STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225533	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wachusett Manor	32 Hospital Hill Road Gardner, MA 01440

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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 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. 42761 Based on observation, interview, and policy review, the facility failed to maintain a clean and homelike environment on one Unit (#4) out of three units observed. Specifically, the facility failed to ensure that the flooring in the Unit #4 multi-purpose room was in good repair and homelike condition. Findings include: Review of the facility's policy titled Homelike Environment, dated 2001 and revised February 2021, indicated the following: -Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. -Facility staff and management maximizes, to the extent possible, characteristics of the facility that reflect a personalized, homelike setting. On 8/8/24 at 7:45 A.M., the surveyor observed the following in the residents' multi-purpose room on Unit #4: -Several gouges and holes in the flooring throughout the room. -One area where the flooring was torn and lifted at the transition from the hallway into the multi-purpose room. On 8/8/24 at 8:45 A.M., the surveyor observed several residents seated in the Unit #4 multi-purpose room for breakfast. The surveyor also observed three staff members in the Unit #4 multi-purpose room at this time assisting the residents with the breakfast meal. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/9/24 at 12:10 P.M., the Maintenance Director said the flooring in the Unit #4 multi-purpose room was very old and had several gouged areas and holes in the flooring. The Maintenance Director said he thought the gouges and holes were from the use of equipment such as mechanical lifts and scraping the floor when it needed to be cleaned. The Maintenance Director said the floor had been like this for some time and this was not the first time he had been aware of the condition of the floor. The Maintenance Director also said he was not aware of any plans to make the multi-purpose room floor more homelike for the residents on the unit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect the Resident's status for one Resident (#2) out of a total sample of 19 residents. Specifically, the MDS failed to accurately reflect that Resident #2 was diagnosed with Anxiety Disorder and had natural teeth that were broken. Findings include: Resident #2 was admitted to the facility in May 2022, with diagnoses including Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with daily activities) and lack of coordination (a muscle control issue that makes it difficult to coordinate movements). Review of Resident #2's care plans, last revised 5/24/24, indicated: -The Resident was diagnosed with Anxiety Disorder. -The Resident was prescribed medications to manage their Anxiety Disorder. -The Resident was at risk for altered dentition related to missing and broken teeth. Review of Resident #2's Physician's orders for August 2024 indicated: -To monitor the Resident for signs and symptoms of anxiety. -The Resident was prescribed Olanzapine (anti-psychotic [used to treat psychosis- a collection of symptoms that affect your ability to tell what is real and what is not] medication) 5 milligrams (mg) for anxiety. Review of Resident #2's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident did not have a diagnosis of Anxiety Disorder, nor did the Resident have broken natural teeth. During an interview on 8/13/24 at 11:10 A.M., the MDS Nurse said that the MDS Assessment had been inaccurately coded and should have marked the Resident as having Anxiety Disorder and broken natural teeth.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on observation, interview, record, and policy review, the facility failed to provide care in accordance with professional standards of practice relative to providing a pressure redistribution cushion (cushion that spreads pressure more evenly across its surface to reduce the amount of pressure on any one part of the body) to a wheelchair when the Resident was at risk for skin breakdown for one Resident (#5) out of a total sample of 19 residents. Specifically, for Resident #5 the facility staff failed to: -Follow a Physician's order to provide a pressure redistribution cushion to the Resident's wheelchair. -Implement the Resident's care plan for a new cushion to the Resident's wheelchair. -Provide a pressure relieving device to the Resident's chair as indicated in the Minimum Data Set (MDS) Assessment and for the Resident who was assessed as being at a high risk for skin breakdown. Findings include: Review of the facility policy titled Support Surface Guidelines, dated September 2013, included: -Review the resident's care plan to assess for any special needs of the resident. -Redistributing support surfaces are to provide comfort for all bed or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. -Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface . Resident #5 was admitted to the facility in October 2016 with diagnoses of Spinal stenosis (an abnormal narrowing of the spinal cord resulting in pressure on the spinal cord causing pain or numbness in the arms or legs), abnormal posture, osteoarthritis (a degenerative joint disease that results from breakdown of joint cartilage and underlying bone), difficulty in walking, and muscle weakness. Review of the MDS assessment dated [DATE] indicated that Resident #5 was moderately cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 9 out of 15 and had a pressure reducing device for the wheelchair. Review of the Resident's care plan last revised on 7/30/24, included an intervention of new cushion applied to wheelchair, initiated 1/5/22. Review of the Resident's August 2024 Physician's orders included an active order for a pressure redistribution cushion to chair, initiated on 10/1/22. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's August 2024 Treatment Administration Record (TAR) included at the top heading under unscheduled other orders: Pressure redistribution cushion to chair. On 8/8/24 at 9:49 A.M., the surveyor observed Resident #5 sitting in a wheelchair with no pressure redistribution seat cushion. On 8/8/24 at 4:09 P.M., the surveyor observed Resident #5 sitting in a wheelchair, and there was no pressure redistribution seat cushion observed on the wheelchair. During an interview at the time, Resident #5 said he/she had not been in bed since the surveyor saw him/her last but did use the bathroom a couple of times with staff assistance. During an interview and observation on 8/12/24 at 8:40 A.M., Certified Nurses Aide (CNA) #2 said that she had taken care of the Resident before but does not ever remember using a seat cushion in the wheelchair. CNA #2 checked under the Resident, who was sitting in the wheelchair, and confirmed that there was no seat cushion in use on the Resident's wheelchair. During an interview and observation on 8/12/24 at 8:43 A.M., Nurse #1 said there was no seat cushion in use on the Resident's wheelchair. Nurse #1 reviewed the current Physician's orders and confirmed that there was an active order to use a pressure redistribution cushion on the Resident's wheelchair. During an interview on 8/12/24 at 8:48 A.M., Unit Manager (UM) #2 said that he went to the Resident's room and could not locate any seat cushion in the Resident's unit. UM #2 said that even if there wasn't an order there should have been a seat cushion in place (on the wheelchair). During an interview on 8/12/24 at 8:56 A.M., Resident #5 said that he/she did not remember ever having a seat cushion, but would like one because the wheelchair would be much more comfortable if there was a seat cushion.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services in accordance with professional standards of practice for one Resident (#43) out of a total sample of 19 residents. Specifically, the facility staff failed to: -verify the Physician orders for the appropriate liter per minute (LPM- the flow rate that supplemental oxygen is set for delivery) of Oxygen when the Resident was ordered for seven (7) LPM of Oxygen. -ensure that Resident #43 was administered the appropriate liter flow for the oxygen delivery device (nasal cannula - a thin flexible tube that provides supplemental oxygen to patients through the nose via nasal prongs) being used when the Resident was found to be ordered for and administered greater than six (6) LPM of Oxygen that was not compliant with professional standards of practice. Findings include: Review of the facility policy titled Oxygen Administration, revised October 2010, indicated the following: -Verify that there is a Physician's order for this procedure. Review the Physician's orders or facility protocol for oxygen administration. -Review the Resident's care plan to assess for any special needs of the Residents. -Adjust the oxygen delivery service so that it is comfortable for the Resident and the proper flow of oxygen is being administered. Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All Oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for Oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in PaCO2 (carbon dioxide). -Nasal cannulae provide approximately 24-40% oxygen with flowrates up to 6 L/min [LPM] in adults, although the patient's respiratory patterns can influence the actual, delivered FIO2; Oxygen supplied to adults by nasal cannula at flows </= to 4 L/min need not be humidified. -Equipment maintenance and supervision: All oxygen delivery equipment should be checked at least once daily . Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. Resident #43 was admitted to the facility in March 2024, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD - a chronic lung disease that block airflow and make it difficult to breathe) and Chronic Respiratory Failure (CRF - a long term condition that occurs when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, identified with symptoms of trouble breathing and fatigue). Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #43 utilized Oxygen and was usually able to make him/herself understood. Review of the August 2024 Physician Order Summary Report indicated the following order: -supplemental Oxygen via nasal cannula (a thin flexible tube that provides supplemental oxygen to patients through the nose via nasal prongs) continuous (delivered around the clock) 7 liters (LPM) every shift for shortness of breath. -change humidification bottle every night shift, every seven days for maintenance of oxygen equipment. Further review of the August 2024 Physician's Order Summary Report indicated no orders to titrate (increase or decrease) the Resident's Oxygen liter flow from the ordered 7 LPM. Review of Resident #43's August 2024 Medication Administration Record (MAR) indicated that the Resident received Oxygen via nasal cannula continously at 7 LPM every shift for shortness of breath. During an observation and interview on 8/8/24 at 9:21 A.M., the surveyor observed Resident #43 seated in bed with Oxygen administered via nasal cannula. The surveyor observed that the liter flow on the oxygen concentrator (medical device that uses air in the atmosphere, filters it, and delivers air that is 90 - 95% oxygen concentrated) was set to 8 LPM and had a humidifier bottle attached. Resident #43 said that he/she does not touch the oxygen concentrator and that his/her LPM should be set at 7 LPM. During an observation on 8/12/24 at 7:51 A.M., the surveyor observed the Resident seated in bed with Oxygen administered via nasal cannula and the liter flow on the oxygen concentrator set to 6 LPM with a humidifier bottle attached. During an interview at the time, Resident #43 said that the oxygen concentrator is supposed to be set at 7 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 12:59 P.M., the surveyor and Nurse #3 observed Resident #43's oxygen concentrator and observed that it was set at 6 LPM. Nurse #3 said that it is the Nurse's responsibility to ensure that the oxygen concentrator is set to the appropriate setting, that it should have been set at 7 LPM and it had not been. Nurse #3 said the Resident had behaviors of adjusting the oxygen concentrator flow rate. Nurse #3 also said that breathing in too much oxygen could cause damage to the Resident's lungs and too little [oxygen] could cause shortness of breath and anxiety. Review of Resident #43's clinical record did not indicate documentation that the Resident had personally adjusted and/or changed the settings on his/her oxygen concentrator since his/her admission to the facility. Further review of the clinical record did not indicate care planning for Resident #43 self-adjusting his/her oxygen concentrator liter flow rate or that the facility staff verified the appropriate Oxygen liter flow for the Resident with diagnoses of COPD and CRF. During an interview on 8/13/24 at 8:53 A.M., the surveyor and the Director of Nursing (DON) spoke with Resident #43 regarding his/her oxygen concentrator. Resident #43 said that he/she does not touch the oxygen concentrator and that only the nursing staff adjusts the [liter flow] settings.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on interview and record review, the facility failed to ensure that one resident (#71) out of a total sample of 19 residents received trauma-informed care in accordance with professional standards of practice. Specifically, the facility failed to complete a trauma history assessment for Resident #71 who had a diagnosis of Post Traumatic Stress Disorder (PTSD: a mental and behavioral disorder that develops from having experienced a traumatic event, causing flashbacks, nightmares and severe anxiety), placing the Resident at risk for re-traumatization. Findings include: Review of the facility policy titled Trauma Informed and Culturally Competent Care Level III, last revised August 2022, indicated the following: -Purpose: >To guide staff in providing care that is culturally competent and trauma informed in accordance with professional standards. >To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. -Resident Screening: >Utilize initial screening to identify the need for further assessment and care. -Resident Assessment: >Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. Resident #71 was admitted to the facility in August 2022, with diagnoses including PTSD and Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations). Review of the most recent comprehensive Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #71 was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 5 out of 15 and had an active diagnosis of PTSD. Review of the August 2024 Physician's orders indicated the Resident had an active legal Guardianship (Guardian: a court appointed person who makes important personal and healthcare decisions for an adult who lacks the capacity to make their own decisions) in place. On 8/8/24 at 8:00 A.M., the surveyor observed that Resident #71 had his/her room door closed, privacy curtain closed around the bed, and bed linens pulled up over his/her head. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 9:57 A.M., Resident #71's Guardian said that the Resident had increased behaviors of self-isolating in his/her room and refusing care. During an interview on 8/12/24 at 10:56 A.M., Nurse #4 said Resident #71 refuses care occasionally and likes to keep covered up, with a coat and hat on all the time. Nurse #4 said when the Resident refuses care, staff will tell the Nurse and then the Guardian is notified as required. During an interview on 8/12/24 at 12:51 P.M., CNA (Certified Nurses Aide) #3 said Resident #71 refuses care at times and gets very angry and upset when clothing is removed for care. CNA #3 said the Resident likes to be in his/her room with the privacy curtain closed tight around the bed and the door shut all the time. Review of the comprehensive medical record failed to indicate evidence of any assessment for trauma history when the Resident had an active diagnosis of PTSD and demonstrated increased behaviors of refusal of care and self-isolation. During an interview on 8/12/24 at 4:43 P.M., the Director of Nursing (DON) said a trauma assessment had not been done for Resident #71. The DON said a trauma assessment is important because past history of trauma could affect the delivery of care. During an interview on 8/13/24 at 2:15 P.M., Social Worker (SW) #1 said the trauma informed care assessment should be completed on admission for each resident. SW #1 said Resident #71 had a diagnosis of PTSD and should have been assessed for trauma history and triggers so staff could provide personalized care and manage behaviors. SW#1 said the trauma assessment was not completed until the surveyor notified the DON on 8/12/24 that there was no trauma assessment found in the Resident's medical record. SW#1 further said Resident #71 should have been assessed for trauma informed care on admission to the facility.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, and record review, the facility failed to provide dental services for one Resident (#2) out of a total sample of 19 residents. Specifically, the facility staff failed to obtain consent for dental services from Resident #2's Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) in a timely manner after the HCP had been invoked (made active by the Physician). Findings include: Resident #2 was admitted to the facility in May 2022, with diagnoses that included Alzheimer's Disease (a progressive disease beginning with mild memory loss and leading to the loss of the ability to carry on a conversation and respond to the environment, involves parts of the brain that control thought, memory, and language) and lack of coordination. Review of the facility policy for Dental Examination/Assessment, last revised December 2023, indicated: -That each resident will undergo a dental assessment within .90 days of admission. -Resident shall be offered dental services as needed. Review of Resident #2's clinical record indicated: -The Resident declined Dental Services on 5/31/22, shortly after admission to the facility. -The Resident's HCP had been invoked by the Physician on 8/4/22. -No evidence that the consent for Dental services had been reviewed and completed by the HCP after the Physician determination that the Resident lacked the capacity to make informed decisions regarding their own medical care. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a total of 15, and was able to communicate their needs verbally. Further review of the MDS Assessment indicated that Resident #2 had no problems with their teeth. Review of Resident #2's care plan for Dentition last revised 5/24/24, indicated: -The Resident was at risk for altered dentition related to broken and missing teeth -An intervention for a dental consult as necessary was initiated 6/29/22 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 10:29 A.M., Resident #2 said he/she would like to receive dental services at the facility and had never been seen by the Dentist. The surveyor observed that Resident #2 had some missing teeth, broken teeth, and stained teeth. Review of the clinical record did not indicate that Resident #2 had been seen by the Dentist during his/her stay in the facility. During an interview on 8/12/24 at 10:05 A.M., Additional Staff #3 (Medical Record Personnel) said she was responsible for obtaining consent for residents to be seen by the contracted facility Dentist but she had not obtained a consent to date for Resident #2. During an interview on 8/12/24 at 11:05 A.M., Additional Staff #2 (Regional Registered Nurse) said that the facility should have contacted the HCP after the HCP had been invoked to obtain the consent for dental care and they had not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42761 Based on observation, interview, record and policy review, the facility failed to implement infection control practices designed to prevent development and transmission of infection and provide a sanitary environment for two Residents (#20 and #67) out of a total sample of 19 residents. Specifically, facility staff failed to: 1. adhere to Standard Precautions (infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status) and Contact Precautions (infection prevention measures used to prevent transmission of infections which are spread by direct or indirect contact with the resident or the resident's environment) when Certified Nurse Aide (CNA) #1 provided personal care to Resident #20, who required Contact Precautions relative to a multi-drug resistant organism (MDRO), then handled Resident #67's wheelchair, increasing Resident #67's risk for illness. 2. distribute ice in a sanitary manner into bins used to keep residents' drink items cool for meal service, increasing the residents' risk for illness. 3. implement the facility's water management program, increasing the risk for illness in residents. Findings include: Review of the facility's policy titled Infection Control Policy and Procedure, dated 2022, indicated the following: -Staff were required to follow hand hygiene practice consistent with accepted standards of practice. -Infectious organisms may be transmitted by direct (skin to skin) or indirect (inanimate objects) contact. -Healthcare staff . often move from resident to resident and therefore may serve as a vehicle for transferring effective organisms. -Staff were required to perform hand hygiene before and after contact with a resident. Review of the Centers for Disease Control and Prevention (CDC) guidelines titled Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, indicated the following: -Protect yourself and your patients from deadly germs by cleaning your hands. -Cleaning one's hands reduces the spread of germs, including those resistant to antibiotics. -After touching a patient or patient's surroundings. -After contact with blood, body fluids, or contaminated surfaces. (continued on next page)

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	225533	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wachusett Manor	32 Hospital Hill Road Gardner, MA 01440

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #20 was admitted to the facility in May 2024 with a diagnosis of urinary tract infection (UTI: bacterial infection of the urinary tract). Review of Resident #20's clinical record indicated the following: -The Resident had an indwelling urinary catheter. -The Resident required Contact Precautions due to having Vancomycin Resistant Enterococcus (VRE: MDRO) in his/her urine. -A Physician's order, start date 8/1/24, for Ampicillin (antibiotic medication) Oral Capsule 500 milligrams (mg), give 1 capsule by mouth every 6 hours for UTI for 7 Days. Resident #67 was admitted to the facility in December 2023, with a diagnosis of Need for Assistance with Personal Care. On 8/8/24 at 7:35 A.M., the surveyor observed a Contact Precautions sign posted outside of Resident #20's and #67's shared room. The surveyor observed the following listed on the Contact Precautions sign: -Everyone must put on gloves and gown before room entry. -Do not wear the same gown and gloves for the care of more than one person. On 8/8/24 at 9:00 A.M., the surveyor observed CNA #1 put on a disposable gown and gloves, and assisted Resident #20 into his/her room by pushing his/her wheelchair. Upon entering the room, CNA #1 released Resident #20's wheelchair handles, then moved to Resident #67 who was sitting in a wheelchair and used her same gloved hands to move Resident #67 closer to his/her bed. The surveyor observed CNA #1 place her hands back onto the handles of Resident #20's wheelchair and move the Resident to his/her bedside. The surveyor observed CNA #1 close the privacy curtain between the two beds. The lower part of Resident #20's wheelchair and the Resident's urinary catheter tubing and urinary collection bag as well as CNA #1's lower legs were visible to the surveyor below the bottom of the privacy curtain. The surveyor observed CNA #1 remove Resident #20's urinary catheter collection bag from underneath the wheelchair and drop it on the floor, then pulled the urinary catheter tubing and bag from underneath the wheelchair to beside the Resident's right foot, dragging the bag on the floor. CNA #1 then assisted Resident #20 into his/her bed. The surveyor then observed CNA #1 open the privacy curtain. The CNA held a full plastic bag in her left hand, walked toward Resident #67 who was still sitting in his/her wheelchair, and moved the Resident in his/her wheelchair to his/her bedside. CNA #1 did not remove her gloves and gown and she did not perform hand hygiene before she assisted Resident #67. The surveyor observed CNA #1 remove her gown and gloves and performed hand hygiene, then exited the room carrying the plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 1:45 P.M., CNA #1 said she assisted Resident #20 back to bed that same morning. CNA #1 said she always had a hard time reaching around the Resident's chair to unsecure the urinary catheter collection bag from underneath the wheelchair, so every time she removed the collection bag, it would fall on the floor. CNA #1 said Resident #20's urinary catheter collection bag fell on the floor that morning when she was assisting the Resident back to bed, so she had to drag the urinary catheter collection bag on the floor, under the wheelchair, to make sure it did not get caught on anything when she transferred the Resident to bed. CNA #1 said she had also removed bed linens from Resident #20's bed and placed them in a plastic bag because the bed linens had some dried blood on them and the bed linens were the items in the plastic bag during the surveyor's observation. CNA #1 said she needed to move Resident #67 to his/her bedside in order to exit the room, so she moved the Resident by handling his/her wheelchair, but she did not remove her gloves and gown and perform hand hygiene after she provided personal care to and handled Resident #20's urinary catheter tubing and collection bag. CNA #1 said she should have removed her gloves and gown and performed hand hygiene after she assisted Resident #20, before she assisted Resident #67. During an interview on 8/8/24 at 2:00 P.M., the Infection Preventionist (IP) said Resident #20's urinary catheter collection bag should not have been on the floor, and should have either been properly disinfected or replaced. The IP said Contact Precautions were implemented for Resident #20 to reduce the risk for transmission of infection because the Resident was actively being treated with antibiotics for VRE in his/her urine. The IP also said CNA #1 should have removed her gloves and gown and performed hand hygiene after she assisted Resident #20, before she assisted Resident #67. 2. On 8/8/24 at 7:05 A.M, the surveyor observed that the ice machine in the facility's kitchen was empty and it was not running. The surveyor observed that two large bags of ice were stored in the facility's walk-in freezer. The surveyor also observed that the ice in both bags were thick, solid, and formed as blocks of ice. During an interview on 8/8/24 at 8:45 A.M., the Food Service Director (FSD) said that the ice machine in the facility's kitchen was not working and some parts were on order to fix the ice machine. The FSD said that while the facility awaited the parts and repair for the ice machine, the facility was purchasing large bags of ice and storing them in the walk-in freezer. On 8/8/24 at 11:30 A.M., the surveyor observed a staff member in the facility's kitchen handle a large bag of ice and throw it to the floor. During an interview on 8/8/24 at 3:30 P.M., Dietary Aide #1 said the ice machine in the facility's kitchen did not work and that large bags of ice were being used to place into the plastic bins where the kitchen staff stored containers of milk and juice used for resident consumption at meal times. Dietary Aide #1 said kitchen staff would dump the ice from the bags into the bins with the drinks. At this time, the surveyor observed a grey plastic bin located on top of a three tier cart that contained one unopened half gallon of milk and several plastic pitchers of juice in the kitchen next to Dietary Aide #1. Dietary Aide #1 said ice would be placed into the grey plastic bin to keep the drinks cool, then sent to a resident unit for resident consumption at the evening meal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 3:43 P.M., the FSD said the ice machine in the kitchen had not been working for a couple of weeks and the facility had parts on order for it to be repaired. The FSD said the facility had been purchasing large bags of ice while waiting for the ice machine to be repaired and that the bags of ice were used to keep drinks cool for meal service. The FSD said the ice pieces in the large bags would stick together, so in order for staff to be able to dump the ice into the drink bins, they would have to drop the bags of ice on the floor, then dump the ice into the bins once the ice was broken up. At this time, the FSD removed one large bag of ice from the freezer and dropped it on the floor in the cold food storage room outside of the walk-in freezer. The FSD then said after breaking the ice, staff would open the bag and dump the ice into the bins that contained containers of drinks for resident consumption. When asked if there was any other way the ice could be broken other than dropping it on the floor, the FSD said the ice could probably be broken on a food preparation table instead. During an interview on 8/8/24 at 4:00 P.M., the IP said staff should not be breaking bags of ice on the floor when the ice was being used to keep resident drink containers cool. The IP said staff should break the ice on a surface that is not the floor, such as a table. 3. Review of the facility's Water Management Program, revised 5/19/23 and reviewed 6/12/24, indicated the following: -Identify where potentially hazardous conditions could exist where pathogens/Legionella (bacteria usually found in soil and water that can become a health hazard when it grows in human made water systems and is spread through the inhalation of contaminated aerosolized water particles) could grow . -Determine where control measures should be applied and conduct regular monitoring to ensure control measures are performing as designed. -Flush dead legs (stagnant or unused section of plumbing that can provide a habitat for the growth of microorganisms) quarterly. -Flush low utilization sinks and fixtures monthly (more often if needed). -Monitor and document implementation of control measures on record keeping logs. During an interview on 8/8/24 at 12:00 P.M., the Maintenance Director said he could not provide evidence that dead legs were flushed quarterly or that low utilization sinks and faucets were flushed monthly since the last recertification survey.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48206 Based on observation and interview, the facility failed to maintain resident wheelchairs in a clean and sanitary manner for two Residents (#291 and #293), out of a total sample of 19 residents. Specifically, the facility failed to ensure that: 1. Residents #291's wheelchair was clean, sanitary, and in good repair. 2. Resident #293's wheelchair was clean and sanitary. Findings include: Review of the facility policy titled Cleaning Wheelchairs and Gerichairs (specialized recliners that are upholstered in non-permeable, easily sanitized vinyl), revised 9/5/2017, indicated: -If items (wheelchairs and gerichairs) are the responsibility of Environmental Services, the first step is . arrange to get wheelchairs or gerichairs from the residents at a convenient time for the resident. -Set up a schedule, with input from Nursing, to collect, wash, and dry chairs. -Take chairs to an open area - basement or shower room- use pressure washer or scrub by hand with a brush or sponge and germicide solution. -Rinse thoroughly with water and dry completely with rags. Pay special attention to the seats and wheels. 1. Resident #291 was admitted to the facility in August 2024, with diagnoses of muscle wasting and atrophy (thinning of muscle mass), and hemiplegia (paralysis of one side of the body). During an observation and interview on 8/8/24 at 9:18 A.M., the surveyor observed Resident #291 lying in bed with a wheelchair placed at his/her bedside. Resident #291 said that he/she was recently admitted to the facility for rehabilitation services and the wheelchair was provided to him/her by the facility. The surveyor observed that the left armrest of the wheelchair had a protective cover that was peeling away with no cushioning underneath. The surveyor also observed that the wheelchair cushion had a burn hole, and the wheelchair frame and wheel spokes were covered in dust and debris. 2. Resident #293 was admitted to the facility in August 2024 with diagnoses of Congestive Heart Failure (CHF- caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs) and Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes restricted airflow from the lungs and difficulty breathing). (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/8/24 at 9:55 A.M., the surveyor observed Resident #293 in bed with a wheelchair placed at the foot of his/her bed. Resident #293 said that he/she had recently been admitted to the facility for rehab services and the wheelchair was provided to him/her by the facility. The surveyor observed the facility wheelchair cushion to be ripped with duct tape patching an area, a metal connector on the left side was exposed, and the support frame and wheel spokes to be covered with dried brown substance, dust, and debris. During an observation on 8/9/24 at 9:42 A.M., the surveyor observed Resident #293's in bed with the same wheelchair from the day before at the foot of the bed. The surveyor observed the wheelchair frame underneath the seat was caked with debris and dust, observed the seat cushion was sticky and adhered to the frame with brown caked substance between the cushion and the chair when lifted. During an interview on 8/9/24 at 11:17 A.M., Unit Manager #1 (UM#1) said that the facility provides newly admitted residents with wheelchairs until rehab services can assess them for mobility needs. UM#1 said the facility has a wheelchair cleaning schedule and when a resident discharges, housekeeping will clean the wheelchair. She said that housekeeping will notify her at the beginning of the month on what wheelchairs need to be cleaned. During a second interview and observation at 11:26 A.M., the surveyor and UM#1 observed Resident #291's wheelchair. The surveyor observed the left wheelchair armrest had been replaced and was cushioned. The surveyor further observed the wheelchair frame and wheel spokes remained covered with dust and debris. UM#1 said that the wheelchair cushion had a burn hole and that the wheelchair frame was dirty. During the continued observation and interview at 11:26 A.M, the surveyor and UM#1 observed Resident #293's wheelchair. UM#1 lifted the wheelchair cushion which stuck to the seat surface and observed the frame to be dusty with debris. UM#1 said that Resident #291 and #293 wheelchairs were dirty, needed to be cleaned, and did not appear to have been cleaned since the two residents were admitted to the facility. UM#1 said that the housekeeping department was responsible for wheelchair cleaning. During an interview on 8/9/24 at 2:40 P.M. the Housekeeping Director said that she was new in the position and provided the surveyor with a wheelchair cleaning schedule beginning July 2024. The surveyor reviewed the schedule with Housekeeping Director which indicated the unit with Residents #291 and #293 was due to have wheelchairs cleaned the week ending August 3, 2024. The surveyor requested evidence that the wheelchairs were cleaned as indicated on the schedule. The Housekeeping Director said that there were no logs to show evidence that the cleaning schedule was completed. The Housekeeping Director said that a cleaning log would be implemented so she could follow the cleaning schedule more closely.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 42761 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure that the facility was free of pests in the main facility kitchen, on two units (Unit Two and Unit Four) and in the residents rooms for three Residents (#17, #69 and #290). Specifically, the facility staff failed to implement measures to eradicate and contain small flies located in the facility's main kitchen, the kitchenette on Unit Two, dining room on Unit Four, and in Resident's #17, #69 and #290 rooms, increasing the risk for contamination of clean surfaces and transmission of infectious pathogens. Findings include: Review of the North Carolina State University Extension Publication titled Phorid Flies (https://content.ces.ncsu.edu/phorid-flies) dated 11/17/21 indicated: -Phorid flies are mainly nuisance pests, but there are some cases of larval infestations of human orifices such as the eyes, wounds, and intestines. -Phorid flies are capable of transmitting bacterial pathogens onto foods or working surfaces in food preparation facilities. -These instances are fairly rare and the presence of these flies in and around the home is typically only a nuisance to those affected. --Phorid fly control begins with finding and eliminating larval development sites such as rotting food, where moisture exists around plumbing lines and drains and cracks in structures like foundations, walls, windows Review of the facility's Pest Control Service Inspection Report, dated 5/8/24, indicated the following: -The storage area outside of the walk-in refrigerator (main kitchen) was inspected and no pest activity was observed. -The main kitchen's dry storage room was inspected and no pest activity was observed. -The main kitchen area was inspected. A few Phoroid Flies (mainly nuisance pests: flies that are capable of transmitting bacterial pathogens onto foods or working surfaces in food preparation areas) were observed on the trap next to the ice machine. Review of the facility's Pest Control Service Inspection Report, dated 6/12/24, indicated the following: -The scheduled pest control service was completed. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No pest problems were reported in the log book. Review of the facility's Pest Control Service Inspection Report, dated 7/5/24, indicated commercial pest control was provided to the facility relative to a service call for mice. Further review of the Pest Control Service Inspection Report included no evidence that routine pest control services were provided on 7/5/24. On 8/8/24 at 6:55 A.M., the surveyor observed small flies in the facility's main kitchen, specifically in the food preparation area, the cold storage room outside of the walk-in freezer and walk-in refrigerator, and in the dry food storage room. On 8/8/24 at 8:09 A.M., the surveyor observed a meal tray in Resident #17's room that contained uneaten food. The surveyor observed small flies on the uneaten food. On 8/8/24 at 9:36 A.M., the surveyor observed Resident #69 sitting on the edge of his/her bed. The surveyor further observed two small flies in the air above Resident #69's head. On 8/8/24 at 12:00 P.M., the Maintenance Director said that the facility had a pest control program in place. The Maintenance Director said he was not sure how often pest control services were provided, but he thought that someone from the pest control company serviced the facility every other month. The Maintenance Director also said that he was unsure when pest control services were last provided to the facility, but he thought it was a couple of weeks prior, and that the facility had been receiving services to treat for fruit flies. The Maintenance Director said that the pest control company had not left any paperwork from their visits at the facility, but he would contact the pest control company to acquire the pest control service records. On 8/8/24 at 5:15 P.M., the Maintenance Director said he had contacted the pest control company, but the pest control company had not called back as yet. On 8/9/24 at 7:05 A.M., the surveyor observed the following in the Unit Two Short Hall Kitchenette: -Three small dessert plates that were unevenly stacked, with the top plate and the middle plate containing brown food crumbs. -One plastic cup that contained a straw and a small amount of orange juice. When the surveyor tipped the cup to look inside it, the surveyor observed two small flies exit the cup. -One small flying in the air that landed and sat on the inner doorframe of the Kitchenette. During an interview on 8/9/24 at 7:08 A.M., [NAME] #1 said the facility had been dealing with small flies, off and on, for a while. [NAME] #1 said dietary staff from the Kitchen were responsible to make rounds in the mornings to pick up any food items from the evening prior and bring them back to the Kitchen for disposal. [NAME] #1 said that staff on the resident units were supposed to bag any food items still on the units after the Kitchen was closed and place them in the unit Kitchenettes to be picked up in the morning. He said Kitchen staff also left an enclosed cart on the units that meal trays could be placed in, to keep food items contained. [NAME] #1 said sometimes staff did not follow this process and food items were left open on the units. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/9/24 at 7:10 A.M., the Food Service Director (FSD) said the small flies observed by the surveyor in the kitchen areas on 8/8/24 were drain flies. The FSD said that the pest control company was actively servicing the facility for the drain flies and that the services were provided monthly. The FSD said the drain fly activity had not worsened, but it had not improved and that the drain flies had been present for about two years. During an interview on 8/9/24 at 7:30 A.M., the Administrator said that the facility had pest control services in place and that services were provided monthly. The Administrator said that he had not observed any small flies on the resident units at the facility and that he thought the small flies were only present in the lower level of the facility, where the main kitchen was located. The Administrator further said he thought the small fly activity was almost rectified. During an interview on 8/9/24 at 8:37 A.M., Resident #290 said he/she had been at the facility for the past two weeks and observed small flies in his/her room, but had not brought this up to facility staff. During an interview on 8/9/24 at 8:45 A.M., Resident #69 said he/she observed small flies in his/her room a few days prior, but had not brought this up to facility staff. During an interview on 8/9/24 at 10:28 A.M., Housekeeper #1 said the dining room sink on Unit Four often has small flies in it, but that she had not received any specific instruction on how to get rid of them. Housekeeper #1 did not say whether she had communicated observations of small flies in the Unit Four dining room sink to administration. During a follow-up interview on 8/9/24 at 12:10 P.M., the Maintenance Director said he received records from the pest control company relative to pest control services that same morning and provided a copy of the records to the surveyor for May 2024 through July 2024. The Maintenance Director said that he had not contacted the pest control company for the records of services provided until the surveyor requested evidence of a pest control program, so he had no way of knowing whether recommendations in addition to routine monthly services had been made to the facility relative to pest control. The surveyor and the Maintenance Director reviewed the pest control service inspection reports from May 2024, June 2024, and July 2024 with the Maintenance Director. The Maintenance Director further said he had not contacted the pest control company for any additional services relative to small flies anytime between 7/5/24, and when he requested the inspection reports on 8/8/24.