STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225545	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Courtyard-Medford	200 Governors Avenue Medford, MA 02155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49873 Based on observation, record review and interview the facility failed to ensure that care was provided in a manner that promoted dignity and enhanced the quality of life for three Residents (#14, #130, and #132) in a total sample of 41 residents. Specifically, 1. For Resident #14, Resident #130, and Resident #132, the facility failed to provide a dignified meal service and 2. For Resident #132, the facility failed to provide privacy for a Foley catheter bag (a urinary collection bag). Findings include: Review of the facility's policy titled OPS206 Resident Rights Under Federal Law, dated February 2023, indicated: 1. Resident Rights: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1.1 The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality. 8. Privacy and confidentiality: the resident has a right to personal privacy and confidentiality of his/her personal and medical records. 8.1 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care. 1 (a.) During an observation on 3/19/24 at 8:45 A.M., Resident #130 was in bed, visible from the doorway, eating French toast with his/her hands and had syrup on his/her hands. Staff checked in on the Resident during his/her meal and did not intervene to assist the Resident with eating or to maintain his/her dignity. During an observation on 3/20/24 at 8:58 A.M., Resident #130 was in bed, visible from the doorway, eating cornflakes with his/her hands and had milk on his/her hands. Staff checked in on the Resident during his/her meal and did not intervene to assist the Resident with eating or to maintain his/her dignity. During an observation on 3/20/24 at 9:20 A.M., Resident #130 was in bed, visible from the doorway, eating pancakes with his/her hands and had syrup on his/her hands. Staff checked in on the Resident during his/her meal and did not intervene to assist the Resident with eating or to maintain his/her dignity. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/20/24 at 12:45 P.M., Resident #130 was in the dining room eating a cup of mandarin oranges with his/her hands. Staff were present during the observation and at no time did staff intervene to assist the Resident with eating or to maintain his/her dignity. 1 (b.) During an observation on 3/20/24 at 1:10 P.M., Resident #132 was in the dining room eating green beans with his/her hands. Staff were present during the observation and at no time did staff intervene to assist the Resident with eating or to maintain his/her dignity. 1. (c.) During an observation on 3/21/24 at 9:18 A.M., Resident #14 was in the dining room eating French toast with his/her hands and had syrup on his/her hands. Staff were present during the observation and at no time did staff intervene to assist the Resident with eating or to maintain his/her dignity. During an interview on 3/21/24 at 11:42 A.M., Unit Manager #1 said that residents would not eat with their hands unless they were provided finger foods such as a sandwich. Unit Manager #1 said she would expect residents to be offered finger food if they are unable to use utensils or decline feeding assistance. 2. Resident #132 was admitted to the facility in October 2020 with diagnoses that include but are not limited to benign prostatic hyperplasia and obstructive and reflux uropathy. Review of Resident #132's care plan, dated October 2020, indicated: Focus: Resident requires indwelling Foley catheter. Intervention: Provide privacy and comfort. During an observation on 3/19/24 at 8:20 A.M., Resident #132's Foley bag was observed hanging from the side of the bed with urine in it and without a privacy bag. They Foley bag was visible to staff and Resident #132's roommate. During an observation on 3/20/24 at 8:07 A.M., Resident #132's Foley bag was observed hanging from the side of the bed with urine in it and without a privacy bag. They Foley bag was visible to staff and Resident #132's roommate. During an observation and interview on 3/21/24 at 9:36 A.M., CNA #3 observed that Resident #132's Foley bag was hanging from the side of the bed with urine in it and without a privacy bag. The Foley bag was visible to staff and Resident #132's roommate. CNA #3 said Foley bags should have privacy bags, but a lot of mornings he comes in and the night shift staff haven't put privacy bags on. CNA #3 said Resident #132's Foley bag did not have a privacy bag because he hadn't had time yet to go around and fix things. During an interview on 3/21/24 at 11:42 A.M., Unit Manager #1 said she would expect privacy bags to be covering Foley bags for privacy and dignity.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to ensure that one Resident (#156) had the right to be informed and provide consent for the administration of psychotropic medication, out of a total sample of 41 residents. Findings include: Review of the facility policy titled Psychotropic Medication Use, dated 10/24/22, indicated the following: - Facility staff should inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulations. Resident #156 was admitted in April 2022 with diagnoses including dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #156 scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Resident #156 has a health care proxy, and the health care proxy was activated on 10/17/22. Review of the active physician's orders indicated that Resident #156 was receiving the following medications: -Trazodone (a medication used to treat depression) (initiated 2/10/24) -Zoloft (a medication used to treat depression) (initiated 2/11/24) Review of the discontinued physician's orders indicated that Resident #156 received the following: -Zoloft (a medication used to treat depression) from 4/19/22 to 2/10/24 -Ativan (a medication used to treat anxiety) from 5/24/22 to 9/13/22 Review of the psychotropic medication consent forms indicated that the following consents were not signed by either a facility representative or a resident representative. - Trazodone - Ativan - Zoloft (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 8:07 A.M., Unit Manager #4 said that she has been trying to reach the healthcare proxy to sign the consents. Unit Manager #4 said that she has not mailed the consents and that staff wait for the representative to come in the facility to sign the consents. During an interview on 3/21/24 at 10:13 A.M., the Director of Nursing said that she would not administer a medication without a consent signed and if family was not able to be reached, then she would fax the consent or mail the consents for them to sign.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48990 Based on observations, record review, and interviews, the facility failed to ensure one Resident (#37), out of 41 total sampled residents, was assessed for the ability to self-administer medications. Specifically, a nurse left medications unattended with Resident #37 to self-administer without a physician's order and an assessment for self-administration completed. Findings include: Review of the facility policy titled NSG309 Medications: Self-Administration, revised 3/1/22, indicated: -Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined the patient is able to self administer: -A physician/advanced practice provider (APP) order is required. -Evaluation of capability must be performed initially, quarterly, and with any significant change in condition. Resident #37 was admitted to the facility in June 2020 with diagnoses including diabetes and anemia. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/6/24, indicated that Resident #37 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #37's medical record failed to indicate Resident #37 was assessed for self-administration of medication. Review of Resident #37's active physician's orders failed to indicate a physician order for self-administration of medication. On 03/19/24 9:13 A.M., the surveyor observed Resident #37 with a medication cup in his/her hand containing approximately four pills. Resident #37 swallowed two of the pills in front of the surveyor. There was no nurse in the room or in the hallway outside the Resident's room. Resident #37 said the nurse usually leaves pills because he/she can do it by his/herself. While the surveyor was in the room at 9:16 A.M., Nurse #1 came into the room to deliver Resident #37 a hot chocolate and then left. Resident #37 had approximately two pills left in the medication cup he/she was holding during his/her interaction with Nurse #1. On 03/21/24 8:26 A.M., the surveyor observed Resident #37 with a medication cup in his/her hand and was putting a white pill into his/her mouth. There was no nurse in the room or in the hallway outside the Resident's room at this time. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 8:29 A.M., Nurse #1 said she sometimes leaves medications unattended with Resident #37. Nurse #1 said she did not know if she was supposed to do that. During an interview on 3/21/24 at 8:30 A.M., Unit Manager #3 said nurses must stay with residents while they take their medications. During an interview on 3/21/24 at 8:45 A.M., the Director of Nursing (DON) said nurses cannot leave medications unattended at bedside unless they are assessed for self-administration of medications. The DON said Resident #37 was not assessed for self-administration of medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to prevent abuse for 1 Resident (#157) out of a total sample of 41 residents. Specifically, Resident #157 was physically restrained to a chair by a staff member, causing emotional distress and weepiness. Findings include: Review of the facility policy titled Abuse Prohibition, dated 10/24/22, indicated the following: -Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all patients. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. -The center will implement an abuse prohibition program through the following: * Prevention of occurrences * Identification of possible incidents or allegations which need investigation * Investigation of all incidents and allegations * Protection of patients during investigation * Reporting of incidents, investigations, and center response to the results of their investigation. -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, injury, or mental anguish. Resident #157 was admitted in April 2022 with diagnoses including dementia and anxiety. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #157 did not score on the Brief Interview for Mental Status (BIMS), but is severely cognitively impaired. Review of the MDS indicated that Resident #157 requires supervision with mobility. Review of the Incident Report investigation, dated 3/8/24, indicated the following: At about 6:45am today, pt was found by nurse from a different department crying upon examination, pt restrained by clothing on a chair in the common area. Review of a witness statement, dated 3/8/24, indicated the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Approximately 6:45 AM, I was helping a resident in his/her wheelchair to get to the common area on the unit. After he was set, I noticed Resident #157 sitting in a chair crying, behind me. I walked over to him/her and saw that there was a blanket covering the back of the chair. I pulled the blanket back, and noted that his/her shirt was pulled over the back of the chair he/she was sitting on. It was so far down that I had a hard time pulling it off the back of the chair . During an interview on 3/21/24 at 10:08 A.M., the Director of Nursing said that she was told of the incident by the MDS nurse, who noticed that Resident #157's shirt was up and over the back of the chair and tucked under. The Director of Nursing said that the shirt being tucked under was preventing the Resident from rising and the Resident was teary and whining. The Director of Nursing said that she interviewed the certified nursing aide and nurse that were on the unit, but neither admitted to restraining the Resident. The Director of Nursing said that there was no way the Resident could have tucked his/her shirt behind him/her in the chair. The Director of Nursing notified the Resident's family, police, and terminated both employees. She said that they are doing education shiftly and initiated a quality assurance performance improvement (QAPI) program. On 3/21/24, the facility provided the surveyor with a plan of correction that addressed the areas of concern identified during this survey. The plan of correction is as follows: -Investigation of the circumstances leading up to and including the restraint -Education of restraints and abuse to all employees on every shift, before the beginning of their shift daily for 14 days, then weekly for two weeks, then monthly for 2 months until 3/25/24. -Audit of each unit on 3/12/24 for restraints -The Director of Nursing, Assistant Director of Nursing, Unit Manager, Supervisors, and Facility Educator are responsible for completion of the education. REF to F604.

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to prevent 1 Resident (#157) from being free from restraints, out of a total of 41 residents. Specifically, Resident #157 was physically restrained to a chair by a staff member. Findings include: Review of the facility policy titled Restraints: Use of, dated 6/15/22, indicated the following: -Patients have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the patient's medical symptoms. -Physical restraint is defined as any manual method, physical or mechanical device, equipment, or materials that meets all of the following criteria: -Is attached or adjacent to the patient's body -Cannot be removed easily by the patient -Restricts the patients freedom of movement or normal access to their body Resident #157 was admitted in April 2022 with diagnoses including dementia and anxiety. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #157 did not score on the Brief Interview for Mental Status (BIMS), but is severely cognitively impaired. Review of the MDS indicated that Resident #157 requires supervision with mobility. Review of the Incident Report investigation, dated 3/8/24, indicated the following: At about 6:45am today, pt was found by nurse from a different department crying upon examination, pt restrained by clothing on a chair in the common area. Review of a witness statement, dated 3/8/24, indicated the following: Approximately 6:45 AM, I was helping a resident in his/her wheelchair to get to the common area on the unit. After he was set, I noticed Resident #157 sitting in a chair crying, behind me. I walked over to him/her and saw that there was a blanket covering the back of the chair. I pulled the blanket back, and noted that his/her shirt was pulled over the back of the chair he/she was sitting on. It was so far down that I had a hard time pulling it off the back of the chair . (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/21/24 at 10:08 A.M., the Director of Nursing said that she was told of the incident by the MDS nurse, who noticed that Resident #157's shirt was up and over the back of the chair and tucked under. The Director of Nursing said that the shirt being tucked under was preventing the Resident from rising and the Resident was teary and whining. The Director of Nursing said that she interviewed the certified nursing aide and nurse that were on the unit, but neither admitted to restraining the Resident. The Director of Nursing said that there was no way the Resident could have tucked his/her shirt behind him/her in the chair. The Director of Nursing notified the Resident's family and police and terminated both employees. She said that they are doing education shiftly and initiated a quality assurance performance improvement (QAPI) program. On 3/21/24, the facility provided the surveyor with a plan of correction that addressed the areas of concern identified during this survey. The plan of correction is as follows: -Investigation of the circumstances leading up to and including the restraint -Education of restraints and abuse to all employees on every shift, before the beginning of their shift daily for 14 days, then weekly for two weeks, then monthly for 2 months until 3/25/24. -Audit of each unit on 3/12/24 for restraints -The Director of Nursing, Assistant Director of Nursing, Unit Manager, Supervisors, and Facility Educator are responsible for completion of the education.

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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** 41019 Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for two Residents (#164, and #2), out of 41 total sampled residents. Specifically, 1. For Resident #164, the facility failed to develop a care plan related to the use of a suction machine. 2. For Resident #2, the facility failed to apply braces as indicated in his/her plan of care. Findings include: 1. Resident #164 was admitted in April 2023 with diagnoses including dysphagia and dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #164 did not score on the Brief Interview for Mental Status (BIMS) and is severely cognitively impaired. Review of the MDS indicated that Resident #164 is dependent with all activities of daily living. During an observation on 3/19/24 at 11:25 A.M., Resident #164 was lying in bed and had a suction machine sitting on his/her bedside table. The cannister of the suction contained a yellowish/red fluid inside and the tubing to the suction machine was hanging, unbagged, directly touching the nightstand. During an observation on 3/20/24 at 9:39 A.M., Resident #164 was lying in bed and had a suction machine sitting on his/her bedside table. The cannister of the suction contained a yellowish/red fluid inside and the tubing to the suction machine was hanging, unbagged, directly touching the nightstand. Review of the care plan did not indicate any care plan for the use of the suction machine. Review of the progress noted, dated 1/11/24, indicated the following: Resident #164 is seen after recent call on 1/9 from nurse at the facility. She reported that ptp has been having lots of secretions in her mouth and nose. Staff has had to suction ptp to clear his/her airway. Review of the progress note, dated 3/11/24, indicated the following: Pt has had several similar episodes during the past 2-3 months, which are usually managed with suctioning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 10:16 A.M., the Director of Nursing said that there should be a care plan for the use of a suction machine and she is not sure why there was a machine in the Resident's room to begin with. The Director of Nursing was not aware that Resident #164 was being suctioned since January. 49880 2. Resident #2 was admitted to the facility in August 2020 with diagnoses that included muscle weakness, primary osteoarthritis, and chronic pain syndrome. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/24/24, indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #2 is cognitively intact. On 3/19/24 at 11:47 A.M. the surveyor observed Resident #2 sitting in a chair in his/her room. Resident #2 was not wearing any braces on either his/her left or right arm. On 3/19/24 at 2:20 P.M., the surveyor observed Resident #2 lying in bed. Resident #2 was not wearing any braces on either his/her left or right arm. On 3/20/24 at 7:57 A.M., the surveyor observed Resident #2 sleeping in bed. Both of Resident #2's arms were visible over the blankets, neither arm had a brace in place. On 3/20/24 at 10:44 A.M., the surveyor observed Resident #2 in his/her wheelchair in the hallway. The surveyor did not observe a brace on either arm of Resident #2. On 3/20/24 at 12:28 P.M., the surveyor observed Resident #2 sitting in his/her wheelchair in his/her room waiting for the lunch meal. The surveyor did not observe a brace on either arm of Resident #2. Resident #2 said that usually he/she applies the braces on his/her own, but that staff do not check to ensure that he/she is wearing them. Resident #2 said that he/she does not refuse to wear the braces. On 3/21/24 at 6:51 A.M., the surveyor observed Resident #2 sleeping in bed without a brace to either his/her right or left arm. Two braces were observed in Resident #2's room on a box across the room from Resident #2's bed. Review of Resident #2's physician's order, dated 1/5/24, indicated Resident to wear wrist cock-up splint [a splint that holds the wrist in neutral position to reduce pain] to left hand/ wrist every night during sleep. Don (apply) with nighttime care and doff (remove) in the morning with skin checks pre/post Resident #2's physician's orders further indicated an order, dated 10/22/20, WHFO palmar med right brace [wrist/ hand/ finger/ orthotic brace utilized to support appropriate positioning of a joint to prevent contratures and manage pain] to be worn at all times. Remove for hygiene, transfers and ambulation. Check skin integrity QS [every shift] Review of Resident #2's functional mobility care plan, dated 8/21/23, indicated that Resident [#2] exhibits or is at risk for alterations in functional mobility related to contracture deformity. Preventative and Treatment: left hand contracture, WHFO palmar brace. Use of braces as ordered. (continued on next page)

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	225545	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Courtyard-Medford	200 Governors Avenue Medford, MA 02155

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 3/21/24 at 6:58 A.M., Nurse #4 said that Resident #2 did not have his/her braces on. Nurse #4 said that she did not apply them on her shift. During an interview on 3/21/24 at 8:28 A.M., the Director of Nursing (DON) said she would expect the braces to be on as ordered.

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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** 44095 Based on observation, record review and interview, the facility failed to meet professional standards of quality for four Residents (#17, #33, #164, and #434), out of a total sample of 41 residents. Specifically, the facility failed to: 1.) For Resident #17, the facility failed to ensure nursing transcribed physician's orders accurately and failed to implement the 24-hour chart check policy to identify and correct improper physician's orders. 2.) For Resident #33, the facility failed to ensure nursing transcribed physician's orders accurately and failed to implement the 24-hour chart check policy to identify and correct improper physician's orders. 3.) For Resident #164, the facility failed to obtain a physician order for the use of a suction machine. 4.) Resident #434 the facility failed to obtain daily weights as ordered. Findings include: 1.) For Resident #17, the facility failed to ensure nursing transcribed physician's orders accurately and failed to implement the 24-hour chart check policy to identify and correct improper physician's orders. Review of the facility policy titled, Transcription of Orders, dated as reviewed 5/1/23, indicated: - Orders from an authorized licensed independent practitioner are accepted by a licensed nurse. Review of the facility policy titled, 24 Hours Chart Check, dated as 6/1/21, indicated: - Licensed nursing staff are responsible for completing a chart check once every 24 hours. The 24-hour chart check includes all physician/ advanced practice provider orders written in the last 24 hours from the prior chart check. - The licensed nurse completing the 24-hour chart check identifies and corrects improper orders in the medication record and/or on the Medication Administration Record. Resident #17 was admitted to the facility in December 2020 with diagnoses including chronic obstructive pulmonary disease, allergic rhinitis, and overactive bladder. Review of the Minimum Data Set (MDS) assessment, dated 1/3/24, indicated Resident #17 had a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15 which indicated he/she had a moderate cognitive impairment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 24-Hour Chart Check form, dated January 2024, indicated a chart check was completed on 1/20/24. Review of the physician's note, dated 1/19/24, indicated: - add intranasal antihistamine to intranasal glucocorticoid. - Azelastine-Fluticasone (Dymista, medication used for allergies) 137-50 microgram, 1 spray by nasal route in the morning and 1 spray before bedtime. Review of the physician's order in the paper medical record, dated 1/19/24, indicated: - Dymista Nasal Suspension 137-50 micrograms (Azelastine HCl-Fluticasone Propionate), 1 spray in both nares twice a day for allergic rhinitis. Review of the physician's order transcribed in the electronic health record, dated 1/22/24, indicated: - Dymista Nasal Suspension 137-50 micrograms (Azelastine HCl-Fluticasone Propionate), 2 puffs in both nostrils one time a day for COPD. During an interview on 3/20/24 at 10:24 A.M., Nurse #8 reviewed the physician's order in the medical record, and she said the order was not transcribed correctly. Nurse #8 said the transcription error should have been caught during the 24-hour chart check but was not. During an interview on 3/20/24 4:37 P.M., the Director of Nursing (DON) said nursing should transcribe physician's orders correctly and nursing should implement a 24-hour chart check to review accuracy of physician's orders. 49880 2.) For Resident #33, the facility failed to ensure nursing transcribed physician's orders accurately and failed to implement the 24-hour chart check policy. Resident #33 was admitted to the facility in December 2020 with diagnoses that include schizophrenia, chronic pain and chronic kidney disease. Review of Resident #33's most Recent Minimum Data Set (MDS) assessment, dated 2/21/24, indicated that Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #33 is cognitively intact. Review of Resident #33's medical record indicated a written physician's order dated 3/18/24 for Metformin (a medication used to lower blood sugar) 1000 mg by mouth twice daily. Review of Resident #33's Medication Administration Record indicated that the physician's order dated 3/18/24, had been incorrectly transcribed into the electronic medical record as Metformin 500 mg, give one tablet by mouth two times a day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #33 medical record indicated a form titled 24- hour chart check which indicated that a 24-hour chart check was performed on 3/18/24 and 3/19/24. The Nurse performing the 24- hour chart check signed off on the form indicating that orders were checked for accuracy in transcription. During an interview on 3/21/24 at 8:23 A.M., the Director of Nursing (DON) said that she would have expected the transcription error to have been corrected by nursing with the 24- hour chart checks. 41019 3.) The facility failed to ensure there was a physician's order for the use of a suction machine for Resident #164. Resident #164 was admitted in April 2023 with diagnoses including dysphagia and dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #164 did not score on the Brief Interview for Mental Status (BIMS) and is severely cognitively impaired. Review of the MDS indicated that Resident #164 is dependent with all activities of daily living. During an observation on 3/19/24 at 11:25 A.M., Resident #164 was lying in bed and had a suction machine sitting on his/her bedside table. The cannister of the suction contained a yellowish/red fluid inside and the tubing to the suction machine was hanging, unbagged, directly touching the nightstand. During an observation on 3/20/24 at 9:39 A.M., Resident #164 was lying in bed and had a suction machine sitting on his/her bedside table. The cannister of the suction contained a yellowish/red fluid inside and the tubing to the suction machine was hanging, unbagged, directly touching the nightstand. Review of the physician's orders did not indicate an order for the suction machine or the care of the suction machine. Review of the progress noted, dated 1/11/24, indicated the following: Resident #164 is seen after recent call on 1/9 from nurse at the facility. She reported that ptp has been having lots of secretions in his/her mouth and nose. Staff has had to suction ptp to clear his/her airway. This is the second time the nurse has witnessed Resident #164 have an episode like this. She describes that episodes happen all of a sudden without any apparent provocative factors and then it's like a volcano with a lot of secretions coming out of the Resident's mouth and notstrils. Secretions are white, not too thick. Nurse can hear gurgling sound of secretions in throat. They have had to suction mouth to remove copious secretions. Review of the progress note, dated 3/11/24, indicated the following: Pt has had several similar episodes during the past 2-3 months, which are usually managed with suctioning. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/24 at 1:26 P.M., Unit Manager #4 said that Resident #164 sometimes has secretions in his/her mouth that need to be suctioned and that if a physician order is needed then they could ask for one. During an interview on 3/21/24 at 10:16 A.M., the Director of Nursing said that there should be a physician's order for a suction machine and she is not sure why there was a machine in the Resident's room to begin with. The Director of Nursing was not aware that Resident #164 was being suctioned since January. 46339 4. For Resident #434 the facility failed to obtain daily weights as ordered. Resident #434 was admitted to the facility in March 2024 with diagnoses including chronic diastolic congestive heart failure, dependence on renal dialysis. Review of Resident #434's Brief Interview for Mental Status dated 3/14/24, indicated the Resident scored a 15 out of possible 15 indicating he/she was cognitively intact. Review of Resident #434's current physician orders indicated the following: -Daily weights per Nurse Practitioner in the morning (6:00 A.M) Review of the Medication Administration Record (MAR) failed to indicate weights were documented on the following days: -On 3/17/24 no documentation. -On 3/18/24 no documentation. Review of the progress notes failed to indicate the Nurse practitioner had been notified of the weights not being obtained. During an interview on 3/20/24 at 1:10 P.M., Nurse #9 said daily weight should be done as ordered, she further said if the Resident has a diagnosis of heart failure, any refusal should be reported to the Nurse Practitioner. During an interview on 03/21/24 at 10:27 A.M., the Director of Nursing said daily weights should be completed as ordered if refused, it should be documented in the medical record and reported to the physician.

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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 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** 49873 Based on observations, record review, and interviews, the facility failed to provide assistance with activities of daily living (ADLs) as needed for one Resident (#130) out of a total of 41 sampled residents. Findings include: Review of the policy titled NSG270 Meal Service dated, June 2021, indicated: Practice Standards: 4. Staff will provide assistance during meal services to meet patient needs. 4.1 Provide cueing, prompting, or assist a patient to eat, when applicable. Resident #130 was admitted to the facility in March 2021 and has diagnosis including but not limited to dementia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #130 scored a 3 out of 15 on the Brief Interview for Mental Status Exam (BIMS) indicating a severe cognitive impairment. Review of Resident #130's care plan indicated the following: Provide resident/patient with limited assist with cuing of one for eating, dated 2/16/24. Review of Resident #130's Kardex (a form indicating a residents care needs) , dated 3/21/24, indicated: provide resident/patient with limited assist with cuing of one for eating. During an observation on 3/19/24 at 8:45 A.M., Resident #130 was observed in bed, eating French toast with his/her hands, dropping pieces on the floor and on himself/herself. On 3/20/24 beginning at 8:48 A.M., the surveyor made the following observations and interview: Resident #130 was observed in bed eating a completely peeled banana with his/her hands, while CNA #1 prepared Resident #130's breakfast tray on his/her dresser across the room. CNA #1 gave Resident #130 a bowl of cornflakes in milk with a spoon and left the room. Resident #130 dropped his/her spoon in his/her lap and ate some of the cornflakes out of the milk with his/her hands and also dropped cornflakes in his/her lap. CNA #1 returned to Resident #130's room, took away the bowl of cereal, leaving the spoon in his/her lap. CNA #1 set up a plate of pancakes for Resident #130 with a fork and left the room. Resident #130 was observed holding the fork upside down with a piece of pancake on it, unable to bring the piece of pancake to his/her mouth. Resident #130 set down the fork and began eating the pancakes with his/her hands. Resident #130 said it's hard to use a fork sometimes. CNA #1 returned to the room, took the fork away but left the plate of pancakes that Resident #130 was eating with his/her hands. CNA #1 left the room and Resident #130 continued eating pancakes with his/her hands, sometimes dropping pieces on the floor and in his/her lap. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 9:53 A.M., CNA #1 said she sets up Resident #130's tray and he/she eats with his/her hands and makes a mess. CNA #1 said Resident #130's Kardex says he/she eats independently. The surveyor showed CNA #1 that Resident #130's Kardex said he/she requires limited assist with cuing of one for eating. CNA #1 said this means she sets up everything for Resident #130. CNA #1 said that Resident #130 has declined due to his/her dementia and had started eating with his/her hands about one month ago. CNA #1 said that nursing and nutrition are aware that Resident #130 eats with his/her hands. During an interview on 3/21/24 at 11:45 A.M., Unit Manager #1 said Resident #130 used to eat independently with setup but has declined in the past month and now requires limited assistance with verbal cueing during eating. Unit Manager #1 said Resident #130 needs encouragement for eating, and lets you assist him/her. Unit Manager #1 said Resident #130 has finger food and staff offer finger foods to him/her and place them in his/her hands. Unit Manager #1 said that if Resident #130 were offered foods that are not finger foods, then she would expect staff to assist him/her with eating and would not expect Resident #130 to eat those types of foods with his/her hands.

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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 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** 36431 Based on observation, record review and interview for one Resident (#114), out of a total sample of 41 residents, the facility failed to ensure quality of care that met professional standards of practice when Resident #144 sustained two purple and blue areas on his/her skin on his/her left arm, which was not identified by staff performing daily care nor identified by nursing staff performing weekly skin checks in accordance with the physician's orders and plan of care. Findings include: Review of the facility's policy titled Skin Integrity and Wound Management revised 2/1/23, indicated the following: To provide safe and effective care to promote optimal skin health, prevent pressure injuries, and promote healing within the context of what matters most to patients. 6. The license nurse will: evaluate any reported or suspected skin changes or wounds; document newly identified skin/wound impairments as a change in condition, document skin/wound findings on the 24-hour report and perform and document skin inspection on all newly admitted /readmitted patients weekly thereafter and with any significant change of condition. Resident #114 was admitted to the facility in September 2020 with diagnoses that include but not limited to unspecified dementia, atrial fibrillation, chronic obstructive pulmonary disease, adult failure to thrive and fibromyalgia. Review of Resident #114's Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #114 scored a 14 out of 15 on the Brief Interview for Mental Status exam indicating he/she had intact cognition. The MDS further indicated the Resident was dependent on staff for shower/bathing. On 3/19/23 at 10:00 A.M., the surveyor observed Resident #114 in bed, Resident #144's left forearm had two circular areas on his/her forearm in varying color of purple, blue and yellow, consistent with bruising. Resident #114 said he/she may have bumped it (arm) on the door. Resident #114 said the nurses must have seen it, and that he/she did not tell them. Review of Resident #114's medical record indicated the following: -A physician's order dated 2/9/2021, weekly head to toe skin assessment every night shift Tue. For skin integrity. -A care plan focus, dated as revised 4/26/23, Resident is at risk for skin breakdown related to limited mobility, incontinence, and recent GI surgery, with the intervention dated 9/20/2020 observe skin condition daily with ADL (activity of daily living) care and report abnormalities. -A care plan focus, Resident is at risk for injury or complications related to the use of anticoagulant therapy dated 9/9/202. Interventions included: Observe for active bleeding, i.e., bruising, dated 9/9/2020. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 8:51 A.M., the surveyor observed Resident #114 in bed eating his/her breakfast. Resident #114's left forearm bruise was observed as faded blue and yellow. Resident #114 pulled up his/her sleeve revealing a circular bruise larger than a quarter, that was blue and yellow in areas. Review of the Skin Check-V 4, for Resident #114 dated 2/21/24, 2/28/24, 3/1/24, 3/6/24, 3/13/24 did not identify any new skin injury/wound. The Skin Check -V4 dated 3/20/24 at 06:00 (A.M.), conducted after the observation was made on 3/19/24 of Resident #114's left arm bruising, failed to identify the bruising. Review of the progress notes in Resident #114's medical record indicated the following: On 3/1/24 Resident was send (sic) to the ER (emergency room) On 3/1/24 Resident returned to floor; no skin issues observed. During an interview on 3/20/24 at 2:05 P.M., Nurse #10 said if a resident has a new skin injury including a bruise or skin tear an incident report is completed, and said the doctor and responsible family is notified. Nurse #10 said Resident #114's bruises on his/her left arm have been there for about the last two weeks. Nurse #10 said she thought the bruises were from lab work when the Resident went to the hospital recently. Nurse #10 reviewed the weekly Skin Check-V 4 in the medical record dated 3/1/24, 3/6/24 3/13/24 and 3/20/24 and said the skin checks do not indicate the presence of Resident #114's left arm bruises. Nurse #10 said bruises should have been identified by staff and on the skin checks.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49873 Based on observations, record reviews and interviews, the facility failed to identify and prevent a decrease in range of motion for one Resident (#48) out of a total sample of 41 residents. Findings include: Review of the facility's policy titled NSG259 Range of Motion and Mobility, dated June 2022, indicated: Policy: Centers will provide services care and equipment to ensure that a patient: Who enters the center without limited range of motion (ROM) does not experience reduction in ROM unless a clinical condition demonstrates that a reduction in ROM is clinically unavoidable; With limited ROM receives appropriate treatment and services to increase and/or prevent further decrease in ROM; With limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Nursing and rehabilitation will collaborate to identify services, care, and equipment based on individual patient needs. Purpose: To maintain or improve to the highest level of ROM and mobility. To prevent contractures and shortening of musculoskeletal structures. To prevent complications of immobility. Resident #48 was admitted to the facility in September 2019 with diagnoses including anemia, heart failure, thyroid disorder, and osteoarthritis of the left shoulder. Review of Resident #48's most recent Minimum Data Set (MDS), dated [DATE], indicated Resident #48 scored a 15 out of 15 on the Brief Interview for Mental Status Exam (BIMS), indicating he/she was cognitively intact. The MDS also indicated Resident #48 had no functional impairment in range of motion to both upper extremities. Review of Resident #48's medical record indicated the following: Resident #48 did not have a neurological diagnosis that would indicate unavoidable, progressive contractures. An Occupational Therapy evaluation note dated 7/25/23 indicated that Resident #48's upper extremity range of motion was within functional limits and tone was normal. Resident #48 had up to 70% available active range of motion, limited secondary to body habitus (physical body shape/morbid obesity). Occupational Therapy and Physical Therapy notes from 7/25/23 to 10/21/23 indicated that Resident #48 had been seen for ambulation, standing, dressing, and osteoarthritis of the left shoulder, but failed to indicate a range of motion deficit of Resident #48's left hand. Since discharge from rehabilitation skilled services on 10/21/23, the subsequent quarterly Interdisciplinary Therapy Screen completed, dated 3/1/24, failed to identify a range of motion deficit of Resident #48's left hand. Progress notes failed to indicate Resident #48 had a decrease in range of motion of his/her left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/19/24 at 8:32 A.M., Resident #48 was sitting up in bed, brushing his/her teeth with his/her left hand using only the index finger, middle finger and thumb of his/her left hand. His/her fourth and fifth fingers were observed flexed, nearly touching the palm. During an observation and interview on 3/19/24 at 10:22 A.M., Resident #48 said he/she can't straighten out the fingers of his/her left hand and has been unable to straighten them out for months. Resident #48's left hand was observed flexed 90 degrees at the first knuckle across four fingers. Resident #48 said he/she tries to do his/her own hand exercises and demonstrated attempting to use his/her right hand to passively open the fingers of his/her left hand to a neutral position but was unable to do so. Resident #48 said he/she told CNA #1 about his/her concerns with his/her left hand, and that CNA #1 told Resident #48 that it's probably arthritis and is not something that can be fixed. Resident #48 said he/she is not aware that CNA #1 notified a nurse, and that nursing and occupational therapy did not come to see Resident #48 after he/she shared his/her concerns about his/her left hand with CNA #1. During an observation on 3/20/24 at 9:15 A.M., Resident #48 was sitting up in bed eating and drinking with his/her left hand using using only the index finger, middle finger and thumb of his/her left hand to hold utensils and a cup. His/her fourth and fifth fingers were observed flexed, nearly touching the palm. During an interview on 3/20/24 at 1:57 P.M., CNA #1 said she didn't tell a nurse about Resident #48's concern with his/her left hand because it looks like arthritis. CNA #1 said that she thinks Resident #48 has medication for pain if he/she needs it. CNA #1 said she is not aware that Resident #48 has been seen by rehabilitation for his/her for hands. During an observation and interview on 3/20/24 at 4:26 P.M., Nurse #6 said that she has cared for Resident #48 for five years. Nurse #6 said she is not aware of any change in range of motion of Resident #48's left hand. Nurse #6 entered Resident #48's room with the surveyor and saw his/her left hand. Nurse #6 said Resident #48's left hand looked contracted and that she had never noticed it before. Resident #48's left hand was observed flexed 90 degrees at the first knuckle across four fingers. Nurse #6 and Resident #48 both tried to passively extend the fingers on Resident #48's left hand to a neutral position but were unable to do so. Resident #48 winced in pain during the attempted passive extension and when asked by Nurse #6, said his/her pain level was four out of ten. Resident #48 said he/she needs to be able to use his/her hands. Nurse #6 said that Resident #48's left hand had resistance with attempted extension and appeared contracted. Nurse #6 said this was a new issue for Resident #48. During an interview on 3/21/24 at 10:52 A.M., Rehabilitation Services Staff #3 said she just received an order to evaluate Resident #48's hands today. Rehabilitation Services Staff #3 said that residents are screened quarterly by rehabilitation. During an interview on 3/21/24 at 11:57 A.M., Unit Manager #1 said she is not aware that Resident #48 has had any changes in range of motion of his/her hands and that nobody brought it to her attention. Unit Manager #1 said she would expect staff to report a change in range of motion so that nursing can do an assessment, let the provider know, and make a request for rehabilitation. Unit Manager #1 said she is aware that rehabilitation used to work with Resident #48 on ambulation but is not aware that he/she had been seen by rehabilitation for his/her hands. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 12:18 P.M, Rehabilitation Services Staff #1 said that the quarterly rehabilitation screen doesn't specifically address range of motion and that he would expect a request be submitted to rehabilitation to evaluate a resident for a decrease in range of motion. Rehabilitation Services Staff #1 said that rehabilitation services received the first request to evaluate Resident #48's hands from the provider last night and hadn't received a request to evaluate his/her hands before. Review of an Occupational Therapy evaluation note from 3/21/24 indicated that Resident #48 is both right-handed (for writing) and left-handed (for utensils). Resident #48 was able to bring all fingers into neutral with passive range of motion, and rated pain seven out of ten. Resident #48 had impaired upper extremity strength. Resident #48 reported moderate difficulty with using a knife to cut his/her food. Resident #48 is at risk for contractures and impairments to skin integrity without skilled therapeutic intervention. It was recommended that Resident #48 wear finger separators and a resting hand splint to both hands in order to reduce risk for contractures. During an interview on 3/21/24 at 11:30 A.M., Rehabilitation Services Staff #3 said she was able to extend Resident #48's fingers of his/her left hand to neutral by going very slowly and extending one finger at a time. Rehabilitation Services Staff #3 said Resident #48 had some range of motion deficit while eating and recommended resting hand splints and finger braces to prevent contraction of both hands.

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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 reviews and interviews the facility failed to provide care according to professional standards of practice for one Resident (#136) with a gastrostomy tube (g-tube) a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications, out of a total sample of 41 residents. Findings include: Resident #136 was admitted to the facility in February 2024 with diagnoses including dysphagia, diverticulum of esophagus, gastrostomy tube. Review of Resident #136's Minimum Data Set (MDS) dated [DATE] indicated the Resident scored an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was moderately cognitively impaired. The MDS further indicated that the Resident had a gastrostomy tube. Review of the current physician's orders indicated the following: -Enteral feed order continuous for nutrition Nepro 1.8 continuous at 45 ml/hr. (milliliter/hour), 60 ml of free water before and after medication. -70 ml free water every two hours via G-tube -Enteral feed continuous every shift On 3/19/24 at 9:28 A.M., the surveyor observed a bag of cream liquid which hung from the tube feed pole in Resident #136's room. The feeding tube was connected to the Resident. The bag failed to indicate the name of the Resident, the date and time it was hung and the name of the nurse that hung the bag. The feeding pump indicated it was infusing at a rate of 45 milliliters/ hour with a water flush of 70 milliliter every two hours. The surveyor was unable to determine when the bag was hung. On 3/20/24 at 7:10 A.M., the surveyor observed a bag of cream liquid which hung from the tube feed pole in Resident #136's room. The feeding tube was connected to the Resident. The bag failed to indicate the name of the Resident, the date and time it was hung and the name of the nurse that hung the bag. The feeding pump indicated it was infusing at a rate of 45 milliliters/ hour with a water flush of 70 milliliter every two hours. The surveyor was unable to determine when the bag was hung. On 3/20/24 at 9:19 A.M., the surveyor observed a bag of cream liquid which hung from the tube feed pole in Resident #136's room. The feeding tube was connected to the Resident. The bag failed to indicate the name of the Resident, the date and time it was hung and the name of the nurse that hung the bag. The feeding pump indicated it was infusing at a rate of 45 milliliters/ hour with a water flush of 70 milliliter every two hours. The surveyor was unable to determine when the bag was hung. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/24 at 1:06 P.M., Nurse #9 said the contents of the bag was Nepro and the bag should be labeled with name of the feed, date and time when it was hung and the initials of the nurse that hung the feeding. On 3/20/24 at 1:15 P.M., the surveyor reviewed the ready-to-hang enteral feeding container Nepro instructions which indicated the following but not limited to: -Hang products up to 48 hours after initial connection when clean technique and only one new feeding set are used. Otherwise hang no longer than 24 hours. During an interview on 3/20/24 at 10:22 A.M., the Director of Nursing said the enteral feeding should be labeled, dated, and initialed by the nurse hanging the feeding.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observations, record review and interviews, the facility failed to provide respiratory care services consistent with professional standards of practice for four Residents (#36, #133, #95, #163) out of a total sample of 41 residents. Specifically: 1. For Resident #133 the facility failed to develop and maintain a plan for the care of the nebulizer machine, (a small machine that turns liquid medicine into a mist that can be easily inhaled), mask and tubing. 2. For Resident #36 the facility failed to develop and maintain a plan for the care for the CPAP (continuous positive airway pressure) machine, including the mask, and tubing. 3. For Resident #95 the facility failed to change oxygen tubing per physician's orders 4. For Resident #163 the facility failed to change oxygen tubing per physician's orders. Findings include: Review of facility Procedure, titled Respiratory Equipment/ Supply/ Cleaning/ Disinfection, revised 7/15/21, indicated 5. Schedule for Supply Changes: Oxygen delivery devices should be changed every seven days and as needed for soiling and Nebulizers/Aerosols should be changes daily and as needed for soiling. 1. Resident #133 was admitted to the facility in December 2023 with diagnoses that include but not limited to acute respiratory failure, severe persistent asthma with exacerbation, and personal history of other diseases of the respiratory system. Review of the Minimum Data Set assessment (MDS), dated [DATE], indicated Resident #133 scored a 13 out of 15 on the Brief Interview for Mental Status exam, indicating a moderately impaired cognition. During an observation and interview on 3/19/24 at 10:15 A.M., Resident #133 was resting in bed. An uncovered nebulizer mask was resting on top of the contents in the bedside table drawer. Resident #133 said he/she uses a nebulizer when needed. On 3/20/24 at 8:28 A.M. Resident #133 was observed resting in bed. The nebulizer mask was observed uncovered and in the top drawer resting on items. Review of Resident #133's medical record indicated the following: -A physician's order dated 1/29/2024, Ipratropium-albuterol Solution 0.5-2.5 (3) mg/3ml, 3 milliunit (sic) inhale orally every 4 hours as needed for SOB (shortness of breath) or wheezing pretreatment evaluation in supplemental documentation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Treatment Administration Record (TAR) indicated the as needed Ipratropium-albuterol solution was administered at 2344 (11:44 P.M.) on 3/17/24. Review of Resident #133's medical record failed to indicate a physician's order or care plan for the care of the nebulizer machine including the tubing or mask was developed or implemented. During an interview and observation on 3/21/24 at 7:03 A.M., Nurse #16 went with the surveyor to Resident #133's room. The nebulizer mask was observed to be uncovered and on top of items in the bedside drawer. Nurse #16 took a closer look at the mask, which was observed to be dated 3/4/24. Nurse #16 said the tube and mask should be changed weekly and the mask should be covered to keep less contaminates from it. 2. Resident #36 was admitted to the facility in January 2024 with diagnoses that include but not limited to end stage renal disease and dependence on renal dialysis. Review of Resident #36's MDS, dated [DATE], indicated he/she scored 11 out of a 15 on the Brief Interview for Mental Status exam, indicating Resident #36 as having moderately impaired cognition. During an interview on 3/19/24 at 10:40 A.M., Resident #36 said his/her CPAP machine is not working. The CPAP mask was observed to be uncovered and hanging off the back of the bedside table. On 3/20/24 at 8:55 A.M., Resident #36 was not in his/her room. The CPAP machine vessel was observed to contain water. The CPAP mask and tubing were not dated, and the mask was uncovered and hanging off the bedside table. No bag was observed near the Resident's area. Review of Resident #36's orders indicated the following: -An order dated as active 12/4/2023 CPAP on HS (hour of sleep) every evening shift and night shift. Review of the current physician's orders and care plans failed to indicate interventions for the care of the CPAP machine. During an interview on 3/20/24 at 4:13 P.M. Nurse #15 said Resident #36 does use the CPAP and it is applied on the 3:00 P.M. 11:00 P.M., shift. During an interview on 3/21/24 at 7:13 A.M., Nurse #16 said the CPAP mask should be covered when not in use and showed the surveyor that the facility has bags designated for the use to cover respiratory equipment. 49880 3. Resident #95 was admitted to the facility in December 2020 with diagnoses that included emphysema, chronic bronchitis, sleep apnea and abnormal finding of lung field. Review of Resident #95's most recent Minimum Data Set (MDS) assessment, dated 12/20/23, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that Resident #95 was cognitively intact. The MDS Assessment further indicated that Resident #95 utilizes oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/24 at 8:25 A.M., the surveyor observed Resident #95 lying in bed utilizing oxygen via nasal canula. The date on the nasal canula tubing was 2/14/24. On 3/19/24 at 2:18 P.M., the surveyor observed Resident #95 lying in bed utilizing oxygen via nasal canula. The date on the nasal canula tubing was 2/14/24. On 3/20/24 at 7:36 A.M., the surveyor observed Resident #95 sleeping in bed utilizing oxygen via nasal canula. The date on the nasal canula tubing was 2/14/24. On 3/20/24 at 10:51 A.M., the surveyor observed Resident #95 lying in bed utilizing oxygen via nasal canula. The date on the nasal canula tubing was 2/14/24. Review of Resident #95's physician's orders indicated an order dated 10/24/23, Oxygen tubing change weekly label each component with date and initials. Review of Resident #95's February and March 2024 Treatment Administration Record indicated that oxygen tubing was changed on 2/20/24, 2/27/24, 3/5/24, 3/12/24 and 3/19/24. During an interview on 3/21/24 at 7:09 A.M., Nurse #4 said that she would expect a nurse to follow physician's orders to change oxygen tubing and that if it was signed off as completed that it was done. During an interview on 3/21/24 at 8:26 A.M., the Director of nursing (DON) said that she would expect oxygen tubing to be changed weekly as ordered. 4. Resident #163 was admitted to the facility in November 2022 with diagnoses that included Chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow to the lungs), chronic respiratory failure and anxiety disorder. Review of Resident #163's most recent MDS assessment indicated a BIMS score of 11 out of 15 indicating moderate cognitive impairment. The MDS assessment further indicated the Resident required continuous oxygen use. On 3/19/24 at 9:23 A.M. and 2:21 P.M, the surveyor observed Resident #163 lying in bed utilizing oxygen via nasal canula. The date on the nasal canula tubing was 2/27/24. On 3/20/24 at 7:38 A.M. and 10:53 A.M, the surveyor observed Resident #163 lying in bed utilizing oxygen via nasal canula. The date on the nasal canula tubing was 2/27/24. Review of Resident #163's physician's orders, dated 11/17/22, indicated Oxygen tubing change weekly label each component with date and initials. Change every Thursday. Review of Resident #163's March 2024 Treatment Administration Record indicated that oxygen tubing was changed on 3/7/24 and 3/14/24. During an interview on 3/21/24 at 7:09 A.M., Nurse #4 said that she would expect a nurse to follow physician's orders to change oxygen tubing and that if it was signed off as completed that it was done. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/24 at 8:26 A.M., the Director of nursing (DON) said that she would expect oxygen tubing to be changed weekly as ordered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on record review, policy review and interview, the facility failed to provide care and services consistent with professional standards for four Residents (#49, #434, #36 and #105), out of 17 residents who required renal dialysis (a life sustaining treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) out of a total sample of 41 residents. Specifically, 1. The facility failed to ensure that emergency smooth clamps were kept with Residents (#49, #434, #36 and #105) for emergencies related to a hemodialysis catheter (a plastic tube used for exchanging blood between a patient and a hemodialysis machine). Findings include: Review of the facility's Minimum Data Resident Matrix provided by the facility on 3/19/24, four hours after the survey commenced indicated 17 residents were checked off as receiving dialysis. Review of the facility policy titled 'Hemodialysis External Catheter Evaluation and Maintenance' last revised December 2021, indicated the following but not limited to: *Maintain two smooth edge clamps with the patient at all times. *Smooth edge clamps must be placed at bedside at time of admission. *Smooth edged clamps are to be attached to the patient's clothing during transport to and from dialysis facility or for any appointment(s) outside the nursing center. *If the patient is mobile throughout the center, smooth edged clamps must be attached to the patient's clothing at all times. *In the event of a catheter fracture or breakage, immediately clamp the catheter as close to the chest wall, or catheter exit site, as possible. 1 (a). Resident #49 was admitted to the facility in February 2024 with diagnoses including end stage renal disease, dependence on renal dialysis. Review of Resident #49's Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 13 out of a possible 15 on the Brief Interview for Mental Status indicating he/she was cognitively intact. Review of Resident #49's medical record indicated the following orders: *External hemodialysis catheter left upper chest. *Check for smooth clamps at the bedside and on patient wheelchair (if applicable) every shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/24 at 11:37 A.M., the surveyor observed Resident #49 sitting in his/her wheelchair. The surveyor did not observe emergency smooth clamps on the Resident's wheelchair nor the bedside. On 3/20/24 at 9:23 A.M., the surveyor observed Resident #49 sitting in his/her wheelchair. The surveyor did not observe emergency smooth clamps on the Resident's wheelchair nor the bedside. On 3/21/24 at 8:57 A.M., the surveyor observed Resident #49 lying in his/her bed. The surveyor did not observe emergency smooth clamps on the Resident's wheelchair nor the bedside. During an interview on 3/21/24 at 9:06 A.M., Nurse #11 said the emergency smooth clamps should be on the wall above the bed in the Resident's room. During an interview on 3/21/24 at 10:22 A.M., the Director of Nursing said the smooth clamps should be in the Resident's room taped to the wall above the bed, or their wheelchair if applicable. 1(b). Resident #434 was admitted to the facility in March 2024 with diagnoses including chronic diastolic congestive heart failure, dependence on renal dialysis. Review of Resident #434's Brief Interview for Mental Status dated 3/14/24, indicated the Resident scored a 15 out of a possible 15 indicating he/she was cognitively intact. Review of Resident #434's medical record indicated the following order: *Check smooth clamps at the bedside and on patient wheelchair (if applicable) every shift. *External hemodialysis catheter double lumen CVC dialysis internal jugular right tunneled do not change end caps. On 3/19/24 at 8:48 A.M., the surveyor observed Resident #434 lying in his/her bed. The surveyor did not locate emergency smooth clamps in the Resident's room. On 3/19/24 at 11:18 A.M., the surveyor observed Resident #434 lying in his/her bed. The surveyor did not locate emergency smooth clamps in the Resident's room. On 3/20/24 at 9:35 A.M., the surveyor observed Resident #434 in his/her room. The surveyor did not locate emergency smooth clamps in the Resident's room. During an interview on 3/21/24 at 9:06 A.M., Nurse #11 said the emergency smooth clamps should be on the wall above the bed in the Resident's room. During an interview on 3/21/24 at 10:22 A.M., the Director of Nursing said the smooth clamps should be in the Resident's room taped to the wall above the bed, or their wheelchair if applicable. 36431 1 (c.) Resident #36 was admitted to the facility in January 2024 with diagnoses that include but not limited to end stage renal disease and dependence on renal dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's MDS, dated [DATE], indicated he/she scored 11 out of 15 on the Brief Interview for Mental Status exam, indicating Resident #36 as having moderately impaired cognition. Review of Resident #36's medical record indicated the following: -External hemodialysis catheter double lumen CVC internal jugular right tunneled, dated 12/5/2023. -Check smooth clamps at the bedside and on patient wheelchair (if applicable) every shift, dated 12/4/2023. -A care plan focus, risk for impaired renal function and is at risk for complications related to hemodialysis, dated as initiated 1/11/2024, with the intervention dated 1/11/24 maintain smooth catheter clamps at the bedside (and on patient when out of bed) in case of breakage or excessive bleeding from catheter. During an interview on 3/19/24 at 10:40 A.M., Resident #36 said he/she went to dialysis yesterday and his/her access is in his/her chest. There were no smooth clamps observed near or readily available in Resident #36's room. On 3/20/24 at 8:55 A.M., Resident #36 was not observed in his/her room. There was no smooth clamp observed in the resident's area. Nurse #10 said Resident #36 was at dialysis and returns between 9:30 A.M. -10:00 A.M. On 3/20/24 at 10:10 A.M., Resident #36 returned from dialysis and was observed in his/her room eating breakfast. No smooth clamp was located on his/her wheelchair nor observed on the bedside table or above the bed. The bedside table drawer was filled with items, but no smooth clamp was observed or readily available in Resident #36's room. During an interview on 3/20/24 at 4:00 P.M. Nurse #15 said the smooth clamp for Resident #36 should be available in the Resident's room. 49873 1 (d.) Resident #105 was admitted to the facility in October 2023 with diagnoses including but not limited to end stage renal disease and dependence on renal dialysis. Review of Resident #105's MDS indicated he/she scored 10 out of a 15 on the Brief Interview for Mental Status exam, indicating Resident #105 as having moderately impaired cognition. Review of Resident #105's medical record indicated that Resident #105 has a hemodialysis catheter. Review of Resident #105's care plan indicated: Intervention: Maintain smooth catheter clamps at the bedside (and on patient when out of bed) in case of breakage or excessive bleeding from catheter, dated 11/1/2023. During an observation on 3/19/24 at 8:20 A.M. Resident #105 was observed sleeping in bed. No smooth clamp was located on his/her wheelchair nor observed on bedside or above the bed. (continued on next page)

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Regalcare at Courtyard-Medford	200 Governors Avenue Medford, MA 02155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/20/24 at 12:15 P.M., Resident #105 stated he/she had just returned from dialysis and was very tired. There were no smooth clamps observed near or readily available in Resident #105's area. During an interview on 3/20/24 at 12:33 P.M., Unit Manager #1 said staff doesn't send smooth clamps down to dialysis with residents since there is a supply of smooth clamps in the dialysis den and it's a short trip to get to the dialysis den downstairs. Unit Manager #1 said the clamp was not at Resident #105's bedside this morning because it was taped up on the wall, but it had fallen down.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44095 Based on observation, policy review, record review and interview, the facility failed to ensure pharmaceutical services met the needs of each resident for one Resident (#17) in a total sample of 41 residents. Specifically, for Resident #17 the facility failed to ensure routine drugs were available for administration. Findings include: Review of the facility policy, Medication Shortages/ Unavailable Medications, dated as Revised 1/1/22, indicated: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take action to notify the Pharmacy. Resident #17 was admitted to the facility in December 2020 with diagnosis including chronic obstructive pulmonary disease, allergic rhinitis, and overactive bladder. Review of the Minimum Data Set (MDS) assessment, dated 1/3/24, indicated Resident #17 had a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15 which indicated he/she had a moderate cognitive impairment. The MDS indicated Resident #17 was frequently incontinent of bladder. On 3/19/24 at 10:16 A.M., the surveyor observed Nurse #3 prepare medications for Resident #17. Nurse #3 said she did not have Resident #17's physician's ordered Myrbetriq (medication used to treat an overactive bladder). Review of the physician's order, dated 12/28/20, indicated: -Myrbetriq Tablet Extended Release 24 Hour 25 mg, give 1 tablet by mouth one time a day for overactive bladder. Review of the Medication Administration Record (MAR), dated March 2024, indicted the Myrbetriq was not administered on 3/12/24, 3/14/24, 3/15/24, 3/16/24, and 3/20/24 Review of the eMAR notes, dated 3/12/24, 3/15/24, 3/16/24, indicated: -Myrbetriq Tablet Extended Release 24 Hour 25 mg, give 1 tablet by mouth one time a day for overactive bladder, awaiting delivery. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/24 at 10:21 A.M., Nurse #3 said that she has not had the Myrbetriq for Resident #17 for several days. Nurse #3 said she was not sure why the pharmacy has not sent the medication. During an interview on 3/20/24 at 10:22 A.M., Nurse #8 said Resident #17's Myrbetriq has not been available for administration for about a week. Nurse #8 said she contacted the pharmacy, and the pharmacy told her that the medication had been delivered but it was too early for a refill so the medication would not be sent. Nurse #8 said that the pharmacy told her that the Myrbetriq could be delivered if facility provided an override request and the facility would pay for the medication, Nurse #8 said she did not authorize the delivery of the medication and said the DON would have to approve the medication delivery. Nurse #8 said the pharmacy should have reached out to the DON for authorization and payment. On 3/20/24 at 10:45 A.M., the surveyor made the Director of Nursing (DON) aware of the missing medication. The DON said the medication should be available.

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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. 49880 Based on record review, policy review, and interview, the facility failed to ensure that each Resident's drug regimen was free from unnecessary psychotropic medications for two Residents out of a total sample of 41 residents. Specifically, for Resident #2 and Resident #33 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: Review of facility policy titled Behaviors: Management of Symptoms, revised 10/24/22, indicated Complete the Abnormal Involuntary Movement Scale (AIMS) per nursing schedule for patients receiving antipsychotic medications. Review of the Assessment Grid attached to the policy indicated that an AIMS assessment should be completed Upon new order for an antipsychotic and every 6 months when on an antipsychotic. 1. Resident #2 was admitted to the facility in August 2020 with diagnoses that included major depressive disorder, post-traumatic stress disorder and anxiety disorder. Review of Resident #2's most recent Minimum Data Set (MDS) assessment, dated 1/24/24, indicated that Resident #2 has a Brief Interview for Mental Status score of 15 out of 15, indicating that Resident #2 is cognitively intact. The MDS Assessment further indicated that Resident #2 received an antipsychotic medication. Review of Resident #2's active physician's orders, dated 11/21/23, indicated seroquel (an antipsychotic medication) 75 milligrams three times daily. Review of Resident #2's assessments indicated that the most recent AIMS assessment was completed on 1/21/22. Review of Resident #2's psychotropic medication care plan, dated as revised 8/21/23, indicated that [Resident #2] is at risk for complications related to the use of psychotropic drugs. On 3/21/24 at 10:44 A.M., the surveyor and Unit Manager #2 reviewed Resident #2's medical record and Unit Manager #2 said the most recent AIMS assessment was completed on 1/21/22. During an interview on 3/21/23 at 11:15 A.M., the Director of Nursing (DON) said that she would expect that an AIMS assessment is completed every 6 months for a resident who is receiving antipsychotic medications. 2. Resident #33 was admitted to the facility in December 2020 with diagnoses that included schizophrenia, schizoaffective disorder and major depressive disorder. (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 #33's most recent MDS assessment, dated 2/21/24, indicated a BIMS score of 15 out of 15, indicating that Resident #33 is cognitively intact. The MDS assessment further indicated that Resident #33 received an antipsychotic medication. Review of Resident #33's active physician's orders indicated an order, dated 12/15/21, for ziprasidone (an antipsychotic medication) 80 milligrams, give two capsules at bedtime. Review of Resident #33's active physician orders indicated an order, dated 2/12/24, for Perphenazine (an antipsychotic medication) 16 milligrams two times a day. Review of Resident #33's assessments indicated that the most recent AIMS assessment was completed on 12/27/22. Review of Resident #33's Behavioral Health note, dated 3/8/2024, indicated that the last AIMS assessment was completed 12/27/22 and that a new AIMS assessment is due as the last test was over 6 months ago. Review of Resident #33's psychotropic medication care plan, dated 1/25/22, indicated [Resident #33] is at risk for complications related to the use of psychotropic drugs. During an interview on 3/21/23 at 11:15 A.M., the Director of Nursing (DON) said that she would expect that an AIMS assessment is completed every 6 months for a resident who is receiving antipsychotic medications.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 44095 Based on observations, records reviewed, policy review, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when 3 out of 4 nurses observed made 5 errors out of 25 opportunities, resulting in a medication error rate of 20%. Those errors impacted 3 Residents (#69, #19, and #17), out of 4 residents observed. Findings include: Review of the facility policy, General Dose Preparation and Medication Administration, dated as revised 1/1/22, indicated: 3.7 Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record. 3.11 Facility staff should not split tablets. 3.12 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.) 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in facility's medication administration schedule. 4.1.3 Check the expiration date on the medication. 1.) For Resident #69, the facility failed to ensure nursing administered the correct form of multiple vitamin. Resident #69 was admitted to the facility in September 2023 with diagnoses of dementia and anemia. On 3/19/24 at 9:19 A.M., the surveyor observed Nurse #1 administer medications to Resident #69 including: - one multiple vitamin tablet with minerals Review of the physician's orders, dated 9/1/23, indicated: -Multivitamin Oral Tablet (Multiple Vitamin), give 1 tablet by mouth one time a day for supplement. During an interview on 3/19/24 at 9:25 A.M., Nurse #1 said she administered the wrong multiple vitamin. During an interview on 3/20/24 at 4:32 P.M., the Director of Nursing (DON) said nursing should administer the correct multiple vitamin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) For Resident #19 the facility failed to ensure nursing administered medications on time. Resident #19 was admitted to the facility in July 2022 with diagnoses including schizophrenia and depression. On 3/19/24 at 9:48 A.M., the surveyor observed Nurse #2 administer medications to Resident #19 including: - Risperdal 3 milligrams (mg), 1 tablet Review of the physician's order, dated 6/31/23, indicated: - Risperdal oral tablet 3 milligrams (mg) (Risperidone), give 3 mg by mouth two times a day for agitation, increased confusion. Scheduled twice daily at 8:00 A.M., and 8:00 P.M., Administered 1 hour and 48 minutes after the scheduled time. During an interview on 3/19/24 at 9:59 A.M., Nurse #2 said he was late on the medication pass and medications should be administered within one hour of the scheduled time. During an interview on 3/20/24 at 4:33 P.M., the Director of Nursing (DON) said nursing should administer medications within one hour of their scheduled time. 3.) For Resident #17 the facility failed to ensure nursing administered Lactaid with a meal, the correct form of guaifenesin, and administered an inhaler that was opened an undated and therefore nursing was unable to determine if the medication was good. Resident #17 was admitted to the facility in December 2020 with diagnoses including chronic obstructive pulmonary disease, and overactive bladder. On 3/19/24 at 10:04 A.M., the surveyor observed Nurse #3 administer medications to Resident #17 including: - one Lactaid tablet - one and a half tablets of guaifenesin 400 mg (total dose 600 mg), not extended release. - one inhalation of Fluticasone-Umeclidinium-Vilanterol inhaler, opened and undated. Review of the physician's order, dated 6/17/21, indicated: - Lactaid Tablet (Lactase), give 1 tablet by mouth with meals for bowel irritation. Scheduled three times daily at 8:00 A.M., 12:00 P.M., and 5:00 P.M., administered 2 hours and 4 minutes after the scheduled time and without a meal. Review of the physician's order, dated 10/12/23, indicated: -guaifenesin (ER) oral tablet extended release 12 Hour 600 milligrams (Guaifenesin), give 1 tablet by mouth two times a day for cough/congestion. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's order, dated 10/19/23, indicated: - Fluticasone-Umeclidinium-Vilanterol inhaler 100-62.5-25 micrograms, give 1 puff inhale orally one time a day for COPD. Further review of the manufacture's guidelines indicated to discard the inhaler 6 weeks after opening. During an interview on 3/19/24 at 10:21 A.M., Nurse #3 said that the Lactaid should have been administered with breakfast, she did not have the correct form of guaifenesin and the inhaler did not have a date opened. During an interview on 3/20/24 at 4:34 P.M., the Director of Nursing (DON) said nursing should administer medications with meals, administer the correct form of guaifenesin, and check the expiration date of medications before administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observations, interviews, and policy review, the facility failed to ensure that medications and biologicals were appropriately stored in locked compartments and not accessible to unauthorized individuals, medication with shortened expiration were dated, and topical medications were stored separately from oral medications on four of six units. Specifically; 1.) the facility was observed to have multiple medications and biologicals that were left unlocked at the resident's bedside on two of six resident units for five Residents (#125, #30, #37 #133 and #105), out of a total sample of 41 residents. 2.) the facility failed to ensure the medication cart on one of six units had dated medication when opened and properly stored topical medication from by mouth medication. 3.) the facility failed to ensure that one of six medication rooms was locked and secured. Findings include: Review of the facility policy titled Storage and Expiration Dating of Medications, Biologicals, revised 8/7/23, indicated, but was not limited to, the following: -The facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by resident's or visitors. -Facility should store bedside medications or biologicals in a locked compartment within the resident's room. -When an opthalmic solution or suspension has a manufactures shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container. -Topical (external) use medications or other medications should be stored separately from oral medications when infection control issues may be a consideration. 1a.) Resident #125 was admitted to the facility in July 2022 with diagnoses including hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/10/24, indicated that Resident #125 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The surveyor observed the following medications/biologicals on the D unit, unlocked and clearly visible, in Resident #125's room: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/19/24 at 8:39 A.M., one bottle of 200 mg (milligram) caffeine pills on bedside shelf and one bottle of men's one-a-day multivitamins on over the bed table. -On 3/19/24 at 1:18 P.M., one bottle of 200 mg caffeine pills on bedside shelf and one bottle of men's one-a-day multivitamins on over the bed table. -On 3/20/24 at 7:14 A.M., one bottle of 200 mg caffeine pills on bedside shelf and one bottle of men's one-a-day multivitamins on over the bed table. -On 3/20/24 at 10:42 A.M., one bottle of 200 mg caffeine pills on bedside shelf and one bottle of men's one-a-day multivitamins on over the bed table. -On 3/20/24 at 12:12 P.M., one bottle of 200 mg caffeine pills on bedside shelf and one bottle of men's one-a-day multivitamins on over the bed table. -On 3/21/24 at 7:58 A.M., one bottle of 200 mg caffeine pills on bedside shelf and one bottle of men's one-a-day multivitamins on over the bed table. During an interview on 3/21/24 at 8:06 A.M., Nurse #13 said he thinks caffeine pills and one-a-day multivitamins should be locked in either the medication cart or at bedside so that other residents do not have access to the medications. During an interview on 3/21/24 at 8:11 A.M., Unit Manager #3 said those medications are at bedside because he/she had been assessed to self-administer those medications. Unit Manager #3 said she has known those medications have been unlocked at the bedside in room [ROOM NUMBER]B. During an interview on 3/21/24 at 8:40 A.M., the Clinical Lead #1 said caffeine pills and multivitamins should not be left unlocked at the bedside, even if they are able to self-administer medications. During an interview on 3/21/24 at 8:40 A.M., Regional Nurse #1 said caffeine pills and multivitamins should not be left unlocked at the bedside, even if they are able to self-administer medications. 1b.) Resident #30 was admitted to the facility in March 2023 with diagnoses including heart failure and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/27/23, indicated that Resident #30 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. The surveyor observed the following medications/biologicals, unlocked and clearly visible on the D unit, in Resident #30's room: -On 3/19/24 at 8:17 A.M., saline nasal spray, neosporin, and dry mouth spray on the over the bed table. -On 3/20/24 at 7:14 A.M., dry mouth spray on the over the bed table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/20/24 at 10:22 A.M., dry mouth spray on the over the bed table. -On 3/21/24 at 7:59 A.M., dry mouth spray on the over the bed table. Review of Resident #30's medical record on 3/21/24 failed to indicate a self-administration of medication assessment was present. During an interview on 3/21/24 at 8:06 A.M., Nurse #13 said saline nasal spray, neosporin, and dry mouth spray should not be left unlocked at bedside. During an interview on 3/21/24 at 8:11 A.M., Unit Manager #3 said saline nasal spray, neosporin, and dry mouth spray should not be left unlocked at bedside. During an interview on 3/21/24 at 8:37 A.M., the Director of Nursing (DON) said saline nasal spray, neosporin, and dry mouth spray should not be left unlocked at bedside. 1c.) Resident #37 was admitted to the facility in June 2020 with diagnoses including diabetes and anemia. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/6/24, indicated that Resident #37 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The surveyor observed the following medications/biologicals, unlocked and clearly visible, in Resident #37's room: -On 3/19/24 at 9:13 A.M., one bottle of zeasorb antifungal powder and one bottle of [NAME] lotion on a shelf. -On 3/19/24 at 1:21 P.M., one bottle of zeasorb antifungal powder and one bottle of [NAME] lotion on a shelf. -On 3/20/24 at 7:21 A.M., one bottle of [NAME] lotion on a shelf. -On 3/20/24 at 8:49 A.M., one bottle of [NAME] lotion on a shelf. -On 3/20/24 at 11:07 A.M., one bottle of [NAME] lotion on a shelf. -On 3/21/24 at 8:03 A.M., one bottle of [NAME] lotion on a shelf. Review of Resident #37's medical record on 3/21/24 failed to indicate a self-administration of medication assessment was present. During an interview on 3/21/24 at 8:06 A.M., Nurse #13 said [NAME] lotion and zeasorb antifungal powder should not be left unlocked at bedside. During an interview on 3/21/24 at 8:11 A.M., Unit Manager # 3 said [NAME] lotion and zeasorb antifungal powder should not be left unlocked at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/24 at 8:37 A.M., the Director of Nursing (DON) said [NAME] lotion and zeasorb antifungal powder should not be left unlocked at bedside. 36431 1d.) Resident #133 was admitted to the facility in December 2023 and has diagnoses that include but are not limited to acute respiratory failure with hypoxia, and severe persistent asthma with exacerbation. During an observation and interview on the C Unit on 3/19/24 at 10:15 A.M., Resident #133 was resting in bed, a handheld inhaler was on his/her over bed table. It was not labeled or secure. Resident #133 said he/she uses it when he/she needs it. On 3/19/24 at 12:07 P.M. the handheld inhaler was observed on Resident #133's over bed table, not secured. On 3/19/24 at 1:01 P.M., the handheld inhaler was observed on Resident #133's over bed table, not secured. On 3/20/24 at 8:27 A.M., the handheld inhaler was observed on Resident #133's over bed table, not secured. On 3/20/24 at 1:07 P.M., the handheld inhaler was on Resident #133's over bed table, not secured. Review of Resident #133's medical record on 3/20/24 failed to indicate a self-administration of medication assessment was present. During an interview on 3/20/24 at 1:07 P.M., Nurse #10 said Resident #133 transferred to the unit with the inhaler and had an order to have it with him/her. Nurse #10 reviewed the physician's orders and said Resident #133 has an order for albuterol inhaler and did not have an order to keep the medication bedside. During an interview on 3/20/24 at 1:14 P.M., Resident #133 said to Nurse #10 and the surveyor that a nurse gave the inhaler to him/her and did not take it back. Nurse #10 observed the inhaler and said it was not labeled with the Resident's name. Nurse #10 was unable to find Resident #133's albuterol inhaler in the medication cart. Nurse #10 said all medications are to be labeled with the resident's name, secure and locked in the medication cart. 49873 1e.) Resident #105 was admitted to the facility in October 2023 and has diagnoses that include but are not limited to diabetes, dementia, and renal disease. During an observation on 3/20/24 at 8:00 A.M on the C unit, three boxes of eye drops labeled Systane, Refresh Digital, and Refresh Relieva PF were on Resident #105's bedside table, not secured. Review of Resident #105's physician's orders, dated 10/31/2023, indicated Resident #105 may not self-administer medications. (continued on next page)

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Regalcare at Courtyard-Medford	200 Governors Avenue Medford, MA 02155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/24 at 1:36 P.M., Unit Manager #1 said that medications should not be left at bedside. 46339 During the inspection of the medication cart on Unit F, on 3/20/23 at 6:30 A.M., the surveyor observed the following in the medication cart: -Atropine sulphate opthalmic eye drop 1 % opened and undated thus unable to determine the expiration date. -Clotrimazole 1% topical cream in the medication cart stored with by mouth medications. During an interview on 3/20/24 at 6:44 A.M., Nurse #5 said eye drops should be dated when opened and be discarded after 28 days, he further said the topicals ointments should be kept separately in the treatment cart. During an interview on 3/21/24 at 10:22 A.M., the Director of Nursing said eye drops should be dated when opened, the topicals should be separated from the by mouth medications and be kept in the treatment cart. 43846 2. On 3/19/24 from 7:46 A.M. to 8:57 A.M., the surveyor observed the A unit medication room was unlocked and unsupervised. On 3/20/24 at 7:10 A.M. and 9:10 A.M., the surveyor observed the A unit medication room was unlocked and unsupervised. During an interview on 3/20/24 at 7:12 A.M., Nurse #4 said that the medication room should be locked at all times and is not locked at this time. During an interview on 3/20/24 at 10:22 A.M., Unit Manager #2 said the medication room door should always be locked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41019 Based on observation and interview, the facility failed to distribute food in a sanitary manner during the breakfast meal. Specifically, ensure the management of pests to prevent the potential contamination of food. Findings include: During an observation on 3/19/24 at 8:39 A.M., the food truck on one of the units was open and contained several trays that had not been passed out. Inside the back of the food truck was a large cockroach climbing up the inside of the food transport truck. The trays were removed from the truck and checked. The surveyor immediately notified the Director of Nursing and she said that she would implement a plan right away to clean all of the food transport trucks.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on observation, record review and interviews for two Residents (#17 and #49) of 41 sampled Residents, the facility failed to ensure nursing maintained accurate documentation. 1.) For Resident #17 the facility failed to ensure nursing maintained accurate documentation in the medical record for a.) nebulizer tubing changes documented as completed and b.) wound treatments documented as completed. 2.) For Resident #49 the facility failed to ensure nursing maintained accurate documentation in the medical record for an implanted port valved catheter that the Resident did not have. Findings include: 1.) For Resident #17 the facility failed to ensure nursing maintained accurate documentation in the medical record for a.) nebulizer tubing changes documented as completed and b.) wound treatments documented as completed. Resident #17 was admitted to the facility in December 2020 with diagnoses including chronic obstructive pulmonary disease, allergic rhinitis, and overactive bladder. Review of the Minimum Data Set (MDS) assessment, dated 1/3/24, indicated Resident #17 had a Brief Interview for Mental Status (BIMS) score of 10 out of a possible 15 which indicated he/she had a moderate cognitive impairment. The MDS indicated Resident #17 was frequently incontinent of bladder. a.) Nursing inaccurately documented nebulizer tubing changes as completed. On 3/19/24 at 10:18 A.M. and 3/20/24 at 12:35 P.M., there was no nebulizer machine in Resident #17's room. Resident #17 said he/she does not use a nebulizer. Review of the physician's order, dated 7/24/23, indicated: -Replace and date nebulizer tubing and mouth piece/mask every night shift Review of the Treatment Administration Record (TAR), dated March 2024, indicated nursing implemented the physician's order for the nebulizer tubing and mouth piece changes on 3/19/24 and 3/20/24. b.) Nursing inaccurately documented wound treatments completed. During an interview on 3/19/24 at 10:06 A.M., Nurse #3 said that Resident #17 does not have any skin breakdown other than redness to his/her breasts. Review of the Skin Check. - V 4 assessment, dated 3/4/24, 3/8/24, 3/18/24, failed to include skin breakdown on the buttocks. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's order, dated 12/29/23, indicated: - Wash left buttock with wound cleanser and pat dry. Apply xeroform and clean dry dressing. Apply skin prep to peri wound. Change daily. - Wash right buttock with wound cleanser. Pat dry. Apply xeroform and cover with clean dry dressing. Change daily. Review of the Treatment Administration Record (TAR), dated March 2024, indicated nursing implemented the left and right buttock wound dressing changes on 3/18/24 and 3/19/24. During an interview on 3/20/24 at 12:45 P.M., Resident #17 said he/she does not have a bandage or dressing on his/her bottom anymore. Resident #17 said staff put cream on his/her bottom. During an interview on 3/20/24 at 2:22 P.M., Nurse #8 said she has not completed a treatment to Resident #17's buttocks in a few months and she only applied barrier cream. During an interview on 3/20/24 at 4:52 P.M., the Director of Nursing (DON) said that treatments should only be documented as completed if they are actually completed. 46339 2. Resident #49 was admitted to the facility in February 2024 with diagnoses including end stage renal disease, dependence on renal dialysis. Review of Resident #49's Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 13 out of a possible 15 on the Brief Interview for Mental Status. Indicating he /she was cognitively intact. Review of the medical record indicated the following physician orders that were discontinued on 3/20/24: * Implanted port valved flush when accessed 10 milliliter normal saline. * Intravenous: change administration set every 24 hours label with date/time/initials change sterile end cap on intermittent administration with each use. *Change needleless connector upon admission and weekly every 24 hours. Review of the Medication Administration Record (MAR) for the month of March 2024 indicated that nursing staff signed on the MAR that the tasks were completed as ordered from 3/1/24 through 3/20/24. Further review of the medical record failed to indicate that the Resident had an implanted port valve. During an interview on 3/21/24 at 1:37 P.M., Unit Manager #5 said the Resident did not have an implanted valve port and that nurses should not have signed off in the MAR as completed. She further said that the documentation was inaccurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 10:22 A.M., the Director of Nursing said nurses should not document on tasks that were not completed.

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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. 36431 Based on observation, record review and interview the facility failed to ensure infection control practices were implemented to prevent the spread of infection on one of six resident care units. Specifically, 1. staff failed to remove gloves and perform hand hygiene when exiting a resident room and 2. failed to adhere to infection control practices, when staff removed food that was handled and consumed by a resident and placed the food on another resident's tray where it was consumed by the other resident, increasing the risk of communicable infection. Findings include: Review of the facility's policy titled, Infection Control Policies and Procedures, dared 6/30/23 indicated: Hand Hygiene: HCP (Health Care Personnel) will perform hand hygiene per CDC guidelines and policy. Review of the Centers for Disease Control and Prevention, Hand Hygiene Guidance, not dated indicated the following: The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices -Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal During an observation on the C unit on 3/19/24 at 8:12 A.M., a staff member exited a resident room, wearing gloves on both hands, holding a (clean) colostomy bag appliance. The staff member removed both gloves in the hall, deposited them in the medication cart trash, then without hand hygiene proceeded placed the colostomy bag on the counter on the nursing desk, used the keyboard, then picked up the colostomy bag, and returned and entered the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 9:58 A.M., Unit Manager #1 said staff should not have exited a resident's room wearing gloves and that staff should have removed the gloves and perform hand hygiene before exiting a room. 49873 2. Review of the facility's s policy titled NSG270 Meal Service, dated June 2021 indicated the following: Policy: Person-centered meal service includes the delivery of a safe, sanitary, and comfortable environment for meals. Practice Standards: 1. Staff will utilize proper handling techniques during meal service. 2. Staff will use proper hygienic practices during meal service. On 3/20/24 at 12:45 P.M., A resident took a grilled cheese sandwich from another resident's plate and ate it with his/her hands while the other resident was watching television with his/her back to them. On 3/20/24 at 12:50 P.M., Unit Manager #1 walked up to the table, saw the resident eating the other resident's grilled cheese. Unit Manager #1 took the partially eaten grilled cheese from in front of the resident and put it back on the other resident's tray. The other resident then ate the grilled cheese that had been handled by Unit Manager #1 and the resident. During an interview on 3/21/24 at 11:42 A.M., Unit Manager #1 said that residents should not handle or touch each other's food.