meals. During an interview on 2/13/25 at 9:58 A.M., the Director of Nurses (DON) said if Resident's care plan says that he/she needs to be supervised/assisted for eating, the care plan should be followed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, record review, and interview, the facility failed to address a change in condition related to edema management for one Resident (#19) out of a total sample of 23 residents. Findings include: Resident #19 was admitted in October 2019 with diagnoses including history of an embolism of the lower extremity and hemiplegia of the left side. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #19 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the MDS indicated Resident #19 requires substantial assistance to dependence with activities of daily living. During an observation on 2/11/25 at 8:14 A.M., Resident #19 was lying in bed with his/her left leg exposed. Resident #19's left leg was large and swollen throughout the leg. Resident #19 said that he/she has had increased leg swelling and pain in his/her left calf since last week. Resident #19 said he told his occupational therapist about it, but no one has done anything about it. Review of the medical record failed to indicate that Resident #19 had any edema or diagnoses that would cause edema of the left leg. During an interview on 2/12/25 at 12:31 P.M., Nurse #2 said that Resident #19's leg has been like that for a while and that it is not pitting edema. Nurse #2 said that he does not think the Nurse Practitioner or Physician had been notified because it is normal for Resident #19. Nurse #2 could not say what was causing the swelling. During an interview on 2/12/25 at 12:46 P.M., Rehab Staff #1 said that she has worked with Resident #19 recently and knows that Resident #19 notified nursing of his/her leg swelling. Rehab staff #1 said that as far as she knows, the swelling has gotten worse. During an interview on 2/12/25 at 1:27 P.M., Rehab Staff #2 said that she worked with Resident #19 on 2/4/25 and said that Resident #19 told her that his/her leg felt like it had a cramp in it. Rehab staff #2 said she looked at the leg and it was swollen with 2+ edema without redness or warmth. Rehab staff #2 said she notified Nurse #2 and asked Nurse #2 to relay that information to the physician. Rehab staff #2 said she also worked with Resident #19 on 2/11/25 and notified Nurse #2 about the leg swelling again. She said Nurse #2 told her that he's been watching it and it looks the same. Rehab staff #2 was told by Nurse #2 that sometimes Resident #19 can be behavioral. During an interview on 2/12/25 at 1:26 P.M., Nurse Practitioner #1 said she was never notified of the leg swelling, but that Resident #19 has a history of a deep vein thrombosis (occurs when a blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs. Deep vein thrombosis can cause leg pain or swelling). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 12:18 P.M., Physician #1 said he was never made aware of the leg edema. Review of the medical record indicated that on 2/12/25, 8 days after the occupational therapist reported the swelling to nursing, the nurse practitioner was notified, and an ultrasound was ordered to rule out a DVT (deep vein thrombosis).

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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. 49880 Based on record review and interview the facility failed to ensure that one Resident (#58) out of a total sample of 23 residents received proper treatment and assistive devices to maintain their vision. Specifically, the facility failed to ensure that Resident #58 had a follow up and consultation for cataract surgery as recommended by the consulting eye doctor. Findings include: Resident #58 was admitted to the facility in April 2024 with diagnoses that include stiff man syndrome and anxiety. Review of Resident #58's most recent Minimum Data Set (MDS) Assessment, dated 1/10/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident's vision is impaired and he/she does not utilize corrective lenses. Review of the consultant eye doctor visit note, dated 7/11/24 indicated the following: -Assessment: 1. Cataract, mixed; Bothersome; L > R (left greater than right). -Plan: 1. Cataract surgery recommended; ophthalmology consult; Follow-Up: 3-4 Months; Referral: Ophthalmology Consult (Cataract Surgeon) -Consult with primary care physician regarding surgical recommendation -Monitor and advised patient on condition and visual changes -Patient wants to proceed with surgery; Spoke with RN (registered nurse) on need for referral to cataract surgeon. Review of Resident #58's progress notes failed to indicate any follow up was completed in regard to a consult for cataract surgery. Review of a social services progress note, dated 1/9/25, indicated the need for an ophthalmologist appointment, but the medical record failed to indicate any further follow up. Review of the medical record failed to indicate that the resident has an activated healthcare proxy, indicating that the Resident makes his/her own decisions about healthcare options. During an interview on 2/11/25 at 7:49 A.M., Resident #58 said that he/she has cataracts in both eyes and can barely see anymore. He/she said their vision has gotten worse since admission to the facility. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 2/12/25 at 12:22 P.M., Resident #58 said that he/she is responsible for making their own healthcare decisions and would like to follow up about his/her options for cataract surgery. Resident #58 further said that his/her decline in vision makes it hard to read and watch the television at times. During an interview on 2/12/25 at 12:45 P.M., Nurse #3 said that Resident #58 has some visual issues. She said that if the eye doctor recommended a follow up then a follow up appointment should have been scheduled. She was not sure if Resident #58 required any follow up. During an interview on 2/12/25 at 1:11 P.M., the Director of Nurses said she would expect that staff have a follow up conversation with the Resident about their desire to proceed with the follow up, and if the Resident wants to proceed, the physician should be made aware and a follow up should be scheduled.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observation, record review, and interview, the facility failed to provide care and services consistent with professional standards of practice by not following a physician's order for air mattress settings to promote the healing of existing pressure ulcer for one Residents (#20), out of a total sample of 23 residents. Findings include: Resident #20 was admitted to the facility in March 2024 with diagnoses including multiple sclerosis, pressure ulcers stage 3 and 4 of back and sacrum. Review of Resident #20's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated the Resident had pressure ulcers. On 2/11/25 at 7:47 A.M., the surveyor observed Resident #20 lying in his/her bed the air mattress was set at 100 lbs. (pounds). On 2/12/25 at 6:45 A.M., the surveyor observed Resident #20 lying in his/her bed the air mattress was set at 100 lbs. (pounds). Review of the physician order dated 10/10/24 indicated the following: -Air mattress to be set at 150, check for proper functioning and placement every shift. Review of the care plan with a focus of Actual alteration in skin integrity related to pressure ulcer, date as initiated 3/26/24 indicated the following intervention: Pressure redistribution air mattress set as ordered in bed. During an interview on 2/12/25 at 11:02 A.M., the Director of Nursing said that nurses should be checking air mattress orders and settings every shift to ensure that they are at the correct settings. During an interview on 2/12/25 at 11:22 A.M., Nurse #1 said the air mattress should be set per the orders and nurses are to ensure it is set correctly.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observation, record review and interview the facility failed to adhere to professional standards for the administration of enteral feeding (nutrition taken through a tube directly to the stomach or small intestine) for one Resident (#20) out of a total sample of 23 residents. Specifically, the facility failed to implement the enteral feeding in accordance with the physician's order to receive the enteral feeding for 24 hours per day. Findings include: Resident #20 was admitted to the facility in March 2024 with diagnoses including multiple sclerosis, dysphagia, gastrostomy status. Review of Resident #20's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated the Resident utilizes a feeding tube. During an interview on 2/12/25 at 6:45 A.M., Resident #20 was observed lying in his/her bed, the Resident told the surveyor he/she had gone on a leave of absence to his/her apartment the day before at 12:00 P.M. and returned to the facility around 7:00 P.M. The Resident said he/she does not eat anything by mouth and so he/she goes without food when he/she is away from the facility. Review of the current physician orders indicated the following: -NPO diet (Nothing by Mouth) texture, thin liquids consistency. -Enteral feed order every shift infuse Osmolite 1.5 at 55 ml (milliliter)/ hour x 24 hours. Review of the medical record failed to indicate the physician was notified that the Resident had not received the enteral feeding per the orders the day the Resident was away from the facility for seven hours. During an interview on 2/12/25 at 11:15 A.M., Nurse #1 said the Resident receives the tube feeding continuously, she further said the physician should be notified if the Resident is out of the facility and does not receive the enteral feeding as ordered. During an interview on 2/12/25 at 11:33 A.M., Unit Manager #1 said the Resident should be receiving the enteral feeding as per the orders.

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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 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** 41019 Based on observations, interview, and record review, the facility failed to ensure that respiratory care and services consistent with professional standards of practice, were provided for two Residents (#3 and #11), out of a total sample of 23 residents. Specifically, 1. For Resident #3, the facility failed to label and date the oxygen tubing and maintain a clean oxygen filter. 2. For Resident #11, the facility failed to label and date nebulizer tubing and store it in properly in a bag. Findings include: Review of the facility policy titled Oxygen Administration Policy and Procedure, dated 12/6/22, indicates the following: - Procedures: Check the physician order. If it is unclear, clarification must be obtained. - Precautions: Do not operate a concentrator without a filter or with a dirty filter. 1. Resident #3 was admitted in October 2010 with diagnoses including anemia. Review of the minimum data set (MDS), dated [DATE], indicated Resident #3 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Review of the MDS indicated Resident #3 requires assistance to dependence with activities of daily living. During an observation on 2/11/25 at 8:17 A.M., Resident #3 was lying in bed with oxygen on and running. Resident #3's oxygen tubing was not labeled or dated. The filter in the oxygen concentrator was covered in dust. During an observation on 2/12/25 at 9:00 A.M., Resident #3 was lying in bed with oxygen on and running. Resident #3's oxygen tubing was not labeled or dated. The filter in the oxygen concentrator was covered in dust. During an interview on 2/12/25 at 9:00 A.M., Nurse #2 said that the night nurse is supposed to change the tubing weekly and is supposed to label and date. Nurse #2 said that maintenance is responsible for changing filters in the concentrators. 49880 2. Resident #11 was admitted to the facility in July 2024 with diagnoses including chronic pain syndrome and lack of coordination. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's most recent Minimum Data Set (MDS) Assessment, dated 1/9/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. Review of physician's orders indicated the following order, dated 2/8/25: -Ipratropium-Albuterol Solution 0.5-2.5 (3) MG (milligram)/3ML (milliliter)- 1 vial inhale orally every 4 hours as needed for Wheezing-SOB (shortness of breath) administer via nebulizer. On 2/11/25 at 8:08 A.M., the surveyor observed a nebulizer machine with tubing and a mask attached at the Resident's bedside. The nebulizer tubing was not labeled with a date, and it was not stored in a bag and no bag was present. The nebulizer mask was in the drawer of the bedside table with other supplies in the drawer. On 2/11/25 at 1:22 P.M., the surveyor observed a nebulizer machine with tubing and a mask attached at the Resident's bedside. The nebulizer tubing was not labeled with a date. The mask was now stored in a bag labeled as issued on 2/16/25. On 2/12/25 at 7:15 A.M., the surveyor observed a nebulizer machine with tubing and a mask attached at the Resident's bedside. The nebulizer tubing was not labeled with a date. The mask was stored in a bag labeled as issued on 2/16/25. During an interview on 2/12/25 at 12:50 P.M., Nurse #3 said that respiratory tubing should be labeled with the date and changed weekly. Nurse #3 said that as part of the resident assessment is ensuring that the tubing is labeled appropriately and if it is not, it should be replaced. During an interview on 2/12/25 at 11:06 A.M., the Director of Nursing (DON) said that nurses should be assessing the oxygen or nebulizer tubing as part of their assessment and if it is unlabeled or soiled then it should be replaced and labeled with the date. The DON further said that respiratory equipment should be stored properly in a a bag.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on record reviews, policy reviews and interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental, and psychosocial well-being for one Resident (#28) out of a total sample of 23 residents. Specifically, for Resident #28, the facility failed to ensure a psychiatric consult was completed. Findings Include: Resident #28 was admitted to the facility in December 2024 with diagnoses that included dementia without behaviors, dysphagia, and schizophrenia. Review of Resident #28's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a six out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating severe cognitive impairments. Further review of the MDS indicated the Resident is receiving an antipsychotic medication. Review of Resident #28's physician order, dated 7/24/24, indicated Psychological evaluation and treatment for: Adjustment to need for placement in facility and Med management, if required. [sic] Review of Resident #28's active physician's orders indicated: -Haldol (an antipsychotic medication) 0.5 milligrams every six hours, initiated 12/13/24. -Olanzapine (an antipsychotic medication) 7.5 milligrams daily, initiated 12/13/24. Review of Resident #28's nursing progress note, dated 1/28/25, indicated Resident noted very agitated this afternoon. For no apparent reason started to curse everyone, very aggressive grabbed the computer by the nursing station and attempted to throw it at Writer or anyone else close to her. For safety issue, Writer run to the toilet. Male CNA (certified nursing assistant) approached her and hold the computer to prevent further damage. Now resident tried to open the back door by pushing it several times and hardly. Nurse on Team one helped Writer to administer Haldol 0.5ml (milliliters) Intramuscularly to Right Deltoid. Resident calmed down after approximately half hour, compliant with medications. [sic] Review of Resident #28's physician progress note, dated 2/4/25, indicated Schizophrenia-I was asked to evaluate patient because as per staff patient has become more agitated recently patient was on IM (intramuscular) Haldol and also p.o. (by mouth) Haldol seems to have been dropped off because it had an end date as per staff patient seems to benefit from the Haldol so we will resume the Haldol orders and have psych follow up with the patient for any needed medication adjustments. [sic] (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's MMR (monthly medication review) by the Consultant Pharmacist, dated 12/1/24 through 12/24/24, indicated The resident currently has a scheduled order for Zyprexa, and now also Haldol. Please perform an AIMS (Abnormal Involuntary Movement Scale) evaluation and put the results electronic medical record, under Assessments. Alternately, make sure that this resident is seen by Psych and that the practitioner completes an AIMS as part of their evaluation. [sic] Review of Resident #28's MMR follow-through form on 2/13/25, dated 1/8/25, indicated staff was enrolling Resident with Psych services. Review of request for Psych services on 2/13/25 in Resident #28's medical record indicated the form was blank. Review of Resident #28's medical record on 2/13/25 failed to indicate that he/she had been seen by psych services. During an interview on 2/13/25 at 9:55 A.M., Nurse #4 was unaware of Resident #28 not having an AIMS and that Resident was not enrolled in Psych services, but they should have been. During an interview on 2/13/25 at 9:58 A.M., the Director of Nursing (DON) said that request for service form must be faxed for Resident to be enrolled and was unaware that the form was blank in Resident's #28's chart or if the need for Resident to be enrolled had been followed up on. The DON said that the Resident should have been seen by Psych services.

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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. 50338 Based on record review and interview the facility failed to ensure residents were free of unnecessary medications and were properly assessed for possible adverse reactions to psychotropic medications for one Resident (#28) out of a total of 23 sampled residents. Specifically, for Resident #28, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS, a clinical outcome checklist completed by a healthcare provider to assess the presence and severity of adverse outcomes, such as abnormal movements of the face, limbs, and body in patients) assessment was completed. Findings Include: According to CMS guidelines, an AIMS (Abnormal Involuntary Movement Scale) test should be conducted on a nursing home resident when a resident starts or has significant changes to medications that can cause tardive dyskinesia, like certain antipsychotics. Review of facility policy titled [Outside Vendor] Behavioral Health, dated April 2023, indicated the purpose is to ensure all residents taking antipsychotic are monitored for adverse side effects. It is the policy of [Outside Vendor] Behavioral Health that anyone on our caseload at a facility who is treated with an antipsychotic medication is assessed with an AIMS (Abnormal Involuntary Movement Scale) test every 6 months. Resident #28 was admitted to the facility in December 2024 with diagnoses that included dementia without behavioral disturbance, dysphagia, and schizophrenia. Review of Resident #28's most recent Minimum Data Set (MDS) assessment, dated 12/18/24, indicated that Resident #28 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. The MDS Assessment further indicated that Resident #28 received an antipsychotic medication. Review of Resident #28's active physician's orders indicated: - Haldol (an antipsychotic medication) 0.5 milligrams every six hours, initiated 12/13/24. - Olanzapine (an antipsychotic medication) 7.5 milligrams daily, initiated 12/13/24. Review of Resident #28's MMR (monthly medication review) by the Consultant Pharmacist, dated 12/1/24 through 12/24/24, indicated The resident currently has a scheduled order for Zyprexa, and now also Haldol. Please perform an AIMS evaluation and put the results in the electronic medical record, under Assessments. Alternately, make sure that this resident is seen by Psych and that the practitioner completes an AIMS as part of their evaluation. [sic] Review of Resident #28's medical record on 2/13/25 failed to indicate that an AIMS assessment was completed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's psychotropic medication care plan on 2/13/25, dated as revised 8/21/24, indicated that [Resident #28] takes antipsychotic related to history of schizophrenia. [sic] Review of Resident #28's medical record on 2/13/25 failed to indicate that he/she had been evaluated or seen by behavioral health/ psych services. During an interview on 2/13/25 at 7:51 A.M., Nurse #4 said AIMS assessments are completed by psych services and should be included in their notes. During an interview on 2/13/25 at 9:58 A.M., the Director of Nursing (DON) said that she would expect an AIMS assessment to be completed every 6 months by psych services for a resident who is receiving antipsychotic medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50338 Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure food was labeled in the main kitchen refrigerators, and that dented cans were not accepted into storage/circulation. Findings include: Review of the facility's undated policy titled Food Receiving and Storage, indicated, but was not limited to, the following: - When food is delivered to the facility it will be inspected for safe transport and quality before being accepted. - All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). On 2/11/25 at 6:51 A.M., the surveyor observed a significantly dented can of carrots, a significantly dented can of beef stew, and three significantly dented cans of tropical fruit salad on the can rack in the kitchen storage room. On 2/11/25 at 6:51 A.M., the surveyor made the following observations in the main kitchen refrigerator: -One opened, undated and unlabeled ham roast. -One pan of cooked meat in juices, undated and unlabeled. During an interview on 2/11/25 at 7:36 A.M., the cook said that dented cans should not go on the can rack and should instead be placed in the office. During an interview on 2/11/25 at 7:13 A.M., the cook said that all food in the kitchen refrigerators should be dated and labeled. During an interview on 2/12/25 at 8:00 A.M., the Food Service Director (FSD) said dented cans should be set aside in the office to be returned as they pose a risk for botulism if consumed (a rare but serious illness caused by a toxin that attacks the nervous system and can lead to paralysis and death). The FSD said that the meats in the refrigerator should be dated and labeled when opened.

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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 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** 41019 Based on record review and interview the facility failed to maintain accurate and complete medical records for four Residents (#46, #43, #3 and #20) out of a total sample of 23 residents. Specifically, 1. For Resident #46 the facility failed to maintain an accurate diagnosis list. 2. For Resident #43 the facility failed to document the appropriate location of a blood pressure measurement. 3. For Resident #3 the facility failed to ensure that the medical record included information pertaining only to that resident. 4. For Resident #20 the facility failed to accurately document the intake of enteral feeding per day. Findings include: 1. Resident #46 was admitted in October 2024 with diagnoses including methicillin resistant staphylococcus aureus (MRSA) and human immunodeficiency virus (HIV) disease. Review of the minimum data set (MDS), dated [DATE], indicated Resident #46 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. During observations throughout survey, Resident #46 did not have any precautions in place for any infectious disease. Review of the hospital discharge paperwork, dated 10/24/24, indicated Resident #46 had a skin wound on his/her upper lip, but was swabbed negative for MRSA. Review of the diagnosis list for Resident #46 indicated he/she has MRSA on the lip. Review of the current physician's orders indicate Resident #46 is receiving Mupirocin ointment (a topical ointment for bacterial skin infections) for a MRSA infection. During an interview on 2/12/24 at 12:14 P.M., Physician #1 said he was never able to figure out if Resident #46 had MRSA or not. Review of the medical record indicated Resident #46 has an active diagnosis of MRSA despite being admitted from the hospital with a negative MRSA diagnosis. 2. Resident #43 was admitted in April 2024 with diagnoses including hypertension, hemiplegia, and cerebral infarction. (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 the Minimum Data Set (MDS), dated [DATE], indicated Resident #43 scored an 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. Review of the care plan for Resident #43 indicated the following: Focus- Blood pressure to be taken on the left leg only due to vascular implants and grafts (initiated 4/25/24) Review of the physician's orders for Resident #43 indicated the following: - TAKE BP [blood pressure] on LEFT LEG only (initiated 4/13/24) Review of the Vitals Summary for blood pressure indicated that Resident #43's blood pressure was taken on the right or left arm 15 times during the month of February. During an interview on 2/12/25 at 11:02 A.M., the Director of Nursing said that nurses should be documenting on the appropriate location that they take the blood pressure and not taking or documenting the blood pressure on either arm. 3. Resident #3 was admitted in October 2010 with diagnoses including anemia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #3 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Review of the MDS indicated Resident #3 requires assistance to dependence with activities of daily living. Review of the medical record indicated that on 7/1/24 a progress note from another resident from another building was uploaded to the medical record of Resident #3. During an interview on 12/12/25 at 11:02 A.M., the Director of Nursing said that Resident #3's medical record should not contain any other medical information from any other resident. 46339 4. Resident #20 was admitted to the facility in March 2024 with diagnoses including multiple sclerosis, dysphagia, gastrostomy status. Review of Resident #20's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated the Resident utilizes a feeding tube. During an interview on 2/12/25 at 6:45 A.M., Resident #20 was observed lying in his/her bed, the Resident told the surveyor he/she had gone on a leave of absence to his/her apartment the day before at 12:00 P.M., and returned to the facility at 7:00 P.M. The Resident said he/she does not eat anything by mouth and so he/she goes without food when he/she is away from the facility. Review of the current physician orders indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enteral feed order every shift infuse Osmolite 1.5 at 55 ml (milliliter)/ hour x 24 hours. -Enteral tube feed intake every shift. -Free water bolus at 160 ml (milliliter) every 4 hours. Review of the medication administration record (MAR) for February 2025 indicated incorrect documentation of the enteral intake amount. On 2/11/25 the MAR indicated incorrect documentation as the Resident had been out of the facility for about seven hours. Further review of the MAR indicated inconsistency with the amount documented per shift and per day. During an interview on 2/12/25 at 11:15 A.M., Nurse #1 said the Resident receives the tube feeding continuously and the total enteral intake should be the osmolite at 55 ml/hour for 8 hours per shift and including the water flushes. She further said there were multiple shifts with inaccurate total intake documentations. During an interview on 2/12/25 at 11:33 A.M., Unit Manager #1 said the nurses should document accurately the enteral intake.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41019 Based on observation and interview, the facility failed to adhere to infection control practices and standards increasing the risk of contamination and spread of infection for residents in the facility. Specifically, the facility failed to unglove hands after bagging soiled linens and proceeded to wear the contaminated gloves in the hallway and potentially contaminate the soiled linen chute. Findings include: During an observation on 2/11/25 at 7:59 A.M., a certified nursing aide exited a Resident room with a bag of soiled linen wearing the same gloves that were used to bag the linen. The certified nursing aide walked through the hallway and disposed of the dirty linen in the linen chute. The certified nursing aide then removed the potentially contaminated gloves. During an observation on 2/12/25 at 8:45 A.M., a certified nursing aide exited a Resident room with a bag of soiled linen wearing the same gloves that were used to bag the linen. The certified nursing aide walked through the hallway and disposed of the dirty linen in the linen chute. The certified nursing aide then removed the potentially contaminated gloves. During an interview on 2/13/25 at 12:45 P.M., the Infection Preventionist said that gloves should not be worn in hallways and staff should remove gloves and complete hand hygiene before entering the hallway.