

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Regalcare at Courtyard-Medford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Governors Avenue Medford, MA 02155	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50338 Based on observations and interviews the facility failed to provide a dignified experience for one Resident (#167) out of a total sample of 42 residents and for residents on two of six units. Specifically: 1.) For Resident #167 the facility failed to place the Resident's nephrostomy tube drainage bag in a privacy bag, leaving it exposed to others. 2.) For residents on two of six, units the facility failed to ensure that staff did not refer to residents as feeders within earshot of residents or speak a foreign language while within earshot of residents. Findings include: Review of the facility policy, titled Resident Rights, revised April 2022, indicated the following: - Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to a dignified experience. 1.) Resident #167 was admitted to the facility in December 2024 with a diagnosis of prostate cancer with irradiation cystitis with hematuria (caused by radiation therapy, leading to inflammation and bleeding in the bladder, resulting in painful urination and blood in the urine), hydronephrosis (back up of urine in one or more kidneys), and had bilateral nephrostomy tubes. Review of the Minimum Data Set (MDS) assessment, dated 11/23/24, indicated Resident #167 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 13 out of 15. Further review of the MDS indicated Resident #167 was dependent for bed mobility and had an indwelling catheter (including nephrostomy tubes). On 3/5/25 at 10:24 A.M., the surveyor observed Resident #167 lying in bed, with both nephrostomy urinary drainage bags on top of sheets. The drainage bag was fully visible from the hallway and not placed in a privacy bag to conceal from public view. (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	On 3/6/25 at 5:36 A.M., the surveyor observed Resident #167 lying in bed, with the nephrostomy urinary drainage bag on top of sheets. The drainage bag was fully visible from the hallway and not placed in a privacy bag to conceal from public view. On 3/11/25 at 8:10 A.M., the surveyor observed Resident #167 lying in bed, with the nephrostomy urinary drainage bag hanging off right side of bed. The drainage bag was fully visible from the hallway and not placed in a privacy bag to conceal it from public view. During an interview on 3/11/25 at 11:08 A.M., Nurse #2 said all drainage bags should be placed in a privacy bag. During an interview on 3/11/25 at 11:18 A.M., Unit Manager #2 said the nephrostomy urinary drainage bags should be hanging on side of bed in a privacy bag. During an interview on 3/11/25 at 12:25 P.M., the Director of Nursing (DON) said the nephrostomy urinary drainage bags should have been in a privacy bag to maintain the Resident's dignity. 45763 2.) During the resident group meeting on 3/5/25 at 10:05 A.M. the surveyors met with residents and the following concern was expressed: - Staff talking in foreign language outside of the residents' door. On 3/5/25 at 7:22 A.M., the surveyor observed two staff members speaking in a foreign language to each other in a common area on the C Unit, there was a resident within earshot of the staff members. On 3/5/25 at 7:29 A.M. the surveyor observed two staff members speaking in a foreign language to each other in a common area on the D Unit within earshot of residents. On 3/7/25 at 8:50 A.M. the surveyor observed a staff member say some of them are feeders in a common area on the C Unit while passing out breakfast trays. There were three residents within earshot of the staff member. On 3/7/25 at 8:55 A.M. the surveyor observed a staff member say we have feeders, I have feeders in a common area on the C Unit while passing out breakfast trays. There were three residents within earshot of the staff member. On 3/7/25 at 8:56 A.M. the surveyor observed a staff member ask another staff member who is a feeder? in a common area on the C Unit while passing out breakfast trays. The surveyor observed the other staff member respond she is a feeder while pointing at a resident who was within earshot of the staff members. On 3/11/25 at 8:40 A.M. the surveyor observed a staff member say he's a feeder in a common area on the C Unit while passing out breakfast trays. There were three residents within earshot of the staff member. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 12:58 P.M. the Director of Nursing (DON) said staff should not refer to residents as feeders, but rather by their names, and that staff should not be speaking a foreign language to each other in front of residents.		

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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** 48990 Based on record review and interviews, the facility failed to obtain written informed consent for the use of psychotropic medication for two Residents (#138 and #40) out of a total sample of 42 residents. Specifically, 1.) For Resident #138, the facility failed to obtain written informed consent for use of ramelteon (a hypnotic medication). 2.) For Resident #40, the facility failed to obtain written informed consent for the use of depakote (a mood stabilizer medication). Findings include: Review of the facility policy titled 'Psychotropic Medications', revised April 2022, indicated, but was not limited to: - An informed consent from the resident (or legally authorized individual in the case of resident incompetence) is required for administration of psychoactive medication. 1.) Resident #138 was admitted to the facility in June 2024 with diagnoses including functional urinary incontinence and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/29/25, indicated Resident #138 had severe cognitive impairment based on a Staff Assessment for Mental Status. This MDS also indicated Resident #138 was receiving hypnotic medication. Review of Resident #138's medical record indicated he/she was discharged to the hospital on 10/2/24 and was readmitted to the facility on [DATE]. Review of Resident #138's hospital discharge summary, dated 10/24/24, indicated: - Discharge medication list includes: Start taking these medications: Ramelteon 8 milligram (mg) tablet by mouth nightly. Review of Resident #138's physician orders upon readmission to the facility from the hospital, dated 10/24/24, indicated a new physician order for Ramelteon 8 mg once daily for anxiety. Review of Resident #138's medication administration record, dated 10/24/24 to 3/4/25, indicated he/she received ramelteon 8 mg daily as ordered by the physician. Review of Resident #138's medical record, dated 10/24/24 to 3/4/25, failed to indicate the Resident or the Resident's representative was informed of the risks/benefits or gave consent to administer ramelteon 8 mg. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/6/25 at 9:07 A.M., Resident #138's health care proxy said she was never made aware and never consented to Resident #138 receiving ramelteon. Resident #138's health care proxy said she would have never consented to this medication and did not want him/her to receive it because of the side effects. During an interview on 3/6/25 at 9:34 A.M., Unit Manager #2 said signed consent is required before the administration of any psychotropic medications, including ramelteon. Unit Manager #2 reviewed Resident #138's medical record and said she checked everywhere the consent could be stored but was unable to find it. Unit Manager #2 said it must have been missed. During an interview on 3/6/25 at 11:02 A.M., the Director of Nursing (DON) said a consent, including education of risks/benefits of the medication, must be obtained and a consent form signed before administration of psychotropic medication. 52138 2.) Resident #40 was admitted to the facility in October 2024 with diagnoses including Alzheimer's Disease. Review of Resident #40's most recent Minimum Data Set (MDS) assessment, dated 2/10/25, indicated the Resident scored 1 out of a possible 15 on the Brief Interview for Mental Status exam, indicating the Resident had severe cognitive impairment. Review of Resident #40's physician orders indicated the following order: - Depakote sprinkles (a mood stabilizer medication) 125 mg (milligrams). Give 2 capsules by mouth two times a day for dementia with behavioral discontrol, initiated on ordered 2/11/25. Review of Resident #40's Medication Administration Record indicated the Resident has been taking the Depakote since prescribed. Review of Resident #40's medical record failed to indicate a signed consent for the use of Depakote from Resident #40 and/or his/her health care proxy. During an interview on 3/05/25 at 1:53 P.M., Unit Manager #1 said consent needs to be obtained from the resident or their representative prior to the start of a psychotropic medication. Unit Manger #1 said the consent should be in written form and the facility had only obtained verbal consent for the use of Depakote from Resident #40's health care proxy. During an interview on 3/6/25 at 9:41 A.M., the Director of Nursing said written consent for the use of psychotropic medications should always be obtained, even if verbal consent was initially given.		

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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. 50338 Based on observation, record review and interview, the facility failed to ensure that one Resident (#117) did not self-administer medications out of a total sample of 42 residents. Specifically, Resident (#117) was observed with a cup of pills left on lunch tray for self-administration without being assessed for self-administration. Findings include: Review of the facility policy titled 'Medication Storage', dated March 2022, indicated the following: - The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Resident #117 was admitted to the facility in June 2024 with diagnoses including acute transverse myelitis in demyelinating disease of central nervous system (an inflammatory condition that damages the myelin sheath, the protective covering of nerve fibers in the spinal cord). Review of Resident #117's Minimum Data Set (MDS) assessment, dated 2/20/25, indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating he/she was cognitively intact. The MDS further indicated the Resident did not reject care. On 3/5/25 at 1:55 P.M., the surveyor observed a medicine cup on the Resident's lunch tray with five tablets identified as renal-vite oral tablet, sevelamer carbonate oral tablets, and Tylenol extra strength tablets. Resident #117 said that his/her nurse had brought the medication in when he/she returned from dialysis and left for him/her to take. Review of the medical record indicated the following physician's orders: - Renal-vite oral tablet 0.8 mg (milligrams). Give one tablet by mouth one time a day for supplement. - Sevelamer Carbonate oral tablet 800 mg. Give two tablets by mouth three times a day for supplement with meals. - Tylenol Extra Strength oral tablet 500 mg. Give two tablets by mouth three times a day for pain. Review of medical record failed to indicate Resident #117 had been care planned to self administer medication and failed to indicate a resident self-medication administration assessment had been completed. During an interview on 3/5/25 at 2:00 P.M., Nurse #3 said that Resident #117 should not have his/her medications left at bedside as he/she has not been assessed for self administration of medication. He also said that nurses are supposed to stay with the Resident during medication administration to ensure all medications are taken. (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 3/10/25 at 12:24 P.M., the Director of Nursing (DON) said medications should not be left at the bedside unless a Resident has been assessed as able to self administer. He also said nurses are expected to stay with the resident until all the medications are consumed and should not leave any medications unattended with Resident #117.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations and interviews, the facility failed to maintain a homelike environment on: 1) Six out of six resident units (A, B, C, D, E, F, and G) in the facility which included stained ceiling tiles, chipped and loose floor tiles, broken blinds, holes in walls, gouged walls, peeling baseboards, missing baseboards, peeling wallpaper, dark and brown substance on ceiling tiles, streaks of dried soap on the wall, loose fitting ceiling tiles, flickering lights, and missing closet doors. 2) Specifically in Resident #80's room a significant portion of the heater was covered in tape. Findings include: A review of the facility policy titled 'Accommodation of needs and preferences and homelike environment policy', with no revision date, indicated the following: - The facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. - The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, and wellbeing to the extent possible in accordance with the resident's own needs and preference. - Definitions: Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas lobby, outdoor patios, therapy areas and activity areas. - A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of homelike should include the resident's opinion of the living environment. - Orderly is defined as an uncluttered physical environment that is neat and well kept. Procedure: - The resident's environment will be maintained in a homelike manner to ensure, appropriate housekeeping and private closet space for each resident. 1.) On 3/10/25 at 7:47 A.M., to 9:06 A.M., the surveyor observed the following in A Unit and the Dining area: A 101- Stained ceiling tiles. A 102-Stained ceiling tiles, unfinished wall painting. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A 103- The Resident told the surveyor his/her toilet was clogged and not flushing. The Resident tried to flush the toilet with the surveyor in the room. The toilet was clogged. A 104- The bathroom sink drainpipe was wrapped in a towel. The towel was wet. A 106- Hole in the wall under the bathroom sink next to the drainpipe. Hole in the wall in the corner of the bathroom, next to the toilet. A 108- Hole in the wall under the bathroom sink next to the drainpipe. A 109- Hole in the wall under the bathroom sink next to the drainpipe. A 114- Stained ceiling tiles next to the bathroom door. A 115- Stained ceiling tile in the closet, gouged wall in the closet, peeling baseboards. Hole in the bottom wall next to the toilet, the toilet appeared not securely fit to the floor. Stained ceiling tile in the bathroom. Dining area- Space underneath the diet kitchen sink cabinet which appeared dirty. Peeled wallpaper behind the ice machine. A 117- Stained ceiling tile in the bathroom. A 118- Stained ceiling tiles above the television and clock. A 119- Stained ceiling tile above the closet, next to the room entrance. Stained ceiling tiles above the tub in the bathroom. A 121- A dark and brown substance next to the ceiling tiles in the bathroom. The wall below the area appeared wet. A 124- Stained ceiling tile at the entrance to the room. Hole in the wall next to the sprinkler in the ceiling. A 125- Broken window blinds. A 126- Stained ceiling tiles above the bathroom sink and above the door. A 127- Streaks of dried soap on the wall under the soap dispenser in the bathroom. A 128- Loose closet door handle and a gouge under the bathroom sink. A 130- Chipped floor tile on the bathroom floor and hole in the bottom wall in the left corner next to the toilet. A 131- Hole in the bottom left wall in the bathroom corner next to the toilet. Peeling and cracked baseboard next to the toilet, chipped ceiling tile in the bathroom. Stained, wet, peeling ceiling tiles at the room entrance. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/10/25 at 9:12 A.M., to 9:47 A.M., the surveyor observed the following on the B Unit: B 101- Break in baseboard behind the toilet. B 102- Steel wool stuck in a hole under the bathroom sink drainpipe. Stained ceiling tiles above the bed light, next to the privacy curtains in the middle of the room. B 104- Peeling baseboard next to the dresser at the room entrance. Peeling baseboard behind the toilet. B 105- Chipped and cracked floor tiles next to the toilet. Space between ceiling tiles above the toilet. B 106- Space between ceiling tiles above the entrance to the room. B 107- Chipped floor tile next to the toilet. Hole in the bottom wall in the corner of the bathroom next to the bathroom sink. B 109- Cracked floor tile around the toilet. B 110- Loose fitting ceiling tile above the toilet in the bathroom. B 111- Stained ceiling tiles above the entrance to the room. B 113- Hole in the ceiling in the bathroom and storage room next to the bathroom. B 114- Stained ceiling tile in the closet. B 115- Peeling baseboard in the bathroom. B 116- Chipped floor tiles under the bathroom sink next to the trash can. B 117- Stained and cracked ceiling tile above the toilet. B 118- Baseboard off the wall on the floor under the bathroom sink. B 119- Hole in the wall under the heater stuffed with steel wool. On 3/10/25 at 9:52 A.M., to 10:24 A.M., the surveyor observed the following in the C Unit: C 101- Flickering lights in the bathroom. C 102- Closet without a closet door. C 104- Hole in the bottom wall behind the toilet, hole in the wall from the bathroom sink drainpipe. C 105- Chipped floor tile in front of bed B. Chipped floor tile next to the toilet. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	E 109- Holes on the bottom walls on both sides of the toilet. Hole in the corner of the bathroom. E 110- Hole in the wall from the bathroom sink drainpipe. Hole on the bottom wall next to the toilet on the left side. On 3/10/25 at 11:54 A.M., to 12:13 P. M., the surveyor observed the following on the F Unit: F 101- Chipped tile next to the heater. F 102- Broken blinds. Hole in the wall in the corner of the bathroom. Hole in the wall from the drainpipe from the bathroom sink. F 103- Chipped floor tiles at the bathroom entrance. F 104- Broken blinds. Hole in the bottom left side of the wall next to the toilet. Hole in the wall in the corner in the bathroom. F 105- Hole in the wall from the drainpipe from the bathroom sink. F 106- Hole in the wall from the drainpipe from the bathroom sink. F 107- Space between the wall and ceiling tiles next to the bathroom entrance. Hole in the wall from bathroom sink drainpipe. Broken blinds. F 108- Hole in the wall from drainpipe from the bathroom sink. Small dresser missing the top drawer. F 109- Hole on the bottom wall of the right side of the toilet. Chipped floor tile in front of the bathroom. The hallway in front of room F 109 has a hole in the wooden floor. During an interview on 3/11/25 at 7:36 A.M., Unit Manager #2 said, for repairs on the unit, staff write the repairs needed on a work order book on the unit, the Maintenance Director is responsible for completing rounds daily to work on repairing the concerns written in the work order book. Unit Manager #2 said if the repair is an emergency, the Maintenance Director is called on the phone to respond to the repair immediately. Unit Manager #2 said she has seen holes in walls in residents' rooms. Unit Manager #2 said she has reported these concerns at morning meeting to management. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/11/25 at 10:12 A.M., the Administrator and Maintenance Director said staff communicate repairs needed in the facility in a work order binder on each unit. The Maintenance Director said if there is a repair emergency, staff will call him so he can address the concern immediately. The Maintenance Director said for the repairs added in the work order logbook, he does rounds three times a day, every day, and addresses the repairs. The Maintenance Director said for all completed repairs, he crosses out the concern in the work log. A review of the worklogs on all the units failed to indicate that staff had noted down the concerns identified above except for broken blinds that needed repair in room E-106. The repair concern was dated 3/7/25 and had not been addressed. The Administrator said staff will be educated on how to identify repair concerns on the units. The Administrator and Maintenance Director said there are still a lot more repairs that need to be completed in the facility, especially in the residents' rooms to create a homelike environment. 45763 2.) Resident #80 was admitted to the facility in September 2020 with a diagnosis of hypertension. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #80 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. During an interview and observation in room [ROOM NUMBER]d on 3/5/25 at 11:38 A.M., the surveyor observed that a significant portion of the cover for Resident #80's heater was covered in a variety of tape. Resident #80 said the heater cover has been broken for three and a half years and that he/she had been told it was too expensive to repair it. The Resident said he/she had been told to take care of it him/herself so his/her sister bought the tape to hold the cover in place. During an interview on 3/5/25 at 12:50 P.M., the Maintenance Director said there was nothing functionally wrong with the heater just that the cover was broken. The Maintenance Director said he wouldn't be able to buy a separate cover so in order to fix it he would have to replace the entire heater which was expensive. The Maintenance Director said keeping the heater in its current state was the lesser of two evils. During an interview on 3/11/25 at 9:50 A.M. the Administrator said he would not consider the current state of Resident #80's heater to be an appropriate permanent fix, and that he was unaware of the issue. Refer to F925.		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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** 48990 Based on observations, record review and interviews, the facility failed to ensure four Residents (#138, #110, #106, and #130) were free from abuse and neglect out of a total sample of 42 residents. Specifically, 1.) For Resident #138, the facility failed to ensure staff provided necessary care of repositioning and incontinence care resulting in the deterioration of a pressure wound. 2.) For Residents #110, #106 and #130, the facility neglected to provide the necessary care for incontinence management. Findings include: Review of the facility policy titled, Abuse: Prevention, dated revised 3/2022, indicated the following: Purpose: To allow residents freedom of the risk of abuse, neglect, involuntary seclusion, and misappropriation and exploitation of resident property. Policy: - The facility will be proactive with any type of abuse. - The facility Administrator will be the Abuse Prevention Coordinator. - The Administrator or designee has the ability to delegate actions and tasks to other employees, such as gathering of pertinent data, so that a timely resolution of an event and/or alleged event will occur. Procedure: - 3. The Administrator will ensure that residents, families, and staff have information on how to and whom they may report concerns, incidents, and grievances without fear of retribution, and provide feedback regarding concerns that have been expressed. - 6. Facility specific characteristics will be considered when planning for prevention. Such characteristics may include: a. Features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	b. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs; c. The supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their beds; and d. The assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident rooms, residents with self-injurious behaviors, residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff. Review of the facility policy titled, Abuse Prohibition, dated 3/2022, indicated the following: Purpose: - Each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property, Every resident in the facility will always be treated with respect and dignity, - Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Policy: - Residents will not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteer staff, family members, friends, or other individuals, - Staff will refrain from all actions that could be considered abuse, mistreatment, neglect, exploitation, and/or misappropriation. 1.) For Resident #138, the facility failed to ensure staff provided necessary care to reposition and provide incontinence care resulting in the deterioration of a pressure wound. Resident #138 was admitted to the facility in June 2024 with diagnoses including functional urinary incontinence and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/29/25, indicated Resident #138 had severe cognitive impairment based on a Staff Assessment for Mental Status. The MDS further indicated Resident #138 had a stage three pressure ulcer, required substantial/maximal assistance to roll in bed, was always incontinent of bowel and bladder, and was dependent of staff for toileting hygiene and transfers. Review of Resident #138's medical record indicated he/she had been transferred to the hospital on 3/4/25 for deteriorating coccyx wound with increased size, drainage, and foul smell. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During a telephone interview on 3/6/25 at 9:07 A.M., Resident #138's health care proxy said she does not believe Resident #138 was repositioned every two hours or was receiving incontinence care timely and that this caused his/her pressure ulcer to worsen. During a follow-up telephone interview on 3/10/25 at 8:56 A.M., Resident #138's health care proxy said she was looking for another facility for Resident #138 because he/she was being neglected at the facility. Resident #138's health care proxy said Resident #138's wound worsened to a stage four pressure ulcer with visible bone in the wound bed because he was not being turned and repositioned every two hours which the physician had ordered. Resident #138's health care proxy said Resident #138 also often did not have necessary incontinence care provided. Resident #138's health care proxy said she had told the Administrator, the Director of Nursing (DON), the Unit Manager, and many nurses and certified nurses assistants (CNAs) that Resident #138 was not being repositioned or having necessary incontinence care, but it continued. Review of Resident #138's plan of care related to actual alteration in skin integrity, initiated 11/7/24, indicated: - Turn and reposition every 2-3 hours every shift. Review of Resident #138's plan of care related incontinence of bladder, initiated 6/4/24, indicated: - Check twice a shift and as needed for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Review of Resident #138's report titled 'Documentation Survey Report' (a report including certified nursing (CNA) documentation), dated 10/24/24 to 3/4/25, indicated the Resident was always incontinent and always required staff assistance for repositioning. Review of Resident #138's assessment titled 'Skin Observation Tool', dated 10/25/24, indicated the Resident did not have any pressure ulcers on 10/25/24. Review of Resident #138's Wound Nurse Practitioner progress note, dated 10/29/24, indicated initial exams for two new wounds including: - Initial exam: left buttock pressure ulcer, stage 1. - Initial exam: MASD (moisture associated skin damage) coccyx. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 10/29/24, 11/5/24, 11/19/24, 11/26/24, 12/3/24, 12/10/24, 12/17/24, 12/27/24, 12/31/24, 1/7/25, 1/14/25, 1/21/25, 1/28/25, 2/4/25, 2/11/25, 2/18/25, 2/25/25, and 3/4/25, indicated: - Treatment recommendations for left buttock pressure ulcer and MASD coccyx include prompt peri care and frequent repositioning. Review of Resident #138's Wound Nurse Practitioner progress note, dated 11/5/24, indicated: (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	- Deteriorating left buttock pressure ulcer, unstageable. - MASD to coccyx was reclassified as an unstageable pressure ulcer. - Deteriorating pressure ulcer coccyx, unstageable. - New stage three right buttock pressure ulcer. During a review of Resident #138's 'Documentation Survey Report' from time between new wound was noted and when the wound deteriorated, dated 10/30/24 to 11/5/24, indicated: - Toileting hygiene was not provided on 4 shifts. - Turning and repositioning every 2 hours was not provided 12 times. Review of Resident #138's Wound Nurse Practitioner progress note, dated 12/10/24, indicated: - Deteriorating coccyx pressure ulcer which increased in size. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 11/6/24 to 12/10/24, indicated: - Toileting hygiene was not provided on 33 shifts. - Turning and repositioning every 2 hours was not provided 45 times. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 12/17/24, indicated: - Coccyx pressure wound reclassified to a stage three and increased in size. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 12/11/24 to 12/17/24, indicated: - Toileting hygiene was not provided on 7 shifts. - Turning and repositioning every 2 hours was not provided 17 times. Review of Resident #138's nursing progress note, dated 1/27/25, indicated: - (Health care proxy) stated he/she need to be changed right now. The nurse explained that I will notify the nursing aide for you. The resident aide was on break, the nurse was on break, two of the aide was with a resident in shower room. The other one was helping a resident with food. After a couple of minutes, while this writer was verify a dressing order, so that she was going to change when she heard someone was screaming at her: hey you, if you don't want to do your job just (expletive) stay home. This writer reply are you talking to me please do not yelled at me. This family member keep shouting and screaming at the nurse . This writer did not reply, just report it to the aide to change the resident as soon as he returned from break. [sic] (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #138's Wound Nurse Practitioner progress notes, dated 2/11/25, indicated: - Pressure ulcer to coccyx is deteriorating this week. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 2/1/25 to 2/11/25, indicated: - Toileting hygiene was not provided on 16 shifts. - Turning and repositioning every 2 hours was not provided 31 times. Review of Resident #138's nursing progress note, dated 2/12/25, indicated: - Pressure ulcer to coccyx deteriorating this week. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 2/18/25, indicated: - Deteriorating coccyx pressure ulcer which increased in size. - New stage two right buttock pressure ulcer. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 2/12/25 to 2/18/25, indicated: - Toileting hygiene was not provided on 6 shifts. - Turning and repositioning every 2 hours was not provided 5 times. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 3/4/25, indicated: - Deteriorating coccyx pressure ulcer. - New left buttock maceration. - Stable right buttock stage two pressure ulcer. Review of Resident #138's nursing progress note, dated 3/4/25, indicated: - Coccyx wound in deteriorating, foul smell noted, with increased size and drainage. NP (nurse practitioner) orders to send patient for ED (emergency department) evaluation. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 2/19/25 to 3/4/25, indicated: - Toileting hygiene was not provided on 9 shifts. - Turning and repositioning every 2 hours was not provided 9 times. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #138's hospitalist progress note, dated 3/7/25, indicated: - No definite sacral osteomyelitis, but the MRI is not adequate for evaluation due to significant motion artifact. - Recommendations for wound care include to change positions regularly. Review of Resident #138's entire medical record, dated 10/24/24 to 3/4/25, failed to indicate the Resident refused repositioning or incontinence care. During a telephone interview on 3/7/25 at 6:29 A.M., Certified Nurse Assistant (CNA) #7 said the facility has been short staffed several days a week for the past few months. CNA #7 said several days a week there was only one CNA on the overnight shift making it physically impossible to turn and reposition all the residents on the unit. CNA #7 said she does not believe Resident #138 was repositioned every two hours consistently over the past three months. During a telephone interview on 3/7/25 at 8:40 A.M., Nurse Practitioner (NP) #1 said she sees that staff isn't always able to reposition and provide toileting/incontinence care. During an interview on 3/7/25 at approximately 1:00 P.M., the Administrator said not providing services or care to residents when needed is considered neglect. During an interview on 3/7/25 at 1:12 P.M., Certified Nurse Assistant (CNA) #8 said leaving a resident in their feces or urine for hours or not turning and repositioning them is neglect. During an interview on 3/7/25 at 1:17 P.M., Nurse #8 said leaving a resident in their feces or urine for hours or not turning and repositioning them is neglect. Nurse #8 said not providing frequent repositioning or prompt incontinence care could cause a wound to deteriorate. During an interview on 3/7/25 at 1:19 P.M., Unit Manager #2 said Resident #138 should have been repositioned every two hours and incontinence care should have been provided promptly. Unit Manager #2 said repositioning and incontinence care should be documented by the CNAs, which is where the information from the report titled 'Documentation Survey' populates, under repositioning and toileting hygiene. Unit Manager #2 said if a Resident refuses repositioning or incontinence care that should be documented accordingly. Unit Manager #2 said not providing frequent repositioning or prompt incontinence care could cause a wound to deteriorate. During an interview on 3/7/25 at 1:58 P.M., the Director of Nursing (DON) said residents who are incontinent should be changed every 2-3 hours. The DON said he would have to defer to the Administrator's definition of neglect and would not answer if not providing care could be considered neglect. During an interview on 3/7/25 at 2:49 P.M., the Wound Nurse Practitioner (NP) said not providing frequent repositioning or prompt incontinence care could cause a wound to deteriorate. The Wound NP said 50% of the time during weekly wound visits Resident #138's brief was soiled or full of urine. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/10/25 at 10:11 A.M., the Director of Nursing (DON) and the Regional Nurse Consultant said CNA documentation should be completed by the end of each shift, including repositioning and incontinence care. The DON and Regional Nurse Consultant declined to comment on if not providing frequent repositioning or prompt incontinence care can cause a wound to deteriorate. 41456 2a.) Resident #110 was admitted to the facility in April 2022 with diagnoses including dementia. Review of Resident #110's most recent Minimum Data Set (MDS) assessment, dated 1/9/25, indicated the Resident scored a 0 out of a possible 15 on the Brief Interview for Mental Status exam, indicating he/she has severe cognitive impairment. The MDS indicated the Resident requires substantial assistance for toilet transfers and is dependent on staff for toileting tasks. Section H of the MDS indicated Resident #110 is always incontinent of both bowel and bladder. On 3/5/25 at 9:00 A.M., Resident #110 was observed sitting in his/her wheelchair in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 12:00 P.M. Throughout this time Resident #110 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. On 3/7/25 at 8:05 A.M., Resident #110 was observed sitting in his/her wheelchair in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 11:57 A.M. Throughout this time Resident #110 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. At 1:12 P.M., the surveyor returned to the unit and Resident #110 was observed lying in bed. Review of Resident #110's most recent Norton Pressure Ulcer assessment dated [DATE], indicated the Resident has double incontinence and is a high risk for pressure ulcer development. Review of Resident #110's ADL care plan indicated the following intervention: - Provide resident/patient with limited assist of 1 for toileting after meals and as needed. Review of Resident #110's incontinence care plan, failed to indicate an intervention of a toileting schedule or how often the Resident should be checked/changed. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said the unit is very short staffed, and because of this it takes a long time to provide care to residents and ensure that all the care is being completed. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/7/25 at 1:12 P.M., CNA #5 and #6 said they provide incontinence care to residents on the floor in the morning and then again in the afternoon. CNA #5 said the staff on the floor know the residents well on the floor and can predict when they go to the bathroom so there is no need to check for incontinence. CNA #5 said she did not provide care to Resident #110 while the surveyor was off the unit. CNA #5 said Resident #110 requires maximal assistance from staff for toileting and is incontinent of both bladder and bowel. CNA #5 said she provided care to Resident #110 and assisted him/her back to lunch after bed. CNA #5 said she did not provide incontinent care to the Resident when she placed him/her back in bed and she was waiting until after she completed her afternoon paperwork. During interviews on 3/5/25 at 2:03 P.M., and 3/7/25 at 1:22 P.M., Nurse #1 said all residents should be checked for incontinence and have incontinent care provided to them every 2-3 hours. Nurse #1 said there is not enough staff on the floor for the acuity of the residents and because of this people are often left soaking with incontinence because staff cannot get to the residents on time. Nurse #1 said residents are cared for in the morning and then are often not cared for again until the afternoon when the next shift comes in. Nurse #1 said she and the other staff do not have enough time to complete rounds on residents. During an interview on 3/7/24 at approximately 1:00 P.M., the Administrator said not providing services or care to residents when needed is considered neglect. During an interview on 3/7/25 at 1:58 P.M., the Director of Nursing (DON) said residents who are incontinent should be changed every 2-3 hours. The DON said he would have to defer to the Administrator's definition of neglect and would not answer if not providing care could be considered neglect. 2b.) Resident #106 was admitted to the facility in March 2018 with diagnoses including dementia. Review of Resident #106's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated the Resident scored 3 out of a possible 15 on the Brief Interview for Mental Status exam, indicating he/she has severe cognitive impairment. Section H of the MDS also indicated the Resident is always incontinent of bladder and bowel and is dependent on staff for toileting tasks. On 3/5/25 at 9:00 A.M., Resident #106 was observed sitting on the couch in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 12:00 P.M. Throughout this time Resident #106 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. On 3/7/25 at 8:05 A.M., Resident #106 was observed lying on the couch in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 11:57 A.M. Throughout this time Resident #106 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. At 1:12 P.M., the surveyor returned to the unit and Resident #106 was observed still sitting on the couch. Review of Resident #106's most recent Norton Pressure Ulcer assessment dated [DATE], indicated the Resident has urinal incontinence and is a moderate risk for pressure ulcer development. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #106's ADL care plan indicated the following intervention: -(The Resident) needs assistance of one with bathing, dressing, grooming (needs extra encouragement for hygiene), locomotion, transfers, and toileting. (The Resident) can eat independently with set up of a tray. (He/she) is incontinent of both bowel and bladder. Review of Resident #106's incontinence care plan, failed to indicate an intervention of a toileting schedule or how often the Resident should be checked/changed. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said the unit is very short staffed, and because of this it takes a long time to provide care to residents and ensure that all the care is being completed. During an interview on 3/7/25 at 1:12 P.M., CNA #5 and #6 said they provide incontinence care to residents on the floor in the morning and then again in the afternoon. CNA #5 said the staff on the floor know the residents well on the floor and can predict when they go to the bathroom so there is no need to check for incontinence. CNA #6 said she did not provide care to Resident #106 while the surveyor was off the unit. CNA #6 said Resident #106 requires maximal assistance from staff for toileting and is incontinent of both bladder and bowel. CNA #6 said she provided care to Resident #106 and will be providing care to the Resident again. On 3/7/25 at 1:22 P.M., CNA #5 transferred Resident #106 from the couch to a wheelchair. When Resident #106 stood, a strong odor similar to urine was observed by the surveyor. CNA #5 then assisted the Resident to the bathroom to provide care. Once care was provided, CNA #5 showed the surveyor Resident #106's brief that had just been removed. The brief was soiled with a significant amount of urine. During interviews on 3/5/25 at 2:03 P.M., and 3/7/25 at 1:22 P.M., Nurse #1 said all residents should be checked for incontinence and have incontinent care provided to them every 2-3 hours. Nurse #1 said there is not enough staff on the floor for the acuity of the residents and because of this people are often left soaking with incontinence because staff cannot get to the residents on time. Nurse #1 said residents are cared for in the morning and then are often not cared for again until the afternoon when the next shift comes in. Nurse #1 said she and the other staff do not have enough time to complete rounds on residents. During an interview on 3/7/24 at approximately 1:00 P.M., the Administrator said not providing services or care to residents when needed is considered neglect. During an interview on 3/7/25 at 1:58 P.M., the Director of Nursing (DON) said residents who are incontinent should be changed every 2-3 hours. The DON said he would have to defer to the Administrator's definition of neglect and would not answer if not providing care could be considered neglect. 2c.) Resident #130 was admitted to the facility in December 2020 with diagnoses including Alzheimer's Disease. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #130's most recent Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the Resident was unable to complete the Brief Interview for Mental Status exam and staff had assessed him/her to have severe cognitive impairment. Section H of the MDS also indicated the Resident is always incontinent of bladder and bowel and is dependent on staff for toileting tasks. On 3/5/25 at 9:00 A.M., Resident #130 was observed reclined in his/her reclining Broda chair in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 12:00 P.M. Throughout this time Resident #130 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. On 3/7/25, Resident #130 was observed in the dining room from 10:26 A.M. until 11:57 A.M. Throughout this time Resident #106 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. At 1:12 P.M., the surveyor returned to the unit and Resident #130 was observed still reclined in the dining room. Review of Resident #130's most recent Norton Pressure Ulcer assessment dated [DATE], indicated the Resident has both bladder and bowel incontinence and is a high risk for pressure ulcer development. Review of Resident #130's ADL care plan indicated the following intervention: -(The Resident) needs dependent care of 1-2 for all of (his/her) ADLs. Review of Resident #130's incontinence care plan, failed to indicate an intervention of a toileting schedule or how often the Resident should be checked/changed. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said the unit is very short staffed, and because of this it takes a long time to provide care to residents and ensure that all the care is being completed. During an interview on 3/07/25 at 1:12 P.M., CNA #5 and #6 said they provide incontinence care to residents on the floor in the morning and then again in the afternoon. CNA #5 said the staff on the floor know the residents well on the floor and can predict when they go to the bathroom so there is no need to check for incontinence. CNA #5 said Resident #130 is dependent on staff for all care, including toiling and that the Resident is incontinent of both bladder and bowel. CNA #5 said she did not provide care to Resident #130 while the surveyor was off the unit. CNA #5 said she provided care to Resident #130 this morning and because the Resident did not get up from bed until after breakfast, he/she would not receive care again until the afternoon staff starts their shift. During interviews on 3/5/25 at 2:03 P.M., and 3/7/25 at 1:22 P.M., Nurse #1 said all residents should be checked for incontinence and have incontinent care provided to them every 2-3 hours. Nurse #1 said there is not enough staff on the floor for the acuity of the residents and because of this people are often left soaking with incontinence because staff cannot get to the residents on time. Nurse #1 said residents are cared for in the morning and then are often not cared for again until the afternoon when the next shift comes in. Nurse #2 said she and the other staff do not have enough time to complete rounds on residents. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/7/24 at approximately 1:00 P.M., the Administrator said not providing services or care to residents when needed is considered neglect. During an interview on 3/7/25 at 1:58 P.M., the Director of Nursing (DON) said residents who are incontinent should be changed every 2-3 hours. The DON said he would have to defer to the Administrator's definition of neglect and would not answer if not providing care could be considered neglect. Refer to F686 and F725.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 41456 Based on observations, record review and interviews, the facility failed to ensure one Resident (#130) was free from restraints, out of a total sample of 40 residents. Findings include: Review of the facility policy titled, Use of Restraints, dated April 2022, indicated the following: - Restraints should only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried successfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline of staff convenience, or for the prevention of falls. - Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts the freedom of movement or restricts normal access to one's body. - The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove the device in the same manner in which the staff applied it given that resident's physical condition and this restricts his/her typical ability to change position place, that device may be considered a restraint. - Prior to placing a resident in restraints, there shall be a pre restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. - Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. Resident #130 was admitted to the facility in December 2020 with diagnoses including Alzheimer's Disease. Review of Resident #130's most recent Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the Resident was unable to complete the Brief Interview for Mental Status exam and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #130 was dependent on staff for all care. On 3/4/25 at 9:04 A.M., Resident #130 was observed lying in bed, leaning to the left side of the bed and his/her head was against the side rail. A pillow was observed under his/her right arm. The bed was slanted to the left and approximately 5 inches from the radiator/wall and not in the center of his/her side of the room. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 7:03 A.M., Resident #130 was observed lying in bed. Pillows were placed between the Resident's legs and under his/her right arm. A pillow was also observed under the fitted sheet of the bed on his/her left side. The pillow was not touching the Resident. The Resident's bed was slanted to the left (same side as the pillow) and was approximately 5 inches from the radiator/wall and not in the center of his/her side of the room. Review of Resident #130's care plan for pain indicated the following intervention: - Assist resident to a position of comfort, utilizing pillows and appropriate positioning devices. The record failed to indicate a restraint assessment had been completed or that a Physician's order was in place for the use of a restraint. During an interview on 3/5/25 at 7:05 A.M., Nurse #1 said Resident #130 wiggles around in bed a lot and the nursing assistants put the pillow on the edge of the bed to prevent the Resident from rolling around and rolling out of bed. Nurse #1 did not say the pillow was being used for comfort. Nurse #1 did not know why the bed was so close to the wall. During an interview on 3/5/25 at 7:07 A.M., Unit Manager #1 said she was unsure why the pillow was placed under the fitted sheet and removed it. Unit Manager #1 did not say the pillow was being used for comfort. Unit Manager #1 also said she was unsure why the bed was so close to the wall as it should be in the center of the space and straight. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said Resident #130 slides a lot in bed and the staff have to use pillows to make sure he/she doesn't slide out of bed. During interviews on 3/5/25 at 1:32 P.M., and 3/6/25 at 9:31 A.M., the Director of Nursing (DON) said a restraint is any device added to a person that would limit their movement. The DON said he would have had to see the bed that close to the wall or a pillow in place to know if it was a restraint. When discussing the use of pillows for comfort, the DON could not answer how the pillow could have been used as a positioning device if it was not touching the Resident and under a fitted sheet.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record reviews and interviews, the facility failed to accurately code the Minimum Data Set (MDS) Assessment for two Residents (#130 and #36) out of a total sample of 42 residents. Specifically, 1.) For Resident #130, the facility failed to accurately code that the Resident had bilateral upper and lower extremity contractures. 2.) For Resident #36, the facility failed to accurately code that the Resident sustained a fall. 1.) Resident #130 was admitted to the facility in December 2020 with diagnoses including Alzheimer's Disease. Review of Resident #130's most recent Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the Resident was unable to complete the Brief Interview for Mental Status exam and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #130 was dependent on staff for all care. On 3/4/25 at 9:04 A.M., Resident #130 was observed lying in bed with bilateral upper and lower extremity contractures. Review of section GG of the MDS failed to indicate Resident #130 had bilateral upper and lower extremity contractures. During an interview on 3/11/25 at 10:49 A.M., the Director of Rehabilitation said Resident #130 has had bilateral upper and lower extremity contractures for over a year. During an interview on 3/12/25 at 8:16 A.M., the MDS Nurse said the MDS was inaccurate, and Resident #130 has bilateral upper and lower contractures. 48990 2.) Resident #36 was admitted to the facility in January 2024 with diagnoses including anemia and age related cognitive decline. Review of Resident #36's Minimum Data Set (MDS) assessment, dated 7/24/24, failed to indicate the Resident had any falls since the previous MDS (5/1/24). Review of Resident #36's nursing progress note, dated 7/8/24, indicated: - Patient fell out of his/her bed, while bed was in low position, he/she was found between the two beds in his/her room. Review of Resident #36's facility incident report, dated 7/8/24, indicated: (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Unwitnessed Fall: Nursing Description: About 6:30pm, Resident was found laying down on the floor in his/her room in between the two beds. During an interview on 3/5/25 at 3:50 P.M., The MDS Nurse reviewed Resident #36's medical record and said the MDS, dated [DATE], was inaccurate. The MDS Nurse said according to Resident Assessment Instrument (RAI) guidelines, the Resident's fall on 7/8/24 should have been captured on the 7/24/25 quarterly assessment but was not. During an interview on 3/11/25 at 9:15 A.M., the Director of Nursing (DON) said all MDS's should be coded according to RAI guidelines.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50338 Based on observation, record review, and interviews, the facility failed to ensure care and services are provided according to accepted standards of clinical practice for two Residents (#143 and #117) out of a total sample of 42 residents. Specifically: 1.) For Resident #143, the facility failed to obtain daily weights as indicated in physician's orders. 2.) For Resident #117, the facility failed to obtain a physician's order for the use of an air mattress. Findings include: Review of the facility policy titled 'Weight Management', dated April 2022, indicated the purpose is to monitor the Resident's weight from time of admission and to provide interdisciplinary support and/or intervention to avert adverse trends. Review of the facility policy titled 'Preventative Pressure Ulcer', date April 2022, indicated the purpose is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. - Supports surfaces and pressure redistribution: select appropriate support surfaces based on the Resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. 1.) Resident #143 was admitted to the facility in January 2025 with diagnoses that include diabetes, and congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/7/25, indicated that Resident #143 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. The MDS indicated Resident #143 had a diagnosis of congestive heart failure. Review of Resident #143's physician's orders, dated 1/20/25, indicated daily weights. Notify MD (Medical Doctor/Nurse Practitioner) for weight over 2lb (pounds) or more within 1-2 days. One time a day for Congestive Heart Failure (CHF). Review of the weights portal in the electronic medical record (EMR) indicated the following weights: - 2/12/25 156.2 Lbs. - 2/13/25 156.0 Lbs. - 2/14/25 157.0 Lbs. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/16/25 157.0 Lbs. - 2/17/25 157.0 Lbs. - 2/20/25-2/27/25 Medical leave of absence (MLOA) - 2/28/25 158.9 Lbs. - 3/3/25 158.0 Lbs. - 3/6/25 158.0 Lbs. Review of Resident #143's Medication Administration Record (MAR) indicated: - 3/1/25 coded as 7 (sleeping). - 3/2/25 no entry. - 3/3/25 coded as 7 (sleeping). - 3/4/25 no entry. - 3/5/25 coded as 2 (refused). - 3/6/25 158.0 Lbs. - 3/7/25 coded as 2 (refused). Review of Resident #143's nursing progress notes failed to indicate that MD had been notified that the Resident was not weighed 3/1/25 through 3/5/25 and 3/7/25. During an interview on 3/7/25 at 7:47 A.M., Nurse #5 said that daily weights should be completed at 6:30 A. M. every day as indicated in the physician's orders. She said that if a resident refuses to be weighed it should be documented and physician should be notified. During an interview on 3/7/25 at 7:54 A.M., Unit Manager #3 said if unable to obtain weight on scheduled shift, then would try to obtain on next shift and if he/she still refused, would notify the physician. During an interview on 3/10/25 at 10:25 A.M., the Director of Nurses (DON) said that he would expect that nurses are following physician's orders as it is the standard of practice. 2.) Resident #117 was admitted to the facility in June 2024 with diagnoses including acute transverse myelitis in demyelinating disease (an inflammatory condition that damages the myelin sheath, the protective covering of nerve fibers in the spinal cord) of central nervous system, paraplegia and diabetes. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 2/20/25, indicated that Resident #117 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS further indicated that Resident #117 was dependent for bed mobility and had a stage 3 pressure ulcer. Review of Resident #117's physician's orders, dated 3/6/25, failed to indicate an order for an air mattress to his/her bed. Review of Resident #117's active plan of care failed to include the interventions of an air mattress to his/her bed. On 3/7/25 at 8:22 A.M., Unit Manager #4 and the surveyor observed Resident #117 on an air mattress in his/her bed. During an interview on 1/10/25 at 9:04 A.M., Unit Manager #4 said she would expect a Resident with an air mattress to have a physician's order so the appropriate setting for Resident's mobility and weight could be monitored. During an interview on 3/10/25 at 10:25 A.M., the Director of Nursing said he would expect a Resident with an air mattress to have a physician's order.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 48990 Based on interviews and record review, the facility failed to provide necessary treatment and services to maintain activities of daily living for one Resident (#138) out of a total sample of 42 residents. Specifically, the facility failed to address and provide therapy services for a decline Resident #138's ability to self-feed from set-up assistance to total dependence. Findings include: Review of facility policy titled 'Rehabilitation Services', dated April 2022, indicated: - Physical/Occupational therapy services are part of a constellation of rehabilitative services designed to improve or restore functionality following disease, injury, or loss of a body part. - Impairments, functional limitations, and disabilities thus identified are then addressed by the design and implementation of a therapeutic intervention tailored to the specific needs of the individual Resident. - The goal for a Resident is to return to the highest level of function realistically attainable and within the context of the disability. Resident #138 was admitted to the facility in June 2024 with diagnoses including functional urinary incontinence and dementia. During a telephone interview on 3/6/25 at 9:07 A.M., Resident #138's health care proxy said before Resident #138 went to the hospital on 10/2/24 he/she was able to feed himself/herself. Resident #138's health care proxy said since he/she returned from the hospital on 10/24/25 he/she was totally dependent on staff to feed him/her. Resident #138's health care proxy said the facility did not want to provide any therapy services and she had to fight for physical therapy, but they never addressed his/her ability to self-feed. Review of Resident #138's medical record indicated he/she was discharged to the hospital on 10/2/24 for diarrhea and altered mental status found to have Clostridium difficile (a bacterium that causes diarrhea and inflammation of the colon). Review of quarterly Minimum Data Set (MDS) assessment prior to discharge to hospital, dated 9/11/24, indicated Resident #138 was able to feed himself/herself after set-up. Review of discharge Minimum Data Set (MDS) assessment, dated 10/2/24, indicated Resident #138 was able to feed himself/herself after set-up. Review of Resident #138's report titled 'Documentation Survey Report' (a report including certified nursing (CNA) documentation), dated 10/24/24 to 10/2/24, indicated the Resident was usually able to feed himself/herself after set-up. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #138's hospital discharge summary, dated 10/24/24, indicated: - Goals of care: Goal was for patient to return to LTC (long term care) eating on his/her own. Review of Resident #138's nursing progress note, dated 10/30/24, indicated: - Significant change identified by IDT (interdisciplinary team) today due to decline in ADL (activities of daily living) and mobility function, decline in cognition and increase assistance with decision making. Review of Resident #138's speech therapy evaluation, dated 10/30/24, indicated an evaluation for dysphagia (difficulty swallowing) and: - Prior level of function: Self Feeding = Did not test. - Clinical Bedside Assessment of Swallowing: Self Feeding: TD (typical development) (Patient is unable to participate in less than 25% of the activity or is unable to initiate, participate, or perform any part of the activity. Staff provides 100% assistance.) Further review of this speech therapy evaluation failed to indicate speech therapist made referrals to assess Resident's decline in self-feeding or rationale for why referral was not made. Review of Significant Change in Status Minimum Data Set (MDS) assessment, dated 11/6/24, indicated Resident #138 was dependent on staff to feed him/her. Review of Resident #138's medical record indicated he/she was discharged to the hospital on 11/8/24 for hypoxia, more somnolence, and decreased level of alertness and poor po (by mouth) intake. Review of medical record from 10/24/24 to 11/8/24 failed to indicate any assessment or intervention for decline in self-feeding or rationale for why referral was not made. Review of Resident #138's report titled 'Documentation Survey Report', dated 11/1/24 to 11/8/24, indicated the Resident was usually dependent of staff to feed him/her. Review of Resident #138's medical record indicated he/she was readmitted to the facility 11/12/24. Review of Resident #138's speech therapy evaluation, dated 2/5/25, indicated: - Prior Level of Function: Self Feeding: TD (typical development) (Patient is unable to participate in less than 25% of the activity or is unable to initiate, participate, or perform any part of the activity. Staff provides 100% assistance.) - Clinical Bedside Assessment of Swallowing: Self Feeding: TD (Patient is unable to participate in less than 25% of the activity or is unable to initiate, participate, or perform any part of the activity. Staff provides 100% assistance.) Review of the most recent Minimum Data Set (MDS) assessment, dated 1/29/25, indicated Resident #138 was dependent of staff on staff to feed him/her. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #138's report titled 'Documentation Survey Report', dated 2/26/2 to 3/4/25, indicated the Resident was usually dependent of staff to feed him/her. Review of medical record from 11/12/24 to 3/4/25 failed to indicate any assessment or intervention for decline in self-feeding or rationale for why referral was not made. During an interview on 3/6/25 at 9:35 A.M., Unit Manager #2 said she was hired at the facility after Resident #138's October hospitalization , and she never knew his/her cognitive/functional status prior to that hospitalization . Unit Manager #2 said since that hospitalization he/she was dependent on staff for eating, but she believed that was his/her baseline. During a telephone interview on 3/7/25 at 6:29 A.M., Certified Nurse's Assistant (CNA) #7 said she had known Resident #138 since he/she was admitted in June 2024. CNA #7 said before his/her October 2024 hospitalization he/she was able to feed himself/herself. CNA #7 said when he/she returned from the hospital he/she lost the ability to self-feed and became dependent on staff for assistance to eat. During an interview on 3/7/15 at 11:16 A.M., the Director of Rehab (DOR) said he was never notified that Resident #138 had a decline in self-feeding. The DOR said they never received a referral for treatment for self-feeding, so the self-feeding decline was not evaluated. The DOR conflictingly said since he/she required supervision with meals for dysphagia and nursing was providing the assist anyway, it was decided to not pursue self-feeding. The DOR said Resident #138 did not have a quarterly screen for self-feeding between 10/24/24 to 2/27/25 because he/she was on caseload for physical therapy (which did not evaluate or treat self-feeding). The DOR said Resident #138 was never seen by any therapy discipline to address a decline in self-feeding. The DOR said he would expect any rationale for not evaluating or treating a decline self-feeding to be documented. The DOR was unable to locate any documentation regarding this. During an interview on 3/10/25 at 10:12 A.M., the Director of Nursing (DON) said he would expect therapy to evaluate a decline in self-feeding and document in the medical record. During a telephone interview on 3/11/25 at 7:53 AM, Speech Therapist (ST) #1 said the ST who evaluated Resident #138 on 10/30/24 no longer worked for the facility, but that she was unaware of any referrals ever made for a decline in self-feeding. ST #1 said if the ST felt any resident could benefit from another discipline, such as occupational therapy for self-feeding, a referral should be made and documented in the record. ST #1 said she personally evaluated Resident #138 on 2/4/25 and felt he might have gotten better at feeding himself, but did not make a referral to occupational therapy because the Resident needed to have supervision by staff with meals anyway and was being assisted by staff with meals. Refer to F758.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 41456 Based on observations, record review and interview, the facility failed to provide assistance with activities of daily living (ADLs) for five Residents (#110, #106, #130, #148, and #87) out of a total sample of 42 residents. Specifically, the facility failed to: 1.) Provide incontinence care for Residents #110, #106, and #130; 2.) Provide showers for Residents #106 and #148; and 3.) Provide assistance with self-feeding for Resident #87. Findings include: Review of the facility policy titled, Activities of Daily Living Support, revised April 2022, indicated the following: - Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out their activities of daily living (ADLs). - Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. - Residents will be provided with care, treatment and services to ensure that their activities of daily living do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. - Appropriate care and services will be provided for residents who are unable to carry out their ADL's independently, with the consent of the resident and in coordination with the plan of care, including appropriate support and assistance with: - a. Hygiene (bathing, dressing, grooming, and oral care); - c. Elimination (toileting) - d. dining (meals and snacks) - If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care period approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate. 1a.) Resident #110 was admitted to the facility in April 2022 with diagnoses including dementia. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #110's most recent Minimum Data Set (MDS) assessment, dated 1/9/25, indicated the Resident scored a 0 out of a possible 15 on the Brief Interview for Mental Status exam, indicating he/she has severe cognitive impairment. The MDS further indicated Resident #110 requires substantial assistance for toilet transfers and is dependent on staff for toileting tasks. Section H of the MDS indicated Resident #110 is always incontinent of both bowel and bladder. On 3/5/25 at 9:00 A.M., Resident #110 was observed sitting in his/her wheelchair in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 12:00 P.M. Throughout this time Resident #110 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. On 3/7/25 at 8:05 A.M., Resident #110 was observed sitting in his/her wheelchair in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 11:57 A.M. Throughout this time Resident #110 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. At 1:12 P.M., the surveyor returned to the unit and Resident #110 was observed lying in bed. Review of Resident #110's most recent Norton Pressure Ulcer assessment, dated 1/8/25, indicated the Resident has double incontinence and is a high risk for pressure ulcer development. Review of Resident #110's ADL care plan indicated the following intervention: - Provide resident/patient with limited assist of 1 for toileting after meals and as needed. Review of Resident #110's incontinence care plan failed to indicate an intervention of a toileting schedule or how often the Resident should be checked/changed. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said the unit is very short staffed, and because of this it takes a long time to provide care to residents and ensure that all the care is being completed. During an interview on 3/7/25 at 1:12 P.M., CNA #5 and #6 said they provide incontinence care to residents on the floor in the morning and then again in the afternoon. CNA #5 said the staff on the floor know the residents well on the floor and can predict when they go to the bathroom so there is no need to check for incontinence. CNA #5 said she did not provide care to Resident #110 while the surveyor was off the unit. CNA #5 said Resident #110 requires maximal assistance from staff for toileting and is incontinent of both bladder and bowel. CNA #5 said she provided care to Resident #110 and assisted him/her back to lunch after bed. CNA #5 said she did not provide incontinent care to the Resident when she placed him/her back in bed and she was waiting until after she completed her afternoon paperwork (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 3/5/25 at 2:03 P.M., and 3/7/25 at 1:22 P.M., Nurse #1 said all residents should be checked for incontinence and have incontinent care provided to them every 2-3 hours. Nurse #1 said there is not enough staff on the floor for the acuity of the residents and because of this people are often left soaking with incontinence because staff cannot get to the residents on time. Nurse #1 said residents are cared for in the morning and then are often not cared for again until the afternoon when the next shift comes in. Nurse #1 said she and the other staff do not have enough time to complete rounds on residents. During an interview on 3/7/25 at 1:58 P.M., the Director of Nursing said residents who are incontinent should be changed every 2-3 hours. The DON said this is something that is expected and told to nursing staff during their orientation process. 1b.) Resident #106 was admitted to the facility in March 2018 with diagnoses including dementia. Review of Resident #106's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status exam, indicating he/she has severe cognitive impairment. Section H of the MDS indicated the Resident is always incontinent of bladder and bowel and is dependent on staff for toileting tasks. On 3/5/25 at 9:00 A.M., Resident #106 was observed sitting on the couch in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 12:00 P.M. Throughout this time Resident #106 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. On 3/7/25 at 8:05 A.M., Resident #106 was observed lying on the couch in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 11:57 A.M. Throughout this time Resident #106 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. At 1:12 P.M., the surveyor returned to the unit and Resident #106 was observed still sitting on the couch. Review of Resident #106's most recent Norton Pressure Ulcer assessment, dated 2/5/25, indicated the Resident has urinal incontinence and is a moderate risk for pressure ulcer development. Review of Resident #106's ADL care plan indicated the following intervention: - (The Resident) needs assistance of one with bathing, dressing, grooming (needs extra encouragement for hygiene), locomotion, transfers, and toileting. (The Resident) can eat independently with set up of a tray. (He/she) is incontinent of both bowel and bladder. Review of Resident #106's incontinence care plan failed to indicate an intervention of a toileting schedule or how often the Resident should be checked/changed. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said the unit is very short staffed, and because of this it takes a long time to provide care to residents and ensure that all the care is being completed. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/07/25 at 1:12 P.M., CNA #5 and #6 said they provide incontinence care to residents on the floor in the morning and then again in the afternoon. CNA #5 said the staff on the floor know the residents well on the floor and can predict when they go to the bathroom so there is no need to check for incontinence. CNA #6 said she did not provide care to Resident #106 while the surveyor was off the unit. CNA #6 said Resident #106 requires maximal assistance from staff for toileting and is incontinent of both bladder and bowel. CNA #6 said she provided care to Resident #106 and will be providing care to the Resident again. On 3/7/25 at 1:22 CNA #5 transferred Resident #106 from the couch to a wheelchair. When Resident #106 stood, a strong odor similar to urine was observed by the surveyor. CNA #5 then assisted the Resident to the bathroom to provide care. Once care was provided, CNA #5 showed the surveyor Resident #106's brief that had just been removed. The brief was soiled with a significant amount of urine. During an interviews on 3/5/25 at 2:03 P.M., and 3/7/25 at 1:22 P.M., Nurse #1 said all residents should be checked for incontinence and have incontinent care provided to them every 2-3 hours. Nurse #1 said there is not enough staff on the floor for the acuity of the residents and because of this people are often left soaking with incontinence because staff cannot get to the residents on time. Nurse #1 said residents are cared for in the morning and then are often not cared for again until the afternoon when the next shift comes in. Nurse #1 said she and the other staff do not have enough time to complete rounds on residents. During an interview on 3/7/25 at 1:58 P.M., the Director of Nursing said residents who are incontinent should be changed every 2-3 hours. The DON said this is something that is expected and told to nursing staff during their orientation process. 1c.) Resident #130 was admitted to the facility in December 2020 with diagnoses including Alzheimer's Disease. Review of Resident #130's most recent Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the Resident was unable to complete the Brief Interview for Mental Status exam and staff had assessed him/her to have severe cognitive impairment. Section H of the MDS indicated the Resident is always incontinent of bladder and bowel and is dependent on staff for toileting tasks. On 3/5/25 at 9:00 A.M., Resident #130 was observed reclined in his/her reclining Broda chair in the dining room. The Resident was observed sitting in the dining room from 9:00 A.M. until 12:00 P.M. Throughout this time Resident #130 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. On 3/7/25, Resident #130 was observed in the dining room from 10:26 A.M. until 11:57 A.M. Throughout this time Resident #106 was not observed to have either of the two nursing assistants or the nurse working on the floor approach the Resident to check for incontinence or to provide care. At 1:12 P.M., the surveyor returned to the unit and Resident #130 was observed still reclined in the dining room. Review of Resident #130's most recent Norton Pressure Ulcer assessment, dated 12/18/25, indicated the Resident has both bladder and bowel incontinence and is a high risk for pressure ulcer development. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #130's ADL care plan indicated the following intervention: - (The Resident) needs dependent care of 1-2 for all of (his/her) ADLs. Review of Resident #130's incontinence care plan, failed to indicate an intervention of a toileting schedule or how often the Resident should be checked/changed. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said the unit is very short staffed, and because of this it takes a long time to provide care to residents and ensure that all the care is being completed. During an interview on 3/07/25 at 1:12 P.M., CNA #5 and #6 said they provide incontinence care to residents on the floor in the morning and then again in the afternoon. CNA #5 said the staff on the floor know the residents well on the floor and can predict when they go to the bathroom so there is no need to check for incontinence. CNA #5 said Resident #130 is dependent on staff for all care, including toiling and that the Resident is incontinent of both bladder and bowel. CNA #5 said she did not provide care to Resident #130 while the surveyor was off the unit. CNA #5 said she provided care to Resident #130 this morning and because the Resident did not get up from bed until after breakfast, he/she would not receive care again until the afternoon staff starts their shift. During interviews on 3/5/25 at 2:03 P.M., and 3/7/25 at 1:22 P.M., Nurse #1 said all residents should be checked for incontinence and have incontinent care provided to them every 2-3 hours. Nurse #1 said there is not enough staff on the floor for the acuity of the residents and because of this people are often left soaking with incontinence because staff cannot get to the residents on time. Nurse #1 said residents are cared for in the morning and then are often not cared for again until the afternoon when the next shift comes in. Nurse #1 said she and the other staff do not have enough time to complete rounds on residents. During an interview on 3/7/25 at 1:58 P.M., the Director of Nursing said residents who are incontinent should be changed every 2-3 hours. The DON said this is something that is expected and told to nursing staff during their orientation process. 2.) Review of the resident group monthly meeting notes from November 2024 to January 2025 indicated the residents of the facility have been complaining about not being offered showers consistently and feel showers are not occurring as often as they should. 2a.) Resident #148 was admitted to the facility April 2022 with diagnoses including Alzheimer's Disease. Review of Resident #148's most recent Minimum Data Set (MDS) assessment, dated 1/23/25, indicated the Resident scored a 2 out of a possible 15 on the Brief Interview for Mental Status exam, indicating he/she had severe cognitive impairment. The MDS further indicated Resident #148 was dependent on staff for all functional daily tasks. On 3/04/25 at 9:59 A.M., Resident #148 was observed lying in bed with significant dry skin build-up on his/her face and scalp. The Resident was able to say he/she was not in pain but was unable to answer any questions about ADL care. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #148's ADL care plan indicated the following: - Focus: (The Resident) requires extensive to dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Chronic disease/condition: End stage dementia with limited mobility. Further review of Resident #148's care plans indicated a care plan for resistance to care, however, the care plan failed to indicate the Resident refuses showers. Review of the shower schedule indicated Resident #148 is scheduled for showers on Wednesdays and Sundays. Review of the Documentation Survey Report (a report indicating all ADL care provided) for the months of October 2024, November 2024, December 2024, January 2025, February 2025 and March 2025 failed to indicate Resident #106 has been provided a shower in the past six months. Review of the medical record failed to indicate Resident #148 has refused a shower if offered. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said residents are scheduled to have at least two showers a week. CNA #4 said she is always able to provide showers to residents but not all staff do because the floor is very busy and has a lot of dependent residents so showers cannot be completed. During an interview on 3/11/25 at 9:19 A.M., Unit Manager #1 said showers should be given twice a week to all residents and if a resident refuses, the refusal should be documented by the nursing assistants and nurses. Unit Manager #1 said she believes Resident #148 was given a shower last week but is unable to say why there is no documentation of it. During an interview on 3/11/25 at 9:41 A.M., the Director of Nursing (DON) said showers are provided twice a week or as needed. The DON said nursing has to document the refusal of care. 2b.) Resident #106 was admitted to the facility in March 2018 with diagnoses including dementia. Review of Resident #106's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated the Resident scored 3 out of a possible 15 on the Brief Interview for Mental Status exam, indicating he/she has severe cognitive impairment. Section H of the MDS also indicated the Resident is always incontinent of bladder and bowel and is dependent on staff for toileting tasks. On 3/4/25 at 9:51 A.M., Resident #106 was observed sitting on the couch in the dining room. The Resident has significantly greasy hair with white flakes similar to dandruff. The Resident was unable to be interviewed. Review of Resident #106's ADL care plan indicated the following intervention: - (The Resident) needs assistance of one with bathing, dressing, grooming (needs extra encouragement for hygiene), locomotion, transfers, and toileting. (The Resident) can eat independently with set up of a tray. (He/she) is incontinent of both bowel and bladder. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower list indicated Resident #106 is scheduled for showers on Tuesdays and Saturdays. Review of the Documentation Survey Report (a report indicating all ADL care provided) for the months of January 2025, February 2025 and March 2025 failed to indicate Resident #106 has been provided a shower in the past three months. Review of the medical record failed to indicate Resident #106 has refused a shower if offered. During an interview on 3/5/25 at 1:48 P.M., Certified Nursing Assistant (CNA) #4 said residents are scheduled to have at least two showers a week. CNA #4 said she is always able to provide showers to residents but not all staff do because the floor is very busy and has a lot of dependent residents so showers cannot be completed. During an interview on 3/11/25 at 9:19 A.M., Unit Manager #1 said showers should be given twice a week to all residents and if a resident refuses, the refusal should be documented by the nursing assistants and nurses. Unit Manager #1 said she was unable to recall the last time Resident #106 was provided with a shower. During an interview on 3/11/25 at 9:41 A.M., the Director of Nursing (DON) said showers are provided twice a week or as needed. The DON said nursing has to document the refusal of care. 45763 3.) Resident #87 was admitted to the facility in December 2020 and had diagnoses of dementia, need for assistance with personal care and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 2/19/25, indicated that Resident #87 scored a 3 out of a possible 15 on the Brief Interview for Mental Status exam, indicating the Resident had severe cognitive impairment. The MDS further indicated the Resident required substantial/maximal assistance with eating. Review of Resident #87's activity of daily living care plan indicated the following intervention: -Resident #87 is dependent for bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, toileting related to generalized weakness, dementia with cognitive loss. Mod (moderate) assist with eating. Dressed in bed for dignity. Position with assist of 2 in bed, initiated 12/2/21. Review of Resident #87's comprehensive nutritional evaluation, dated 2/17/25, indicated Resident #87 required total feeding assistance at mealtimes. Review of Resident #87's most recent occupational therapy (OT) discharge summary, dated 3/5/25, indicated the Resident required modx1 (moderate, one staff) assistance with eating. On 3/4/25 at 8:55 A.M., the surveyor observed Resident #87 in bed in his/her room, the Resident's breakfast tray was in front of the Resident and there were no staff or family members in the room or within eyesight of the Resident. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at 9:03 A.M., the surveyor observed Resident #87 in bed in his/her room, the Resident's breakfast tray was in front of the Resident, there was milk spilled on the Residents tray and there were no staff or family members in the room or within eyesight of the Resident. On 3/5/25 at 12:13 P.M., the surveyor observed Resident #87 in bed in his/her room, the Resident was eating lunch and coughing; there were no staff or family members in the room or within eyesight of the Resident. During an interview on 3/6/25 at 5:48 P.M., Nurse #6 said care plans for eating should be followed and that Resident #87 required feeding assistance with meals. Nurse #6 said that the Resident's son provided feeding assistance when he visited but that staff should provide feeding assistance when the son was not visiting; Nurse #6 said he would expect a staff member to be in the Resident's room throughout the entire meal period if the Resident was being fed by staff. During an interview on 3/6/25 at 5:58 P.M., Resident #87's son said the Resident needed to be fed due to his/her Alzheimer's disease and that he would expect staff to assist with feeding as the Resident can't do too much. During an interview on 3/6/25 at 6:15 P.M., the Registered Dietitian (RD) said Resident #87 required total feeding assistance due to dementia and mobility issues. The RD said she would expect a staff to be with the Resident during the entire meal period. During an interview on 3/6/25 at 6:50 P.M., the Director of Rehabilitation (DOR) said he would expect staff to be with Resident #87 throughout the entire meal period due to the Resident's cognitive fluctuation. During an interview on 3/6/25 at 7:30 P.M., the Director of Nursing (DON) said he would expect staff to provide the level of assistance outlined in the care plan and recommended by rehabilitation services.		

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to provide an activity program for four Residents (#106, #110, #130 and #148) out of a total sample of 42 residents. Findings include: 1.) Resident #106 was admitted to the facility in March 2018 with diagnoses including dementia. Review of Resident #106's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated the Resident scored 3 out of a possible 15 on the Brief Interview for Mental Status exam, indicating he/she has severe cognitive impairment. The MDS further indicated Resident #106 is always incontinent of bladder and bowel and is dependent on staff for care. Review of Section F on the MDS indicated that staff assessed Resident #106's activity preferences and listed his/her activities of preference are listening to music, being around animals such as pets, keeping up with the news, reading magazines, books and newspapers, doing things with groups of people, participating in group activities and spending time outdoors. On 3/5/25 the following was observed: - At 9:26 A.M., the activity assistant came to the unit and put music on. She was not observed entering resident rooms to the common area were to begin. Resident #106 was already in the common area sitting on the couch. - At 9:30 A.M., the activity calendar had sorting and sequencing as the activity. This did not occur. The activity assistant began a basketball activity. Resident #106 was given one opportunity to roll the basketball into the hoop. - At 9:39 A.M., the activity assistant started a picture game where residents needed to find the missing item in the picture. Resident #106 was not able to participate in this activity. The activity assistant never approached the Resident to offer extra support or provide individual activity materials. - At 10:07 A.M., the activity assistant again put music on and began singing. From 10:07 A.M. until 10:43 A.M., the activity assistant sang music while looking at the lyrics on her phone and did not interact with Resident #106. The Resident was lying down on the couch throughout this time and was in and out of sleep. - At 10:43 A.M., a second activity assistant came to the floor and the first activity assistant left. From 10:43 A.M. until the unit prepared for lunch at 12:00 P.M., the activity assistant sat at a table in the common area with three residents while Resident #106 remained on the couch. Throughout this time, the activity assistant did not attempt to engage Resident #106 in the conversation/coloring activity or provide individual activity materials to him/her. - The activity calendar lists emotion posters for 11:15 A.M. This activity did not occur. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #106 was observed not moving from the couch from 8:00 A.M. to 12:00 P.M. On 3/7/25, the following was observed: - At 9:27 A.M., the activity assistant came to the unit and put music on. She was not observed entering resident rooms to the common area were to begin. Resident #106 was already in the common area sitting on the couch. - The 9:30 A.M. activity listed on the activity calendar was morning stretches. The activity assistant began exercising without explaining the activity to the residents in the room. Resident #106 continued to sit on the couch without exercising and the activity assistant did not approach the Resident to get him/her to engage in the activity. - At 9:45 A.M., the activity assistant began balloon toss without explanation. The activity assistant tossed the balloon to Resident #106 and the balloon bounce off his/her head. - At 10:35 A.M., Resident #106 was given a brief hand massage. - At 11:00 A.M., the activity assistant put on music and began singing. The Residents in the room were not engaged in the song, did not have any individual activity materials in front of them and Resident #106 was observed to be sleeping on the couch. - At 11:30 A.M., a second activity assistant began a coloring activity. Resident #106 was not provided with any activity or coloring materials. - Resident #106 was observed not moving from the couch from 8:00 A.M. to 11:57 A.M. Review of Resident #106's activity care plan indicated the following interventions: - I (the Resident) would benefit from accommodation for cognitive limitations by using demonstrations, reminders, one-to-one settings, small groups, and/or verbal prompts. - I (the Resident) like to use a computer, do crossword/sudoku, listen to classical music, look out the window, lay down/rest, meditate, read on the computer, reading Machinal engineering system, and/or [NAME], spending time by myself in my bedroom, or common spaces. - Compliment (the Resident) for activity participation. - Provide 1:1 (one-on-one) visits that incorporate (the Resident's) past interest: active games (i.e. tennis, soccer, exercising), surfing the web together - looking at machinal engineer systems, listening/watching classical music, watching a soccer/tennis/rowing program, play trivia games, also include sensory therapy, active games/exercise during 1:1 visits. Respect (his/her) right to refuse. - I would benefit from accommodation for hearing loss by using placement near the speaker/leader, and/or written instructions/gestures. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 3/10/25 at 10:58 A.M., and 1:24 P.M., the Activity Director said she develops the activity calendar based on all cognitive levels and ensures activities range from high and low functioning activities. The Activity Director said she expects the calendar to be followed as written. The Activity Director said low level activities are typically done on the units and include activities such as sensory activities, reminiscing, nails, massage, sorting, and music. The Activity Director said the activity assistants should also be completing one-on-one visits and attempting to invite all residents to the activities. The Activity Director said the activity assistant on Resident #106's unit does not seem to be a good fit for the unit and she may not know how to organize activities for residents with a lower cognitive ability and she should be attempting to engage Resident #106 in all activities. The Activity Director said the facility could do a better job with activities on that unit. 2.) Resident #110 was admitted to the facility in April 2022 with diagnoses including dementia. Review of Resident #110's most recent Minimum Data Set, dated dated dated [DATE], indicated the Resident scored a 0 out of a possible 15 on the Brief Interview for Mental Status, which indicated he/she has severe cognitive impairment. The MDS also indicated the Resident requires substantial assistance for toilet transfers and is dependent on staff for toileting tasks. Review of Section F on the MDS indicated that staff assessed Resident #110's activity preferences and listed his/her activities of preference are reading books, magazines and newspapers, listening to music, being around animals such as pets, keeping up with the news, being in groups of people, participating in favorite activities, spending time outdoors and religious activities. On 3/5/25 the following was observed: - At 9:26 A.M., the activity assistant came to the unit and put music on. She was not observed entering resident rooms to the common area were to begin. Resident #110 was already in the common area sitting in his/her wheelchair. - At 9:30 A.M., the activity calendar had sorting and sequencing as the activity. This did not occur. The activity assistant began a basketball activity. Resident #110 was given one opportunity to roll the basketball into the hoop and was unable to complete this task. The Activity assistant never returned to the Resident for another opportunity to participate. - At 9:39 A.M., the activity assistant started a picture game where residents needed to find the missing item in the picture. Resident #110 was not able to participate in this activity and eventually fell asleep. The activity assistant never attempted to engage the Resident or provide him/her with individual activity materials. - At 10:07 A.M., the activity assistant again put music on and began singing. From 10:07 A.M. until 10:43 A.M., the activity assistant sang music while looking at the lyrics on her phone and did not interact with Resident #110. The Resident was sleeping in his/her wheelchair. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 10:43 A.M., a second activity assistant came to the floor and the first activity assistant left. From 10:43 A. M. until the unit prepared for lunch at 12:00 P.M., the activity assistant sat at a table in the common area with three residents while Resident #110 remained in his/her wheelchair not engaged. Throughout this time, the activity assistant did not attempt to engage Resident #110 in the conversation/coloring activity or provide individual activity materials to him/her. - The activity calendar lists emotion posters for 11:15 A.M. This activity did not occur. On 3/7/25, the following was observed: - At 9:27 A.M., the activity assistant came to the unit and put music on. She was not observed entering resident rooms to the common area were to begin. Resident #110 was already in the common area sitting in his/her wheelchair. - The 9:30 A.M. activity listed on the activity calendar was morning stretches. The activity assistant began exercising without explaining the activity to the residents in the room. Resident #110 continued to sit in his/her wheelchair without exercising and the activity assistant did not approach the Resident to get him/her to engage in the activity. - At 9:45 A.M., the activity assistant began balloon toss without explanation. The activity assistant tossed the balloon to Resident #110 and he/she was not able to hit the balloon back. - At 10:35 A.M., the activity assistant was providing hand massages. Resident #110 was sleeping and she did not attempt to wake the Resident to give him/her a hand massage. - At 11:00 A.M., the activity assistant put on music and began singing. The Residents in the room were not engaged in the song, did not have any individual activity materials in front of them and Resident #110 was observed to be sleeping. - At 11:30 A.M., a second activity assistant began a coloring activity. Resident #110 was sitting close to the table but was not provided with coloring materials. Review of Resident #110's activity care plan indicated the following interventions: - Compliment (the Resident's) participation and efforts. - Gently attempt to use cueing, demonstration, and/or redirect (the Resident) attention as necessary with (the Resident's) tolerance to remain on task. - Give (the Resident) time to respond, providing simple, clear directions for task with (the Resident's) abilities, giving (the Resident) time to process/respond. - Recreation staff will encourage (the Resident) in activity preferences: Religious services, outdoor programs, bingo, pokeno, musical programs, card games, active games, veteran clubs and movies. Respect (his/her) right to refuse. - Repeat instructions and demonstrate actions on a one-to one basis within group program. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #110's most recent activities assessment, dated 1/8/25, indicated the following: - Resident #110 has had a slight decline over the past year and requires more cueing, re-direction and demonstration for active participation. - Resident #110's favorite activities are: playing cards, watching boxing programs and sports programs, touch sensory, active games, spending time outside in good weather, playing mini bingo/table games with staff support, arts and crafts, musical programs, religious services, men's club, sporting programs, and watching movies. - The interventions/approaches for Resident #110 are: giving him/her time to respond, providing simple ,clear directions for task within his/her abilities, and giving him/her time to process/respond. During interviews on 3/10/25 at 10:58 A.M., and 1:24 P.M., the Activity Director said she develops the activity calendar based on all cognitive levels and ensures activities range from high and low functioning activities. The Activity Director said she expects the calendar to be followed as written. The Activity Director said low level activities are typically done on the units and include activities such as sensory activities, reminiscing, nails, massage, sorting, and music. The Activity Director said the activity assistants should also be completing one-on-one visits and attempting to invite all residents to the activities. The Activity Director said the activity assistant on Resident #110's unit does not seem to be a good fit for the unit and she may not know how to organize activities for residents with a lower cognitive ability and she should be attempting to engage Resident #110 in all activities. The Activity Director said the facility could do a better job with activities on that unit. 3.) Resident #130 was admitted to the facility in December 2020 with diagnoses including Alzheimer's Disease. Review of Resident #130's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #130 was dependent on staff for all care. Review of Section F on the MDS, dated [DATE], indicated that staff assessed Resident #130's activity preferences and listed his/her activities of preference are listening to music, being around animals such as pets, keeping up with the news, being in groups of people, participating in favorite activities, spending time outdoors and religious activities. On 3/5/25 the following was observed: - At 9:26 A.M., the activity assistant came to the unit and put music on. She was not observed entering resident rooms to the common area were to begin. Resident #130 was already in the common area reclined in a Broda chair. The Resident was observed to have bilateral UE (upper extremity) contractions of elbows and shoulders. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 9:30 A.M., the activity calendar had sorting and sequencing as the activity. This did not occur. The activity assistant began a basketball activity. Resident #130 was not approached to participate and was positioned at the side of the room, not with the other residents who the activity assistant was engaging with. - At 9:39 A.M., the activity assistant started a picture game where residents needed to find the missing item in the picture. Resident #130 was not approached to participate and was positioned at the side of the room, not with the other residents who the activity assistant was engaging with. Resident #130 was given a sensory mat that he/she would be unable to use due to contractures, and the mat was placed on the table a foot away from him/her. - At 10:07 A.M., the activity assistant again put music on and began singing. From 10:07 A.M. until 10:43 A.M., the activity assistant sang music while looking at the lyrics on her phone and did not interact with Resident #130. - At 10:43 A.M., a second activity assistant came to the floor and the first activity assistant left. From 10:43 A.M. until the unit prepared for lunch at 12:00 P.M., the activity assistant sat at a table in the common area with three residents while Resident #130 remained removed from the group. - The activity calendar lists emotion posters for 11:15 A.M. This activity did not occur. On 3/7/25, the following was observed: - At 9:27 A.M., the activity assistant came to the unit and put music on. She was not observed entering resident rooms to the common area were to begin. Resident #130 was still in his/her room and the surveyor did not observe the activity assistant enter the Resident's room to see if he/she could attend the activity. - At 10:35 A.M., the activity assistant was providing hand massages. Resident #130 was reclined in his/her Broda chair and the activity assistant was not observed approaching the Resident to provide a hand massage. - At 11:00 A.M., the activity assistant put on music and began singing. The Residents in the room were not engaged in the song, did not have any individual activity materials in front of them and Resident #130 was observed to be sleeping. - At 11:30 A.M., a second activity assistant began a coloring activity. Resident #130 was brought closer to the table by the activity assistant, however she did not provide any one-on-one activities to the Resident. Review of Resident #130's activity care plan indicated the following: - Focus: needs one-to-one recreation interventions to help promote sensory, mental and social stimulation - Goal: will make eye contact, follow 1-step directions during one-to-one recreation sensory therapy, physical programs, and social stimulation 3-5 times per week. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Interventions: encourage (the Resident) participation in one-to-one recreation visits 3-5 times per week of (the Resident's) preference of: musical programs, exercising, and socialization, reading (mysteries), pet therapy (dogs and/or cats), praying together, sensory therapy. Respect (his/her) right to refuse. - Offer gentle, hand-over-hand guidance for sensory and physical stimulation. - Provide demonstration, verbal cueing, 1-step direction and giving (the Resident) time to respond to stimuli. Review of Resident #130's most recent activity assessment, dated 12/19/24, indicated the following: - Resident #130's favorite activities are 1:1 visits for sensory, physical stimulation and companionship. - Activity staff should be providing 1:1 visits, providing hand-over-hand guidance, cueing/re-directions, demonstration and 1 step directions. - Resident #130 may have changes in facial expressions at times and can be passive at times. During interviews on 3/10/25 at 10:58 A.M., and 1:24 P.M., the Activity Director said she develops the activity calendar based on all cognitive levels and ensures activities range from high and low functioning activities. The Activity Director said she expects the calendar to be followed as written. The Activity Director said low level activities are typically done on the units and include activities such as sensory activities, reminiscing, nails, massage, sorting, and music. The Activity Director said the activity assistants should also be completing one-on-one visits and attempting to invite all residents to the activities. The Activity Director said the activity assistant on Resident #130's unit does not seem to be a good fit for the unit and she may not know how to organize activities for residents with a lower cognitive ability and she should be attempting to engage Resident #130 in all activities. The Activity Director said the facility could do a better job with activities on that unit. 4.) Resident #148 was admitted to the facility April 2022 with diagnoses including Alzheimer's Disease. Review of Resident #148's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #148 was dependent on staff for all functional daily tasks. Review of Section F on the MDS indicated that Resident #148's activity preferences are to listen to music, be around animals such as pets, do favorite activities, get fresh air when the weather is good, and participate in religious activities. Throughout all days of survey, Resident #148 was always observed in bed and the television was never on and no music was ever playing in his/her room. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/24 from 9:27 A.M. to 12:00 P.M., two activity assistants were observed on Resident #148's unit. At no point was either assistant observed entering Resident #148's room to provide a one-on-one visit. On 3/7/25 from 9:30 A.M., to 11:57 A.M., two activity assistants were observed on Resident #148's unit. At no point was either assistant observed entering Resident #148's room to provide a one-on-one visit. Review of Resident #148's activity care plan indicated the following: - Focus: (the Resident) seems to need bed-side sensory/activity stimulation secondary to late-stage terminal diagnosis of Alzheimer's Disease. - Keep stimulation within optimal levels for (the Resident's) tolerance. - Provide hand-over-hand guidance for sensory stimulation within (the Resident's) tolerance level. - Provide one-on-one contacts based on (the Resident's) individual preference: play Italian music, provide sensory stimulation, review (his/her) life story to (him/her). - Re-direct (the Resident's) attention to recreation program, via demonstration, cueing/demonstration, simple single step activity cueing, hand-over-hand guidance, giving (the Resident) time to process and respond. Review of Resident #148's most recent activity assessment, dated 1/23/25, indicated the following: - Resident #148 continues to be responsive to 1:1 activity visits 3 times per week and will make brief eye contact, use verbalization, and may have changes in facial expression. During interviews on 3/10/25 at 10:58 A.M., and 1:24 P.M., the Activity Director said she develops the activity calendar based on all cognitive levels and ensures activities range from high and low functioning activities. The Activity Director said she expects the calendar to be followed as written. The Activity Director said low level activities are typically done on the units and include activities such as sensory activities, reminiscing, nails, massage, sorting, and music. The Activity Director said the activity assistants should also be completing one-on-one visits and attempting to invite all residents to the activities. The Activity Director said the activity assistant on Resident #148's unit does not seem to be a good fit for the unit and she may not know how to organize activities for residents with a lower cognitive ability and she should be attempting to engage Resident #148 in one-on-one bedside sensory activities. The Activity Director said the facility could do a better job with activities on that unit.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - 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** 45763 Based on observation, record review and interview the facility failed to ensure that three Residents (#70, #629, and #130) out of a total sample of 42 residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically: 1. For Resident #70, the facility failed to a) initiate a treatment for a genital wound which subsequently became infected and deteriorated and b) failed to implement the wound Nurse Practitioner's (NP) recommendation for a change in wound treatment. 2. For Resident #629, the facility failed to obtain an antibiotic medication from the pharmacy in a timely manner, resulting in a worsening skin infection. 3. For Resident #130, the facility failed to complete weekly documentation of skin conditions. Findings Include: 1a.) Resident #70 was admitted to the facility in October 2022 with a diagnosis of diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/30/24, indicated that Resident #70 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating the Resident was cognitively intact. Review of Resident #70's activities of daily living (ADL) care plan indicated the Resident was at risk for decreased ability to performs ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to weakness. Interventions in the care plan included: -Provide resident/patient with total assist of 1 for personal hygiene (grooming), initiated 10/18/22. Review of Resident #70's most recent [NAME] plus pressure ulcer scale, dated 12/30/24, indicated the Resident was at high risk for developing pressure injuries. Review of Resident #70's hospital discharge paperwork, dated 12/29/24 indicated Resident #70 was hospitalized from 12/26/24 to 12/29/24. Further review of the hospital paperwork indicated the Resident had a genital lesion, that the Resident had first noticed the lesion in his/her nursing facility after his/her most recent admission (13 days earlier) and that the Resident associated the lesion with a cut he/she experienced from his/her urinary catheter. Further review of the hospital paperwork indicated that the hospital assessed the genital wound on 12/28/24, described the wound as scabbed and were cleansing the wound with soap and water. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of NP #2's progress note dated 12/31/24 indicated Resident #70 returned to the facility from the hospital on 12/29/24 and that the Resident's hospitalization was complicated by a genital lesion. Further review of NP #2's progress note indicated the Resident had a small genital lesion most likely related to pressure from a urinary catheter. Review of the physician note, dated 1/2/25, indicated Resident #70 had a history of foley trauma of his/her urethra with a cut which was slow healing. Review of a nursing progress note, dated 1/8/25, indicated that therapy reported blood dripping from Resident #70's genitals. Review of a nursing note, dated 1/13/25, indicated that the nurse had reported a small pressure area on Resident #70's genitals to the NP. Review of the incident report titled new pressure ulcer, dated 1/13/25, indicated Resident #70 had an area on his/her genitals which was previously seen by the NP and documented as pressure due to the Foley catheter; the wound was noted with slough. Review of NP #2's progress note, dated 1/14/25 indicated Resident #70 had a small ulcer on his/her genitals that was tender and draining purulent discharge. Further review of NP #2's progress note indicated that the lesion appeared bigger than previously observed with a recommendation to continue to clean the lesion daily with NS (normal saline). Review of a nursing progress note, dated 1/14/25, indicated that Resident #70 was started on an antibiotic by the NP for infection. Review of a nursing progress note, dated 1/15/25, indicated Resident #70 was started on an antibiotic due to a pressure area on his/her genitals. Review of NP #2's progress note, dated 1/21/25, indicated Resident #70's genital lesion improved after treatment with antibiotics but remains open with yellow slough with a plan to wash the wound daily with NS. Review of Resident #70's physician orders indicated the following order: Genitals: Cleanse wound area with NS pad dry twice daily, initiated 1/20/25. Genitals: Monitor for bleeding until the end of the month, if bleeding continue, will refer PT (patient) to urology. Notify NP/MD (medical doctor) for excessive bleeding, initiated 1/8/25 Further review of Resident #70's physician orders indicated that the order for cleansing the wound area with NS was initiated 20 days after the facility became aware of Resident #70's genital wound and an order to monitor for genital bleeding was initiated eight days after the facility became aware of Resident #70's genital wound. Review of Resident #70's Medication Administration Records and Treatment Administration Records (MAR/TAR) failed to indicate that the Residents genital wound was being cleansed with normal saline until 1/21/25, 21 days after the facility became aware of Resident #70's genital wound. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the wound NP's progress note, dated 1/21/25, indicated Resident #70 had a traumatic wound on his/her genitals measuring 3 x 2.5 x 0.6 cm (centimeters) with 60% soft tissue and 40% slough. Further review of the progress note indicated a recommendation for the following treatment: Wash with wound cleanser, pat dry, medihoney to slough, cover with collagen wafer and ABD (a gauze pad). Prompt peri care and frequent repositioning. Keep area dry. During an interview on 3/6/25 at 12:28 P.M., Nurse # 7 said when a resident had a wound, nursing would notify the provider who would either ask nursing what kind of treatment they think would be appropriate for the wound or would place a treatment order themselves. Nurse #7 said she would expect a treatment to be in place for all wounds. Nurse #7 said Resident #70 had a laceration on his/her genitals. During interviews on 3/6/25 at 3:51 P.M., and 3/7/25 at 8:40 A.M. and 11:48 A.M. NP #2 said all wounds should have treatments in place. NP #2 said that if a treatment was not implemented that it would put the resident at high risk for wound infection. NP #2 said Resident #70 had a wound on his/her genitals which developed from a urinary catheter. NP #2 said she had first noticed that the Resident had an open wound on his/her genitals when she assessed the Resident on 12/31/24 after his/her re-admission from the hospital. NP #2 said she would have expected an order for cleansing the wound with normal saline to have been initiated when the Resident was readmitted from the hospital on 12/29/24. NP #2 said that on 1/14/25 she was concerned the Resident's wound was infected because it was draining pus, white exudate, was red and macerated so she started the resident on antibiotics; NP #2 said that Resident #70's genital wound looked worse on 1/14/25 than it did on 12/31/24. NP #2 said she assessed the Resident again on 1/21/25 and the wound had no pus but was still open and had slough. During an interview on 3/7/25 at 2:17 P.M. the wound NP said she would have expected that someone started a treatment plan before she was consulted to assess Resident #70's genital wound on 1/21/25 as the wound could deteriorate without a treatment and/or become infected. The wound NP said that on 12/31/24 she had noticed that Resident #70 had a small open wound on his/her genitals while she was assessing a different wound in proximity of the genital wound and that the other wound had since resolved. The wound NP said she wasn't consulted to assess the Resident's genital wound until 1/21/25, but would have expected a treatment to cleanse the wound with NS to have been initiated on 12/31/24 and that she had failed to document her observation of the newer genital wound in her 12/31/24 assessment in error. During an interview on 3/6/25 at 5:06 P.M. Unit Manager #4 said she would have expected a treatment order to be in place for Resident #70's genital wound when he/she first returned from the hospital in December 2024. 1b.) Review of the wound NP's progress note, dated 2/25/25, indicated Resident #70's traumatic genital wound had increased in measurement and that the Resident reported the wound was tender to the touch. Further review of the progress note indicated the genital wound measured 6 x 3.5 x 0.6 cm. with 100% soft tissue with the following recommended treatment: Wash with wound cleanser, pat dry, collagen powder to wound and leave OTA (open to air). Keep wound clean and dry Qday (every day)/PRN (and as needed). (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/6/25 at 12:28 P.M., Nurse # 7 said the wound NP saw Resident #7 and that they received the wound NP's report on 2/26/25. Nurse #7 said she was not sure if there were new recommendations but if there were she would expect them to be implemented right away. Review of Resident #70's physician orders indicated the wound NP's recommended treatment was not implemented until 3/6/25, 8 days after the facility received the recommendation and after the surveyor brought the concern to the attention of the facility. During an interview on 3/6/25 at 3:51 P.M. NP #2 said the wound NP comes in on a weekly basis and that she would expect wound NP recommendations to be implemented within 24 hours of the facility receiving them. NP #2 said she was not aware of any new recommendations to change Resident #70's genital wound treatment. During an interview on 3/7/25 at 2:17 P.M. the wound NP said she comes in once a week and that her notes with recommendations were emailed to the facility by the next day; the wound NP said she would expect her recommendations to be implemented as soon as the facility received them. The wound NP said that Resident #70's gauze pad was getting moist, gross and wadded so she recommended to change the treatment to leave the wound open to air to reduce moisture accumulation on 2/25/25. The wound NP said she was unaware that her most recent recommendation was not implemented until 3/6/25. During an interview on 3/6/25 at 5:06 P.M. Unit Manager # 4 said the wound NP's recommendation was implemented today and that if a wound retains too much moisture that it could make the wound worse; UM #4 said the recommendation should have been implemented earlier. During an interview on 3/6/25 at 7:30 P.M., the Director of Nursing (DON) said he would expect an order for a wound treatment and that he would expect wound NP recommendations to be implemented. 41019 2.) For Resident #629, the facility failed to obtain an antibiotic medication from the pharmacy in a timely manner, resulting in a worsening skin infection. Resident #629 was admitted in July 2024 with diagnoses including type 2 diabetes and peripheral vascular disease. Review of the Minimum Data Set (MDS) assessment, dated 7/31/24, indicated Resident #629 scored a 13 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. During an interview on 3/7/25 at 8:40 A.M., Nurse Practitioner #1 said that she had concerns regarding communication between the facility and the providers. Nurse Practitioner #1 said that she ordered an antibiotic for Resident #629 due to an infection. She said that she was not notified timely by the facility that the order flagged an allergy alert that required her to address, and that therefore the antibiotic was not sent. Nurse Practitioner #1 said that following this incident she filed a safety report with the facility because the infection worsened and the Resident had increased pain because of the delay. Review of the nurse progress note, dated 8/17/24, indicated the following: (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Spoke to on call NP regarding changes to skin tear to R shin. Noted skin around tear is red, warm to the touch, and mildly painful to the patient. Redness continues throughout the front of the patient's shin. Bilateral swelling, which is baseline for patient noted to both legs. R leg noted to be significantly warmer to the left . New orders for Keflex 500 mg TID x 5 days. Override to penicillin allergy. Order to follow up with MD/NP on Monday 8/19/24. Review of the progress note, dated 8/18/24, indicated Keflex Oral Capsule 500 mg - Pharmacy notified. Unable to pull from Medwhiz. (the facility's contracted pharmacy). Review of the progress note, dated 8/19/24, indicated Keflex Oral Capsule 500 mg- Awaiting clarification for pharmacy to send. The record failed to indicate the Physician or Nurse Practitioner were notified that the facility was unable to obtain the medication on 8/17/24, 8/18/24 or 8/19/24. Review of the Medication Administration Record (MAR) for August 2024 indicated that on 8/18/24 and 8/19/24, Resident #629 did not receive the Keflex of 500 mg. During an interview on 3/10/25 at 11:37 P.M., the Director of Nursing said if there is a delay with a pharmacy then the nurses should notify the provider and then the provider would determine the course of action. The Director of Nursing said that they should also let him know if they are missing a medication because he keeps backup medications in the emergency kit. The Director of Nursing said that all of the actions should be documented in the progress notes, but were not. 41456 3.) Resident #130 was admitted to the facility in December 2020 with diagnoses including Alzheimer's Disease. Review of Resident #130's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #130 was dependent on staff for all care. On 3/04/25 at 9:02 A.M., Resident #130 was observed lying in bed with the sheets lifted to expose both legs. The Resident was observed to have black scabs on bilateral knees. Review of Resident #130's physician orders indicated the following orders: - Right buttocks area, cleanse with NS (normal saline). Pat dry and apply xeroform dressing. Cover with DPD dressing every day and pm (night), initiated on 2/7/25. - Check skin daily and report if skin irritation is notes, in the evening for skin breakdown, initiated 1/10/25. Review of Resident #130's nursing notes from 2/7/25 to present failed to indicate skin impairment on the right buttocks requiring the above stated order. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #130's Treatment Administration Record (TAR) failed to indicate the nursing documented any skin irritation or abnormalities per the order. Review of Resident #130's weekly skin assessments, dated 2/17/25, 2/20/25, 2/22/25 and 3/1/25, failed to indicate the right buttock area or the bilateral knee scabs were observed and documented. During an interview on 3/6/25 at 7:39 A.M., Unit Manager #1 said all skin impairments should be included on the weekly skin assessments. Unit Manager #1 said she was unsure if Resident #130 had a skin impairment on his/her buttocks, however said if there was an impairment this should be included on the skin assessment. Unit Manager #1 then entered the Resident's room and observed the two black scabs on the Resident's bilateral knees and also observed a reddened small opened area on the Resident's buttock. Nurse #1 then entered Resident #130's room, observed the two scabs and buttocks and said these areas have been present for a couple of weeks. Both Nurse #1 and Unit Manager #1 said all three of these skin impairments should have been documented on the past skin assessments. During an interview on 3/6/25 at 9:31 A.M., the Director of Nursing said all skin impairments should be documented on the weekly skin assessment, with descriptions of the impairment included.		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observations, interviews and record review, the facility failed to provide necessary treatment, services, and/or interventions to promote healing and prevent new ulcers from developing for four Residents (#138, #30, #167, and #143), who had pressure ulcers, out of 42 total sampled residents. Specifically, 1a.) For Resident #138, the facility failed to implement multiple wound care orders timely, resulting in the deterioration of the wound. 1b.) For Resident #138, the facility failed to ensure staff provided prompt incontinence care and was repositioned every two hours for pressure ulcer care, resulting in the deterioration of the wound. 1c.) For Resident #138, the facility failed to ensure staff implemented an appropriate support surface based on it's therapeutic benefit for the Resident's specific situation when the Resident, who had multiple worsening pressure ulcers and difficulty communicating needs, utilized an air mattress without specified settings. 2a.) For Resident #30, the facility failed to ensure wound care orders were implemented at the correct frequency. 2b.) For Resident #30, the facility failed to ensure staff implemented an appropriate support surface based on it's therapeutic benefit for the Resident's specific situation when the Resident, who had multiple pressure ulcers and incontinence, utilized an air mattress without specified settings. 3.) For Resident #167, the facility failed to ensure wound care recommendations were implemented timely. 4.) For Resident # 143, the facility failed to obtain physician orders for the use of a support surface (air mattress/overlay). Findings include: 1.) Resident #138 was admitted to the facility in June 2024 with diagnoses including functional urinary incontinence and dementia. Resident #138 did not have any pressure ulcers on admission to the facility. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/29/25, indicated Resident #138 had severe cognitive impairment based on a Staff Assessment for Mental Status. This MDS also indicated Resident #138 had a stage three pressure ulcer, required substantial/maximal assistance to roll in bed, and was dependent on staff for toileting hygiene and transfers. During a telephone interview on 3/6/25 at 9:07 A.M., Resident #138's health care proxy said she was concerned that the Resident was not receiving the wound care he/she needs because his/her wounds kept worsening. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #138's medical record indicated he/she had been transferred to the hospital on 3/4/25 for deteriorating coccyx wound with increased size, drainage, and foul smell. 1a.) Review of Resident #138's assessment titled 'Skin Observation Tool', dated 10/25/24, indicated the Resident did not have any pressure ulcers on 10/25/24. Review of Resident #138's Wound Nurse Practitioner progress note, dated 10/29/24, indicated initial exams for two new wounds including: - Initial exam: left buttock pressure ulcer, stage 1. - Initial exam: MASD (moisture associated skin damage) coccyx. - Treatment recommendation for left buttock pressure ulcer and MASD coccyx: Wash with soap and water, pat dry. Apply zinc paste to bilateral buttocks and coccyx QD (every day) and PRN (as needed). Review of Resident #138's physician orders indicated: - Wash with soap and water, pat dry, then apply zinc oxide paste to BL (bilateral) buttocks and coccyx QD and PRN, initiated 10/31/24, which was two days after recommendation was made. Review of Resident #138's treatment administration record (TAR), dated October 2024, failed to indicate any treatment for the Resident's left buttock pressure ulcer or MASD on coccyx on 10/29/24 or 10/30/24. This TAR further indicated that on 10/31/24 the treatment order to Wash with soap and water, pat dry, then apply zinc oxide paste to BL (bilateral) buttocks and coccyx QD and PRN was not marked as implemented, but instead not documented by the nurse. This wound order was not implemented until 11/1/24, which was three days after it was recommended. Review of Resident #138's Wound Nurse Practitioner progress note, dated 11/5/24, indicated: - Deteriorating left buttock pressure ulcer, unstageable. - MASD to coccyx was reclassified as an unstageable pressure ulcer. - Deteriorating pressure ulcer coccyx, unstageable. - New stage three right buttock pressure ulcer. - Treatment recommendation for left buttock pressure ulcer and unstageable coccyx pressure ulcer: Wash with wound cleanser, pat dry. Skin prep to peri skin. Santyl to open area, cover with collagen and sacral dressing, QD and PRN. - Treatment recommendation for right buttock pressure ulcer: Wash with wound cleanser, pat dry, skin prep to peri skin, collagen into open area, cover with sacral dressing, QD and PRN. Review of Resident #138's physician orders indicated: (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- Rt (Right) Buttock: Wash with wound cleanser, pat dry, skin prep to peri skin, collagen into area, cover with sacral dressing QD/PRN, initiated 11/8/24. This wound order was not implemented until three days after the recommendation was made. - Left buttock/coccyx: Wash with wound cleanser, pat dry, skin prep to peri skin. Santyl to open area, cover with collagen and sacral dressing QD and PRN with peri care, initiated 11/8/24. This wound order was not implemented until three days after the recommendation was made. Review of Resident #138's Wound Nurse Practitioner progress note, dated 12/10/24, indicated: - Deteriorating coccyx pressure ulcer which increased in size. - Treatment recommendation for unstageable coccyx pressure ulcer: Wash with wound cleanser, pat dry. Skin prep to peri skin. Collagen with silver to wound bed, cover with sacral dressing QD/PRN/with peri care. Review of Resident #138's physician orders indicated: - Wash with wound cleanser, pat dry, skin prep to peri skin. Collagen with silver to wound bed. Cover with sacral dressing QD/PRN and with peri care, initiated 12/17/24. This wound order was not implemented until seven days after the recommendation was made. Review of Resident #138's medication administration record (MAR) indicated santyl ointment was applied to his/her coccyx wound from 12/10/24 to 12/18/24, which was eight days after santyl was no longer recommended by the Wound Nurse Practitioner. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 12/17/24, indicated: - Coccyx pressure wound reclassified to a stage three and increased in size. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 2/11/25, indicated: - Pressure ulcer to coccyx is deteriorating this week. - Treatment recommendation for stage three coccyx pressure ulcer: Wash with wound cleanser, pat dry. Skin prep to peri skin. Santyl to slough. Collagen to open area and cover with sacral dressing QD/PRN/with peri care. Review of Resident #138's physician orders indicated: - Pressure coccyx wound: Wash with WC (wound cleanser), pat dry, skin prep to peri skin. Santyl to slough, collagen to open area and cover with sacral dressing QD/PRN with peri care, initiated 2/14/25. This wound order was not implemented until three days after the recommendation was made. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #138's nursing progress note, dated 2/12/25, indicated: - Pressure ulcer to coccyx deteriorating this week. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 2/18/25, indicated: - Deteriorating coccyx pressure ulcer which increased in size. - New stage two right buttock pressure ulcer. - Treatment recommendation for stage three coccyx pressure ulcer and stage two right buttock pressure ulcer: Wash with wound cleanser, pat dry. Skin prep to peri skin. Santyl to slough. Collagen to open area and cover with sacral dressing QD/PRN/with peri care. Review of Resident #138's physician orders indicated: - Pressure coccyx wound: Wash with WC (wound cleanser), pat dry, skin prep to peri skin. Santyl to slough, collagen to open area and cover with sacral dressing QD/PRN with peri care, initiated 2/14/25. - No wound treatment order was implemented for the Resident's new stage two right buttock pressure ulcer until 3/4/25. This wound order was not implemented until 14 days after the recommendation was made. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 2/25/25, indicated: - Treatment recommendation for stage three coccyx pressure ulcer and stage two right buttock pressure ulcer: Wash with wound cleanser, pat dry. Skin prep to peri skin. Collagen to open area and cover with sacral dressing QD/PRN/with peri care. Review of Resident #138's physician orders indicated the stage three coccyx pressure ulcer treatment recommendation was never implemented prior to the next scheduled weekly Wound Nurse Practitioner's visit on 3/4/25 during which wound deterioration was noted. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 3/4/25, indicated: - Deteriorating coccyx pressure ulcer. - New left buttock maceration. - Stable right buttock stage two pressure ulcer. Review of Resident #138's nursing progress note, dated 3/4/25, indicated: - Coccyx wound in deteriorating, foul smell noted, with increased size and drainage. NP (nurse practitioner) orders to send patient for ED (emergency department) evaluation. Review of Resident #138's hospitalist progress note, dated 3/7/25, indicated: (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- No definite sacral osteomyelitis, but the MRI is not adequate for evaluation due to significant motion artifact. - Recommendations for wound care include to change positions regularly. During an interview on 3/7/25 at 1:19 P.M., Unit Manager #2 said she usually completes the weekly wound rounds with the Wound Nurse Practitioner. Unit Manager #2 said the Wound Nurse Practitioner verbally communicates wound treatment changes before she leaves the floor. Unit Manager #2 said the Wound Nurse Practitioner always sends the written progress note with the treatment recommendations the next day, and the latest the facility receives it is the next day. Unit Manager #2 said the treatment recommendations should be communicated to the Resident's provider when the recommendation is received and implemented or documented why it was not. Unit Manager #2 said Wound NP treatment recommendations should be addressed and implemented the day they are received. During an interview on 3/7/25 at 2:49 P.M., the Wound Nurse Practitioner (NP) said she always tells the nurse or unit manager if there are any wound treatment recommendations before she leaves the facility. The Wound NP said she always sends the written progress note with the treatment recommendations the next day. The Wound NP said she expects the treatment recommendation to be implemented or addressed prior to the next scheduled dressing change. The Wound NP said not implementing Resident #138's wound treatment recommendations timely could cause the wound to deteriorate. The Wound NP said santyl is a debriding agent that can damage healthy tissue and applying it when no longer indicated could cause a wound to deteriorate. During an interview on 3/10/25 at 10:11 A.M., the Director of Nursing (DON) and the Regional Nurse Consultant declined to comment on what was an acceptable time frame for Wound NP treatment recommendations to be addressed/implemented. 1b.) Review of the facility policy titled 'Preventative Pressure Ulcer', revised April 2022, indicated: - Prevention: Moisture: Keep skin clean and free of exposure to urine and fecal matter. - Prevention: Mobility/Repositioning: At least every two hours, reposition residents who are reclining and dependent of staff for repositioning. During a telephone interview on 3/6/25 at 9:07 A.M., Resident #138's health care proxy said she does not believe he/she is repositioned every two hours or is receiving incontinence care timely and that it's caused his/her pressure ulcers to worsen. Resident #138's health care proxy said she believed this was related to the facility not having enough staff. Review of Resident #138's plan of care related to actual alteration in skin integrity, initiated 11/7/24, indicated: - Turn and reposition every 2-3 hours every shift. Review of Resident #138's plan of care related incontinence of bladder, initiated 6/4/24, indicated: (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- Check twice a shift and as needed for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Review of Resident #138's report titled 'Documentation Survey Report' (a report including certified nursing (CNA) documentation), dated 10/24/24 to 3/4/25, indicated the Resident was always incontinent and always required staff assistance for repositioning. Review of Resident #138's assessment titled 'Skin Observation Tool', dated 10/25/24, indicated the Resident did not have any pressure ulcers on 10/25/24. Review of Resident #138's Wound Nurse Practitioner progress note, dated 10/29/24, indicated initial exams for two new wounds including: - Initial exam: left buttock pressure ulcer, stage 1. - Initial exam: MASD (moisture associated skin damage) coccyx. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 10/29/24, 11/5/24, 11/19/24, 11/26/24, 12/3/24, 12/10/24, 12/17/24, 12/27/24, 12/31/24, 1/7/25, 1/14/25, 1/21/25, 1/28/25, 2/4/25, 2/11/25, 2/18/25, 2/25/25, and 3/4/25, indicated: - Treatment recommendations for left buttock pressure ulcer and MASD coccyx include prompt peri care and frequent repositioning. Review of Resident #138's Wound Nurse Practitioner progress note, dated 11/5/24, indicated: - Deteriorating left buttock pressure ulcer, unstageable. - MASD to coccyx was reclassified as an unstageable pressure ulcer. - Deteriorating pressure ulcer coccyx, unstageable. - New stage three right buttock pressure ulcer. During a review of Resident #138's 'Documentation Survey Report' from time between new wound was noted and when the wound deteriorated, dated 10/30/24 to 11/5/24, indicated: - Toileting hygiene was not provided on 4 shifts. - Turning and repositioning every 2 hours was not provided 12 times. Review of Resident #138's Wound Nurse Practitioner progress note, dated 12/10/24, indicated: - Deteriorating coccyx pressure ulcer which increased in size. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 11/6/24 to 12/10/24, indicated: (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- Toileting hygiene was not provided on 33 shifts. - Turning and repositioning every 2 hours was not provided 45 times. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 12/17/24, indicated: - Coccyx pressure wound reclassified to a stage three and increased in size. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 12/11/24 to 12/17/24, indicated: - Toileting hygiene was not provided on 7 shifts. - Turning and repositioning every 2 hours was not provided 17 times. Review of Resident #138's nursing progress note, dated 1/27/25, indicated: - (Health care proxy) stated he/she need to be changed right now. The nurse explained that I will notify the nursing aide for you. The resident aide was on break, the nurse was on break, two of the aide was with a resident in shower room. The other one was helping a resident with food. After a couple of minutes, while this writer was verify a dressing order, so that she was going to change when she heard someone was screaming at her: hey you, if you don't want to do your job just (expletive) stay home. This writer reply are you talking to me please do not yelled at me. This family member keep shouting and screaming at the nurse . This writer did not reply, just report it to the aide to change the resident as soon as he returned from break. [sic] Review of Resident #138's Wound Nurse Practitioner progress notes, dated 2/11/25, indicated: - Pressure ulcer to coccyx is deteriorating this week. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 2/1/25 to 2/11/25, indicated: - Toileting hygiene was not provided on 16 shifts. - Turning and repositioning every 2 hours was not provided 31 times. Review of Resident #138's nursing progress note, dated 2/12/25, indicated: - Pressure ulcer to coccyx deteriorating this week. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 2/18/25, indicated: - Deteriorating coccyx pressure ulcer which increased in size. - New stage two right buttock pressure ulcer. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 2/12/25 to 2/18/25, indicated: - Toileting hygiene was not provided on 6 shifts. - Turning and repositioning every 2 hours was not provided 5 times. Review of Resident #138's Wound Nurse Practitioner progress notes, dated 3/4/25, indicated: - Deteriorating coccyx pressure ulcer. - New left buttock maceration. - Stable right buttock stage two pressure ulcer. Review of Resident #138's nursing progress note, dated 3/4/25, indicated: - Coccyx wound in deteriorating, foul smell noted, with increased size and drainage. NP (nurse practitioner) orders to send patient for ED (emergency department) evaluation. During a review of Resident #138's 'Documentation Survey Report' from the timeframe before the wound deteriorated, dated 2/19/25 to 3/4/25, indicated: - Toileting hygiene was not provided on 9 shifts. - Turning and repositioning every 2 hours was not provided 9 times. Review of Resident #138's hospitalist progress note, dated 3/7/25, indicated: - No definite sacral osteomyelitis, but the MRI is not adequate for evaluation due to significant motion artifact. - Recommendations for wound care include to change positions regularly. Review of Resident #138's entire medical record, dated 10/24/24 to 3/4/25, failed to indicate the Resident refused repositioning or incontinence care. During a telephone interview on 3/7/25 at 6:29 A.M., Certified Nurse Assistant (CNA) #7 said the facility had been short staffed several days a week for the past few months. CNA #7 said several days a week there is only one CNA on the overnight shift making it physically impossible to turn and reposition all the residents on the unit. CNA #7 said she does not believe Resident #138 was repositioned every two hours consistently over the past three months. During a telephone interview on 3/7/25 at 8:40 A.M., Nurse Practitioner (NP) #1 said she sees that staff isn't always able to reposition and provide toileting/incontinence care. During an interview on 3/7/25 at 1:17 P.M., Nurse #8 said not providing frequent repositioning or prompt incontinence care could cause a wound to deteriorate. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/7/25 at 1:19 P.M., Unit Manager #2 said Resident #138 should have been repositioned every two hours and incontinence care should have been provided promptly. Unit Manager #2 said repositioning and incontinence care should be documented by the CNAs, which is where the information from the report titled 'Documentation Survey' populates, under repositioning and toileting hygiene. Unit Manager #2 said if a Resident refuses repositioning or incontinence care that should be documented accordingly. Unit Manager #2 said not providing frequent repositioning or prompt incontinence care could cause a wound to deteriorate. During an interview on 3/7/25 at 2:49 P.M., the Wound Nurse Practitioner (NP) said not providing frequent repositioning or prompt incontinence care could cause a wound to deteriorate. The Wound NP said 50% of the time during weekly wound visits Resident #138's brief was soiled or full of urine. During an interview on 3/10/25 at 10:11 A.M., the Director of Nursing (DON) and the Regional Nurse Consultant said CNA documentation should be completed by the end of each shift, including repositioning and incontinence care. The DON and Regional Nurse Consultant declined to comment on if not providing frequent repositioning or prompt incontinence care can cause a wound to deteriorate. 1c.) Review of the facility policy titled 'Preventative Pressure Ulcer', revised April 2022, indicated: - Support Surfaces and Pressure Redistribution: Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. Review of Manufacturer's guidelines for Medline Supra APL Mattress System indicated: - To set the Medline Supra APL, first connect the pump and mattress, then power it on and inflate. Adjust the mattress based on the patient's weight. On 3/4/25 at 9:40 A.M. and at 3:04 P.M., the surveyor observed Resident #138 in bed on a Medline Supra APL air mattress. Resident #138 did not respond to the surveyors questions. During both observations the air mattress pump was set to 180 weight (lbs). Review of Resident #138's 'Monthly Weight Report' indicated the following weights: - December 2024: 160.8 lbs. - January 2025: 149.8 lbs. - February 2025: 142 lbs. - March 2025: 141 lbs. Review of Resident #138's physician order, initiated 10/29/24, indicated: - Pressure air pad and pump, every shift, for Dry Skin and limited bed mobility, initiated 10/29/24 and discontinued 3/4/25. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- Low airloss mattress to bed set to comfort, initiated 3/4/25 without stop date. Review of Resident #138's plan of care related to actual alteration in skin integrity, initiated 11/7/24, indicated: - Therapeutic air mattress to be applied: Setting: set to resident's preference. Review of Resident #138's medical record indicated he/she had been transferred to the hospital on 3/4/25 for deteriorating coccyx wound with increased size, drainage, and foul smell. During a telephone interview on 3/6/25 at 9:07 A.M., Resident #138's health care proxy said Resident #138 often called out because he/she was uncomfortable in bed during the past few months. During an interview on 3/10/25 at 9:35 A.M., Unit Manager #2 said Resident #138's air mattress did not require specific settings because it can be changed based on his/her comfort. Unit Manager #2 said Resident #138 had difficulty communicating and could not communicate discomfort verbally. During an interview on 3/11/25 at 10:52 A.M., Unit Manager #2 said Resident #138 had a physician's order for an air mattress for pressure ulcer management. During an interview on 3/11/25 at 10:59 A.M., the Regional Nurse Consultant said she changed all the orders for any residents on air mattresses to be set related to resident comfort. The Regional Nurse Consultant said air mattresses should be set according to facility policy. The Regional Nurse Consultant there is no system in place to monitor the effectiveness or comfort of each resident on an air mattress, even if they are not able to communicate their needs, but they expect the nurses to be monitoring for signs of discomfort and adjusting the air mattress settings as necessary based on the nurses assessment of each resident's comfort. During an interview on 3/7/25 at 2:49 P.M., the Wound Nurse Practitioner (NP) said if air mattresses are used for wounds they require settings usually related to size and weight. If an air mattresses is set too firm or too soft it puts the resident at risk for skin breakdown or worsening wounds. The Wound NP said Resident #138 was on an air mattress to treat his/her pressure ulcers. 2.) Resident #30 was admitted to the facility in December 2020 with diagnoses including diabetes and pressure ulcers. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/22/25, indicated Resident #30 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #30 had a stage three pressure ulcer and a stage four pressure ulcer. 2a.) On 3/10/25 at 2:02 P.M., the surveyor observed Nurse #8 and Unit Manager #2 perform a wound dressing change for Resident #30's left buttock stage four pressure ulcer. Nurse #8 said we always change his/her left buttock dressing twice a day. Review of Resident #30's Wound Nurse Practitioner (NP) progress note, dated 3/4/25, indicated: - Stage four pressure ulcer left buttock. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- Treatment recommendation for pressure ulcer left buttock: Wash with wound cleanser, pat dry. Skin prep peri skin, Santyl to slough. Pack entire wound with collagen. Cover with silicone foam dressing QD (every day)/PRN (as needed). Review of Resident #30's physician's order, initiated 3/4/25, indicated the following for his/her left buttock: - Wash with WC (wound cleanser), pat dry. skin prep PS (peri skin), santyl to slough, pack entire wound with collagen, then silicone foam dsg (dressing) QD/PRN, every day shift and every evening shift. Review of Resident #30's treatment administration record (TAR), dated 3/4/25 to 3/9/25, indicated the physician's order to Wash with WC (wound cleanser), pat dry. skin prep PS (peri skin), santyl to slough, pack entire wound with collagen, then silicone foam dsg (dressing) QD/PRN was documented as implemented twice daily. During an interview on 3/10/25 at 2:40 P.M., Unit Manager #2 said she reviewed the Wound NP's treatment recommendation and the physician's order for Resident #30's left buttock. Unit Manager #2 said it was transcribed incorrectly and accidentally scheduled to be completed twice a day, instead of once a day. During an interview on 3/11/25 at 9:15 A.M., the Director of Nursing (DON) said Resident #30's physician's order for his/her left buttock should have been transcribed at frequency recommended, and the left buttock treatment being completed twice day was incorrect. 2b.) Review of Manufacturer's guidelines for Selectis Serenity Air Mattress indicated: - The Selectis Serenity alternating low air loss mattress system helps provide prevention therapy and treatment of multiple stage wounds. - By tailoring the pressure based on the patient's weight and specific ailment, optimal comfort and support can be achieved. On 3/4/25 at 9:45 A.M., the surveyor observed Resident #30 in bed on a Selectis Serenity air mattress. The air mattress pump was set to 300 pounds (lbs.) weight. Resident #30 said his/her air mattress is uncomfortable. Resident #30 said it often feels deflated and that when she tells them it takes a long time to fix it. During observations on 3/4/25 at 3:10 P.M., 3/5/25 at 7:01 A.M., and 3/6/25 at 5:34 A.M., Resident #30 was in bed on a Selectis Serenity air mattress with the pump set to 300 pounds weight. Review of Resident #30's 'Monthly Weight Report' indicated the following weights: - December 2024: 190.5 lbs. - January 2025: 194.5 lbs. - February 2025: 195.5 lbs. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #30's physician orders indicated: - Low air mattress to bed check every shift/function every shift. Settings are per weight (192.4), initiated 1/29/24 and discontinued 3/4/25. - Air mattress to bed check every shift/function set to resident comfort level, initiated 3/4/25 without stop date. Review of Resident #30's plan of care related to actual alteration in skin integrity, initiated 10/16/24, indicated: - Air mattress, set to patient comfort. During an interview on 3/10/25 at 9:35 A.M., Unit Manager #2 said residents on air mattresses did not require specific settings because it can be changed based on his/her comfort. During an interview on 3/11/25 at 10:52 A.M., Unit Manager #3 said Resident #30 had a physician's order for an air mattress for pressure ulcer management. During an interview on 3/11/25 at 10:59 A.M., the Regional Nurse Consultant said she changed all the orders for any residents on air mattresses to be set related to resident comfort. The Regional Nurse Consultant said air mattresses should be set according to facility policy. The Regional Nurse Consultant there is no system in place to monitor the effectiveness or comfort of each resident on an air mattress, but they expect the nurses to be monitoring for signs of discomfort and adjusting the air mattress settings as necessary based on the nurse's assessment of each resident's comfort. During an interview on 3/7/25 at 2:49 P.M., the Wound Nurse Practitioner (NP) said if air mattresses are used for wounds, they require settings usually related to size and weight. If an air mattress is set too firm or too soft, it puts the resident at risk for skin breakdown or worsening wounds. 50338 3.) Resident #167 was admitted to the facility in December 2024 with diagnoses including diabetes, prostate cancer, and chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/5/25, indicated that Resident #167 is cognitively intact as evidenced by a Brief Mental Status (BIMS) score of 13 out of 15. The MDS also indicated that he/she was at high risk for pressure ulcers and had two Stage 3 pressure ulcers. Review of Resident #167's Norton Plus Pressure Ulcer Scale, dated, 12/6/24, 12/16/24, 12/30/24, 12/31/24, 1/12/25, 1/16/25, and 2/4/25 indicated that he/she was at high risk for pressure ulcers. Review of Resident #167's nursing progress note, dated 12/25/24, indicated Resident sustained a pressure ulcer to coccyx, Nurse Practitioner (NP) #3 notified, area covered pending wound care evaluation. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #167's Treatment Administration Record (TAR), dated 12/7/24, indicated Apply triad and DPD to coccyx area daily. Review of Resident #167's Wound care progress note, dated 12/27/24, indicated pressure ulcer coccyx measuring 3 centimeters (cm) x 2.3 cm x 0.1 cm. Treatment Recommendations: wash, dry, apply Med honey to wound bed, cover with dry protective dressing (DPD) daily and as needed. Review of Resident #167's nursing progress note, dated 12/30/24, indicated Resident followed up by wound care consultant on 12/27/24, report on 12/30/24 as follows: evaluated for new area on coccyx, stage 2. Recommended treatment: Wash with wound cleanser, pat dry, apply med [NAME] to wound bed, cover with dry protective dressing (DPD) daily and as needed. NP #3 in agreement. Order in place. Review of Resident #167's plan of care, dated 12/30/24, indicated actual in skin integrity related to stage 3 to coccyx. Interventions include: -wash with wound cleanser, pat dry, skin prep peri skin, apply collagen wafer, then apply silicone border dressing daily and as needed. Review of Resident #167's TAR, dated 12/30/24, indicated Pressure Coccyx wound: wash with wound cleanser, pat dry, apply med honey to wound bed, cover with DPD daily and as needed. Further review of TAR, dated 12/30/24, failed to indicate that treatment was signed as completed on 12/30/24 or 12/31/24. Review of Resident #167's TAR, dated 12/31/24, indicated Pressure Coccyx wound: wash with wound cleanser, pat dry, apply med honey to wound bed, cover with DPD daily and as needed. Further review of TAR, dated 12/31/24, failed to indicate that treatment was signed as completed on 12/31/24 and 1/1/25. During an interview on 3/11/25 at 9:15 A.M., the Director of Nursing (DON) said he would expect wound care recommendations to be followed. 4.) Resident #143 was admitted to the facility in January 2025 with diagnoses including osteomyelitis (bone infection) of right tibia and fibula, diabetes, and peripheral vascular disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/7/25, indicated that Resident #143 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. The MDS indicated Resident #143 was at risk for pressure ulcer, required maximum assist for bed mobility, and had two deep tissue injuries (DTIs). On 3/04/25 at 8:35 A.M., the surveyor observed Resident # 143 sleeping in bed with air mattress set on fi[TRUNCATED]		

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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. 48990 Based on observation, interview, and record review, the facility failed to consistently provide range of motion (ROM) care and treatment in accordance with professional standards of practice for one Resident (#8) out of a total sample of 42 residents. Specifically, the facility failed to ensure staff implemented Resident #8's physician ordered right hand carot orthosis. Findings include: Review of the facility policy titled 'Rehabilitative Nursing Care', revised April 2022, indicated: - General rehabilitative nursing care is that which does not require the use of a qualified Professional Therapist to render such care. - The facility's rehabilitative nursing care is designed to assist each resident to achieve and maintain an optimal level of selfcare and independence. - Rehabilitative nursing care is performed daily during ADL (activities of daily living) care through passive range of motion. Such services includes, but is not limited to: a. maintaining good body alignment and proper positioning; and f. assisting residents with their routine range of motion exercises. Resident #8 was admitted to the facility in January 2020 with diagnoses including a right hand contracture. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/12/25, indicated Resident #8 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS also indicated Resident #8 had functional limitation in range of motion in one upper extremity. Review of Resident #8's physician order, initiated 4/15/24, indicated: - Apply Carrot Orthosis to right hand daily, remove at HS (bedtime). Review of Resident #8's plan of care related to activities of daily living, revised 4/15/24, indicated: - Apply Carrot to right hand daily. On 3/4/25 at 9:25 A.M., the surveyor observed Resident #8 sitting in bed without a carrot orthosis in his/her right hand. On 3/4/25 at 3:04 P.M., the surveyor observed Resident #8 sitting in bed with a napkin and silver wrapper in his/her right hand. There was no carrot orthosis in his/her right hand. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 6:57 A.M., the surveyor observed Resident #8 in bed with a napkin in his/her right hand. There was no carrot orthosis in his/her right hand. Resident #8 said he/she has a carrot in his/her room but uses the napkin because staff doesn't assist him/her to apply it. Resident #8 further said sometimes when he/she wears it other residents try to take it from him/her, and it is often missing because it was stolen. On 3/5/25 at 10:18 A.M., the surveyor observed Resident #8 sitting in his/her chair with a napkin and silver wrapper in his/her right hand. There was no carrot orthosis in his/her right hand. During an interview and observation on 3/10/25 at 7:57 A.M., Certified Nurse Assistant (CNA) #9 said Resident #8 is supposed to have a carrot orthosis in his/her right hand. CNA #9 said she has not seen it in a while, so instead they tape a washcloth in place on his/her right hand. During this observation Resident #8 was in bed without anything in his/her right hand. During this observation CNA #9 located the carrot orthosis in his/her room. Review of Resident #8's medical record, including medication administration record (MAR), treatment administration record (TAR), progress notes, and care plan, failed to indicate any rationale regarding why Resident #8 was not wearing the right hand carrot orthosis. During an interview on 3/10/25 at 8:10 A.M., Nurse #4 said Resident #8 was supposed to have a carrot orthosis in his/her right hand. Nurse #4 said Resident #8 does not refuse anything to be put in his/her right hand. Nurse #4 said she was not aware if anyone notified the therapy department to order a new one. Nurse #4 said if the carrot orthosis was not available to use, a new one should have been obtained and/or the physician's order and care plan should have been updated. During an interview on 3/11/25 at 8:12 A.M., Unit Manager #2 said Resident #8 should have a carrot orthosis in his/her right hand because he/she has a physician's order for it. Unit Manager #2 said she was not aware that it was missing or that anyone reported to therapy that it was missing. Unit Manager #2 said if it was not used it should not have been documented that it was. Unit Manager #2 further said that if the Resident did not wish to wear it, the conversation and changes should have been documented in the medical record. During an interview on 3/10/25 at 10:12 A.M., the Director of Nursing (DON) said if Resident #8 had a physician's order and care plan for a carrot orthosis to be applied to his/her right hand, it should have been in place. The DON said if it was not in place, the rationale should be documented in the medical record.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observations and interviews the facility failed to ensure an environment free from accident hazards for one Resident (#59) out of a total sample of 42 residents. Specifically, the facility failed to ensure that there was not a space heater placed in Resident #59's room on top of a trash can which had a plastic lid and contained paper waste. Findings Include: Review of life safety code K781, Portable Space Heaters, indicated the following: Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8. Resident #59 was admitted to the facility in November 2023 with a diagnosis of dementia and paraplegia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #59 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had moderate cognitive impairment. Further review of the MDS indicated the Resident was dependent on staff for transferring out of bed. During an interview and observation on 3/4/25 at 10:07 A.M., Resident #59 said the heater in her room was broken and that the facility provided him/her with a space heater (a small portable heating unit) during the interim to keep the room warm. The surveyor observed the Resident in bed and the space heater, which was plugged in and produced heat, placed on top of a trash can with a plastic lid. On 3/4/25 at 7:23 A.M., the surveyor observed Resident #59 in bed, there was a space heater in his/her room. The space heater was on, producing heat, and placed on top of a trash can with a plastic lid. The surveyor observed paper waste products inside the trash can, below the space heater. Review of the maintenance log indicated the following entry: - Resident #59's heat is not working, dated 11/26/24. During an interview on 3/5/25 at 12:17 P.M., Unit Manager #4 said Resident #59 had a space heater and that facility was in the process of getting Resident #59's heat fixed. During an interview on 3/5/25 at 12:50 P.M., the Maintenance Director said the heat in Resident #59's room was not working and that an outside company was in the process of fixing it. The Maintenance Director said the facility provided the Resident with a space heater during the interim but that it should not be placed on top of a trash can with a plastic lid. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 6:40 P.M., the Administrator said Residents should not have space heaters in their rooms.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41456 Based on record reviews and interviews, the facility failed to ensure weekly weights were obtained for one Resident (#106), with a recent weight loss, out of a total sample of 42 residents. Findings include: Review of the facility policy titled, Weight Management, dated April 2022, indicated the following: - Weekly weights should be done on residents who are assessed as high nutritional risk. Resident #106 was admitted to the facility in March 2018 with diagnoses including dementia. Review of Resident #106's most recent Minimum Data Set (MDS) assessment, dated 2/6/25, indicated the Resident scored 3 out of a possible 15 on the Brief Interview for Mental Status exam, which indicated he/she has severe cognitive impairment. The MDS also indicated the Resident is dependent on staff for all self-care tasks. Review of Resident #106's weights indicated that on 11/21/2024, the Resident weighed 117.8 lbs (pounds) and on 2/6/2025, the Resident weighed 109 lbs., which is a -7.47 % loss in three months. Review of Resident #106's physician orders indicated the following orders: - Weekly weights due to weight loss, initiated 2/14/25. - Re-check weight in the morning of 3/1/25 one time only until 3/1/25, initiated on 2/28/25. Review of Resident #106's weight log failed to indicate weekly weights had been taken since the order was initiated on 2/14/25, with weights missing on 2/14/25, 2/21/25 and 3/7/25. Review of Resident #106's Treatment Administration Record (TAR) for March 2025, failed to indicate a weight was obtained on 3/1/25 as ordered. Review of Resident #106's nutritional care plan last revised 2/17/25, indicated the following intervention: - Weigh as indicated and alert dietitian and physician to any significant weight loss or gain. During interviews on 3/5/25 at 11:12 A.M., and 3/6/25 at 7:39 A.M., Unit Manager #1 said all weights that have been obtained are in the record and Resident #106 had a recent weight loss and was put on supplements. Unit Manager #1 said she was unaware of the order of weekly weights and was unsure if this had occurred. Unit Manager #1 reviewed the Resident's weights in the electronic medical record and confirmed the physician's orders had not been completed. Unit Manager #1 also reviewed the facility's risk meeting notes and said there was no indication that Resident #106 had been weighed as ordered. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 9:31 A.M., the Director of Nursing said he expects all orders to be followed as written, including orders to increase the frequency of obtaining weights due to weight loss.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41019 Based on observation, record review, and interview, the facility failed to ensure that there was sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Specifically, 1.) The facility failed to maintain sufficient staffing according to the facility assessment and facility staffing requirements. 2.) The facility failed to ensure staff were not sleeping in resident areas during their shifts on three out of six units. Findings include: 1.) Review of the comprehensive Facility Assessment Tool, updated and reviewed by the facility in October 2024, indicated the following staffing ratios for Certified Nursing Aides (CNAs): - 1:12 ratio for days (ratio of CNA to number of residents to care for) - 1:14 ratio for evenings - 1:21 ratio for nights During an interview on 3/10/15 at 12:54 P.M., the Staff Scheduler said that when he makes the schedule, he does it based off the census on the unit. The Staff Scheduler said that he staffs the units as follows: - A unit, C unit, and D unit require 4 certified nursing aides (CNA's) on 7-3 shift, 4 CNA's on the 3-11 shift, and 2 CNA's on the 11-7 shift. - E and F unit requires 2 CNA's on the 7-3 shift, 2 CNA's on the 3-11 shift, and 1 CNA on the 11-7 shift - B unit requires 2-3 CNA's on the 7-3 shift, 2-3 CNA's on the 3-11 shift, and 1 CNA on the 11-7 shift (depending on the census as it is the short term unit) During a telephone interview on 3/7/25 at 6:29 A.M., Certified Nurse Assistant (CNA) #7 said the facility has been short staffed several days a week for the past few months. CNA #7 said several days a week there is only one CNA on the overnight shift making it physically impossible to turn and reposition all the residents on the unit. During a telephone interview on 3/6/25 at 9:07 A.M., one Resident's health care proxy said that she believes that the Resident, who has wounds, had not been turned and repositioned every two hours and is not receiving incontinence care because of lack of staff. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/25 at 1:48 P.M., CNA #4 said that she is over worked and that not all staff give showers because there are not enough staff to provide showers. CNA #4 said that some residents require two people to assist and those resident's will go without showers because there is not enough staff. CNA #4 said the facility used to put 3 CNA's on the floor and now they only schedule two. CNA #4 said residents stay in bed longer, food takes a while to pass out, and it takes a longer time to get everyone ready. During an interview on 3/5/25 at 2:03 P.M., Nurse #1 said there is just not enough staff so medications are passed out late. Nurse #1 said that it causes trays to be passed out late and residents that require feeding assistance end up with cold food because there's not enough staff to feed them. Nurse #1 said residents are often soaking wet because we can't get to them in time. Nurse #1 said the staff are unable to provide every 2-3 hour incontinence care because they don't have enough staff and don't have time to go around and do rounds on people. During an interview on 3/7/25 at 1:12 P.M., CNA #5 and CNA #6 said they don't feel like they have enough staff and it affects the residents. CNA #5 and #6 said that low staffing delays residents getting up, being fed, and receiving showers. During a telephone interview on 3/7/25 at 8:40 A.M., Nurse Practitioner (NP) #1 said she sees that staff isn't always able to reposition and provide toileting/incontinence care. During the medication pass on 3/5/25, A unit, B unit, and F unit's medications were all delivered one hour and 30 minutes late. Review of the actual daily schedule report for 1/1/25 indicates the following: - B unit 11-7 shift- No CNA scheduled for a census of 17. - C unit 11-7 shift- 1 CNA scheduled for a census of 39. - D unit 11-7 shift - 1 CNA scheduled for a census of 38. Review of the actual daily schedule report for 1/5/25, indicated the following: - A unit 7-3 shift - 2 CNA's for a census of 42, which is a ratio of 1:21 - B unit 11-7- no Nurse on duty - C unit 11-7 shift- one CNA for a census of 39. Review of the actual daily schedule report for 1/19/25 indicated the following: - A unit 7-3 shift- 3 CNA's for a census of 41, which is a ratio of 1:13.6 Review of the actual daily schedule report for 1/20/25 indicated the following: - A unit 7-3 shift- 3 CNA's for a census of 41, which is a ratio of 1:13.6 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A unit 11-7 shift- 0 CNA's for a census of 41 - B unit 11-7 shift- 0 CNA's for a census of 18 - C unit 11-7 shift- 1 CNA for a census of 37 - D unit 11-7 shift- 1 CNA for a census of 38 Review of the actual daily schedule for 2/1/25, indicated the following: - A unit 7-3 shift- 2 CNA's for a census of 41, which is a ratio of 1:20.5 - A unit 11-7 shift- 1 CNA for a census of 41 - D unit 7-3 shift- 2 CNA's for a census of 38 Review of the actual daily schedule for 2/9/25, indicated the following: - D unit 11-7 shift- 1 CNA for a census of 40 Review of the actual daily schedule for 3/1/25 indicated the following: - C unit 3-11- 2 CNA's for a census of 39, which is a ratio of 1:19.5 During an interview on 3/11/25 at 11:13 A.M., the Staff Scheduler said that if there are call outs then he will try to get other staff to stay for the shift or offer bonuses. The Staff Scheduler says he never has an issue getting staff to cover open shifts. During an interview on 3/11/25 at 9:23 A.M., the Administrator said that staffing has stabilized and was more of an issue when he got here. The Administrator said that the facility was pushed to eliminate agency and that they transitioned those agency staff to the building. The Administrator said that staff have come to him about staffing levels and he has explained the process to them and how the facility is staffed based on acuity. The Administrator said that based on the acuity depends on how many staff each unit gets. 48990 2.) Review of the employee handbook, dated April 2, 2024, indicated, but was not limited to the following: - Standards of Conduct: Any violation of company rules, including the following, may result in disciplinary action: Sleeping on duty. During the initial tour of the facility on 3/4/25 at 8:47 A.M., there were multiple concerns regarding care during the night shift including: - One resident said he/she has seen staff sleeping in the resident dining room. This resident said there is not enough staff at night and the call bell wait time can take up to two hours. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Another resident said there is long call light wait times, especially at night. - Another resident said sometimes it takes up to four hours to answer call lights during the night shift. During the 'Resident Group' meeting on 3/5/25 at 10:05 A.M., 13 residents met with the surveyor and indicated the following: - 13 out of 13 expressed concerns with staffing and prolonged call light wait time. - 3 out of 13 residents expressed concerns that staff were sleeping during the night shift. On 3/6/25 at 3:01 A.M., a surveyor entered the F Unit and observed a certified nurse assistant (CNA) covered in a blanket with her head on a pillow and eyes closed, appearing to be asleep. During an interview on 3/6/25 at 3:03 A.M., Nurse #9 said the CNA on F Unit was asleep, and could not say for how long. On 3/6/25 at 3:04 A.M., a surveyor entered D Unit and observed a CNA covered in a blanket laying on two chairs pushed together in the dining room with her eyes closed, appearing to be asleep. There was another CNA with eyes closed, appearing to be asleep, on a chair in the hallway. During an interview on 3/6/25 at 3:06 A.M., Nurse #10, who was working on D Unit, said staff should not be sleeping on the unit. On 3/6/25 at 2:58 A.M., a surveyor entered the A Unit and observed a CNA in a chair covered with a blanket and head on a pillow with her eyes closed, appearing to be asleep, in the resident dining room. The CNA opened her eyes after a few minutes and said she had been sleeping. During an interview on 3/6/25 at 3:01 A.M., Nurse Supervisor #1 and CNA #7 were sitting at the nurse's station on A Unit. They said there was nobody on break on the A Unit. During an interview on 3/6/25 at 3:12 A.M., Nurse Supervisor #1 said there is an ongoing concern with staff sleeping. Nurse Supervisor #1 said she is suspicious when she walks on a unit and the lights are off that staff might be sleeping. Nurse Supervisor #1 said about two weeks ago a CNA was disciplined by being moved to a different unit because she was caught sleeping. During an interview on 3/6/25 at 4:25 A.M., The Administrator and the Regional Nurse Consultant said staff should not be sleeping in resident areas during their shift. The Administrator and Regional Nurse Consultant said if staff want to sleep on their breaks, it must be in the staff break room.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41105 Based on interviews, record review, staff education review, and Facility Assessment review, the facility failed to ensure the nursing staff were trained and demonstrated the competencies and skill sets necessary to provide the level and types of care and services needed as outlined in the Facility Assessment. Specifically, the facility failed to ensure 5 of 5 nurse records reviewed were trained and demonstrated competency related to wound care. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Review of the comprehensive Facility Assessment Tool, updated and reviewed by the facility in October 2024, indicated the following: - The facility accepts residents with a broad range of diseases and disabilities, primarily including common diseases of the elderly for its long-term care unit. These conditions, physical and cognitive disabilities, or combination of conditions require complex medical care and management. - Listed under common diagnoses the facility treats included skin ulcers, injuries, skin and soft tissue infections. - The type of care that the facility provides includes the following: *Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). - The facility considers the following competencies (this is not an inclusive list): *Person-centered-care - This should include but not be limited to person-centered care planning, education of resident and family/resident representative about treatment and medications, documentation of resident treatment preferences, end of life care, and advance care planning. *Medication administration - injectable, oral, subcutaneous, topical. *Resident assessment and examinations - admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment. *Specialized care - wound care/dressings. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Throughout the Recertification survey (3/4/25 through 3/7/25 and 3/10/25 through 3/11/25) the surveyors identified multiple concerns regarding wound care. The surveyor reviewed staff education files for wound competencies for five licensed nurses: - 0 out of 5 nurses had evidence of wound care competencies completed in the past year. During an interview on 3/11/25 at 9:38 A.M., with the Director of Nursing (DON) he said that he was unable to provide wound care competencies for 5 of 5 nurse records reviewed. The DON said that on 1/29/25 there was verbal education regarding wound care provided to him and several facility staff. The DON said that the instructor verbally reviewed wound care however there were no competency's assessed. During an interview on 3/11/25 at 9:48 A.M., the Administrator said that is the expectation that nursing staff demonstrate wound competency.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 41105 Based on record review and interview, the facility failed to complete annual Certified Nurse Aide (CNA) performance reviews for 5 out of 5 eligible sampled CNAs. Findings include: During review of 5 CNA employee records, the Surveyor was unable to locate annual performance reviews for 5 out of 5 eligible CNAs. Employee records indicated the following: - A CNA last had an annual review on 7/13/21; - A CNA last had an annual review on 10/23/21; - A CNA last had an annual review on 3/19/20; - A CNA last had an annual review on 2/26/21; - A CNA never had an annual review, but was eligible. During an interview on 3/11/25 at 9:38 A.M., the Director of Nursing (DON) said it is the expectation that annual reviews be done annually and could not say why that was not happening. During an interview on 3/11/25 at 9:48 A.M., the Administrator said that it is the expectation that all staff receive annual performance reviews. The Administrator said that he could not speak to why reviews were not happening in the past but was aware that they were not done.		

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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. 50338 Based on observations, record review, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when three out of three nurses observed made seven errors out of 29 opportunities, resulting in a medication error rate of 24.14%. Those errors impacted three Residents (#149, #8, and #433), out of three residents observed. Specifically, 1.) For Resident #8, Nurse #4 failed to administer his/her medications within the one-hour time frame. 2.) For Resident #433, Nurse #5 failed to administer his/her medications within the one-hour time frame. 3.) For Resident #149, Nurse #1 failed to administer his/her medications within the one-hour time frame. Findings include: Review of the facility policy titled 'Oral Medication Administration', dated as revised 4/2022, indicated the following: The purpose of this procedure is to provide guidelines for the safe administration of oral medications. - Verify that there is a physician's medication order for this procedure. 1.) Review of Resident #8's physician orders indicated the following: - Phenobarbital 97.2 milligrams (mg) one tablet two times a day for seizures. Scheduled two times daily at 8:00 A.M., and 8:00 P.M. - Carbamazepine 200 mg two tablets a day for seizures. Scheduled two times daily at 8:00 A.M., and 8:00 P.M. - Sodium Chloride (NaCl) one gram (gm) one tablet three times a day for supplement. Scheduled three times daily at 8:00 A.M., 12 P.M., and 4:00 P.M. On 3/5/25 at 9:32 A.M., the surveyor observed Nurse #4 prepare and administer morning medications to Resident #8 including the following: - Phenobarbital 97.2mg one tablet. The medication was administered one hour and 32 minutes after the scheduled time. - Carbamazepine 200 mg two tablets. The medication was administered one hour and 32 minutes after the scheduled time. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- NaCl one gram one tablet. The medication was administered one hour and 32 minutes after the scheduled time. 2.) Review of Resident #433's physician orders indicated the following: - Gabapentin 300 mg one capsule two times a day for pain. Scheduled two times daily at 8:00 A.M., and 8:00 P.M. On 3/5/25 at 10:03 A.M., the surveyor observed Nurse #5 prepare and administer morning medications to Resident #433 including the following: - Gabapentin 300 mg one capsule. The medication was administered two hours and three minutes after the scheduled time. 3.) Review of Resident #149's physician orders indicated the following: - Tylenol 500 mg one tablet three times a day for pain. Scheduled three times daily at 9:00 A.M., 1:00 P.M., and 9:00 P.M. - Eliquis 5mg one tablet two times a day for blood thinner. Scheduled two times daily at 9:00 A.M., and 9:00 P.M. - Buspar 5mg one tablet three times a day for anxiety. Scheduled three times daily at 9:00 A.M., 5:00 P.M., and 9:00 P.M. On 3/5/25 at 10:38 A.M., the surveyor observed Nurse #1 prepare and administer morning medications to Resident #149 including the following: - Tylenol 500 mg one tablet. The medication was administered one hour and 38 minutes after the scheduled time. - Eliquis 5mg one tablet. The medication was administered one hour and 38 minutes after the scheduled time. - Buspar 5mg one table. The medication was administered one hour and 38 minutes after the scheduled time. During an interview on 3/5/25 at 9:35 A.M., Nurse #4 said she was late administering medications and medications should be administered within a one-hour window. During an interview on 3/5/25 at 10:06 A.M., Nurse # 5 said she was late administering medications and medications should be administered within a one-hour window. During an interview on 3/5/25 at 10:40 A.M., Nurse #1 said she was late administered medications and medications should be administered within a one-hour window. During an interview on 3/10/25 at 12:24 P.M., the Director of Nursing (DON) said medications should be administered within one hour of the scheduled times.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 41019 Based on observation, record review, and interview, the facility failed to provide dental services to one Resident (#93) out of a total sample of 42 residents. Findings include: Resident #93 was admitted to the facility in 6/2023 with diagnoses including dementia and depression. Review of the Minimum Data Set (MDS) assessment, dated 1/30/25, indicated Resident #93 scored a 14 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. Review of the oral section of the MDS indicated Resident #93 had no broken teeth. During an interview on 3/4/25 at 9:58 A.M., Resident #93 said his/her teeth were broken and need to be fixed. Review of the medical record and consents failed to indicate that Resident #93 had been seen by the dentist or signed a consent form to be seen by the dentist. During an interview on 3/11/25 at 10:32 A.M., the Medical Records staff member said that Resident #93 had not been seen by a dentist in house and would find out if he/she had been seen outside of the facility. The facility failed to provide any indication that Resident #93 had seen the dentist.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45763 Based on observation and interviews, the facility failed to serve food that was palatable, and at a safe and appetizing temperature, on four out of six units. Findings include: During the initial tour of the facility on 3/4/25 the surveyors met with residents, 12 residents voiced dissatisfaction with the temperature and/or taste of the food served at the facility. During the resident group meeting on 3/5/25 at 10:05 A.M. the surveyors met with residents and the following concerns were expressed. - One Resident said that the food was terrible, that some people aren't getting salt and have to get it themselves. - One Resident said it takes half an hour to get food. - 13 out of 13 residents said food was not hot. On 3/7/25 at 9:06 A.M., the E Unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 9:15 A.M., and the following was recorded and observed: - Scrambled eggs tasted warm, not hot and bland. - Potatoes tasted warm, not hot. - Toast was soft. - Oatmeal was bland. - Juice tasted cool, not cold. - Milk tasted cool, not cold. - Coffee was hot. On 3/7/25 at 7:48 A.M., the B Unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 8:01 A.M., and the following was recorded and observed: - Scrambled eggs tasted warm, not hot, and bland. - Potatoes tasted warm, not hot, and were spicy. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Toast was warm and soggy. - Oatmeal tasted warm, not hot. - Juice tasted cool, not cold. - Milk tasted cool, not cold. On 3/7/25 at 8:15 A.M., the F Unit food truck arrived at the resident care unit, the surveyor observed that the food truck door was left open while staff passed the trays out. After all resident trays were served the surveyor received the test tray at 8:34 A.M., and the following was recorded and observed: - Scrambled eggs tasted warm, not hot and bland. - Potatoes were warm, not hot and had so much black pepper that they were indelibly spicy. - Oatmeal tasted warm, not hot, and bland; there were no sugar packets or condiments on the tray. - Toast tasted warm, not hot and had a soggy texture. - Juice tasted cold. - Milk tasted cold. - Coffee tasted hot. On 3/7/25 at 8:37 A.M., the C Unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 8:58 A.M., and the following was recorded and observed: - Scrambled eggs were lukewarm, not hot. - The potatoes were soggy, overly peppery/spicy, and tasted lukewarm/room temperature, not hot. - Toast tasted room temperature. - Oatmeal tasted warm, not hot and tasted watery. - Juice tasted cool, not cold. - Milk tasted cool, not cold. - Coffee tasted hot. On 3/7/25 at 8:05 A.M., the D Unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 8:26 A.M., and the following was recorded and observed: (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Scrambled eggs tasted lukewarm and bland. - Potatoes tasted lukewarm, almost cold. - Oatmeal tasted warm, not hot, and bland. On 03/11/25 at 07:41 A.M. the surveyor observed the Food Service Director (FSD) calibrate all six thermometers to be used for test trays, the thermometers were submersed in ice water and all thermometers read within a degree of 32 degrees Fahrenheit. On 3/11/25 at 8:10 A.M., the F Unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 8:42 A.M., and the following was recorded and observed: - Oatmeal was 124.1 degrees Fahrenheit and tasted luke warm, not hot, and bland. There were no condiments on the tray. - Waffle was 114.2 degrees Fahrenheit, tasted luke warm, not hot, and was incredibly hard around the edges. - Scrambled eggs were 114 degrees Fahrenheit and lukewarm, not hot. The eggs had a crumbly texture, consistent with overcooking, and tasted bland. - Sausage was 127 degrees Fahrenheit and tasted warm, not hot. On 3/11/25 at 8:01 A.M., the D Unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 8:15 A.M., and the following was recorded and observed: - Waffle was 135 degrees Fahrenheit and tasted cool and hard. - Coffee was 167 degrees Fahrenheit and tasted hot. - Juice was 34.5 degrees Fahrenheit and tasted cold but was watery. - Milk was 37.8 degrees Fahrenheit and tasted cold. - Scrambled eggs were 137.7 degrees Fahrenheit and tasted cool and bland. - Sausage was 137 degrees Fahrenheit and tasted warm, not hot. - Oatmeal was 136.9 degrees Fahrenheit and tasted lukewarm, not hot and bland. On 3/11/25 at 8:27 A.M., the C Unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 8:44 A.M., and the following was recorded and observed: (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Scrambled eggs were 129.9 degrees Fahrenheit, tasted warm not hot, and had a crispy texture mixed throughout consistent with overcooking. - Waffle was 123 degrees Fahrenheit and tasted lukewarm, not hot. The waffle was soggy in the middle but had a dark color and crunchy texture around the perimeter consistent with burning; the surveyor was unable to cut the perimeter of the waffle without using significant force due to the density of the waffle. - Sausage was 130 degrees Fahrenheit and tasted warm, not hot. - Oatmeal was 137 degrees Fahrenheit and tasted hot. - Juice was 43.1 degrees Fahrenheit and tasted cold, but was partially frozen. - Milk was 32 degrees Fahrenheit and tasted cold but was partially frozen. - Coffee was 143 degrees Fahrenheit and tasted hot. On 3/11/25 at 8:58 A.M., the E Unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 9:00 A.M., and the following was recorded and observed: - Scrambled eggs were 124.8 degrees Fahrenheit and tasted warm, not hot. - Waffles were 121.6 degrees Fahrenheit and tasted warm, not hot. - Sausage was 135.1 degrees Fahrenheit and tasted hot. - Oatmeal was 126.1 degrees Fahrenheit and tasted hot. - Milk was 39.9 degrees Fahrenheit and tasted cold. - Juice was 45.8 degrees Fahrenheit and tasted cold. - Coffee was 159.4 degrees Fahrenheit and tasted hot. During and interview on 3/7/25 at 1:16 P.M., the Food Service Director (FSD) said food hot food leaves the kitchen at a temperature of around 175 degrees Fahrenheit and that he would expect hot food to be at least 150 degrees Fahrenheit when it arrives to the residents. The FSD said cold food should be below 40 degrees Fahrenheit when it arrives to the residents.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure that food was dated, that produce with significant signs of decomposition were discarded, and that food was covered in a walk-in refrigerator in the setting of potential environmental contaminants. Findings include: Review of the facility's policy titled 'Food Brought into the Facility', revised [DATE], indicated, but was not limited to, the following: - Visitors and family members should take all food to the nurses station before it is provided to the resident. - Perishable food must be stored and identified with the residents name, food item, and use-by date. These can be stored in the nursing unit kitchen nourishment refrigerator. - The nursing staff is responsible for discarding perishable foods on or before the use-by date. Review of the facility's policy titled 'Food Storage', revised [DATE], indicated, but was not limited to, the following: - Prepared foods in the refrigerator shall be kept covered, labeled and dated. - Refrigerators and freezers shall be kept clean at all times, and should be on a daily and weekly cleaning schedule as assigned. On [DATE] at 7:17 A.M., the surveyor made the following observations during the initial walkthrough of the kitchen: - A greyish-black wispy growth on the walls, ceiling and fan cover of the walk-in refrigerator. - The metal shelving in the walk-in refrigerator was rusting and covered with a significant amount of a thin flaking substance. There was food stored on top of and below the shelving. - A pan containing a package of hot dogs in the walk-in refrigerator, the package was open, unwrapped and undated. - A rack with a pan of Salisbury steaks, the Salisbury steaks and rack were uncovered in the walk-in refrigerator. - Ham open and wrapped but undated in the walk-in refrigerator. - A bag of shredded mozzarella cheese wrapped but undated in the walk-in refrigerator. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A piping bag of whipped cream open and undated in the walk-in refrigerator. - Iceberg lettuce with significant signs of decomposition, including color and textural changes. - Cabbage with significant signs of decomposition, including color and textural changes. - Celery with significant signs of decomposition, including color and textural changes. - Carrots with significant signs of decomposition, including color and textural changes. On [DATE] at 7:44 A.M., the surveyor made the following observations in the A Unit kitchenette refrigerator: - A cup of coleslaw, uncovered and undated. On [DATE] at 7:41 A.M., the surveyor made the following observation in the B Unit kitchenette refrigerator: - A container of food undated and unlabeled. On [DATE] at 7:56 A.M., the surveyor made the following observations in the C Unit kitchenette refrigerator: - A glass jar of pre-prepared soup opened and dated ,d+[DATE]. - A green cup of liquid undated and unlabeled. - A cup of creamy coffee undated, the cup had a crusty substance surrounding the mouth nozzle. On [DATE] at 7:49 A.M., the surveyor made the following observations in the D Unit kitchenette refrigerator: - A Ziploc bag containing a muffin which was undated and unlabeled. - A bottle of lemonade open and undated. - A bottle of fruit punch open and undated. On [DATE] at 8:04 A.M., the surveyor made the following observations in the E Unit kitchenette refrigerator: - A tub of orange liquid dated ,d+[DATE]. - A white tub of a thick orange substance undated and unlabeled, the tub had a crusted substance around the opening. - A thawed pre-packaged meal, the packaging on the meal instructed to keep the food item frozen. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A cup containing a separated milky solid, the cup was undated. On [DATE] at 9:36 A.M., the surveyor made the following observations in the Governor's dinning room kitchenette refrigerator: - A white plastic container of food undated and unlabeled - A container of pasta and sauce labeled with a resident name and dated ,d+[DATE]. - A plastic container of milky soup undated and unlabeled. - An individual milk container with an expiration date of [DATE]. - An individual container of milk with an expiration of [DATE], the container of milk was bulging. - A plastic container with cherry tomatoes, the cherry tomatoes were discolored/blackened and had a white, wispy growth permeating throughout the container. - A cup of juice with a lid on it, undated. During an interview on [DATE] at 9:42 A.M., Nurse Supervisor #1 said that staff should date all food items in kitchenette refrigerators and that the white wispy substance growing on the cherry tomatoes looked like mold. During an interview on [DATE] at 8:04 A.M., the Food Service Director (FSD) said the refrigerator should be deep cleaned monthly and as needed and that the substance on the walls must have been missed. The FSD said anything placed in the walk-in refrigerator should be covered including the Salisbury steaks. The FSD said he would consider getting new racks as the flaking metal on the current racks could contaminate leftover food, and that the racks should be clean. The FSD said all food must be labeled and dated when placed into kitchenette refrigerators and discarded if expired or undated.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48990 Based on observation, record review and interview, the facility failed to accurately document in the medical record for 2 Residents (#36 and #138) out of 42 total sampled residents. Specifically, 1.) For Resident #36, the facility failed to document accurately that a cervical collar was not applied. 2.) For Resident #138, the facility failed to ensure they maintained complete and accurate medical records related to documentation of activities of daily living (basic tasks everyone needs to do each day, such as eating, dressing, hygiene, and using the toilet). Findings include: Review of the facility policy titled 'Charting and Documentation', revised April 2022, indicated: - Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1.) Resident #36 was admitted to the facility in January 2024 with diagnoses including age related cognitive decline and a history of stroke with left sided hemiplegia (one sided muscle weakness). Review of the most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated Resident #36 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. This MDS also indicated Resident #36 was totally dependent on staff for all activities of daily living, including repositioning and dressing. Review of Resident #36's plan of care related to activities of daily living, revised 4/15/24, indicated: - Apply Cervical Collar at all times, may remove for daily hygiene and skin checks. - Document Resident behavior if he/she refuses, document all refusals. Review of Resident #36's physician order, initiated 4/15/24, indicated: - Apply cervical collar at all times may remove for hygiene and skin check; If resident is non compliant notify MD (physician) and document refusals every shift. On 3/4/25 at 10:15 A.M. and at 3:07 P.M., the surveyor observed Resident #36 in bed. He/she was not wearing a cervical collar, which was on his/her dresser. Resident #36's neck was at an extreme angle with his/her head resting on his/her chest. On 3/5/25 at 6:58 A.M., 3/5/25 at 10:20 A.M., and 3/6/25 at 5:31 A.M., the surveyor observed Resident #36 in bed. He/she was not wearing a cervical collar. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #36's treatment administration record (TAR) indicated the following order documented as implemented on every shift on 3/4/25, 3/5/25, and 3/6/25. - Apply cervical collar at all times may remove for hygiene and skin check; If resident is non compliant notify MD (physician) and document refusals every shift. Review of the TAR failed to indicate Resident #36 refused to wear cervical collar. Review of Resident #36's medical record failed to indicate Resident #36 refused to wear his/her cervical collar or that the physician had been notified of any refusal. During an interview on 3/10/25 at 7:50 A.M., Certified Nurse Assistant (CNA) #9 said Resident #36 needs to wear a cervical collar at all times. During an interview on 3/10/25 at 8:07 A.M., Nurse #8 said Resident #36 needs to wear a cervical collar at all times and if he/she refused it, the refusal should be documented. During an interview on 3/10/25 at 8:17 A.M., Unit Manager #2 said Resident #36 needs to wear a cervical collar at all times and if he/she refused it, the refusal should be documented. Unit Manager #2 said if the physician's order says to document refusals and notify the provider of noncompliance, that should have been done. During an interview on 3/10/25 at 10:12 A.M., the Director of Nursing (DON) said if there is a physician's order to wear the cervical collar, it should be in place. The DON said if the physician's order says to document refusals and notify the provider of noncompliance, that should have been done. During an interview on 3/11/25 at 9:41 A.M., the DON said documentation has been an ongoing issue in the building with it being not done and being inaccurate. 2.) Resident #138 was admitted to the facility in June 2024 with diagnoses including functional urinary incontinence and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/29/25, indicated Resident #138 had severe cognitive impairment based on a Staff Assessment for Mental Status. This MDS also indicated Resident #138 had a stage three pressure ulcers, required substantial/maximal assistance to roll in bed, and was dependent of staff for toileting hygiene and transfers. Review of Resident #138's report titled 'Documentation Survey Report' (a report including certified nursing (CNA) documentation), dated January 2025 and February 2025, indicated CNA documentation for all activities of daily living was not documented on the following dates and shifts: - 1/1/25 on 7:00 A.M. to 3:00 P.M., and 11:00 P.M. to 7:00 A.M. - 1/2/25 on 11:00 P.M. to 7:00 A.M. - 1/4/25 on 11:00 P.M. to 7:00 A.M. - 1/5/25 on 7:00 A.M. to 3:00 P.M. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/6/25 on 11:00 P.M. to 7:00 A.M. - 1/12/25 on 3:00 P.M. to 11:00 P.M. - 1/13/25 on 3:00 P.M. to 11:00 P.M. - 1/17/25 on 3:00 P.M. to 11:00 P.M. - 1/18/25 on 3:00 P.M. to 11:00 P.M. - 1/19/25 on 7:00 A.M. to 3:00 P.M., and 11:00 P.M. to 7:00 A.M. - 1/20/25 on 11:00 P.M. to 7:00 A.M. - 1/21/25 on 11:00 P.M. to 7:00 A.M. - 1/22/25 on 3:00 P.M. to 11:00 P.M. and 11:00 P.M. to 7:00 A.M. - 1/23/25 on 3:00 P.M. to 11:00 P.M. and 11:00 P.M. to 7:00 A.M. - 1/24/25 on 11:00 P.M. to 7:00 A.M. - 1/25/25 on 3:00 P.M. to 11:00 P.M. - 1/26/25 on 7:00 A.M. to 3:00 P.M., 3:00 P.M. to 11:00 P.M., and 11:00 P.M. to 7:00 A.M. - 1/27/25 on 7:00 A.M. to 3:00 P.M. and 3:00 P.M. to 11:00 P.M. - 1/28/25 on 7:00 A.M. to 3:00 P.M. - 1/29/25 on 3:00 P.M. to 11:00 P.M. - 1/30/25 on 3:00 P.M. to 11:00 P.M. and 11:00 P.M. to 7:00 A.M. - 1/31/25 on 7:00 A.M. to 3:00 P.M. and 3:00 P.M. to 11:00 P.M. - 2/1/25 on 7:00 A.M. to 3:00 P.M. - 2/2/25 on 7:00 A.M. to 3:00 P.M. and 11:00 P.M. to 7:00 A.M. - 2/4/25 on 3:00 P.M. to 11:00 P.M. - 2/5/25 on 3:00 P.M. to 11:00 P.M. - 2/7/25 on 7:00 A.M. to 3:00 P.M. and 3:00 P.M. to 11:00 P.M. - 2/9/25 on 11:00 P.M. to 7:00 A.M. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Regalcare at Courtyard-Medford		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/19/25 on 11:00 P.M. to 7:00 A.M. - 2/27/25 on 11:00 P.M. to 7:00 A.M. During an interview on 3/7/25 at 1:12 P.M., CNA #8 said CNA documentation for activities of daily living should be completed by the end of the shift, and at the latest the next shift. During an interview on 3/10/25 at 9:35 A.M., Unit Manager #2 said CNA documentation for activities of daily living should be completed by the end of the shift, and at the latest the next shift. During an interview on 3/10/25 at 10:12 A.M., the Director of Nursing (DON) said CNA documentation for activities of daily living should be completed by the end of the shift. During an interview on 3/11/25 at 9:41 A.M., the DON said documentation has been an ongoing issue in the building with it being not done and being inaccurate.		

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F 0844 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 48990 Based on interviews and review of the Health Care Facility Reporting System (HCFRS-State Agency reporting system), the facility failed to provide written notice to the State Agency of a change in the Director of Nursing position. Findings include: During an interview on 3/5/25 at 3:28 P.M., the Administrator said there was a recent change in the Director of Nursing position and the new Director of Nursing started in October 2024. Review of HCFRS on 3/4/24, failed to indicate the facility submitted a change in Director of Nursing notice, as required. During an interview on 3/5/25 at 3:59 P.M., the Administrator said they did not report the change in Director of Nursing position to the state agency, as required, but should have.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, record review, and interviews, the facility failed to maintain and implement an effective pest control program on six out of six resident units in the facility which included residents reporting mice sightings daily and mice droppings in resident's rooms and resident areas. Findings include: Review of the facility policy title Pest Control, dated 1/2025, indicates the following: - Facility Management * Conduct regular inspections for potential pest entry points and address any issues promptly. * Coordinate with a licensed pest control provider to implement an IPM program. * Maintain records of pest control activities and treatment applications. - Prevention * Seal cracks and crevices around doors, windows, and utilities * Maintain proper sanitation practices, including regular cleaning of spills and debris. * Store food in airtight containers. * Regular inspect incoming deliveries for pests. - Monitoring * Establish pest monitoring stations in key areas. Throughout the survey and during the resident council meeting, multiple residents complained of pests; specifically mice, were running throughout the facility, particularly at night. Review of resident council minutes, dated 11/22/24, indicated the following: - Agenda item three: Maintenance, housekeeping, and exterminator vendor continue to work together to control mouse sightings. (Company name) started after meeting to increase Exterminator Vendor to weekly. Council members continue to report seeing mice in room. Educated residents to inform staff so that it can be documented in the Pest control book at the front desk, 11/22/24. Review of the pest control logs indicated that the pest control company provided services on 12/3/24, 12/20/24, 1/3/25, 2/7/25, 2/21/25, and on 3/7/25. There was no indication that the pest control company had visited weekly in the facility. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 3/6/25 at 3:04 A.M., a surveyor observed a mouse running in the hallway on the C Unit into a resident's room. During an observation on 3/6/25 at 3:07 A.M., the surveyors observed four mice on the A Unit. One mouse was behind the linen cart, one ran out from under the refrigerator, one ran down a wheelchair, and another ran out from under the kitchenette. 43807 Observations and interviews were conducted on all resident units as follows: A Unit: A 101-During an interview on 3/10/25 at 7:47 A.M., the Resident in bed A reported seeing mice daily from the heater during the night.(The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). A 103-During an interview on 3/10/25 at 7:57 A.M., the Resident in bed B reported seeing mice daily during the night coming from the heater.(The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 14/15 indicating intact cognition). A 109-On 3/10/25 at 8:09 A.M., the surveyor observed mice droppings in the closet, next to the dresser and air conditioner. A 111- During an interview on 3/10/25 at 8:10 A.M., the Resident in bed B reported seeing mice coming from under the heater, at least 2-4 mice daily. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition.) A 112-During an interview on 3/10/25 at 8:12 A.M., both Residents reported seeing mice every night. (The Residents' Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 13/15 and 15/15 respectively indicating intact cognition). A 113-On 3/10/25 at 8:18 A.M., the surveyor observed mice droppings next to the wheelchair storage area. The Resident in bed A said he/she sees mice daily during the night. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). A 114- On 3/10/25 at 8:19 A.M., the surveyor observed mice droppings in the bathroom. A 116-During an interview on 3/10/25 at 8:25 A.M., the Resident in bed A said he/she has seen mice in the room during the day and night. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 13/15 indicating intact cognition). On 3/10/25 at 8:43 A. M, the surveyor observed mice droppings next to the bookshelf in the dining room on unit A. A 120-On 3/10/25 at 8:45 A.M., the surveyor observed mice droppings in the storage room next to the bathroom. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A 121-During an interview on 3/10/25 at 8:48 A.M., the Resident in bed B reported seeing mice at night coming from the radiator.(The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). A 122-During an interview on 3/10/25 at 8:50 A.M., the Resident in B bed reported seeing mice at night. He/she said the mice traps in the room are not working. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). A 124- During an interview on 3/10/25 at 8:55 A.M., the Resident in B bed reported seeing mice coming from the radiator daily. He/she said he/she put a towel under the radiator and the mice are coming into the room less. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). B Unit: B 101-During an interview on 3/10/25 at 9:12 A.M., the Resident in bed B and the Resident's family member said they do see mice in the room daily. They both said the mice traps in the room are not working. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). C Unit: C 101-During an interview on 3/10/25 at 9:52 A.M., the Resident in bed A reported seeing mice in the room daily. (Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). C 102- During an interview on 3/10/25 at 9:54 A.M., the Resident in B bed said mice are present in the room daily and are coming from the radiator. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 14/15 indicating intact cognition). C 103-During an interview on 3/10/25 at 9:55 A.M., the Resident in bed B said mice are present in the room daily and they come from the radiator. Mice droppings observed next to the radiator. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 14/15 indicating intact cognition). C 104-On 3/10/25 at 9:58 A.M., the surveyor observed mice droppings at the entrance to the room. C 109-During an interview on 3/10/25 at 10:04 A.M., the Resident in bed B reported seeing mice daily coming from the radiator. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 11/15 indicating moderate impaired cognition). C 110-During an interview on 3/10/25 at 10:05 A.M., the Resident in bed A reported seeing mice coming into the room from the hallway daily. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 14/15 indicating intact cognition). (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C 118-During an interview on 3/10/25 at 10:17 A.M., the Resident in bed A reports seeing mice in the room yesterday. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 11/15 indicating moderate impaired cognition). C 121-During an interview on 3/10/25 at 10:21 A.M., the Resident in bed B reported mice are coming into the room from the radiator daily. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). C 122-On 3/10/25 at 10:22 A.M., the surveyor observed mice droppings under the bathroom sink. C 124-On 3/10/25 at 10:24 A.M., the surveyor observed mice droppings at the bathroom entrance. D Unit: D 108-During an interview on 3/10/25 at 11:08 A.M., both Residents in the room reported seeing mice coming into the room from the radiator daily. (The Residents' Minimum Data Set (MDS) dated [DATE] and 12/30/24 respectively indicated a Brief Interview for Mental Status Score (BIMS) of 13/15 and 15/15 indicating intact cognition). D 114-During an interview on 3/10/25 at 11:17 A.M., the Resident reported there was a mouse in the room today. He/she said staff removed it. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 15/15 indicating intact cognition). E Unit: E 108- On 3/10/25 at 11:48 A.M., the surveyor observed a mouse running around in the room. F Unit: F 102- During an interview on 3/10/25 at 11:58 A.M., the Resident in bed A reported seeing mice in the room daily. (The Resident's Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of 14/15 indicating intact cognition). During an interview on 3/11/25 at 7:33 A.M., Certified Nurse's Assistant (CNA) #1 said she continues to see mice and mice droppings in resident's rooms and on the unit. She said the residents have a lot of food in the room that is not stored properly and is left out. During an interview on 3/4/25 at 2:00 P.M., the Ombudsman said that the mice issue has been ongoing and asked the Administrator about implementing sealed plastic containers as storage for resident's food items and snacks. The Ombudsman said she opened a case regarding the mice on October 18th, 2024. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/11/25 at 7:36 A.M., Unit Manager #2 said she continues to see mice and mice droppings on the unit. She said she has tried to help residents store food in sealed containers but some of the residents have refused to use the sealed containers to store food. Unit Manager #2 said she has seen holes in walls in the residents' bathrooms. She said mice can hide and nest in those holes. Unit Manager #2 said there is a pest control book at the front desk. All staff are expected to report any mice sightings so pest control can address the concerns when they come to the building. During an interview on 3/11/25 at 7:20 A.M., the Housekeeping Manager said she expects the housekeeping staff to clean all residents' rooms daily. She said she expects them to wipe all items in the room, sanitize everything, sweep, mop, and take out the trash. The Housekeeping Manager said she expects the housekeepers to move items in the room and clean behind them, clean in room corners and in storage rooms. She said she is aware of the mice problem in the facility and her staff should always be available to clean mice droppings. The House Keeping Manager said keeping all the residents' rooms clean ensures a homelike environment for the residents. During an interview on 3/5/25 at 12:56 P.M., the Maintenance Director said that the facility uses an outside pest control company that he believes comes out once every 10 days. The Maintenance Director said that the mice problem has gotten really bad in the last 3-4 months and a lot of it is self-inflicted because a lot of residents are hoarders with food. The Maintenance Director said that the facility was going to provide plastic containers, but they haven't been given out yet. During an interview on 3/11/25 at 9:24 A.M., the Administrator said the pest control company is coming into the facility weekly due to the mice problem. He said families and residents have been educated to report any mice sightings to the front desk so the pest control company can address the concerns when they visit the facility. He said when holes are identified in walls, the Maintenance Director is notified to plug in the holes in walls with steel wool prior to the pest control company arriving at the facility. He said he expects the pest control company to address and treat the holes in the walls. The Administrator said he then expects the Maintenance Director to patch the holes afterwards. The Administrator said most of the residents on the units do not store their food in sealed containers. He said managers on the units emphasize proper food storage with residents. He said he expects all the residents to store food in sealed Tupperware provided by the facility. He said Tupperware has not been handed out to all residents in the facility because a bulk Tupperware order has not been made yet.		