STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225546	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Merrimack Valley	80 Boston Road Billerica, MA 01862

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 46339 Based on record review, observations and interviews, the facility failed to protect four Residents (#264, #97, #60 and #103), from neglect, out of a total sample of 30 residents. Specifically: 1. For Resident #264, the facility neglected to complete a full weekly skin check as ordered. Failed to acknowledge and respond to initial wound cultures completed on 4/26/24. Failed to notify Medical Doctor of the wound culture results 4/30/24. Failed to initiate Flagyl (antibiotic) treatment as ordered and without dosage, resulting in a worsening stage 4 pressure injury to the coccyx with a major wound infection requiring antibiotics treatment, surgical debridement, hospitalization and resulting in the resident's ultimate death. 2a. For Resident #97, the facility failed to provide care and treatment to prevent the development of pressure ulcers. Specifically, the facility failed to provide care and treatment resulting in the development of a stage 4 pressure injury to the sacrum resulting in the development of osteomyelitis requiring antibiotics treatment, surgical debridement, and multiple hospitalization s, and failed to arrange a wound clinic follow up. 2b. For Resident #97, the facility failed to respond to and implement interventions when Resident #97 developed one deep tissue pressure injury to the left heel. 3. For Resident #60, the facility failed to implement treatments, physician orders, and care plan interventions resulting in the development of a Stage 3 pressure injury to the lower back requiring antibiotic treatment and hospitalization , and failed to respond to and implement new interventions when Resident #60 developed a Stage 2 pressure injury to the right buttock, Stage 1 pressure injury to the right lateral foot, Unstageable DTI to the right outer calf, Unstageable DTI to the right heel, and failed to arrange a wound clinic follow up as indicated by the Physician. 4. For Resident #103, the facility failed to respond to and implement new interventions when a sacral wound worsened and developed signs and symptoms of infection resulting in hospitalization from [DATE] through 11/6/24 for worsening wounds, treatment with intravenous (IV) antibiotics for osteomyelitis (a bone infection), and the need for ileostomy formation for fecal diversion away from the wound. The facility also failed to arrange a wound clinic follow up as indicated by the Nurse Practitioner. Findings include: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Merrimack Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Boston Road Billerica, MA 01862	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of facility policy titled 'Abuse-prevention' last reviewed July 2023, indicated the following but not limited to: -Assure that residents are free from neglect by having the structures and process to provide needed care and services to all residents, which includes, but not limited to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently. 1. Resident #264 was admitted to the facility in March 2024 with diagnoses including Parkinson's disease and dementia. Review of Resident #264's Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #264 had severely impaired cognition as indicated by staff interview on the Brief Interview for Mental Status exam (BIMS). The MDS further indicated that the Resident had one unstageable pressure ulcer and one stage 2 pressure ulcer. The MDS further said the Resident was dependent on staff for all activities of daily living. Review of Resident #264 medical records indicated the following: Review of Resident #264's Norton Plus Pressure Ulcer Scale, dated 3/22/24 indicated a score of 8 which indicated the resident was at a high risk for developing pressure ulcer. Review of the medical record indicated a care plan Focus: At risk for break in skin integrity date initiated 3/22/24. Goal: Maintain intact skin with no skin breaks through next review. Interventions: -Clean and dry skin after each incontinent episode. -Pressure reducing mattress. -Treatment as ordered Review of weekly skin integrity data collection-V1 dated 4/25/24 indicated the following: -Skin tear to bilateral upper extremities. Review of Resident #264's medical record indicated Nurse #9 neglected to complete a full skin check as ordered and failed to indicate in the medical record that a full skin check had not been completed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 12/5/24 at 2:13 P.M., Nurse #9 said she only completed a partial skin check on 4/25/24 which included skin tears to bilateral extremities. Nurse #9 said she did not check Resident #264's coccyx. She said that Resident #264 was being combative and sundowning. Nurse #9 further said she should have documented that a partial skin check had been completed. Nurse #9 said she was concerned with the wound care at the facility as she would at times come back after two days and find the same dressings she had applied to the resident's wounds. She said she brought the concerns of the nurses not completing wound treatments and just signing off on the Treatment Administration Record (TAR) to the Director of Nursing (DON), the Assistant Director of Nursing and the two 3-11 shift supervisors. She said she also expressed the lack of competencies in wound care with the nurses at the facility especially the in house wound team who were giving recommendations to the physician and nurse. Review of Resident #264's wound observation tool -V2 dated 4/26/24 indicated the following: Resident #264 acquired a pressure ulcer to the coccyx while at the facility, Location: Coccyx Type: Pressure Stage: Unstageable Specify: slough/eschar/necrosis 75% Overall impression: First observation, no reference Drainage amount: small Wound measurements: 5.3 cm length (L) x3.1 cm width (W) x 0.1 centimeters (cm) depth (D) Additional comments: Coccyx macerated with necrosis wound with strong odor. Infection signs: Strong odor, black, green tissue Pain: Related to wound Current treatment plan: Manuka honey (a specialized honey used in wounds due to its antibacterial properties and tissue regeneration effects) and foam dressing. Review of the wound observation tool data dated 4/26/24 failed to indicate a description of the other 25% of the wound. Review of physician's order dated 4/26/24 indicated the following: Wound culture and sensitivity to coccyx. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the electronic medical records indicated the following laboratory results for wound culture collected on 4/26/24 and reported on 4/30/24 to the facility: Results as follow, Escheria coli heavy growth, skin flora isolated moderate growth and vancomycin resistant enterococcus faecalis heavy growth. Review of the medical record failed to indicate the physician was made aware of the wound culture results dated 4/30/24. Review of Resident #264 care plan date initiated 4/29/24 indicated the following focus and interventions: -The Resident has potential/actual impairment to skin integrity of the coccyx related to pressure and moisture. With the following Interventions but not limited to: -Assess location, size and treatment of skin injury. Report abnormalities failure to heal, signs and symptoms of infection, macerated to Medical Doctor. - Review of Resident #264's wound observation tool -V2 dated 5/1//24 indicated the following: Location: Coccyx Type: Pressure Stage: Unstageable Specify: Slough/Eschar Overall impression: Unchanged with 25% slough, 25% necrosis. Drainage amount: Moderate serosanguinous Wound measurements: 7.0 x 4.0 x 0.1 cm depth Additional comments: edges are macerated/peeling skin surrounding. Infection signs: no Pain: no Current treatment plan: drawtex (dressing that absorbs wound drainage) and foam dressing. Review of nurse's progress note dated 5/1/24 indicated the following: Wound culture results cannot be located. MD (medical doctor) notified; wound does not show signs of infection. MD did not want a new culture. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of nurse's note dated 5/7/24 indicated the following: Mattress swapped out for air mattress on shift due to wound. Review of the medical record indicated Resident #264 air mattress was not applied until 11 days after the coccyx wound was first identified (4/26/24). Review of Resident #264's wound observation tool - V2 dated 5/8/24 indicated the following: Location: coccyx Type: pressure Stage: unstageable Specify: slough/eschar Overall impression: Worsening 80% slough, 20% necrosis. Drainage amount: moderate serosanguinous Wound measurements: 9.0 x 5.0 x 0.1 cm depth Additional comments: edges are macerated/peeling skin surrounding with redness surrounding. Infection signs: Odor to wound. Pain: no Current treatment plan: Santyl (ointment used to remove damaged tissues from wounds) and cover with foam. Review of the nurse's note dated 5/8/24 indicated the wound was worsening and wound culture and sensitivity to be obtained. Review of Physician #1's progress note dated 5/10/24 indicated the following: Patient had urine culture done with Foley change that showed Pseudomonas (a gram-negative bacteria that causes infections) of note the patient is allergic to Levaquin also his/her coccygeal wound has been getting worse with is smelly with more drainage is growing out Enterococcus and E. coli so far only once sensitivity available would also be sensitive to cefepime. [sic] Review of the medical record indicated orders implemented on 5/10/24 for cefepime (an antibiotic used to treat infections) intravenous 2 grams every 12 hours for wound infection and urinary tract infection for 10 days. Review of the medical record indicated that the antibiotic treatment was initiated 15 days after the initial observation of the wound with infection on 4/26/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #264's wound observation tool-V2 dated 5/15/24 indicated the following: Location: Coccyx Type: pressure Stage: Unstageable Specify: slough/eschar Overall impression: unchanged 5% slough, 85% necrosis Drainage amount: Moderate purulent Wound measurements: 6.0 x 4.0 x 0.1 cm depth Additional comments: green around the edges Infection signs: odor, purulent drainage Pain: no Current treatment plan: Santyl and foam dressing. Review of the wound observation tool assessment dated [DATE] indicated the wound continued to worsen with presence of odor and purulent drainage despite being on antibiotic treatment. Record review failed to indicate the physician was notified of the wound worsening with presence of odor and purulent drainage. Review of the physician note dated 5/17/24 indicated the following: This IV (intravenous) cefepime to continue through 5/21. Reviewing labs the Enterococcus was never covered can give him/her amoxicillin for another 10 days. [sic] Review of the medical record indicated the following order dated 5/17/24: Amoxicillin (antibiotic) 500 mg give one capsule by mouth three times a day for 10 days due to enterococcus (bacteria) in the wound. Review of the medical record indicated there was a delay in treating the Enterococcus bacteria for six days after the facility received the wound culture results. Review of Resident #264's wound observation tool-V2 dated 5/29/24 indicated the following: Location: coccyx Type: pressure (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Stage: unstageable Specify: slough/eschar Overall impression: improving 75% slough. Drainage amount: moderate serosanguinous, Wound measurements: 10 x 5.0 x1.4 cm depth Tunneling/undermining: undermine from 3 o'clock to 12 o'clock Additional comments: green tissue noted throughout wound bed undermining depth noted at 3 o'clock measuring 4.5 cm slough mixture that covered top of wound bed not allowing us to visualize the depths has now been debrided which allows us to see the slough on the base of the wound bed, macerated at 4-6 o'clock. Infection signs: no Pain: no Current treatment. Melgisorb (a brand of wound dressing used for wounds with moderate to heavy drainage) cover with foam. Review of the nurse's progress note dated 6/2/24 indicated the wound had odor, and physician #1 ordered Flagyl antibiotic. Review of medical records indicated orders implemented on 6/2/24 for flagyl oral capsule (flagyl oral capsule can be applied topically to decrease wound odor), apply to coccyx wound topically two times a day for 7 days. Review of the MAR (Medication Administration Record) for June 2024 indicated the facility neglected to implement flagyl antibiotic, as ordered, for 7 days, and the order was incomplete without a dosage. Review of the medical record TAR (Treatment Administration Record) dated 6/2/24 through 6/5/24 failed to indicate that the wound dressing changes were done as ordered, and therefore there was no evidence that the flagyl antibiotic had been applied as ordered. Review of the medical record indicated the following physician note dated 6/3/24, The patient being seen and follow-up for wound care. Concerned about the smell of his/her decubitus ulcer and was put on topical Flagyl over the weekend. The patient recently completed IV (intra venous) cefepime (antibiotic) there is question that his/her wound is worsening. Resident is on oral flagyl (antibiotic) based on prior cultures resident would generally be a candidate for cipro (antibiotic) but they are allergic. Would need to reinitiate cefepime if needed. At this point wound appears larger but not worsening with infection continue to follow closely. [sic] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of medical record failed to indicate the physician was notified that the Resident only received flagyl for three days and not for seven days as ordered. Review of wound observation tool-V2 dated 7/3/24 indicated the following: Location: coccyx Type: pressure Stage: unstageable Specify: slough/eschar Overall impression: worsening 90% necrosis. Drainage amount: large serosanguinous Wound measurements: 15 x 10 x 2.0 cm depth Tunneling/undermining: undermining 3-11 o'clock Additional comments: undermining depth noted at 3 o'clock measuring 2.5 cm macerated edge at 3-7 o'clock on antibiotic, coccyx wound extends to right and left buttock. 3-9 o'clock necrotic area. 9-3 o'clock granulation. Macerated granulated tissue extending to left and right buttock push score 17. Infection signs: yes Pain: no Current treatment. Santyl and foam dressing. Review of physician #2's (Physician #2 was covering for Physician #1) progress note dated 7/3/24 indicated the following: The patient is seen in follow-up as requested by nursing. The patient has been noted with foul smelling discharge from a large chronic sacral pressure wound. On examination the wound is with large amount of foul-smelling discharge, necrotic. I discussed with patient's spouse, nursing manager and director of nursing. This morning the resident is unlikely to heal without extensive debridement and antibiotic therapy. Superficial culture should not be relied on to guide antibiotic therapy as the frequently represent colonization. Spouse agrees with my assessment and wants patient to be transferred to the hospital for continuation of care. Review of the hospital medical record dated 7/3/24 indicated the following: Resident presents from nursing home for evaluation of worsening pressure ulcers of heels and coccyx. Reportedly today there was a different doctor on the wound team who insisted the patient come to the emergency department for further evaluation of right heel and coccyx pressure ulcers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/20/24 at 10:45 A.M., Resident #264's Spouse said the nursing care was horrible. The Spouse further said that during a family team meeting on 6/25/24 , the family requested for Resident #264 to be sent to the hospital for further wound treatment and they were told by the facility that the facility had seen worse wounds than Resident #264 had. The Spouse further said that when Resident #264 was sent to the hospital in July, the Resident was never cleaned, when they got to the hospital, the nurse at the hospital uncovered the Resident's wound dressing, which had feces in them. The Spouse said that Resident #264's wound needed debridement and ultimately the resident passed away from the wound complications. During an interview on 11/20/24 at 10:57 A.M., Resident #264's Representative #2 said during a team family meeting with the Social Worker, Physical Therapist, and Director of Nursing in the room, had asked at what point do they refer Resident to outside care, they said that they had seen worse cases. Resident Representative #2 said when the covering Doctor came to the facility, he sent the Resident to the hospital for severe infection in the wound that required debridement. Representative #2 said the hospital said the Resident incurred fractures to the coccyx bones due to the extent of the infection that ultimately resulted in Resident #264's death. During an interview on 11/21/24 at 9:13 A.M., Unit Manager #1 and Unit Manager #2 said that they are the wound nurses in the facility and are both Licensed Practical Nurses. They said they took an online course through the facility and an online test which took approximately 8 hours total. They said once the online course was completed, they were considered effective on their own for wound care in the facility. They said no one comes in or completes in-person competencies for wound care with them. Unit Manager #1 and Unit Manager #2 said that at this time they are the only ones rounding as the wound team for all the wounds in the facility. Unit Manager #1 and Unit Manager #2 said that they observe the wounds weekly and make recommendations for treatments to the Physician or Nurse Practitioner. Unit Manager #1 and Unit Manager #2 said they make their recommendations based of their assessment of the wound. If the current treatment is working, then they will continue with it but if it isn't working, the wound is stagnant or not changing or improving, then they will change the treatment. They said if they change a treatment recommendation, they do not specifically document why they are changing the treatment recommendations. Unit Manager #1 and Unit Manager #2 said that a worsening wound would be one with more drainage, redness, signs of infection, and would expect a dressing recommendation to change based on an assessment of a worsening wound as mentioned. Unit Manager #2 said up until recently she did not know how to stage wounds. When asked about referring residents to a wound clinic, they said they do not often refer residents to the wound clinic and manage them in house. They also said that in general they don't see wounds worsening in the facility or wound infections occurring. They said a weekly skin check consisted of assessing a resident's skin from head to toe and documenting any concerns, they said for Resident #264, the skin check that was completed on 4/25/24 was inaccurate as an unstageable pressure ulcer was identified the following day. Unit Manager #2 said Resident #264 was not a concern on her unit with any kind of increased behaviors, Unit Manager #2 said that Resident #264's wounds got infected when Physician #1 was on vacation and that a covering physician sent the Resident to the hospital and that the Resident never returned to the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/20/24 at 10:33 A.M., the Director of Nursing (DON) said the facility does not have a wound doctor, they have a wound team that consist of the Unit Managers from unit A and B, she said the Unit Managers do weekly wound rounds and they give wound recommendations based on their knowledge and expertise. She said transportation with stretcher has been an issue hence unable to send residents to the wound clinic. The DON said she was not part of the wound team; the wound team would go to her if they had a question, or they reach out to corporate. The DON said she was not sure how often the MD/NP Medical Director/Nurse Practitioner looked at the wounds. The DON said that during care the certified nursing assistants would report any skin issues to the nurses and that Resident #264's skin issue should have been identified sooner. The DON said if a wound was getting worse it would have the symptoms of redness, increased slough or drainage and foul odor. For preventative measures, the DON said the residents with pressure ulcers will have an air mattress which is set to comfort. She said if the air mattress is not set properly, it would cause further skin damage/injury to the resident. For Resident #264, the DON said she does not recall the family asking for the Resident to be sent out to the hospital. The DON said that Resident #264 wounds got worse when the Medical Director was on vacation and the covering physician sent the resident to the hospital as the wound required sharps debridement. During an interview on 11/26/24 at 10:11 A.M., for Resident #264 the DON said neglect is defined as not providing care that a resident required. When the surveyor asked the DON if not providing care that a resident required causing physical harm if that was considered neglect she said yes. During an interview on 11/21/24 at 1:34 P.M., CNA #2 said during care they watch for bruises, skin tears, pressure areas on bony areas and notify the nurse, if the resident refuses care they document. During an interview on 11/22/24 at 6:45 A.M., CNA #1 who was the assigned CNA for Resident #264 the night prior to the identification of the coccyx wound on 4/26/24 said if there were any skin concerns noted on the Resident she would have reported to the nurse. During an interview on 11/22/24 at 8:43 A.M., the Regional Director of Clinical Services said that there is not a wound physician who currently rounds in the facility. During an interview on 11/22/24 at 9:38 A.M., Physician #1 said that his expectation is that nurses who are competent in wound care perform wound rounds and make recommendations to him about what residents' needs are and what residents he needs to visualize the wounds of himself. He said he is not a wound expert, and he relies on the wound team for wound treatment recommendations and implementation of new orders. For Resident #264, Physician #1 said he treated the Resident with multiple courses of antibiotics. He said if the wound got bigger with slough and systemic fever, the resident would have been sent to the hospital for debridement. He said Resident #264 should have been sent to the hospital sooner. During an interview on 11/25/24 at 12:25 P.M., Physician #2 said he is an infectious disease specialist and he saw Resident #264 on the day he sent the resident to the hospital. He described seeing the wound as a large sacral ulcer with gangrene (dead tissue), necrotic tissue (dead tissue due to lack of blood flow). He said the presentation of gangrene and necrosis tends to be infection and the wound needed extensive debridement. Review of the hospital discharge record dated 7/3/24 indicated the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Patient has ongoing chronic pressure ulcers in the coccyx and heel. Apparently, patient had a new dressing placed on the day of presentation, when asked further wound team in the facility, the wound appeared significantly worsened after which the patient was sent to the emergency department for further evaluation. The patient had a large wound in the coccyx with soiled dressing and a deep tissue injury to right heel. A cat scan (CT) of pelvis indicated the following: Large broad decubitus ulceration and with extension to the coccygeal bone and underlying bony changes of Cx2 and Cx3 coccygeal segments most consistent with osteomyelitis. Deep extension of soft tissue stranding, and gas as described. Patient was discharge to hospice care. [sic] Review of the hospice care medical records dated 7/28/24 indicated the following: Medical Examiner Case Assessment: Reason for assigned case: Other. Describe the rational for designation of case: Neglect. Will the injury be included in the death certificate: Yes, as primary cause of death. What will be listed as primary cause of death: Osteomyelitis. Injury: Unstageable wound to sacrum. 48671 2a. Resident #97 was admitted to the facility in October 2023 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, dysphagia, cognitive communication deficit, and anxiety. Review of Resident #97's Minimum Data Set (MDS) assessment, dated 9/4/24, indicated that Resident #97 had severely impaired cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out of 15, and is dependent on staff for all activities of daily living tasks. The MDS indicated Resident #97 was at risk for developing pressure injuries and indicated the use of a pressure reducing device for chair and pressure reducing device for bed. Review of Resident #97's Braden Scale for Predicting Pressure Injury Risk, dated 11/5/24, indicated a score of 11 indicating the Resident is at high risk for developing pressure injuries. Review of the initial admission paperwork from October 2023 indicated one R (right) medial foot blister surrounding skin red and blanching. Resident #97 was admitted to the facility in October 2023 and developed an unstageable right buttock wound on 11/22/23 and a Left Heel DTI on 11/28/23 with recommendations for heel booties. Review of the medical record failed to indicate physician treatment orders or care plan interventions were implemented. Review of Resident #97's Wound Observation Tool, dated 11/22/23, indicated: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Right buttock Worsening, granulation tissue, slough tissue, necrotic Tissue present (eschar) present (brown, black, leather). Length 1.5cm. x Width 1.0cm. Depth 0.1cm. Encourage offloading. Treatment orders: Wound care to right buttocks. Clean with ns (NS), pat dry. Apply manuka honey to wound bed and cover with allevyn or equivalent foam dressing. Every day shift and as needed. Dated 11/22/23. Review of the physician progress note dated 11/24/23 indicated no skin rashes or pressure ulcers. Review of the November 2023 Treatment Administration Record (TAR) indicated that the physician order for manuka honey treatment to the right buttock was not documented until 11/24/23 and failed to indicate the treatment order was completed as ordered on 11/26/23, the TAR was left blank and contained no documentation. Review of the physician progress note dated 12/6/23 indicated, coccygeal ulcer with mild redness around it. Possible wound infection based on patient's decreased energy level and foul odor. During an interview on 11/22/24 at 9:36 A.M., Physician #1 (Also the facility Medical Director) said the right buttock wound is referenced as the coccygeal ulcer in the visit note. Review of the medical record indicated that on 12/6/23 the wound to the right buttock deteriorated and required antibiotic therapy and a physician order for Keflex (an antibiotic) 500 mg. (milligrams), 3 times per day for 7 days was ordered on 12/6/23. Further review of Resident #97's medical record indicated the following physician orders: -Wound care to right buttocks. Clean with ns (NS), pat dry. Apply Santyl (collagenase ointment for wounds) to wound bed and cover with allevyn (highly absorbent foam dressing) or equivalent foam dressing. Every day shift every other day and PRN (as needed). Dated 12/8/23. Review of the December 2023 Treatment Administration Record (TAR) indicated that the physician order for Santyl treatment to the right buttock was not documented as completed on 12/8, 12/11 or 12/13, the TAR was left blank and contained no documentation. Review of the Nurse Practitioner Progress note dated 12/12/23 indicated Resident #97's wound is not improving per wound team. Coccyx decubiti. No improvement with recent Keflex. Last dose will be 12/13/2023 continue wound team consult and daily dressings with Santyl for debridement. Review of the weekly wound observation tool dated 12/13/23, indicated the unstageable right buttock pressure wound was showing signs of infection with purulent drainage and order. Resident #97 was documented to have pain and was yelling out. Length 4.5 cm. x Width 1.5 cm. x Depth 1.5 cm. Slough, Eschar. Extent of necrosis is 80% thin light brown. Necrotic tissue peeling up from 4-8 o'clock. Thin light brown color. Red irritation/rash scattered around. Moderate serosanguineous drainage. Treatment in place: Wound care to buttocks. Clean with NS, pat dry. Apply Santyl to wound bed and cover with allevyn or equivalent foam dressing. Encourage offloading. MD not notified, not new area. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The wound observation tool indicated the physician was not notified of the of the wound observation tool assessment on 12/13/23. Review of the care plan failed to indicated there was evidence that offloading of the coccyx wound was implemented. Review of Resident #97's medical record indicated he/she was hospitalized on [DATE] through 12/20/24 due to worsening mental status and fever. Review of the hospital discharge summary dated 12/20/23 indicated the following: admitted for treatment of cellulitis at the sacral wound and osteonecrosis of the left femoral head. CT (Computed Tomography medical imaging scan) showing air in soft tissue of the right medial buttock consistent with sacral ulcer. Incidental finding of left hip avascular necrosis with mild degenerative change noted. Patient to follow-up with [NAME] wound care. Referral sent at discharge, please follow up for making and attendance to that appointment. Avoid direct pressure to the area, frequent pressure offloading. Discharge Wound Care Recommendations included: BID (twice daily) dressing changes. Santyl, Dakins (antiseptic solution used for wound cleaning) soaked wet to dry, cover with 4x 4 gauze. Turn q2h (every 2 hours) hob (head of bed) <30 (less than). No sitting in chair >1hr (greater than one hour) use cushion. Air mattress. Avoid direct pressure to the area, frequent pressure offloading. Review of the re-admission facility physician progress note dated 12/20/23, indicated: Patient hospitalized with fever, CT done which showed hematoma. MRI showed cellulitis but no osteomyelitis, had a bedside debridement by plastic surgery on December 17th. He/she is in for twice daily dressing changes with Dakin's. Osteonecrosis of the left femoral head. Further review of the medical record failed to indicate a physician treatment order for Santyl, Dakins soaked wet to dry, cover with 4 x 4 gauze was ordered, and contained no treatment documentation. Review of Resident #97's medical record failed to indicate that a follow up appointment at the wound clinic was arranged by facility staff. Review of Resident #97's skin integrity care plan dated 10/5/23, and last revised 9/18/24, indicated the following interventions: -Weekly skin checks -Treatments as ordered (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Clean and dry skin after each incontinent episode. -Assess location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. -Follow facility protocols for treatment of injury. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Review of Resident #97's care plan failed to indicate the following interventions were implemented: heel booties, head of bed <30 degrees or less, no sitting in chair greater than one hour, use of cushion, and an air mattress. Review of Resident #97's Weekly Skin Integrity Data Collection form dated 12/21/23, indicated the following: Skin intact: No, discolorations scattered to bilateral arms, open coccyx wound, o [TRUNCATED]

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F 0655 Level of Harm - Actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 48671 Based on observation, interview and record review, the facility failed to ensure it completed a baseline care plan for one Resident (#60) out of 30 sampled residents. Specifically, the facility failed to complete a baseline care plan to address a surgical wound to the lower leg with a leg splint and failed to implement care plan interventions resulting in the development of a Stage 3 pressure injury to the lower back requiring antibiotic treatment and hospitalization , right buttock Stage 2 pressure injury, right lateral foot stage 1 pressure injury, right outer calf DTI (Deep Tissue Injury), and right heel DTI. The facility failed to respond to, and implement new interventions when Resident #60 developed new pressure injuries. Findings include: Resident #60 was admitted to the facility in October 2024 with diagnoses including multiple sclerosis, cellulitis of right lower limb, sepsis due to streptococcus group A, type one diabetes with foot ulcer, unspecified protein calorie malnutrition, muscle weakness, cognitive communication deficit, acute hematogenous osteomyelitis of right ankle and foot, raynaud's syndrome, spinal stenosis, and non-pressure chronic ulcer of right ankle. Review of Resident #60's Minimum Data Set (MDS) assessment, dated 10/18/24, indicated that Resident #60 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15, and is dependent on staff for activities of daily living tasks. Further review of the MDS indicated Resident #60 was at risk for developing pressure injuries and indicated the use of a pressure reducing device for chair and pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, applications of ointments/medications other than to feet, and applications to dressings of feet with or without topical medications. Review of Resident #60's Braden Scale for Predicting Pressure Injury Risk, dated 11/15/24, indicated a score of 16 indicating the Resident is at risk for developing pressure injuries. Review of Resident #60's Nursing Admission/Readmission Collection Tool dated 10/16/24, indicated Diabetic ulcer to RLE (right lower extremity), unable to visualize as dressing is in place and not to be removed until follow up appointment on October 22 with ortho (orthopedic). Limited/non-weight bearing - right. Review of the hospital discharge summary dated 10/16/24, indicated Resident #60 was admitted with group a bacteremia, encephalopathy, right diabetic foot ulcer complicated by cellulitis and acute lateral malleolus osteomyelitis. Discharge instructions included: -Weight bearing restrictions to the right lower extremity. -Right lower extremity in posterior slab splint, elevate right lower extremity above heart as much as possible. (continued on next page)

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F 0655 Level of Harm - Actual harm Residents Affected - Few	-Do not remove dressing before follow up visit. Follow up with orthopedic surgery. -Up in chair x 2hrs max during day w/waffle cushion on chair at all times. -Activity Recommendation OOB (out of bed) to chair with Prevalon Mat (cushion of air to help with transfers). -Equipment Recommendations: Prevalon Mat. Review of the discharge paperwork indicated the following skin conditions: Wounds: Traumatic Malleolus Right Lateral 6/19/24. Incision Leg Right, 10/7/24 Wound Description 4x4's Webril, Plaster Splint Ace (Webril leg splint is a type of medical bandage used to manage swelling, particularly to the lower leg or foot). Review of Resident #60's baseline care plan dated 10/20/24, indicated: -Encourage good nutrition and hydration in order to promote healthier skin. -Encourage offloading, and repositioning. -Enhanced barrier precautions -Follow facility protocols for treatment of injury. Review of Resident #60's baseline care plan was incomplete and failed to include goals or nursing interventions for wound management. Review of the facility document titled Wound Observation Tool dated 10/30/24, indicated that Resident #60 had five new identified skin areas including: - Right Buttock Pressure Stage 2 10/30/24. Measurement: Length 1.4cm. x 1.0cm. x 0.1cm. - Coccyx Pressure Stage 3 Wound Measurements: Length 1.0cm. x Width 1.0cm. x Depth 0.1 cm. - Right Lateral Foot Stage 1 Wound Measurements: Length 1.7cm. x Width 1.3cm. x Depth 0.0cm. - Right Calf Outer Pressure unstageable- DTI (Deep Tissue Injury). Measurements: Length 7.0cm. x Width 3.0cm. x Depth 0.0cm. - Right Heel Pressure unstageable- DTI (Deep Tissue Injury). Measurements: Length 7.0cm. x Width 3.0cm. x Depth 0.0cm. The Skin Check assessment included the following special equipment/preventive measures: Air mattress, offload as tolerated, turn/reposition, offloading heels. Review of Resident #60's care plan for skin breakdown failed to indicate the interventions recommended from the Skin Check assessment were initiated. (continued on next page)

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F 0655 Level of Harm - Actual harm Residents Affected - Few	On 11/18/24 at 8:43 A.M., the surveyor observed Resident #60 sitting up in bed. The Resident said he/she has lower back pain due to bedsores and said he/she developed a wound to his/her lower leg due to a splint that was not removed after surgery and additional wounds to his/her back. The Resident said he/she was scheduled to have wound debridement done but said he/she has not seen a wound doctor in the facility. There was no air mattress on Resident #60's bed. During an interview on 11/25/24 at 2:13 P.M., Nurse #6 said Resident #60 would have benefited from an air mattress on admission because he/she has been getting more wounds. On 11/25/24 at 2:47 P.M., Resident #60 was sitting up in bed. The Resident said he/she was just given a new mattress and said he/she still has pain to the coccyx area. During an interview on 11/21/24 at 9:23 A.M., Unit Manager #2 said the care plan should have been updated because the Resident was admitted with a wound and is at high risk of developing pressure areas. During an interview on 11/21/24 at 11:55 A.M. the Director of Nursing (DON) said that she would expect wound treatment orders and recommendations to be followed and said care plan interventions should have been implemented on admission. The DON said the Resident is high risk for skin break down and she would expect to see an air mattress order in place and to be on the care plan as well as cushioning, turning and repositioning, offloading of heels and use of the plaster splint should have been documented and assessed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to develop and implement person-centered care plans for two Residents (#42, and #83) out of a sample of 30 Residents. Specifically, 1. For Resident #42, the facility failed to implement an Activities of Daily Living (ADL) care plan. 2. For Resident #83 the facility failed to develop a person-centered behavior and history of substance abuse care plan. Findings include: A review of the facility policy titled Area of Focus: Care Planning-Baseline, Comprehensive, and Routine Updates reviewed 1/4/24 indicated the following: -The facility is required to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs. -The comprehensive care plan must include a problem/focus statement, measurable goals, and interventions. A review of the facility policy titled 'Behavioral Health Services' reviewed 9/6/24 indicated the following: -The facility will provide behavioral health care and services that create an environment that promotes emotional and psychosocial well-being, meet each resident's needs and include individualized approaches to care. Procedure: -Complete a social services assessment upon admission/readmission, quarterly and as needed with change in condition. -Initiate behavior monitoring, behavior management care plan and Kardex as indicated by assessment findings. The Social Worker is primarily responsible for initiation of the behavior management care plan. 1. Resident #42 was admitted to the facility in April 2017 with diagnoses including Dementia and depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 indicating severe impairment. Further review of the MDS indicated the following: -The ability to transfer to and from a bed to a chair (or wheelchair))-dependent-helper does all of the effort, resident does none of the effort to complete the activity. A review of Resident #42's Activities Daily Living (ADL) care plan initiated 4/24/19 indicated the following interventions: -Resident utilizes wheelchair and requires staff assist for locomotion. -Resident requires mechanical lift (Hoyer) with two assist for transfers. A review Resident #42's transfer tasks from 5/20/24-5/27/24 indicated that staff signed off they completed transfer tasks as follows: - Transfer-Self Performance-How the resident moves between surfaces including to and from bed, chair, wheelchair, standing position (excludes to/from bath/toilet). - Transfer-Support provided- How the resident moves between surfaces including to and from bed, chair, wheelchair, standing position (excludes to/from bath/toilet). -5/20/24-Day shift-4,2-4-Total dependence (Full staff performance), 2-One-person physical assist, Evening shift-3,2-3-Extensive assistance (Resident involved in activity, staff provide weight bearing support), 2-One-person physical assist. -5/21/24-Evening shift-4,2-4-Total dependence (Full staff performance), 2-One-person physical assist. -5/26/24-Day shift-2,2-2-Limited assistance (Resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight bearing assistance) 2-One-person physical assist. During an interview and record review on 11/22/24 at 6:15 A.M., Certified Nurse's Assistant (CNA) #5 said all staff are expected to follow the care plan, he said all residents on mechanical lifts, Hoyers, for transfers should be transferred by two staff at all times. CNA #5 said if the Resident is not transferred by two staff, the transfer could be dangerous, he said the Resident could get injured, get a skin tear, fall, or get stuck in the equipment during the transfer. CNA #5 said Resident #42 should always be transferred by two staff at all times. CNA #5 did not have any comment after reviewing the May 2024 transfer record indicating he signed off on 5/21/24 evening shift that he transferred Resident #42 alone. CNA #5 did not have any comment when the surveyor asked if he transferred Resident #42 alone on 5/21/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 11/22/24 at 7:46 A.M., CNA #7 said care plans should always be followed, she said residents who should be transferred with a Hoyer lift should be transferred by two staff at all times. CNA #7 said if the residents are transferred by one staff only, they could get hurt, get skin tears, fall, fracture and could possibly die. After reviewing the May 2024 transfer record with the surveyor, CNA #7 had no comment on why she documented that she transferred Resident #42 alone on 5/20/24 day shift. CNA #7 did not have any comment when the surveyor asked if she transferred Resident #42 alone on 5/20/24 day shift. During a telephone interview on 11/22/24 at 9:12 A.M., CNA #9 said all care plans should be followed, she said all residents on Hoyer transfers should be transferred by two staff at all times. CNA #9 was informed by the surveyor that on 5/20/24 evening shift, she signed off the transfer task that she transferred Resident #42 alone. CNA #9 did not have any comment when the surveyor asked if she transferred Resident # 42 alone on 5/20/24 evening shift. CNA #9 said Resident #42 should not be transferred by one staff. During an interview and record review on 11/22/24 at 8:09 A.M., CNA #8 said care plans should be followed at all times, she said residents requiring a two-person transfer should always be transferred by two staff. She said if one staff attempts to complete the transfer, the resident could fall and get injured. CNA #8 and the surveyor reviewed the May 2024 transfer record indicating she transferred Resident #42 alone on 5/26/24 day shift. CNA #8 did not have any comment when the surveyor asked if she transferred Resident #42 alone on 5/26/24 day shift. During an interview and record review on 11/22/24 at 10:15 A.M., Unit Manager #2 said she expects all the staff on the unit to follow care plans. Unit Manager #2 said residents who require a two person transfer with a Hoyer lift should always be transferred by two staff. She said if staff transfer the resident alone, the resident could get stuck in the wheelchair, the Hoyer lift could tip, the Resident could get tangled in the wheelchair and get injured. Unit Manager #2 said Resident #42 should be transferred by two staff at al times. During an interview on 11/25/24 at 6:27 A.M., Nurse #8 said he expects staff to follow all care plans, he said residents who require a Hoyer to transfer should be transferred by two staff at all times. Nurse #8 said if staff transfer the resident alone, the resident could get injured, the resident could fall and acquire skin tears. Nurse #8 said Resident #42 should be transferred by two staff at all times. During an interview and record review on 11/25/24 at 9:08 A.M., The Director of Rehabilitation said Resident #42 should be transferred with a Hoyer lift and two staff should always assist. During an interview on 11/25/24 at 9:58 A.M., the Director of Nurses (DON) said all care plans should be followed as written. She said she expects all residents who are transferred by a Hoyer lift to have two staff assisting during transfers at all times. The DON said she was not aware that staff were documenting that they were transferring Resident #42 alone. The DON said if staff transfer the residents on Hoyer transfers alone, the residents could have potential for injuries which include fractures, and skin tears. The DON said Resident #42 should always be transferred by two staff at all times. 2. Resident #83 was admitted to the facility in August 2021 with diagnoses including major depressive disorder, hallucinations and psychotic disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 indicating severe cognitive impairment. A review of a medication management behavioral health note dated 9/10/24 indicated the following: -Chief complaint- Requested to be seen by staff for anxiety. -History of present illness- hallucinations and paranoid delusions. Substance Use/Addiction history-Resident consumed alcohol in his/her early life, history of alcohol use disorder, history reviewed (no changes). A review of the behavior care plan dated 5/4/23 indicated the following: - Resident has noted behaviors including accusing of others, expressing frustration/anger towards others, disruptive sounds, and wandering causing disruption to others and the environment requiring staff intervention. [sic] A review of the mood and behavior care plan dated 2/7/23 indicated the following: -At risk for change in mood and behavior due to dementia, (resident exhibits confusion, anxiety and paranoia). [sic] During an interview and record review on 11/21/24 at 1:13 P.M., Social Worker #1 and the Surveyor reviewed Resident #83's care plan. Social Worker #1 said that all of the Resident's behaviors were not included in the behavior care plan. She said a hallucinations and a history of alcohol abuse care plan should be developed. The Social Worker said the care plan that included paranoia as a behavior did not personalize the Resident's paranoid delusions. Social Worker #1 said all residents' behavior care plans should be person centered.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, interviews, and record review, the facility failed to provide care and treatment to prevent the development and worsening of pressure injury's (wounds that occur when the skin and tissue are damaged by prolonged pressure, usually on bony areas like the coccyx, hips, heels, or elbows) for six Residents (#264, #103, #97, #60, #63 and #20) out of a total sample of 30 residents. Specifically: 1. For Resident #264, the facility failed to provide care and treatment to prevent the development of pressure ulcers. Specifically, the facility failed to provide care and treatment resulting in a worsening stage 4 pressure injury to the coccyx with a major wound infection requiring antibiotics treatment, surgical debridement, hospitalization and ultimate death. 2. For Resident #103, facility failed to respond to and implement new interventions when Resident #103's wound worsened and developed signs and symptoms of infection. The facility also failed to arrange a wound clinic follow up as indicated by the Nurse Practitioner. 3a. For Resident #97, the facility failed to provide care and treatment to prevent the development of a Stage 4 pressure injury to the sacrum resulting in the development of osteomyelitis requiring antibiotics treatment, surgical debridement, and multiple hospitalization s and failed to arrange for a wound clinic follow up. 3b. For Resident #97, the facility failed to respond to and implement interventions when Resident #97 developed one Deep Tissue Injury to the left heel. 4. For Resident #60, the facility failed to implement treatments, physician orders, and care plan interventions resulting in the development of a Stage 3 pressure injury to the lower back requiring antibiotic treatment and hospitalization , and failed to respond to and implement new interventions when Resident #60 developed a Stage 2 pressure injury to the right buttock, Stage 1 pressure injury to the right lateral foot, Unstageable DTI to the right outer calf, Unstageable DTI to the right heel, and failed to arrange a wound clinic follow up as indicated by the Physician. 5. For Resident #63, the faciltiy failed to apply heel boots (boots primarily used to prevent pressure ulcers, particularly on the heels) as ordered. 6. For Resident #20, the facility failed to ensure an air mattress was set to the correct setting as ordered by the physician. Findings Include: Review of facility policy titled Skin Integrity & Pressure Ulcer/ Injury Prevention and Management, dated as revised 7/9/24 indicted the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Merrimack Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Boston Road Billerica, MA 01862	

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Policy: Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/ injury, complete wound assessment/ documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy, Continent Nurses Society) 1.A skin assessment/inspection should be performed weekly by a licensed nurse. (a) Skin observations also occur throughout points of care provided by certified nursing assistants (CNA) during activities of daily living (ADL) care. Any changes or open areas are reported to the nurse. CNAs will also report to nurse if topical dressing is identified as soiled, saturated, or dislodged. Nurse will complete further inspection/assessment and provide treatment if needed. 2.Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process illness or need for rehabilitation. Review of facility policy titled Treatment Orders, dated as revised 4/19/22, indicated the following: -Based on the comprehensive assessment of a resident, the facility must ensure that- - A resident receives care, consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and -(ii) A resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new pressure ulcers from developing -Procedure: 3. The physician order is followed, as are the manufacturer's instructions for use for each product ordered. 4. Treatment order templates in [the electronic medical record] may be used. 1. Resident #264 was admitted to the facility in March 2024 with diagnoses including Parkinson's disease and dementia. Review of Resident #264's Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #264 had severely impaired cognition as indicated by staff interview on the Brief Interview for Mental Status exam (BIMS). The MDS further indicated that the Resident had one unstageable pressure ulcer and one stage 2 pressure ulcer. The MDS further said the Resident was dependent on staff for all activities of daily living. Review of Resident #264 medical records indicated the following: Review of Resident #264's Norton Plus Pressure Ulcer Scale, dated 3/22/24 indicated a score of 8 which indicated the resident was at a high risk for developing pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record indicated a care plan Focus: At risk for break in skin integrity date initiated 3/22/24. Goal: Maintain intact skin with no skin breaks through next review. Interventions: -Clean and dry skin after each incontinent episode. -Pressure reducing mattress. -Treatment as ordered Review of weekly skin integrity data collection-V1 dated 4/25/24 indicated the following: -Skin tear to bilateral upper extremities. Review of the weekly skin integrity data collection dated 4/25/24 failed to indicate that there were any skin alterations to the coccyx area. During a phone interview on 12/5/24 at 2:13 P.M., Nurse #9 said she only completed a partial skin check on 4/25/24 which included skin tears to bilateral extremities. She said that Resident #264 was being combative and sundowning. Nurse #9 further said she should have documented that a partial skin check had been completed. She also said the nursing assistants should have reported any skin changes to her during incontinence care. Nurse #9 said she was concerned with the wound care at the facility as she would at times come back after 2 days and find the same dressings she had applied to the resident's wounds. She said she brought the concerns of the nurses not completing wound treatments and just signing off on the Treatment Administration Record (TAR) to the DON, the assistant director of nursing and the two 3-11 shift supervisors. She said she also expressed the lack of competencies in wound care with the nurses at the facility especially the wound team who were giving recommendations to the physician and nurse. Review of the medical record indicates Nurse #9 neglected to complete a full skin as ordered and failed to indicate in the medical record that a full skin check had not been completed. Review of Resident #264's wound observation tool -V2 dated 4/26/24 indicated the following: Resident #264 acquired a pressure ulcer to the coccyx while at the facility, Location: Coccyx Type: Pressure Stage: Unstageable Specify: slough/eschar/necrosis 75% Overall impression: First observation, no reference (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Drainage amount: small Wound measurements: 5.3 cm length (L) x3.1 cm width (W) x 0.1 centimeters (cm) depth (D) Additional comments: Coccyx macerated with necrosis wound with strong odor. Infection signs: Strong odor, black, green tissue Pain: Related to wound Current treatment plan: Manuka honey (a specialized honey used in wounds due to its antibacterial properties and tissue regeneration effects) and foam dressing. Review of the wound observation tool data dated 4/26/24 neglected to indicate what the other 25% of the wound looked like. Review of physician's order dated 4/26/24 indicated the following: Wound culture and sensitivity to coccyx. Review of the electronic medical records indicated the following laboratory results for wound culture collected on 4/26/24 and reported on 4/30/24: Results as follow, Escheria coli heavy growth, skin flora isolated moderate growth and vancomycin resistant enterococcus faecalis heavy growth. Review of the medical record failed to indicate the physician was made aware of the wound culture results dated 4/30/24 resulting in continued infectious growth. Review of Resident #264 care plan date initiated 4/29/24 indicated the following focus and interventions: -The Resident has potential/actual impairment to skin integrity of the coccyx related to pressure and moisture. With the following Interventions but not limited to: -Assess location, size and treatment of skin injury. Report abnormalities failure to heal, signs and symptoms of infection, macerated to Medical Doctor. - Review of Resident #264's wound observation tool -V2 dated 5/1//24 indicated the following: Location: Coccyx Type: Pressure Stage: Unstageable Specify: Slough/Eschar (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Overall impression: Unchanged with 25% slough, 25% necrosis. Drainage amount: Moderate serosanguinous Wound measurements: 7.0 x 4.0 x 0.1 cm depth Additional comments: edges are macerated/peeling skin surrounding. Infection signs: no Pain: no Current treatment plan: drawtex (dressing that absorbs wound drainage) and foam dressing. Review of nurse's progress note dated 5/1/24 indicated the following: Wound culture results cannot be located. MD (medical doctor) notified; wound does not show signs of infection. MD did not want a new culture. Review of nurse's note dated 5/7/24 indicated the following: Mattress swapped out for air mattress on shift due to wound. During an interview on 11/20/24 at 10:33 A.M., the Director of Nursing (DON) said the resident with pressure ulcers will have an air mattress which is set to comfort and for nonverbal residents use the facial pain scale to determine comfort. She said if the air mattress is for intervention as a wound there should be an order. She said if the air mattress is not set properly, it would cause further skin damage/injury to the resident. Review of the medical record failed to indicate an order for the air mattress. The medical record also failed to indicate the care plan was updated with the air mattress intervention until 6/3/24. Review of Resident #264's wound observation tool - V2 dated 5/8/24 indicated the following: Location: coccyx Type: pressure Stage: unstageable Specify: slough/eschar Overall impression: Worsening 80% slough, 20% necrosis. Drainage amount: moderate serosanguinous Wound measurements: 9.0 x 5.0 x 0.1 cm depth Additional comments: edges are macerated/peeling skin surrounding with redness surrounding. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Infection signs: Odor to wound. Pain: no Current treatment plan: Santyl (ointment used to remove damaged tissues from wounds) and cover with foam. Review of the nurse's note dated 5/8/24 indicated the wound was worsening and wound culture and sensitivity to be obtained. The nurse's note failed to indicate the wound culture report from 4/26/24 had been obtained and reported to the physician. Review of Physician #1's progress note dated 5/10/24 indicated the following: Patient had urine culture done with Foley change that showed Pseudomonas (a gram-negative bacteria that causes infections) of note the patient is allergic to Levaquin also his/her coccygeal wound has been getting worse with is smelly with more drainage is growing out Enterococcus and E. coli so far only once sensitivity available would also be sensitive to cefepime. [sic] Review of the medical record indicated the cefepime (antibiotic) was started on 5/10/24 for treatment of urinary tract infection due to Pseudomonas (a gram-negative bacteria that causes infections) Review of the medical records indicated orders implemented on 5/10/24 for cefepime (an antibiotic used to treat infections) intravenous 2 grams every 12 hours for wound infection and urinary tract infection for 10 days. Review of the medical record indicated that the antibiotic treatment was initiated 15 days after the initial observation of the wound with infection on 4/26/24. Review of the wound culture results date reported 5/11/24 indicated the following: -Aerobic culture wound, organism 1 heavy growth Escherichia coli. -Organism 3 heavy growth enterococcus faecalis. Review of Resident #264's wound observation tool-V2 dated 5/15/24 indicated the following: Location: Coccyx Type: pressure Stage: Unstageable Specify: slough/eschar Overall impression: unchanged 5% slough, 85% necrosis Drainage amount: Moderate purulent (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Wound measurements: 6.0 x 4.0 x 0.1 cm depth Additional comments: green around the edges Infection signs: odor, purulent drainage Pain: no Current treatment plan: Santyl and foam dressing. Review of the wound observation tool assessment dated [DATE] indicated the wound continued to worsen with presence of odor and purulent drainage despite being on antibiotic treatment. Record review failed to indicate the physician was notified of the wound worsening with presence of odor and purulent drainage. Review of the physician note dated 5/17/24 indicated the following: This IV (intra venous) cefepime to continue through 5/21. Reviewing labs the Enterococcus was never covered can give him/her amoxicillin for another 10 days. [sic] Review of the medical record indicated the following order dated 5/17/24: Amoxicillin (antibiotic) 500 mg give one capsule by mouth three times a day for 10 days due to enterococcus (bacteria) in the wound. Review of the medical record indicated there was a delay in treating the Enterococcus bacteria six days after receiving the wound culture results. Review of Resident #264's wound observation tool -V2 dated 5/22/24 indicated the following: Location: Coccyx Type: Pressure Stage: unstageable Specify: Slough/eschar Overall impression: unchanged 50% slough, 40% necrosis Drainage amount: Moderate purulent Wound measurements: 9.0 x 5.5 x 1.0 cm depth Tunneling/undermining: undermining from 3 o'clock to 11 o'clock (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Additional comments: green tissue noted throughout wound bed undermining depth noted at 3 o'clock measuring 4.5 slough and necrotic mixture that covered top of wound bed not allowing us to visualize the depths has now been debrided which allows us to see the slough on the base of the wound bed measuring larger due to debridement. Infection signs: odor to wound noted to be less strong this week, purulent drainage noted to be a smaller amount. Pain: no Current treatment plan: Santyl cover with hydrofera blue (a wound dressing used for wounds with a lot of drainage) and foam dressing. Review of Resident #264's wound observation tool-V2 dated 5/29/24 indicated the following: Location: coccyx Type: pressure Stage: unstageable Specify: slough/eschar Overall impression: improving 75% slough. Drainage amount: moderate serosanguinous, Wound measurements: 10 x 5.0 x1.4 cm depth Tunneling/undermining: undermine from 3 o'clock to 12 o'clock Additional comments: green tissue noted throughout wound bed undermining depth noted at 3 o'clock measuring 4.5 cm slough mixture that covered top of wound bed not allowing us to visualize the depths has now been debrided which allows us to see the slough on the base of the wound bed, macerated at 4-6 o'clock. Infection signs: no Pain: no Current treatment. Melgisorb (a brand of wound dressing used for wounds with moderate to heavy drainage) cover with foam. Review of the nurse's progress note dated 6/2/24 indicated the wound had odor, and physician #1 ordered Flagyl antibiotic. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of medical records indicated orders implemented on 6/2/24 for flagyl oral capsule (flagyl oral capsule can be applied topically to decrease wound odor), apply to coccyx wound topically two times a day for 7 days. There was no dosage for the flagyl antibiotic order. Review of the Medication Administration Record (MAR) for June 2024 indicated the Flagyl antibiotic was administered six times, 6/2/24 through 6/5/24. Review of the MAR for June 2024 indicated the facility neglected to implement flagyl antibiotic order as ordered for 7 days, and the order was incomplete without a dosage. Review of the medical record TAR dated 6/2/24 through 6/5/24 failed to indicate that the wound dressing changes were done twice daily to the coccyx hence unable to determine how flagyl antibiotic was topically applied to the wound. Review of the medical record indicated the following physician note dated 6/3/24 indicated the following The patient being seen and follow-up for wound care. Concerned about the smell of his/her decubitus ulcer and was put on topical Flagyl over the weekend. The patient recently completed IV (intra venous) cefepime (antibiotic) there is question that his/her wound is worsening. Resident is on oral flagyl (antibiotic) based on prior cultures resident would generally be a candidate for cipro (antibiotic) but they are allergic. Would need to reinitiate cefepime if needed. At this point wound appears larger but not worsening with infection continue to follow closely. [sic] Review of medical record failed to indicate the physician was notified that the Resident only received flagyl for three days and the antibiotic had been discontinued on 6/5/24 and not 6/9/24 as the ordered. Review of Resident #264's wound observation tool-V2 dated 6/3/24 indicated the following: Location: left heel and right heel Type: pressure Stage: NA Specify:NA Overall impression: first observation, no reference Drainage amount: none Wound measurements: 5.0 x 3.5 x 0 cm Tunneling/undermining: NA Additional comments: NA Infection signs: no (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Pain: no Current treatment. Skin prep. Review of the medical record indicated the Resident continued to have skin breakdown as indicated on the wound observation tool dated 6/3/24 for both left and right heels. Review of the medical record indicated a care plan intervention of air mattress dated 6/3/24. Review of Resident #264's wound observation tool-V2 dated 6/5/24 indicated the following: Location: coccyx Type: pressure Stage: unstageable Specify: slough/eschar Overall impression: worsening, 95% slough. Drainage amount: moderate serosanguineous Wound measurements: 13 x 7.5 x 2.2 cm depth Tunneling/undermining undermines from 3 o'clock to 11 o'clock Additional comments: undermining depth noted at 3 o'clock measuring 4.5 macerated edge at 4-6 o'clock. Finished course of antibiotic 5/28. Infection signs: no Pain: no Current treatment. Aquacel ag (a wound dressing that combines hydrofiber with ionic silver to help prevent infection and promote healing) and cover with foam. Review of wound observation tool-V2 dated 6/5/24 indicated the following: Location: left heel Type: pressure Stage: 2 Specify: na Overall impression: unchanged, with clear fluid filled blister. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Drainage amount: none Wound measurements: 6.0 x 4.5 x 0 cm Tunneling/undermining: no Additional comments: redness surrounding blister. Infection signs: no Pain: no Current treatment. Skin prep. Review of Resident #264's wound observation tool-V2 dated 6/5/24 indicated the following: Location: right buttock Type: pressure Stage: unstageable Specify: Deep tissue pressure injury Overall impression: first observation, no reference Drainage amount: none Wound measurements: 3.2 x 1.2 cm Tunneling/undermining: na Additional comments: deep purple Infection signs: no Pain: no Current treatment. Skin prep Review of the wound observation tool indicates that Resident #264 continued to develop new pressure ulcers. Review of Resident #264's wound observation tool-V2 dated 6/12/24 indicated the following: Location: coccyx Type: pressure (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Stage: unstageable Specify: slough/eschar Overall impression: unchanged Drainage amount: moderate serosanguinous, 95% slough. Wound measurements: 11.8 x 7.1 x 1.0 cm Tunneling/undermining: undermines from 3 o'clock to 11 o'clock Additional comments: undermining depth noted at 3 o'clock measuring 2.5 cm macerated edge at 4-6 o'clock finished course of antibiotic 5/28. Infection signs: no Pain: no Current treatment. Aquacel (a wound dressing that combines hydrofiber with ionic silver to help prevent infection and promote healing) cover with foam dressing. Review of Resident #264's wound observation tool-V2 dated 6/12/24 indicated the following: Location: right buttock Type: pressure Stage: unstageable Specify: Deep tissue pressure injury Overall impression: improving. Drainage amount: none Wound measurements: 0.6 x 0.6 cm Tunneling/undermining: na Additional comments: deep purple Infection signs: no Pain: no Current treatment. Skin prep (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Pain: no Current treatment. Skin prep. Review of Resident #264's wound observation tool-V2 dated 6/19/24 indicated the following: Location: coccyx Type: unstageable Stage: slough/ eschar Specify: NA Overall impression: unchanged, 30% slough, 30% necrosis. Drainage amount: moderate serosanguinous Wound measurements: 13 x 8.0 x 1.3 cm Tunneling/undermining: undermines 3 o'clock to 11 o'clock Additional comments: undermining depth noted at 3 o'clock measuring 2.5cm macerated edge at 3-7 o'clock, finished course of antibiotic 5/28 coccyx wound that extends to right and left buttock. 3-9 o'clock necrotic. 9-3 o'clock mixture of granulation and slough. Macerated granulated tissue extending to left and right buttock Pressure ulcer scale for healing (PUSH) score 16 (0 indicates healed ulcer) Infection signs: no Pain: no Current treatment. Aquacel then foam dressing twice a day. Review of Resident #264's wound observation tool-V2 dated 6/19/24 indicated the following: Location: right buttock Type: pressure Stage: unstageable Specify: deep tissue injury Overall impression: unchanged 50% slough in center Drainage amount: none (continued on next page)

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Wound measurements: 1.0 x 0.6 x 0.1cm Tunneling/undermining: NA Additional comments: slough 50% in center, blanchable redness surrounding Pressure ulcer scale for healing (PUSH) score 5 (0 indicates healed ulcer) Infection signs: no Pain: no Current treatment. Manuka honey and foam dressing daily Review of Resident #264's wound observation tool-V2 dated 6/19/24 indicated the following: Location: right heel Type: pressure Stage: unstageable Specify: Deep tissue injury Overall impression: unchanged, 100% necrosis Drainage amount: none Wound measurements: 5.0 cm x 5.0 cm Tunneling/undermining: NA Additional comments: blister that reabsorbed with a hard and black with dark red edges, stable push score 14 Infection signs: no Pain: no Current treatment. Skin prep Review of Resident #264's wound observation tool-V2 dated 6/19/24 indicated the following: Location: left heel Type: pressure Stage: 2 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Specify: NA

Overall impression: unchanged, clear fluid filled blister that absorbed.

Drainage amount: none

Wound measurements: 5.0 x 5.0 cm

Tunneling/undermining: NA

Additional comments: clear fluid filled blister that reabsorbed with red edge from 9-3 push score 11

Infection signs: no

Pain: no

Current treatment. Skin prep

Review of Resident #264's wound observation tool-V2 dated 6/26/24 indicated the following:

Location: coccyx

Type: pressure

Stage: unstageable

Specify: slough/eschar

Overall impression: worsening 35% slough, 35% necrosis

Drainage amount: large serosanguinous

Wound measurements: 14.5 x 9.0 x 2.0cm

Tunneling/undermining: undermines from 3'oclock to 11 o'clock

Additional comments: undermining depth noted 3 o'clock measuring 2.5 macerated edge 3-7 o'clock finished course of antibiotic 5/28, coccyx wound that extends to right and left buttock. 3-9 o'clock necrotic and slough. 9-3 o'clock mixture of granulation, necrotic and slough. Macerated granulated tissue extending to left and right buttock. Necrotic on right side push score 17.

Infection signs: Yes, odor wound cultured.

Pain: no

Current treatment. Santyl and foam dressing twice a day.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review indicates despite multiple treatment with antibiotics the wounds continued to increase in size and with odor. Review of nurse's note dated 6/26/24 indicated the physician was made aware of the coccyx wound worsening. Review of medical records indicated orders implemented on 6/26/24 for amoxicillin-potassium clavulanate (an antibiotic used for treating infections) tablet 875-125 milligram (mg), give one tablet by mouth every 12 hours for wound infection for 10 days. Review of the wound culture results date reported 6/28/24 indicated the following: -Heavy growth Escherichia coli vancomycin resistant enterococcus -Moderate growth staphylococcus aureus -Moderate growth enterococcus faecalis. Review of medical records indicated orders implemented on 6/28/24 for linezolid (an antibiotic used for treating skin infections) 600 mg give one tablet by mouth every 12 hours for infection for 10 days. Review of Resident #264's wound observation tool-V2 dated 6/26/24 indicated the following: Location: right buttock Type: pressure Stage: unstageable Specify: slough/eschar Overall impression: worsening 75% slough. Drainage amount: scant serosanguinous Wound measurements: 0.7 x 0.7 x 0.1cm Tunneling/undermining: NA Additional comments: slough 75% in center blanchable redness surrounding push score 6 Infection signs: no Pain: no Current treatment. Santyl and foam dressing twice daily. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of wound observation tool-V2 dated 6/26/24 indicated the following: Location: left heel Type: pressure Stage: 2 Specify: Na Overall impression: unchanged Drainage amount: none Wound measurements: 5.4 x 5.0 cm Tunneling/undermining: na Additional comments: clear fluid filled blister that reabsorbed with red edge from 9-12 hard skin between 12-3. Push score 11 Infection signs: no Pain: no Current treatment: Skin prep. Review of wound observation tool-V2 dated 6/26/24 indicated the following: Location: right heel Type: pressure Stage: unstageable Specify: deep tissue injury Overall impression: unchanged 100% necrotic Drainage amount: none Wound measurements: 5.8 x 4.4 cm Tunneling/undermining: NA Additional comments: blister that reabsorbed hard and black with light purple edges, stable push score 14. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Infection signs: no Pain: no Current treatment: skin prep. Review of wound observation tool-V2 dated 7/3/24 indicated the following: Location: coccyx Type: pressure Stage: unstageable Specify: slough/eschar Overall impression: worsening 90% necrosis. Drainage amount: large serosanguinous Wound measurements: 15 x 10 x 2.0 cm depth Tunneling/undermining: undermining 3-11 o'clock Additional comments: undermining depth noted at 3 o'clock measuring 2.5cm macerated edge at 3-7 o'clock on antibiotic, coccyx wound extends to right and left buttock. 3-9 o'clock necrotic area. 9-3 o'clock granulation. Macerated granulated tissue extending to left and right buttock push score 17. Infection signs: yes Pain: no Current treatment. Santyl and foam dressing. Review of the medical record wound observation tool dated 7/3/24 indicates the coccyx wound was worsening with 90% necrosis (dead tissue) and increased in size despite being treated with santyl (an ointment used to lift off dead tissue). Review of wound observation tool-V2 dated 7/3/24 indicated the following: Location: right buttock Type: pressure Stage: unstageable Specify: slough/eschar (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Overall impression: unchanged 50% slough, 50% necrosis. Drainage amount: small serosanguinous Wound measurements: 0.9 x 0.8 x 0.1 cm Tunneling/undermining: NA Additional comments: slough 50% on left side blanchable redness surrounding push score 7 Infection signs: no Pain: no Current treatment: Santyl with foam dressing. Review of wound observation tool-V2 dated 7/3/24 indicated the following: Location: right heel Type: pressure Stage: unstageable Specify: deep tissue injury Overall impression: improving, 100% necrosis in wound bed Drainage amount: none Wound measurements: 4.7 x 4.4 cm Tunneling/undermining: NA Additional comments: blister that reabsorbed hard and black stable push score 13 Infection signs: no Pain: no Current treatment: skin prep Review of wound observation tool-V2 dated 7/3/24 indicated the following: Location: left heel Type: pressure (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Stage: 2 Specify: NA Overall impression: unchanged Drainage amount: none Wound measurements: 5.0 x 4.8cm Tunneling/undermining: NA Additional comments: clear fluid filled blister that reabsorbed with red edge from 11-5 o'clock, hard from 6 o'clock to 9 o'clock with slight discoloration push score 11 Infection signs: no Pain: no Current treatment: skin prep. Review of wound observation tool-V2 dated 7/3/24 indicated the following: Location: Left lateral foot Type: pressure Stage: unstageable Specify: deep tissue injury Overall impression: first observation, no reference Drainage amount: none Wound measurements: 0.5 x 0.5 cm Tunneling/undermining: NA Additional comments: deep purple with blanchable redness surrounding push score 5 Infection signs: no Pain: no Current treatment: skin prep. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of physician #2's (Physician #2 was covering for Physician #1 who was on vacation) progress note dated 7/3/24 indicated the following: The patient is seen in follow-up as requested by nursing. The patient has been noted with foul smelling discharge from a large chronic sacral pressure wound. On examination the wound is with large amount of foul-smelling discharge, necrotic. I discussed with patient's spouse, nursing manager and director of nursing. This morning the resident is unlikely to heal without extensive debridement and antibiotic therapy. Superficial culture should not be relied on to guide antibiotic therapy as the frequently represent colonization. Spouse agrees with my assessment and wants patient to be transferred to the hospital for continuation of

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, record review, policy review, and interview, the facility failed to provide care and maintenance of a peripherally inserted central catheter (PICC), consistent with professional standards of practice for one Resident (#70), out of a total sample of 30 residents. Specifically, for Resident #70, the facility failed to ensure nursing completed a PICC line dressing change as ordered by the physician. Findings Include: Review of facility policy titled 'Central Vascular Access Device (CVAD) Dressing Change' revised January 2004, indicated the following but not limited to: -The catheter insertion site is a potential entry site for bacteria that may cause a catheter-related infection. -perform sterile dressing changes: at least weekly -Upper arm circumference with PICC, and external catheter length measurements must still be completed as part of the initial assessment. Resident #70 was admitted to the facility in October 2024 with diagnoses that include acute osteomyelitis right ankle and foot and non-pressure chronic ulcer of right heel and mid foot. Review of Resident #70's Minimum Data Set, dated dated dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that the Resident is cognitively intact. The MDS further indicated that the Resident is on IV (intravenous) and antibiotic medications. The following observation was made by the surveyor: -On 11/19/24 at 8:33 A.M., the surveyor observed the Resident with a PICC line to the right arm. The dressing over the arm was dated 11/4/24. -On 11/19/24 at 12:34 P.M., the surveyor observed the Resident with a PICC line to the right arm. The dressing over the arm was dated 11/4/24. The Resident said the nurses look at it but did not recall anyone taking off the whole thing indicating to the dressing. Review of Resident #70's physician's orders indicated the following: -Change PICC line transparent dressing weekly every Sun Measure upper arm circumference (10cm above antecubital). - Measure external catheter length. Notify MD if length has changed since last measurement AND as needed for concern of line movement or infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Measure upper arm circumference (10cm above antecubital. Measure external catheter length. If length has changed since last measurement; if concern of line movement, infection, hold antibiotic and notify MD, dated 10/29/24. Review of the November 2024 Medication Administration Record indicated the following: -The PICC line dressing was changed on 11/3/24 and documented as NA for arm circumference and external catheter length. -The PICC line dressing change was signed as other/see nurses note on 11/10/24. -The PICC line dressing was documented as changed on 11/17/24. Review of Resident #70's Progress notes indicated the following: -An Orders- Administration Note dated 11/10/24 indicating Change PICC line transparent dressing weekly every Sun Measure upper arm circumference (10cm above antecubital). Measure external catheter length. Notify MD if length has changed since last measurement. at activities -A skilled note dated 11/17/24 indicated the following but not limited to: 'PICC patent, dressing intact'. Review of the progress notes failed to indicate that the PICC line dressing was changed on 11/17/24. Review of the active care plan indicated the following: -Peripherally Inserted Central Catheter (PICC)/ Potential for catheter related bloodstream infection, phlebitis, site infection, deep vein thrombosis, catheter occlusion, and catheter migration, date Initiated 11/14/24, with interventions that include: -Measure upper arm circumference as ordered. -Compare insertion site and precious measurements, notify prescriber with changes. -Measure external catheter length on admission, weekly with each dressing change and as needed. Review of the medical record failed to indicate that arm circumference or external length had been measured until 11/20/24. During an interview on 11/22/24 at 1:51 P.M., Nurse #1 said that PICC line dressings should be changed every seven days. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/24 at 8:01 A.M., the Director of Nurses (DON) said that PICC line dressing changes are weekly. She said that she would expect that every time the nurses are using the PICC line that they are assessing the line and insertion site. She would expect the dressing would also be changed as needed if it was soiled or lifting off.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, record review and interview, the facility failed to ensure services consistent with professional standards were provided for one Resident (#62) who required dialysis (a procedure to remove waste products and excess fluid from the body when the kidneys stop working properly), out of total sample of 30 residents. Specifically, the facility failed to follow physician's orders to ensure that blood pressure readings were not taken on the arm where the dialysis shunt (an access point from the dialysis machine to a blood artery) is located. Findings include: Review of the facility policy titled Hemodialysis Offsite Policy, revised and dated 4/17/23 indicated the following: - The facility should provide immediate monitoring and documentation of the status of the resident's access site(s) upon return form the dialysis treatment to observe for bleeding or other complications such as redness or bleeding. - Avoid taking blood pressure on the arm with the shunt in place. Resident #62 was admitted to the facility in June 2021 with diagnoses including end stage renal disease and type 2 diabetes mellitus. Review of Resident #62's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 14 out of 15 indicating intact cognition. The MDS further indicated that Resident #62 currently receives dialysis treatment. The surveyor made the following observation: - On 11/19/24 at 10:04 A.M., Resident #62 was sitting on his/her bed. The Resident had a dialysis shunt on his/her right arm. During an interview on 11/20/24 at 12:11 P.M., Resident #62 said his/her dialysis shunt has been on his/her right arm for about four years. Review of Resident #62's physician's order dated 5/14/21 indicated the following: - Dialysis patient: Receives Dialysis at [an outside] facility. Do not take BP (blood pressure) on left arm with fistula/shunt. Send to dialysis on Tuesday/Thursday/Saturday The physician's order indicated the incorrect arm (left arm) where the dialysis shunt is located, Resident #62's dialysis shunt is located on his/her right arm. Review of Resident #62's Kardex (a nursing care card) indicated the following under the Resident Care section: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No BP or blood draws in left arm due to fistula even though this is not functional Review of Resident #62's hemodialysis care plan indicated the following interventions dated 7/22/21: - No BP or blood draws in left arm due to fistula even though this is not functional - Observe for bleeding at dialysis access site. Review of Resident #62's physician's orders, Kardex and care plans indicated that his/her dialysis shunt is located on his/her left arm despite the shunt being located on his/her right arm. Review of Resident #62's Blood Pressure Vitals log indicated that the Resident has had his/her blood pressure readings taken on his/her right arm 22 times since March 2024. During an interview on 11/21/24 at 10:31 A.M., Unit Manager #1 said she has worked in the facility since March 2024 and Resident #62 has always had his/her dialysis shunt on his/her right arm since then. Unit Manager #1 continued to say Resident #62 should not be receiving blood pressure readings on his/her right arm where the shunt is because there are a lot of negative implications that could happen. During an interview on 11/21/24 at 12:48 P.M., the Director of Nursing (DON) said blood pressure readings should not be taken on the same arm where a dialysis port is located as it can cause clotting around the dialysis port. The DON continued to say she has worked in the facility for two years and does not remember Resident #62's dialysis port being on his/her other arm.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 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: 1. Ensure the licensed nursing staff were trained and demonstrated competency to identify, assess, evaluate, intervene, and respond to a significant change in condition of a wound, for four Residents (#264, #97, #60, #103), out of a total sample of 30 Residents. 2. Ensure that 31 out of 36 staff education records reviewed, had completed education and competencies and were completed and documented annually, per the Facility Assessment. As a result of these failures, three Residents (#264, #97, #60, and #103) developed pressure injuries that worsened, became infected, required hospitalization , required intravenous antibiotics with surgical intervention and for one of the three Residents, resulted in death. Findings include: 1. According to the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; 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. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies and training in areas as indicated in the facility assessment: - Activities of Daily Living: Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment, supporting resident independence in doing as much of these activities by himself/herself. - Mobility and fall/fall with injury prevention: Transfers, ambulation, restorative nursing, contracture prevention/care, supporting resident independence in doing as much of these activities by him or herself. - Bowel/bladder: Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence, and promote resident dignity. - Skin Integrity: Pressure injury prevention and care, skin care, wound care, surgical and other skin wounds. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Infection Prevention and Control: Identification and containment of infections, prevention of infections. - Management of Medical Conditions: Assessment, early in identification of problem/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), gastroenteritis, infections such as UTI and gastroenteritis, pneumonia, hypothyroidism. - Nutrition: Individualized dietary requirements, liberalized diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions, hypodermoclysis. Review of the Facility Assessment, dated as reviewed with the QAPI committee, in [DATE], indicated the following: - Part 1 Facility Profile Wound Care Manual Annual Review Date [DATE] - Part 5 Training and Competencies Competent Support and Care for our Resident Population Every Day and During Emergencies: Infection control - a facility must include as part of its infection prevention and control program mandatory training that includes written standards, policies, and procedures for the program. Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life. All staff during orientation, annually and as needed. Competency: Person Centered Care Resident Assessment Medication Administration - Part 6- Facility Resources- Medical Equipment Low-air Loss Mattress. Required -Yes. Wound Vac-. Required - No. - Part 7- Healthcare Related Contracts, [NAME], or Other Agreements. Medical Director Contract (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Working with Medical Practitioners Describe your plan to recruit and retain enough medical practitioners e.g., physicians, nurse practitioners) who are adequately trained and knowledgeable in the care of your resident/patients, including how you will collaborate with them to ensure the facility has appropriate medical practices for the needs and scope of your population: - The facility is in contract with Post Acute EMS which provides the facility with medical practitioners 5 days a week on-site and on call services. Describe how the management and staff familiarize themselves with what they should expect from the medical practitioners and other healthcare professionals related to standards of care and competencies that are necessary to provide the level and type of support and care needed for your resident population. For example, do you share expectations from providers that see residents in your nursing home on the use of standards, protocols, or other information developed by your medical director? Do you have discussions on what providers and staff expect of each other in terms of the care delivery process and clinical reasoning essential to providing high quality? - Management team and staff are well trained on long term care/skilled nursing facility regulations. The staff have opened dialogue with medical practitioners about residents' current needs and how prescribed interventions are working for the resident, or not providing the desired outcomes. The medical directors oversight and attendance at monthly QAPI provides a platform for discussion of trends and patterns. Describe process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements. - Clinical outcomes are measured and tracked at the monthly QAPI meeting. Policies and procedures are updated as needed according to regulatory requirements and are reviewed by the IDT on an annual basis or as needed. List health information technology resources such as systems for electronically managing patient records and electronically sharing information with other organizations. - The electronic health record the facility uses are Point Click Care (medical and administrative) and Optima/Net Health (therapy). The facility also utilizes hardware such as laptops, Wi-Fi servers, telephones, iPads, fax. The facility failed to provide training and demonstrated competency in Quality of Care related to wound treatment orders. Skin Integrity: Pressure injury prevention and care, skin care, wound care, surgical and other skin wounds. Resident #264 developed multiple pressure ulcers at the facility, specifically a sacral pressure ulcer that worsened in presentation of size and symptoms of infection which included gangrene and necrosis. The wound worsened at the facility despite being treated with antibiotics for multiple infections and eventually required hospitalization on [DATE] where the Resident underwent surgical debridement due to osteomyelitis of the coccygeal and ultimately died on [DATE] as a result of neglect. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Life Care Center of Merrimack Valley		STREET ADDRESS, CITY, STATE, ZIP CODE: 80 Boston Road Billerica, MA 01862	

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #97 developed a Stage 4 pressure injury to the sacrum resulting in the development of osteomyelitis requiring antibiotics treatment, surgical debridement, and multiple hospitalization s. Resident #97 then developed one Deep Tissue Injury, and failed to arrange a wound clinic follow up for deteriorating wounds. Resident #60, developed a Stage 3 pressure injury to the lower back requiring antibiotic treatment and hospitalization , and failed to respond to and implement new interventions when Resident #60 developed a Stage 2 pressure injury to the right buttock, Stage 1 pressure injury to the right lateral foot, Unstageable DTI to the right outer calf, Unstageable DTI to the right heel, and failed to arrange a wound clinic follow up as indicated by the Physician. Resident #103 was admitted with a sacral pressure ulcer wound that worsened in the facility. Despite documentation of a worsening wound and signs of infection in the wound, treatment and interventions in the place for the wound remained the same, eventually resulting in hospitalization from [DATE] through [DATE] for worsening wounds, treatment with intravenous (IV) antibiotics and multiple surgical debridements for osteomyelitis (A bone infection) and the need for ileostomy formation for fecal diversion away from the wound. Resident #103 was discharged back to the facility with Negative Pressure Wound Therapy (a medical technique used to accelerate wound healing by applying negative pressure to the wound site) for wound management. 2. Review of 18 personnel files of actively working clinical nursing staff in the facility on [DATE] and [DATE] indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Further review of the education files indicated licensed clinical staff did not have the necessary skills and competency to evaluate, document, or recognize a change in condition related to skin integrity and proper wound management. Review of 31 out of 36 licensed nurses working in the facility, educational records failed to indicate competencies were completed, per the Facility Assessment. Competencies reviewed included Skin and Wound Care. There was no documented evidence that licensed clinical staff had the required clinical training or that competencies were completed as indicated in the facility assessment. Review of the Facility Wound Care Manual - Life Care Center Wound Care Tool Box, indicated the following: CWC-Certified Wound Care Champion The Facility's Wound Care Program utilized professional standards from both organizations, the NPIAP (National Pressure Injury Advisory Panel) and WOCN (wound, ostomy, and continence nurse), and has developed a national wound certification and credentialed program designed as CWC (Certified Wound Care-Champions). The certification program is accredited by ANCC (American Nurses Credentialing Center) and consists of five plus hours of didactic lesson with knowledge validation of online examination. Awards 7 CE's (continuing education) for nursing and may be accepted for Therapy. Competency and skills is validated on site in simulated or resident care situations. The facility failed to ensure clinical competency was demonstrated as indicated in per the facility assessment and Wound Care Manual. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, indicated: Title: Accepting, Verifying, Transcribing and Implementing Prescriber Orders According to The Massachusetts Board of Registration in Nursing (Board) is created and authorized by Massachusetts General Laws (M.G.L.) c. 13, SS 13, 14, 14A, 15 and 15D, and M.G.L. c. 112, SS 74 through 81C to protect the health, safety, and welfare of the citizens of the Commonwealth through the regulation of nursing practice and education. In addition, M.G.L. c. 30A, S 8 authorizes the Board to make advisory rulings with respect to the applicability to any person, property or state of facts of any statute or regulation enforced or administered by the Board. Each nurse is required to practice in accordance with accepted standards of practice and is responsible and accountable for his or her nursing judgments, actions, and competency. The Board's regulation at 244 CMR 9.03(6) requires all nurses to comply with any other law and regulation related to licensure and practice. -The nurse is accountable for ensuring that any orders he or she implements are reasonable based on the nurse's knowledge of that particular patient's care needs at that time and must also ensure that the orders (whether written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) originate from an authorized prescriber, pursuant to established protocols of the organization. - It is not within the scope of Licensed Practical or Registered Nurse practice to alter or change the directions provided for in orders from a duly authorized prescriber. Licensed nurses are not authorized to prescribe, renew/refill, or extend a prescription that has expired prior to receipt of an order from duly authorized prescriber. Standing Order / Protocol: Standing orders/protocols include written authorization from a duly authorized prescriber that indicates evidence based practice standards for a specific medication or activity to be implemented by the nurse. Standing orders/protocols are applicable to a specific patient or specific situation and directions remain consistent during implementation. Standing orders / protocols cannot authorize the nurse to: -alter the standing order / protocol once initiated (e.g., independently initiate new medications); -determine choice of intervention based upon a menu of medications, dosing instructions or actions; and/or -prescribe, renew/refill, or extend a prescription that has expired. In 3.04(1): A licensed practical nurse bears full responsibility for the quality of health care she or he provides to patients or health care consumers. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(2) A licensed practical nurse participates in direct and indirect nursing care, health maintenance, teaching, counseling, collaborative planning and rehabilitation, to the extent of his or her generic and continuing education and experience in order to: (a) assess an individual's basic health status, records and related health data; (b) participate in analyzing and interpreting said recorded data, and making informed judgments as to the specific elements of nursing care mandated by a particular situation; (c) participate in planning and implementing nursing intervention, including appropriate health care components in nursing care plans that take account of the most recent advancements and current knowledge in the field; (d) incorporate the prescribed medical regimen into the nursing plan of care; (e) participate in the health teaching required by the individual and family so as to maintain an optimal level of health care; (f) when appropriate, evaluate outcomes of basic nursing intervention and initiate or encourage change in plans of care; and (g) collaborate, cooperate and communicate with other health care providers to ensure quality and continuity of care. During an interview on [DATE] at 11:42 A.M., The Director of Nurses (DON) said the facility has two Licensed Practical Nurses (LPN) with wound certification and said clinical demonstrated competency is required after the Wound Tool 7 hour certification course (The facility's wound care program which provides staff the title of Certified Wound Care-Champion). The DON said all staff upon hire and annually must have clinical wound competencies completed. The DON said the LPN's (wound nurses) manage weekly wound rounds and collect assessment data. The DON said the facility does not have anyone to interpret data and no other clinical oversight of the wound program and said they did have a Registered Nurse on the team but she left four months ago. The DON said clinical competency is provided by the Staff Development Coordinator (SDC) and said it is the expectation for all nurses to have training and clinical wound competency upon hire and annually. During a follow up interview on [DATE] at 12:33 P.M., the DON said she is made aware of infections and worsening wounds and said if a wound looks infected, the wound nurses will update the physician. The DON said, I had concerns with wounds, and I had the infection preventionist do oversight with the wound team and other staff because we had residents hospitalized with infections. The DON continued to say she did not complete the seven hour wound training certification and said just the two nurses are certified in the facility. The DON said the facility follows the Wound Care Manual - Life Care Center Wound Tool Box and staff complete training and wound competencies following this program. Review of the education files for two out of two designated wound nurses indicated there was no documented evidence that competencies were completed as indicated in the Wound Care Manual - Life Care Center Wound Tool Box. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Unit Manager #1 had documented Certified Skin Champion certificate on file dated [DATE] but failed to complete the required clinical competency for skills validation. Unit Manager #2 had documented Certified Skin Champion certificate on file dated [DATE] but failed to complete the required clinical competency for skills validation. Further review of the education files indicated Unit Manager #1 and Unit Manager #2 were Licensed Practical Nurses. During an interview on [DATE] 8:43 A.M., Regional Director of Clinical Services said the facility's philosophy is to have wound certified nurses and rehabilitation person in the building and said they have two wound nurses that are LPNs. The Regional Director of Clinical Services said the LPN's can assess wounds because it is within the nurse practice act for the state of Massachusetts. The Regional Director of Clinical Services said wound nurses need to complete and pass the seven hour facility wound care certification course and have clinical competency to assess the wounds. The Regional Director of Clinical Services said nursing staff must have training and clinical competency to do wound care upon hire and annually said nurses can reach out to her and the DON with wound questions. The Regional Director of Clinical Services said the wound tool box protocol should be followed and said a competency is required after completion of the online course. During an interview on [DATE] at 1:38 P.M., Staff Development Coordinator (SDC) said, she manages the orientation process and reviews a nursing checkoff list verbally to ensure staff are competent. The SDC said not everyone will have a hands-on nursing competencies and said she will verbalize what needs to be done. The SDC said she will sign off the competency packet before they work on the unit but she will not complete the hands on competency with each nurse, she will verbalize only. The SDC continued to say she started working in the facility four months ago and said a lot of competencies were not done for a lot of clinical staff so she was playing catch up. During an interview on [DATE] 8:56 A.M., Unit Manager #1 said she took an online wound course and said she is one of the certified wound nurses who completes weekly wound rounds. Unit Manager #1 said each unit follows the Wound Tool Box and said she will assess and document the healing progress and said if a wound is not improving or is getting infected, the wound nurses will use their professional judgement for new treatment options and run it by the doctor, and he usually approves it. Unit Manager #1 said she did not complete a wound competency after the online course in person or in a simulated setting. During an interview on [DATE] at 9:14 A.M. Unit Manager #2 said she completed the online wound course and is one of the wound nurses who conducts weekly wound rounds in the facility. Unit Manager #2 said she and the other wound nurse will give wound recommendations based on the training and seminars and enter new treatment orders based off what they see during wound rounds. Unit Manager #2 said up until recently I did not know how to stage wounds. Unit Manager #2 said once the course is completed the wound nurses were effective on their own and said no one completed an in person competency or observation during any wound rounds. Unit Manager #2 said she did not complete a wound competency after the online course in person or in a simulated setting. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 9:38 A.M., Physician #1 (who is also the Medical Director of the facility) said he does not visualize many wounds and said if the wound nurses tell him a wound is getting worse, the wound nurses put in new treatments. Physician #1 said I let them decide. I do not know what they order, they are the wound team. I do not know about wounds. Physician #1 continued to say I feel they can accurately assess them. They determine what is needed and put orders in. I don't review the orders they put in. Physician #1 said he expects the wound team to be certified and competent in wounds and said I don't know the rules for what certification is needed. I am assuming the facility takes care of that and they are competent in their wound skills as wound certified nurse's doing the wound rounds. During a follow up interview on [DATE] at 10:16 A.M., Physician #1 said I am not a wound care expert and he is really relying on the wound care team to utilize the best treatment option. During an interview on [DATE] at 9:20 A.M., The Nursing Home Administrator said it is her expectation that clinical staff have the necessary training and clinical competencies per the facility assessment, to care for the residents in the facility and the wound team has been reconstructed and educated on wound care tool box. During an interview on [DATE] at 10:12 A.M., with the Nursing Home Administrator, Director of Nurses (DON) and Regional Director of Clinical Services said staff competencies are based off the requirements outlined in the facility assessment and it is the expectation upon hire and annually that staff have training and competencies completed. The DON said all Nurses must have clinical competencies completed upon hire and annually to assess and provide care. During an interview on [DATE] at 10:50 A.M., the Massachusetts Board of Registration in Nursing said Licensed Practical (LPN) Nurses can function independently, however a Registered Nurse (RN) is responsible for a systemic evaluation and the LPN at a minimum must have documented training and demonstrated clinical competency in wound care. LPN, although bearing full responsibility, does not bear ultimate responsibility. LPN regulations under 3.04, the word participate is used. The RN bears the ultimate responsibility for the quality of nursing care he or she provides to individuals and groups. Although the LPN works under his or her own license and bears responsibility and accountability for their judgments and actions, the RN would need to be involved in the aspects outlined in 3.02 (2) and 3.04 (2). Refer to F686, F835, F837, and F841

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45984 Based on observation, record review and interview, the facility failed to ensure medications were stored as required for one Resident (#38), out of a total sample of 30 residents. Specifically, the facility failed to ensure that medication was not left at the bedside for Resident #38 while unsupervised by staff. Findings include: Review of the facility policy titled Administration of Medications, dated and revised 2/13/24, indicated the following: - The facility will ensure medications are administered safely and appropriately per physician's order to address residents' diagnoses and sign and symptoms. Resident #38 was admitted to the facility in July 2018 with diagnoses including chronic obstructive pulmonary disease (COPD), dysphagia and osteoarthritis. Review of Resident #38's most recent Minimum Data Set Assessment (MDS) indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. The surveyor made the following observations: - On 11/19/24 at 9:22 A.M., Resident #38 was laying in his/her bed with his/her bedside table within his/her reach. On the bedside table was an inhaler. There were no staff present in the Resident's room. Resident #38 shares his/her room with a roommate. - On 11/20/24 at 8:03 A.M., Resident #38 was laying in his/her bed with his/her bedside table within reach. On the bedside table was a medicine cup containing one oval shaped orange pill and one oval shaped yellow pill. Resident #38 shares his/her room with a roommate. Review of Resident #38's physician's orders indicated the following: - Dated 11/20/18: Levothyroxine (Synthroid) 100 MCG (micrograms) Tablet, Give 1 tablet by mouth one time a day related to hypothyroidism. - Dated 4/8/24: Pulmicort Suspension 0.25 MG/2ML (milliliters), 2 ml inhale orally two times a day for crackles lung sounds - Dated 7/24/24: Omeprazole Tablet Delayed Release 20 MG (milligrams), Give 1 tablet by mouth in the morning for indigestion give 1 hour before breakfast, do not crush. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 11/20/24: ProAir HFA Aerosol Solution 108 (90 base) MCG/ACT (Albuterol Sulfate HFA), 2 puff via trach (tracheostomy) every 2 hours as needed for mild SOB (shortness of breath)/Wheeze related to COPD During an interview on 11/20/24 at 8:04 A.M., the surveyor asked Nurse #5 to observe the pills at Resident #38's bedside. When asked if the Resident should have medication at the bedside while unsupervised by staff, she was unsure and asked the Infection Preventionist (IP). During an interview on 11/20/24 at 8:07 A.M, the IP observed the medications with the surveyor and reviewed Resident #38's physician's orders. The IP said the medications were omeprazole and levothyroxine. The IP said the night nurse from last night should have given the medication to Resident #38 and was not sure why she did not, and Resident #38 should not have them at his/her bedside while unsupervised. The IP continued to say missing a dose of levothyroxine could affect his/her thyroid lab values. The surveyor showed the IP a photograph of Resident #38's inhaler at the bedside from the previous morning. The IP and surveyor reviewed Resident #38's document titled NRSG: Medication Self-Administration Review, the IP said Resident #38 should only be self-administering his/her inhaler with staff present. The IP said Resident #38 should not have any the medication or inhalers at his/her bedside. Review of Resident #38's document titled NRSG: Medication Self-Administration Review, dated and signed 7/10/24 indicated that the Resident is able to self-administer Pulmicort Suspension 0.25 mg/ml 2 ml inhale orally and this medication is to be stored with staff and not bedside with resident. There was no documentation indicating that Resident #38 was able to self-administer levothyroxine or omeprazole. During an interview on 11/20/24 at 10:31 A.M., the Director of Nursing (DON) said Resident #38 should not have had medications at the bedside without staff present.

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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. 45984 Based on observation and interview the facility failed to properly follow sanitation and food handling practices to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Review of the facility policy titled Safe Food Handling, dated as revised 4/26/23, indicated the following: - All food purchased, stored, and distributed is handled with accepted food-handling practices and per federal, state and local requirements. - Associates shall wash their hands before handling or consuming food including working with clean equipment and utensils, and: - After handling soiled equipment or utensils - During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks - Before donning gloves to initiate a task that involved working with food - After engaging in any other activities that contaminate the hands - All food is handled carefully to avoid contamination with potentially harmful debris The surveyor made the following observations on 11/22/24 during the breakfast tray line service in the kitchen: - At 7:28 A.M., a dietary aide was observed touching bread with her bare hands, wearing no disposable gloves while toasting the bread. - At 7:47 A.M., the same dietary aide removed her disposable gloves, left the station where she was toasting bread and went into the dry storage room to obtain new loaves of bread. She did not wash her hands or perform hand hygiene and put on a new set of gloves, contaminating the gloves. She then proceeded to grab the bread with the contaminated gloves and toast the bread. - At 7:54 A.M., the same dietary aide removed the gloves, left her station where she was toasting bread and went into the dry storage room to obtain new loaves of bread. She did not wash her hands or perform hand hygiene and put on a new set of gloves, contaminating the gloves. She then proceeded to grab the bread with the contaminated gloves and toast the bread. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/25/24 at 2:07 P.M., the Foodservice Director (FSD) said she expects dietary staff to be washing their hands before doing any task in the kitchen. The FSD continued to say staff should be washing their hands before putting on a new set of gloves, and when leaving their stations to change tasks. The FSD then said staff should not be touching ready to eat food with bare hands.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, interviews and record review, the facility failed to ensure it was administrated in a manner that enabled the facility to ensure that systems were in place to provide competent clinical care and clinical oversight for the treatment to prevent the development and worsening of pressure injuries. Specifically, the facility administrator failed to: 1. Provide nursing staff education, training and competencies to demonstrate competency in providing safe and effective wound care management. 2. Identify concerns outlined by the Medical Director in the Quality Assurance and Performance Improvement (QAPI) program related to documentation, wound dressings, lab services and wound staging and documentation. 3. Implement an effective wound care program that is supervised by a physician for pressure ulcer (wounds that occur when the skin and tissue are damaged by prolonged pressure, usually on bony areas like the hips, heels, or elbows) prevention and care per the Facility Assessment Tool. As a result of these failures, three Residents (#264, #97, #103) developed pressure injuries that worsened, became infected, required hospitalization , required intravenous antibiotics with surgical intervention and for one of the three Residents, resulted in death. Findings include: During the survey process it was identified that the Administration's failure to perform wound care competencies for nursing staff that were delegated to assume the responsibilities of wound care management resulted in a failure to perform skin checks and wound evaluations, implement physician orders, updated the physician and plan of care when significant changes occurred, and the development of a stage 4 pressure ulcer with purulent drainage and odor. Review of the Facility Assessment Tool, dated and revised [DATE], as reviewed with the QAPI committee, indicated the facility last reviewed the Wound Care [NAME] on [DATE]. The section Action needed by committee to ensure policies meet professional standards for the Wound Care [NAME] was blank. Further review of the Facility Assessment Tool under the section Services and Care We Offer Based on our Residents' Needs indicated the following: - General Care: Skin Integrity - Specific Care of Practices: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). - Is the facility able to perform all care activities mentioning in column B (General Care: Skin Integrity): Yes (continued on next page)

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F 0835

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

The Facility Assessment Tool continues to say that the facility employs a Wound Care Nurse for each of the three Resident units in the facility. The staffing data for the Wound Care Nurse position is blank for all three units outlined.

1. The facility failed to provide nursing staff guidance in which staff are expected to demonstrate competency with the activities listed in the training requirements for effective wound care management.

According to the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; 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 18 personnel files of actively working clinical nursing staff in the facility on [DATE] and [DATE] indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Further review of the education files indicated licensed clinical staff did not have the necessary skills to evaluate, document, or recognize a change in condition related to skin integrity and proper wound management.

Review of 31 out of 36 licensed nurses working in the facility, educational records failed to indicate competencies were completed, per the Facility Assessment. Competencies reviewed included Skin and Wound Care. There was no documented evidence that licensed clinical staff had the required clinical training or that competencies were completed as indicated in the facility assessment.

Review of 18 personnel files of actively working clinical nursing staff in the facility on [DATE] and [DATE] indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Further review of the education files indicated licensed clinical staff did not have the necessary skills to evaluate, document, or recognize a change in condition related to skin integrity and proper wound management.

Review of 31 out of 36 licensed nurses working in the facility, educational records failed to indicate competencies were completed, per the Facility Assessment. Competencies reviewed included Skin and Wound Care. There was no documented evidence that licensed clinical staff had the required clinical training or that competencies were completed as indicated in the facility assessment.

Review of the education files for two out of two designated wound nurses indicated there was no documented evidence that competencies were completed as indicated in the Wound Care Manual - Life Care Center Wound Tool Box.

Unit Manager #1 had documented Certified Skin Champion certificate on file dated [DATE] but failed to complete the required clinical competency for skills validation.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Merrimack Valley	80 Boston Road Billerica, MA 01862

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Unit Manager #2 had documented Certified Skin Champion certificate on file dated [DATE] but failed to complete the required clinical competency for skills validation. During an interview on [DATE] at 1:38 P.M., Staff Development Coordinator (SDC) said, she manages the orientation process and reviews a nursing checkoff list verbally to ensure staff are competent. The SDC said not everyone will have hands-on nursing competencies and said she will verbalize what needs to be done. The SDC said she will sign off the competency packet before they work on the unit, but she will not complete the hands on competency with each nurse, she will verbalize only. The SDC said she started working in the facility four months ago and said a lot of competencies were not done for a lot of clinical staff, so she was playing catch up. The SDC did not observe nursing staff completing the neccessary skills to perform clinical nursing care as it relates to wound management and pressure ulcers, therefore was unable to ensure the competencies were demonstrated effectively. During an interview on [DATE] at 9:20 A.M., The Nursing Home Administrator said it is her expectation that clinical staff have the necessary training and clinical competencies per the facility assessment, to care for the residents in the facility and the wound team has been educated on wound care tool box (a wound care manual developed by the facility used for wound care treatment). During an interview on [DATE] at 10:12 A.M., the Nursing Home Administrator, Director of Nurses (DON) and Regional Director of Clinical Services said staff competencies are based off the requirements outlined in the facility assessment and it is the expectation upon hire and annually that staff have training and competencies completed. The DON said all Nurses must have clinical competencies completed upon hire and annually to assess and provide care. 2. Review of the facility policy titled QAPI - Program Design and Scope, dated and revised [DATE], last reviewed [DATE], indicated the following: Policy: - The facility will have a QAPI program that is ongoing, comprehensive and capable of addressing the full range of care and services it provides. - At a minimum, the QAPI program will: - Address all systems of care and management practices - Include clinical care, quality of life and resident choice - Utilize the best available evidence to define measure indicators of quality and facility goals that reflect the processes of care and facility operations that have been shown to be predictive of desired outcomes for residents - Reflect the complexities, unique care and services that the facility provides. Procedure: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Merrimack Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Boston Road Billerica, MA 01862	

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The facility will ensure QAPI programs address systems of care and management practices. Systems of care are the processes in place to achieve an expected clinical outcome. For example, the system for prevention of pressure ulcers also involves the system for ensuring adequate nutrition, as well was the systems for identification of changes in condition and infection prevention. Review of the facility policy titled Quality Assurance & Performance Improvement (QAPI) Plan for the Facility 2024 signed by the Facility Executive Director on [DATE] and the Medical Director on [DATE] indicated the following: - Purpose: The QAPI program is to utilize an ongoing, data driven, proactive approach to advance the quality if life and quality of care for all residents at our facility. QAPI principles will drive our facility decisions to promote excellence in all resident and staff-related areas. All facility associates will be encouraged to be involved in identifying opportunities for improvement, partake in QAPI teams, imbed QAPI activities in all core processes and providing ongoing feedback. - Governance and Leadership: The governing body is ultimately responsible for overseeing the QAPI Committee. The Executive Director has direct oversight responsibility for all functions of the QAPI committee and reports directly to the governing body. The QAPI Committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction. Review of the facility's QAPI plan indicated monthly documentation titled Medical Director Oversight Committee (MDOC) Meeting Minutes completed by the Medical Director of the facility which included the following discussion points: - Dated and signed by the Medical Director and Executive Director [DATE]: - Based on the topics reviewed in QAPI, are there additional quality of care areas that should be reviewed? This was checked yes with the following documentation Assessment documentation, communication, timely intervention. - Are there any compliance or regulatory concerns? This was checked yes with the following documentation Documentation. - Are there any opportunities or changes needed to education programs for staff? This was checked yes with the following documentation orientation enhancement. - Are there any issues based on consultant reports (pharmacy, nutrition, wound), this was check off yes with the following documentation Dressings & compliance. - Dated and signed by the Medical Director and Executive Director on [DATE]: - Based on the topics reviewed in QAPI, are there additional quality of care areas that should be reviewed? This was checked yes with the following documentation Lab services. - Are there any opportunities or changes needed to education programs for staff? This was checked yes with the following documentation documentation. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Any concerns with Event Management Program (e.g. incident reports, falls, skin tears)? This was checked yes with the following documentation thoroughness of investigation and immediate implementation of new interventions. - Dated and signed by the Medical Director and Executive Director on [DATE]: - Are there any issues based on consultant reports (pharmacy, nutrition, wound)? This was checked yes with the following documentation Wounds - staging, documentation. - Any concerns with Event Management Program (e.g. incident reports, falls, skin tears)? This was checked yes with the following documentation need improved detail and investigation root cause. Further review of the MDOC Meeting Minutes failed to indicate that any of the areas that were checked off as yes were addressed through the QAPI process to indicate that the facility developed, implemented, and maintained a comprehensive QAPI plan when these concerns were identified. During an interview on [DATE] at 10:49 A.M., the Nursing Home Administrator (NHA) said she has noticed trends with wounds in the facility. During an interview on [DATE] at 11:43 A.M., with the NHA, the QAPI program was Reviewed. The NHA said she looks for patterns and trends of what is going on in the facility for what to include in QAPI to improve the quality of the facility. The NHA said any plans that are put in place as a result of QAPI are monitored over time to see what is effective and if they are not improving we discuss as a team. The NHA did not mention that wound care has been a part of QAPI this year. The NHA continued to say the facility's wound nurses have not been a part of QAPI. The surveyor showed the NHA the Medical Director Oversight Committee (MDOC) Meeting Minutes that was in the QAPI plan. When asked if there has been any follow up to the identified concerns, especially related to wounds in the facility, the NHA said no and the Medical Director's concerns should have been addressed with follow up QAPI plans. The surveyor asked the NHA if there was any other documentation in the QAPI plan related to pressure ulcers or skin wounds and the NHA said there was not. The surveyor reviewed the QAPI plan and did not identify any information related to wounds including the identification of a problem or any improvement activities. 3. According to the Mayo Clinic, complications and outcomes of Stage 4 pressure ulcers include: - Osteomyelitis, which is characterized by a mixture of inflammatory cells, fibrosis, bone necrosis, and new bone formation. It is associated with nonhealing wounds, surgical flap complications, and an increased length of hospitalization . It may develop within the first 2 weeks of pressure ulcer formation and despite treatment may require amputation in lower extremity cases. - Joint infections (septic arthritis) can damage cartilage and tissue. - Bone infections (osteomyelitis) can reduce the function of joints and limbs. - Long-term, nonhealing wounds can develop into a type of squamous cell carcinoma. - Sepsis (blood infection). (continued on next page)

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During Resident #264, #97 and #103's stay in the facility, the Administrator failed to ensure that the physician provided oversight to ensure the appropriateness and quality of medically related care and recommendations made by facility staff were provided to the residents which resulted in worsening pressure wounds which further resulted in hospitalization , osteomyelitis, and for one resident, death. Resident #264 developed multiple pressure ulcers at the facility, specifically a sacral pressure ulcer that worsened in presentation of size and symptoms of infection which included gangrene and necrosis. The wound worsened at the facility despite being treated with antibiotics for multiple infections and eventually required hospitalization on [DATE] where the Resident underwent surgical debridement due to osteomyelitis of the coccygeal and ultimately died on [DATE] as a result of neglect. Resident #97 developed a Stage 4 pressure injury to the sacrum and development of osteomyelitis requiring antibiotics treatment, surgical debridement, and multiple hospitalization s. Resident #97 then developed two Stage 2 pressure injuries, one Deep Tissue Injury, and failed to arrange a wound clinic follow up for deteriorating wounds. Resident #103 was admitted with a sacral pressure ulcer wound that worsened in the facility. Despite documentation of a worsening wound and signs of infection in the wound, treatment and interventions in the place for the wound remained the same, eventually resulting in hospitalization from [DATE] through [DATE] for worsening wounds, treatment with intravenous (IV) antibiotics for osteomyelitis (A bone infection), and the need for ileostomy formation for fecal diversion away from the wound. Resident #103 was discharged back to the facility with Negative Pressure Wound Therapy (a medical technique used to accelerate wound healing by applying negative pressure to the wound site) for wound management. During an interview on [DATE] at 8:43 A.M., the Regional Director of Clinical Services said that there is not a wound physician who currently rounds in the facility. During an interview on [DATE] at 9:38 A.M., Physician #1 said that his expectation is that nurses who are competent in wound care perform wound rounds and make recommendations to him about what resident's need are and what residents he needs to visualize the wounds of himself. He said he is not a wound expert, and he relies on the wound team to be assessing and implementing the correct orders for wound management. Physician #1 said that he does not believe he is always notified when the wound team changes a treatment order for a resident. He said it is possible that with sooner action to Resident #103's wound worsening the need for hospitalization and ileostomy formation could have been prevented but he can't say with certainty. For Resident #264, Physician #1 said he treated the Resident with multiple courses of antibiotics. He said if the wound got bigger with slough, systemic fever the resident would have been sent to the hospital for debridement. He said Resident #264 should have been sent to the hospital sooner. For Resident #97, Physician #1 said he/she was treated with antibiotics at the end of December but he/she probably should have gone out sooner to the wound clinic for debridement and said he goes by what the wound nurses tell him and he was not aware of the situation as he did not visualize the wounds during that time. During a follow up interview on [DATE] at 10:16 A.M., Physician #1 said, I am not a wound care expert and he is really relying on the wound care team to utilize the best treatment option. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Merrimack Valley	80 Boston Road Billerica, MA 01862

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:43 A.M., the NHA said she should have addressed the physician's concerns regarding wound care that he mentioned in QAPI. Refer to F837

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on interview, record review and the Facility Assessment, the facility failed to ensure the Governing Body provided oversight and accountability for quality of care related to comprehensive wound care management. Specifically: 1. The Governing Body failed to ensure the facility provided consistent and effective nursing staff education and training to provide competent quality of care and effective wound care management as outlined per the Facility Assessment. 2. The Governing Body failed to ensure the facility had implemented an effective wound care program that is supervised by a physician for pressure ulcer (wounds that occur when the skin and tissue are damaged by prolonged pressure, usually on bony areas like the hips, heels, or elbows) prevention and care. As a result of these failures, three Residents (#264, #97, #103) developed pressure injuries that worsened, became infected, required hospitalization , required intravenous antibiotics with surgical intervention and for one of the three Residents, resulted in death. Findings include: Review of the facility policy titled QAPI - Program Design and Scope, revised [DATE], last reviewed [DATE], indicated the following: - The authority for the planning and implementation of the Quality Assurance Performance Improvement (QAPI) program is delegated by the Board of Directors to the Divisional/Regional teams and the Executive Director at the facility. - The Executive Director assumes responsibility for the implementation and coordination of the Quality Assessment and Assurance (QAA) activities as defined in the facility's QAPI plan. The QAPI program is designed to sustain during times of transitions in leadership or staffing. - The Executive Director will assure the QAPI plan is reviewed annually by the QAA Committee. The QAA committee will make any necessary revision to the plan on an ongoing basis as indicated. Any changes to the plan will be communicated to the residents/patients, families, and associates through meetings and other means that are agreed upon by the QAA committee as they occur. Review of the facility policy titled Governing Body, revised [DATE], last reviewed [DATE], indicated the following: - Policy: The facility has an active (engaged and involved) governing body that is responsible for establishing and implementing policies regarding the management of the facility. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- At least quarterly or more often if needed, the Executive Director reports to the governing body including, how the governing body responds back to the Executive Director and what specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) are reported or not reported directly to the governing body. - The Executive Director is held accountable and reports information about the facility's management and operation (i.e., audits, budgets, staffing, supplies, etc.) which is reviewed during facility visits from the regional/division team. 1. Review of the Facility Assessment Template, dated and last revised [DATE] included but was not limited to the following: Persons involved in completing the facility assessment: Executive Director (Nursing Home Administrator), Director of Nursing, Medical Director, Regional [NAME] President and the Regional Director of Clinical Services. - Review of the Facility Assessment Tool indicated the facility last reviewed the Wound Care [NAME] on [DATE]. The section Action needed by committee to ensure policies meet professional standards for the Wound Care [NAME] was blank. Further review of the Facility Assessment Tool under the section Services and Care We Offer Based on our Residents' Needs indicated the following: - General Care: Skin Integrity - Specific Care of Practices: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). - Is the facility able to perform all care activities mentioning in column B (General Care: Skin Integrity): Yes The Facility Assessment Tool continues to say that the facility employs a Wound Care Nurse for each of the three Resident units in the facility. The staffing data for the Wound Care Nurse position is blank for all three units outlined. - Under the section Competent Support and Care for our Resident Population Every Day and During Emergencies: - Topic: Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing [sic] rather than helping relieve suffering and improve quality of life. - Which Staff are Training and what frequency: Direct care staff during orientation, annually and as needed. Under the section Working with Medical Practitioners, indicated the following: (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- the management team and staff are well trained on long term care/skilled nursing facility regulations. The staff have an open dialogue with medical practitioners about residents' current needs and how prescribed interventions are working for the resident, or not providing the desired outcomes. The medical director's oversight and attendance at monthly QAPI provides a platform for discussion of trends and patterns. - clinical outcomes are measured and tracked at the monthly QAPI meeting. Policies and procedures are updated as needed according to regulatory requirements and are viewed by the IDT on an annual basis or as needed. Review of the Facility Wound Care Manual - Life Care Center Wound Care Tool Box, indicated the following: CWC-Certified Wound Care Champion - The Facility's Wound Care Program utilized professional standards from both organizations, the NPIAP (National Pressure Injury Advisory Panel) and WOCN (wound, ostomy, and continence nurse), and has developed a national wound certification and credentialed program designed as CWC (Certified Wound Care-Champions). The certification program is accredited by ANCC (American Nurses Credentialing Center) and consists of five plus hours of didactic lesson with knowledge validation of online examination. Awards 7 CE's (continuing educations) for nursing and may be accepted for Therapy. Competency and skills is validated on site in simulated or resident care situations. Review of 18 personnel files of actively working clinical nursing staff in the facility on [DATE] and [DATE] indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Further review of the education files indicated licensed clinical staff did not have the necessary skills to evaluate, document, or recognize a change in condition related to skin integrity and proper wound management. Review of 31 out of 36 licensed nurses working in the facility, educational records failed to indicate competencies were completed, per the Facility Assessment. Competencies reviewed included Skin and Wound Care. There was no documented evidence that licensed clinical staff had the required clinical training or that competencies were completed as indicated in the facility assessment. During an interview on [DATE] at 9:20 A.M., The Nursing Home Administrator said it is her expectation that clinical staff have the necessary training and clinical competencies per the facility assessment, to care for the residents in the facility and the wound team has been educated on the facility's wound care toolbox (a wound care manual developed by the facility used for wound care treatment). During an interview on [DATE] at 8:43 A.M., the Regional Director of Clinical Services said we have a QAPI process for the wounds in the facility and the wound nurses provide data for QAPI and it allows us to track what is going on in the facility. The Regional Director of Clinical Services continued to say QAPI is the biggest tool for monitoring wound progress and treatment, she said she does not attend QAPI, but she will review QAPI discussions after the fact. (continued on next page)

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:12 A.M. with the Regional Director of Clinical Services, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) they said the Governing Body is very involved in the building. The DON said if concerns are identified through the QAPI process the facility would do their part in the building and if they feel like they need more support whether it is equipment or something else they would reach out to the Governing Body. Additionally, they said staff competencies are based off the requirements outlined in the facility assessment and it is the expectation upon hire and annually that staff have training and competencies completed. The DON said all nurses must have clinical competencies completed upon hire and annually to assess and provide care. During an interview on [DATE] at 10:45 A.M., the Director of Nursing said the governing body of the facility is involved with wound care in the facility and if there were any issues, we would identify them in QAPI and make a plan from the results. During an interview on [DATE] at 10:49 A.M., the Nursing Home Administrator (NHA) said she has noticed trends with wounds in the facility. During an interview on [DATE] at 11:43 A.M., with the NHA, the QAPI program was reviewed. The NHA said she looks for patterns and trends of what is going on in the facility for what to include in QAPI to improve the quality of the facility. The NHA said any plans that are put in place as a result of QAPI are monitored over time to see what is effective and if they are not improving, we discuss as a team and these results should be in the QAPI plan. When asked what has the facility been working on this part year for QAPI the NHA did not mention that wound care has been a part of QAPI this year. The NHA continued to say the facility's wound nurses have not been a part of QAPI. The surveyor and the NHA reviewed the attendance sheets for each month of QAPI and the wound care nurses were not in attendance. The surveyor showed the NHA the Medical Director Oversight Committee (MDOC) Meeting Minutes that was in the QAPI plan. When asked if there has been any follow up to the identified concerns, especially related to wounds in the facility, the NHA said no, and the Medical Director's concerns should have been addressed with follow up QAPI plans. The surveyor asked the NHA if there was any other documentation in the QAPI plan related to pressure ulcers or skin wounds and the NHA said there was not. The surveyor reviewed the QAPI plan and did not identify any information related to wounds including the identification of a problem or any improvement activities. 2. According to the Mayo Clinic, complications and outcomes of Stage 4 pressure ulcers include: - Osteomyelitis, which is characterized by a mixture of inflammatory cells, fibrosis, bone necrosis, and new bone formation. It is associated with nonhealing wounds, surgical flap complications, and an increased length of hospitalization . It may develop within the first 2 weeks of pressure ulcer formation and despite treatment may require amputation in lower extremity cases. - Joint infections (septic arthritis) can damage cartilage and tissue. - Bone infections (osteomyelitis) can reduce the function of joints and limbs. - Long-term, nonhealing wounds can develop into a type of squamous cell carcinoma. - Sepsis (blood infection). (continued on next page)

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During Resident #264, #97 and #103's stay in the facility, the Governing Body failed to ensure that the facility and physician provided oversight to ensure the appropriateness and quality of medically related care and recommendations made by facility staff were provided to the residents which resulted in worsening pressure wounds which further resulted in hospitalization , osteomyelitis, and for one resident, death. Resident #264 developed multiple pressure ulcers at the facility, specifically a sacral pressure ulcer that worsened in presentation of size and symptoms of infection which included gangrene and necrosis. The wound worsened at the facility despite being treated with antibiotics for multiple infections and eventually required hospitalization on [DATE] where the Resident underwent surgical debridement due to osteomyelitis of the coccygeal and ultimately died on [DATE] as a result of neglect. Resident #97 developed a Stage 4 pressure injury to the sacrum and development of osteomyelitis requiring antibiotics treatment, surgical debridement, and multiple hospitalization s. Resident #97 then developed two Stage 2 pressure injuries, one Deep Tissue Injury, and failed to arrange a wound clinic follow up for deteriorating wounds. Resident #103 was admitted with a sacral pressure ulcer wound that worsened in the facility. Despite documentation of a worsening wound and signs of infection in the wound, treatment and interventions in place for the wound remained the same, eventually resulting in hospitalization from [DATE] through [DATE] for worsening wounds, treatment with intravenous (IV) antibiotics and surgical debridement for osteomyelitis (A bone infection), and the need for ileostomy formation for fecal diversion away from the wound. Resident #103 was discharged back to the facility with Negative Pressure Wound Therapy (a medical technique used to accelerate wound healing by applying negative pressure to the wound site) for wound management. During an interview on [DATE] at 10:34 A.M., the Regional Director of Clinical Services said Residents with wounds can be sent out to a wound clinic if needed but transportation has been an issue lately. She continued to say the Physician or Nurse Practitioner will look at the wounds if needed. During an interview on [DATE] at 11:43 A.M., the Director of Nurses said if a recommendation is made to be seen in the wound clinic, she would expect that an appointment is made, however, the facility has trouble getting transportation to and from appointments at this time. During an interview on [DATE] at 8:43 A.M., the Regional Director of Clinical Services said that there is not a wound physician who currently rounds in the facility. She continued to say transportation has been an issue and if needed, the facility has an affiliation with doctor who specializes in wounds, but he has not come to the facility. She then said the facility does not have any contracts with outside wound companies. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Merrimack Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Boston Road Billerica, MA 01862	

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 9:38 A.M., Physician #1 said that his expectation is that nurses who are competent in wound care perform wound rounds and make recommendations to him about what resident's need are and what residents he needs to visualize the wounds of himself. He said he is not a wound expert, and he relies on the wound team to be assessing and implementing the correct orders for wound management. Physician #1 said that he does not believe he is always notified when the wound team changes a treatment order for a resident. He said it is possible that with sooner action to Resident #103's wound worsening the need for hospitalization and ileostomy formation could have been prevented but he can't say with certainty. For Resident #264, Physician #1 said he treated the Resident with multiple courses of antibiotics. He said if the wound got bigger with slough, systemic fever the resident would have been sent to the hospital for debridement. He said Resident #264 should have been sent to the hospital sooner. For Resident #97, Physician #1 said he/she was treated with antibiotics at the end of December but he/she probably should have gone out sooner to the wound clinic for debridement and said he goes by what the wound nurses tell him and he was not aware of the situation as he did not visualize the wounds during that time. During a follow up interview on [DATE] at 10:16 A.M., Physician #1 said, I am not a wound care expert and he is really relying on the wound care team to utilize the best treatment option. During an interview on [DATE] at 8:08 A.M., the Nurse Practitioner said she has not been notified of the facility having trouble getting transportation for Residents who need to leave the facility for wound care. During an interview on [DATE] at 11:43 A.M., the Nursing Home Administrator said she should have addressed the physician's concerns regarding wound care that he mentioned in QAPI.

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F 0838 Level of Harm - Actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on review of the Facility Assessment and interviews, the facility failed to conduct and document a facility wide assessment that accurately reflected the resources necessary to care for it's residents. Specifically, the facility failed to ensure licensed nursing staff were competent in wound care. Findings include: Review of the Facility Assessment, dated as reviewed with the QAPI committee, in [DATE], indicated the following: -Facility Profile indicated the average daily census range: 103 - 108 Part 1 Facility Profile - Wound Care Manual Annual Review Date [DATE] - Review of the diagnosis potentially treated at the facility include, Aphasia, Behavioral Health Disorders (Anxiety /Personality/ Dissociative), Bipolar Disorder, Blood Disorders-DVT, PE, Bleeding, Anemia, Sickle Cell, Bowel Disease- GERD, PUD, Crohn's Inflammatory Bowel Disease, Cancer Care- Prostate, Lung, Colon, Pancreatic, Breast Bone, Communication Barriers (Another Language, Aphasis), Congestive Heart Failure and other respiratory failures, COPD, Chronic Lung Disease, Chronic Bronchitis, Asthma, Coronary Artery Disease, CVA/ Sroke /TIA, Dementia- Alzheimer's or Non-Alzheimer's Dementia, Diabetes- Type I or II, Dialysis- Hemodialysis, Peritoneal, Downs Syndrome/ Autism/ Cerebral Palsy, Drug Use or Abuse (Alcohol Dependence/ Substance Dependance), Dysthrithmias - Afib, Angina, Pace Makers, Defibrillators, Hearing Impairment or Loss, Hemiparesis/Hemiplegia, Huntington's Disease, Hypertension, Hypotension-Orthostatic, Impaired Cognition- not related to dementia, Infections-C-diff, Norovirus, Infections COVID-19, Influenza, TB, Legionella, Infections MRSA/ VRE/CRE/MDRO, Infections-UTI, Soft Tissue, Respiratory, Multiple Sclerosis, Neuropathy, Obesity-Morbid, Orthopedics-Arthritis, Osteoporosis, Orthopedics- Joint Replacement (Hip, Knee, Shoulder), Orthopedics- S/P Fracture Repair, S/P fracture, Paraplegia/Quadriplegia, Parkinsons Disease, Pneumonia, Psychosis (Hallucinations /Delusions), PTSD-Post traumatic stress disorder, PVD-Arterial or Venous, Renal Disorders-ESRD, Acute Renal Failure, Renal Insufficiency, Schizophrenia/Schizoaffective, Seizure Disorder, Substance Use Disorders (SUD), Suicidal History or Ideation, Tourette's Disease, Traumatic Brain Injuries, Vision Disorders-Cataract, Glaucoma, Macular Degeneration, Wounds - Venous, Arterial, Pressure, Surgical, Traumatic. Part 3: Services and Care Offered - Services and Care Offered Based on our Resident Needs - Skin Integrity- Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). (continued on next page)

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F 0838 Level of Harm - Actual harm Residents Affected - Some	- Therapy - PT, OT, Speech/Language, Respiratory, Music, Art, management of braces, splints, CPI. - Management of Medical Conditions: Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), , Infections such as UTI, and gastroenteritis, pneumonia, hypothyroidism. Workforce Profile Direct Care Staff- Wound Care Nurse, Employee. Part 5 Training and Competencies -Competent Support and Care for our Resident Population Every Day and During Emergencies: Infection control - a facility must include as part of its infection prevention and control program mandatory training that includes written standards, policies, and procedures for the program. -Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life. All staff during orientation, annually and as needed. Which Staff are Trained and what frequency? All staff during orientation, annually and as needed. Competency: Person Centered Care Resident Assessment Medication Administration Part 6- Facility Resources- Medical Equipment - Low-air Loss Mattress. Required -Yes. - Wound Vac-. Required - No. Part 7- Healthcare Related Contracts, [NAME], or Other Agreements. - Medical Director Contract Working with Medical Practitioners: (continued on next page)

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F 0838 Level of Harm - Actual harm Residents Affected - Some	- Describe your plan to recruit and retain enough medical practitioners (e.g., physicians, nurse practitioners) who are adequately trained and knowledgeable in the care of your resident/patients, including how you will collaborate with them to ensure the facility has appropriate medical practices for the needs and scope of your population: The facility is in contract with Post Acute EMS which provides the facility with medical practitioners 5 days a week on-site and on call services. - Describe how the management and staff familiarize themselves with what they should expect from the medical practitioners and other healthcare professionals related to standards of care and competencies that are necessary to provide the level and type of support and care needed for your resident population. For example, do you share expectations from providers that see residents in your nursing home on the use of standards, protocols, or other information developed by your medical director? Do you have discussions on what providers and staff expect of each other in terms of the care delivery process and clinical reasoning essential to providing high quality?: Management team and staff are well trained on long term care/skilled nursing facility regulations. The staff have opened dialogue with medical practitioners about residents' current needs and how prescribed interventions are working for the resident, or not providing the desired outcomes. The medical directors oversight and attendance at monthly QAPI provides a platform for discussion of trends and patterns. - Describe process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements: Clinical outcomes are measured and tracked at the monthly QAPI meeting. Policies and procedures are updated as needed according to regulatory requirements and are reviewed by the IDT on an annual basis or as needed. The facility failed to provide training and demonstrated competency in quality of care related to wound treatment orders and skin integrity incuding pressure injury prevention and care, skin care, wound care, surgical and other skin wounds. Review of 18 personnel files of actively working clinical nursing staff in the facility on [DATE] and [DATE] indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Further review of the education files indicated licensed clinical staff did not have the necessary skills to evaluate, document, or recognize a change in condition related to skin integrity and proper wound management. Review of 31 out of 36 educational records for licensed nurses working in the facility, failed to indicate competencies were completed, per the Facility Assessment. Competencies reviewed included Skin and Wound Care. There was no documented evidence that licensed clinical staff had the required clinical training or that competencies were completed as indicated in the facility assessment. (continued on next page)

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Life Care Center of Merrimack Valley	80 Boston Road Billerica, MA 01862

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F 0838 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at 1:38 P.M., Staff Development Coordinator (SDC) said, she manages the orientation process and reviews a nursing checkoff list verbally to ensure staff are competent. The SDC said not everyone will have a hands-on nursing competencies and said she will verbalize what needs to be done. The SDC said she will sign off the competency packet before they work on the unit but she will not complete the hands on competency with each nurse, she will verbalize only. The SDC said she started working in the facility four months ago and said a lot of competencies were not done for a lot of clinical staff so she was playing catch up. During an interview on [DATE] at 10:12 A.M., with the Nursing Home Administrator (NHA), Director of Nurses (DON) and Regional Director of Clinical Services, the Regional Director of Clinical Services said staff competencies are based off the requirements outlined in the facility assessment and it is the expectation upon hire and annually that staff have training and competencies completed. The DON said all nurses in the facility must have clinical competencies completed upon hire and annually to assess and provide care. During an interview on [DATE] at 10:12 A.M., the NHA said it is her expectation that all clinical staff are trained and competent to provide the necessary care and services to residents within the facility. Resident #264 developed multiple pressure ulcers at the facility, specifically a sacral pressure ulcer that worsened in presentation of size and symptoms of infection which included gangrene and necrosis. The wound worsened at the facility despite being treated with antibiotics for multiple infections and eventually required hospitalization on [DATE] where the Resident underwent surgical debridement due to osteomyelitis of the coccygeal and ultimately died on [DATE] as a result of neglect. Resident #97 developed a Stage 4 pressure injury to the sacrum and development of osteomyelitis requiring antibiotics treatment, surgical debridement, and multiple hospitalization s. Resident #97 then developed two Stage 2 pressure injuries, one Deep Tissue Injury, and failed to arrange a wound clinic follow up for deteriorating wounds. Resident #103 was admitted with a sacral pressure ulcer wound that worsened in the facility. Despite documentation of a worsening wound and signs of infection in the wound, treatment and interventions in the place for the wound remained the same, eventually resulting in hospitalization from [DATE] through [DATE] for worsening wounds, treatment with intravenous (IV) antibiotics and multiple surgical debridements for osteomyelitis (A bone infection) and the need for ileostomy formation for fecal diversion away from the wound. Resident #103 was discharged back to the facility with Negative Pressure Wound Therapy (a medical technique used to accelerate wound healing by applying negative pressure to the wound site) for wound management. 45984

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F 0840 Level of Harm - Actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on record review and interviews, the facility failed to ensure that recommended specialist appointments were scheduled for two Residents (#60, and #103), out of a total sample of 30 residents. Specifically: 1. For Resident #60, the facility failed to ensure an outpatient appointment at the wound clinic was scheduled when requested by a Nurse Practitioner after the wound was documented as worsening and with signs of infection. 2. For Resident #103, the facility failed to ensure an outpatient appointment at the wound clinic was scheduled when requested by a Nurse Practitioner after the wound was documented as worsening and with signs of infection. Findings Include: Review of facility policy titled Use of Outside Consultants, dated as reviewed 6/7/24, indicated the following: When the facility does not employ qualified professional personnel to render a specific required service, the facility will make an arrangement for such services with an outside agency. 1. Resident #60 was admitted to the facility in October 2024 with diagnoses including multiple sclerosis, cellulitis of right lower limb, sepsis due to streptococcus group A, type one diabetes with foot ulcer, unspecified protein calorie malnutrition, muscle weakness, cognitive communication deficit, acute hematogenous osteomyelitis of right ankle and foot, raynaud's syndrome, spinal stenosis, and non-pressure chronic ulcer of right ankle. Review of Resident #60's Minimum Data Set (MDS) assessment, dated 10/18/24, indicated that Resident #60 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15, and is dependent on staff for activities of daily living tasks. Further review of the MDS indicated Resident #60 was at risk for developing pressure injuries and indicated the use of a pressure reducing device for chair and pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, applications of ointments/medications other than to feet, and applications to dressings of feet with or without topical medications. Review of the medical record failed to indicate that an appointment was scheduled for Resident #60 to be seen in the wound clinic. Review of the medical record further indicated that Resident #60 was hospitalized from 11/19/24 through 11/22/24 for an infected pressure wound of the lumbar area with increased pain, erythema, purulence, leukocytosis and elevated CRP. Review of Physician progress note dated 11/6/24, indicated: Resume clindamycin (an antibiotic for infection) for 10 days and get follow-up at the Wound Clinic. (continued on next page)

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F 0840 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse Practitioner progress note dated 11/7/24, indicated: Patient has a wound to lower mid back noted to have sloughy tissue surrounding tissue slightly pink no drainage noted. Patient has a scheduled appointment with wound clinic on Tuesday (11/12/24). Review of Physician progress notes dated 11/8/24, indicated: -Patient is back on Clindamycin until 16 November. Will follow-up on results from the Wound Clinic. He/she still has high CRP (an indicator of inflammation in the body). Wound is not improving with antibiotics yet. -Will see if there is been any report from wound clinic the patient has had labs done recently sodium is low at 130 this is patient's baseline CRP continues to be high at 61.5. CBC (complete blood count) within normal limits this is raises concern of residual infection the patient was taken off of clindamycin but went back on it in the setting of the CRP and concern of wound infection. He/she is scheduled to be on clindamycin until November 16. Despite the antibiotics his/her wound looks the same or slightly worse. Review of the physician progress note dated 11/11/24, indicated: Follow-up for diabetes and wound care. Wound care clinic follow-up with tomorrow. Continue with Clindamycin. Wound looks like it needs to be debrided today. We will make sure that he/she can get into wound care at some point this week. Review of the Nurse Practitioner progress note dated 11/12/24, indicated: Patient seen today in follow-up of several concerns, patient had a follow up appointment with orthopedic right ankle no new orders. On assessment patient appeared to be withdrawn reports discomfort to lower back area, has an appointment with the wound clinic on the 24th. Review of the social services note dated 11/14/24, indicated: Resident has multiple wounds that he/she is getting daily dressing for. He/she has a wound on his/her spine that is very concerning. A wound clinic appointment was made for him/her at the end of the month. It is recommended that he/she stay here until at least this appointment. He/she is concerned about the wounds and does not want to go home until they are healing or on the path to healing. Review of the physician progress noted dated 11/15/24, indicated: Back wound was changed to Santyl reevaluate the wound to see if it is debriding. At this point we will renew the Clindamycin. The wound looks a little bit worse he/she is getting Santyl he/she may not be able to wait until wound care which is on November 22. CRP still high around 60. will extend Clindamycin if gets worse he/she may need to go to the hospital before the wound care clinic which is scheduled for the 22nd. Review of the Nurse Practitioner progress note dated 11/19/24, indicated: Patient seen today in follow up of several concerns, on assessment patient appeared to be in distress, reports having generalized pain. Wound to lower midback area noted to have sloughy tissue has a wound appointment this Friday. Patient warm to touch noted to have a low grade fever. New order to send patient out to the hospital for further evaluation. (continued on next page)

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F 0840 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record failed to indicate Resident #60 was seen by the wound clinic on 11/12/24. The surveyor requested all wound clinic visit notes during Resident #60's admission to the facility. The facility was unable to provide the surveyor with any documentation throughout the survey. During an interview on 11/21/24 at 9:14 A.M., Unit Manager #1 and Unit Manager #2 said that there were no recommendations for Resident #60 to go to the wound clinic prior to his/her rehospitalization on [DATE]. During an interview on 11/21/24 at 11:43 A.M., the Director of Nurses said if a recommendation is made to be seen in the wound clinic, she would expect that an appointment is made, however, the facility has trouble getting transportation to and from appointments at this time. During an interview on 11/22/24 at 9:38 A.M., Physician #1 said he is not a wound expert, and he relies on the wound team to be assessing and implementing the correct orders for wound management. During an interview on 11/25/24 at 12:25 P.M., Physician #1 said Resident #60's wounds were increasing and showing signs of infections and said he/she would have benefited from wound debridement at the wound clinic. During an interview on 11/25/24 at 8:01 A.M., Nurse Practitioner (NP) #1 said she did recommend having Resident #60 seen at the wound clinic but was not aware that it was never implemented. NP #1 said she would expect residents to see the wound clinic if it is recommended. NP #1 said Resident #60 had recommendations to see the wound clinic due to his/her wounds not improving. 49880 2. Resident #103 was admitted to the facility in August 2024 with diagnoses that include depression, diabetes, and pressure ulcer of the pressure region, unspecified. Review of Resident #103's most recent Minimum Data Set (MDS) Assessment, dated 11/12/24, indicated a Brief Interview for Mental Status score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident has a pressure ulcer/injury over a bony prominence and is at risk for developing pressure ulcers. Further, the MDS indicated one stage 4 pressure ulcer that was present on admission or reentry to the facility. Review of a Nurse Practitioner Progress note dated, 9/12/24, indicated the following: 9/12/24: Patient seen today in follow-up of coccyx wounds, on assessment patient was in bed, wounds to coccyx area noted to have sloughy tissue scant amount of serosanguinous drainage and redness to surrounding area. Wounds appear to be getting worse, patient will be referred to wound clinic. Patient will continue with current medications and treatment plan. Review of the medical record failed to indicate that an appointment was scheduled for Resident #103 to be seen in the wound clinic. Review of the medical record further indicated that Resident #103 was hospitalized from 9/23/24 through 11/6/24 for an ongoing sacral wound that was worsening resulting in osteomyelitis and the need for ileostomy formation for fecal diversion. (continued on next page)

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F 0840 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/21/24 at 9:13 A.M., Unit Manager #1 and Unit Manager #2 said that there were no recommendations for Resident #103 to go to the wound clinic prior to his/her rehospitalization on [DATE]. During an interview on 11/21/24 at 11:43 A.M., the Director of Nurses said if a recommendation is made to be seen in the wound clinic, she would expect that an appointment is made, however, the facility has trouble getting transportation to and from appointments at this time. During an interview on 11/22/24 at 9:38 A.M., Physician #1 said he is not a wound expert, and he relies on the wound team to be assessing and implementing the correct orders for wound management. During an interview on 11/25/24 at 8:08 A.M., Nurse Practitioner #1 said that she did recommend having Resident #103 seen at the wound clinic, but was not aware that it was never implemented, or that the facility was having trouble with securing transportation to appointments. During an interview on 11/26/24 at 7:13 A.M., Nurse #2 said that the facility does not have a wound physician in house who sees residents with wounds.

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F 0841 Level of Harm - Actual harm Residents Affected - Some	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on observation, document review and interview, the facility failed to ensure the medical director was responsible for the implementation of resident care policies and the coordination of the medical care in the facility. In addition, the facility failed to ensure the appropriateness and quality of medical care and medically related care provided to residents which resulted in worsening pressure wounds for three residents resulting in hospitalization , osteomyelitis, and for one resident, death. Findings Include: Review of facility policy titled Medical Director, dated as reviewed [DATE], indicated the following: -Policy: The facility will have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable for the management of the institution of which it is a distinct part. -The facility must designate a physician to serve as medical director. The medical director is responsible for (i) implementation of resident care policies; and (ii) the coordination of medical care in the facility. -Current professional standards of practice- Refers to approaches to care, procedures, techniques, etc., that are based on research and/or expert consensus and that are contained in current manuals, textbooks, or publications, or that are accepted, adopted, or promulgated by recognized professional organizations or national accrediting bodies. -Medical Director Responsibilities must include their participation in: b. Issues related to the coordination of medical care identified through the facility's Quality Assessment and Assurance (QAA) committee and other activities related to the coordination of care. d. Coordinating and planning for improvement of medical care in the facility. -In addition, the medical director responsibilities should include, but are not limited to: -a. Providing medical decision input and support to the executive director and governing body of the facility. -b. Ensuring the appropriateness and quality of medical care and medically related care. -f. Working with the facilities clinical team to provide surveillance and develop policies to prevent the potential infection of residents. (continued on next page)

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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 0841 Level of Harm - Actual harm Residents Affected - Some	-p. Any issues related to the facility performance improvement, regulatory compliance concerns, and any quality of care or safety issues should be recorded on the Medical Director Facility Oversight Committee Minutes. When requested, twice over the survey period, the facility was unable to provide a job description for the Medical Director position. Review of the facility's QAPI plan indicated monthly documentation titled Medical Director Oversight Committee (MDOC) Meeting Minutes completed by the Medical Director of the facility which included the following discussion points: - Dated and signed by the Medical Director and Executive Director [DATE]: - Based on the topics reviewed in QAPI, are there additional quality of care areas that should be reviewed? This was checked yes with the following documentation Assessment documentation, communication, timely intervention. - Are there any compliance or regulatory concerns? This was checked yes with the following documentation Documentation. - Are there any opportunities or changes needed to education programs for staff? This was checked yes with the following documentation orientation enhancement. - Are there any issues based on consultant reports (pharmacy, nutrition, wound), this was check off yes with the following documentation Dressings & compliance. - Dated and signed by the Medical Director and Executive Director on [DATE]: - Are there any issues based on consultant reports (pharmacy, nutrition, wound)? This was checked yes with the following documentation Wounds - staging, documentation. - Any concerns with Event Management Program (e.g., incident reports, falls, skin tears)? This was checked yes with the following documentation need improved detail and investigation root cause. During an interview on [DATE] at 10:49 A.M., the Nursing Home Administrator (NHA) said she has noticed trends with wounds in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Merrimack Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Boston Road Billerica, MA 01862	

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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 0841 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at 11:43 A.M., with the NHA, the QAPI program was Reviewed. The NHA said she looks for patterns and trends of what is going on in the facility for what to include in QAPI to improve the quality of the facility. The NHA said any plans that are put in place as a result of QAPI are monitored over time to see what is effective and if they are not improving, we discuss as a team. The NHA did not mention that wound care has been a part of QAPI this year. The NHA continued to say the facility's wound nurses have not been a part of QAPI. The surveyor showed the NHA the Medical Director Oversight Committee (MDOC) Meeting Minutes that was in the QAPI plan. When asked if there has been any follow up to the identified concerns, especially related to wounds in the facility, the NHA said no, and the Medical Director's concerns should have been addressed with follow up QAPI plans. The surveyor asked the NHA if there was any other documentation in the QAPI plan related to pressure ulcers or skin wounds and the NHA said there was not. The surveyor reviewed the QAPI plan and did not identify any information related to wounds including the identification of a problem or any improvement activities. Resident #264 developed multiple pressure ulcers at the facility, specifically a sacral pressure ulcer that worsened in presentation of size and symptoms of infection which included gangrene and necrosis. The wound worsened at the facility despite being treated with antibiotics for multiple infections and eventually required hospitalization on [DATE] where the Resident underwent surgical debridement due to osteomyelitis of the coccygeal and ultimately died on [DATE] as a result of neglect. Resident #97 developed a Stage 4 pressure injury to the sacrum and development of osteomyelitis requiring antibiotics treatment, surgical debridement, and multiple hospitalization s. Resident #97 then developed one Deep Tissue Injury, and failed to arrange a wound clinic follow up for deteriorating wounds. Resident #60, developted of a Stage 3 pressure injury to the lower back requiring antibiotic treatment and hospitalization . Resident #60 developed a Stage 2 pressure injury to the right buttock, Stage 1 pressure injury to the right lateral foot, Unstageable DTI to the right outer calf, Unstageable DTI to the right heel, and failed to arrange a wound clinic follow up as indicated by the Physician. Resident #103 was admitted with a sacral pressure ulcer wound that worsened in the facility. Despite documentation of a worsening wound and signs of infection in the wound, treatment and interventions in the place for the wound remained the same, eventually resulting in hospitalization from [DATE] through [DATE] for worsening wounds, treatment with intravenous (IV) antibiotics and multiple surgical debridements for osteomyelitis (A bone infection) and the need for ileostomy formation for fecal diversion away from the wound. Resident #103 was discharged back to the facility with Negative Pressure Wound Therapy (a medical technique used to accelerate wound healing by applying negative pressure to the wound site) for wound management. During an interview on [DATE] at 9:13 A.M., Unit Manager #1 and UM #2 said that at this time they are the only two who complete wound rounds. They said it is not very often that they ask the physician to observe wounds, and it is not often that the physician will visualize the wounds with the wound team. Unit Managers #1 and #2 further said it is not often that residents will be referred to the wound clinic and wounds are managed in house. Unit Managers #1 and #2 said that in general, they are not seeing wounds worsening or becoming infected in the facility. (continued on next page)

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F 0841 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at 11:43 A.M. the Director of Nurses (DON) said she is not part of wound rounds, therefore can't say how often the Nurse Practitioner (NP) or Physician (who is the Medical Director) are looking at the wounds in the facility. She said both the NP and Physician are in the facility frequently but does know how often they are taking down dressings and observing wounds. The DON said the physician is not wound certified and does not believe that the NP is either. During an interview on [DATE] at 9:38 A.M., Physician #1 (who is also the Medical Director of the facility) said he is the Medical Director in the facility and is aware that the survey team has identified some concerns with wound care in the facility. He said that his expectation is that nurses who are competent in wound care perform wound rounds and make recommendations to him about what resident's needs are and what residents he needs to visualize the wounds of himself. He said he is not a wound expert, and he relies on the wound team to be assessing and implementing the correct orders for wound management. Physician #1 said that he does not believe he is always notified when the wound team changes a treatment order for a resident. During a follow up interview on [DATE] at 10:16 A.M., Physician #1 said, I am not a wound care expert and I really rely on the wound care team to utilize the best treatment option.

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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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations, record review and interview, the facility failed to accurately document in the medical record for three Residents (#63, #38, #62) out of a total sample of 30 Residents. Specifically: 1. For Resident #63, the facility documented that the Resident was wearing heel boots (boots primarily used to prevent pressure ulcers, particularly on the heels) as ordered when he/she was not. 2. For Resident #38, the facility documented that the Resident received medication when the Resident did not. 3. For Resident #62, the facility documented the incorrect arm for which the Resident had a shunt placed for dialysis treatment. Findings include: Review of the facility policy titled 'Nursing Documentation' dated as reviewed on 9/5/24 indicated the following: -The medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress. -The process of preparing a complete record of a resident's care documentation is a vital tool for communication among health care team members. Accurate, detailed documentation shows the extent and quality of the care the nurses provide, the outcomes of that care, and the treatment and education that the resident still needs. -Federal regulations require that long term care facilities maintain clinical records for each resident and that these records contain sufficient information to identify the resident. These records must also be complete, accurate, readily accessible, and systematically organized and must provide documentation of the resident's assessments and the care plan and services provided. 1. Resident #63 was admitted to the facility in August 2019 with diagnoses including Dementia. Review of the most recent Minimum Data Set Assessment, dated 9/11/24, did not indicate a Brief Interview for Mental Status (BIMS) score was completed because Resident #63 is rarely and never understood. On 11/20/24 at 7:03 A.M., the surveyor observed Resident #63 sleeping in bed without heel boots on. The surveyor did not observe the heel boots in the room. On 11/21/24 at 7:08 A.M., the surveyor observed Resident #63 sleeping in bed without heel boots on. The surveyor did not observe the heel boots in the room. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #63's November 2024 physician's orders indicated the following: -Heel boots to bilateral heels while in bed as tolerated every shift for DTI (Deep Tissue Injury). [sic] A review of Resident #63's November 2024 Treatment Administration Record (TAR) indicated the following: -On 11/20/24 day, evening and night shift, staff documented that Resident #63 was wearing heel boots in bed as ordered. During an interview and observation on 11/21/24 at 7:12 A.M., Certified Nurse's Assistant (CNA) #4 and the Surveyor observed the Resident in bed without heel boots. CNA #4 searched the Resident's room for the heel boots but was not able to locate them. CNA #4 said the Resident was not wearing heel boots because the heel boots have been in the laundry room. During an interview on 12/4/24 at 7:41 A.M., Nurse #3 said Nurses are responsible for documenting in the TAR, and they should document accurately. Nurse #3 said if the Resident is not wearing any heel boots, Nurses should not document that he/she is wearing them in the TAR. During an interview on 12/4/24 at 7:35 A.M., the Unit Manager #2 said Nurses should document accurately in the TAR. Unit Manager #2 said if the Resident is not wearing heel boots, the Nurses should not document that he/she is wearing them. During an interview on 12/4/24 at 7:47 A.M., the Director of Nurses said Nurses should document accurately in the TAR. 45984 2. Resident #38 was admitted to the facility in July 2018 with diagnoses including chronic obstructive pulmonary disease (COPD), dysphagia and osteoarthritis. Review of Resident #38's most recent Minimum Data Set Assessment (MDS) indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. The surveyor made the following observation: - On 11/20/24 at 8:03 A.M., Resident #38 was laying in his/her bed with his/her bedside table within reach. On the bedside table was a medicine cup containing one oval shaped orange pill and one oval shaped yellow pill. Review of Resident #38's physician's orders indicated the following: - Dated 11/20/18: Levothyroxine (Synthroid) 100 MCG (micrograms) Tablet, Give 1 tablet by mouth one time a day related to hypothyroidism. - Dated 7/24/24: Omeprazole Tablet Delayed Release 20 MG (milligrams), Give 1 tablet by mouth in the morning for indigestion give 1 hour before breakfast, do not crush. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #38's Medication Administration Record for November 2024 indicated that the overnight nurse documented that Resident #38 received his/her Levothyroxine and Omeprazole tablets when the Resident did not. During an interview on 11/20/24 at 8:04 A.M., the surveyor asked Nurse #5 to observe the pills at Resident #38's bedside. When asked if the Resident should have medication at the bedside while unsupervised by staff, she was unsure and asked the Infection Preventionist (IP). During an interview on 11/20/24 at 8:07 A.M, the IP observed the medications with the surveyor and reviewed Resident #38's physician's orders. The IP said the medications were omeprazole and levothyroxine. The IP said the night nurse from last night should have given the medication to Resident #38 and was not sure why she did not, and Resident #38 should not have them at his/her bedside while unsupervised. The IP continued to say missing a dose of levothyroxine could affect his/her thyroid lab values. The IP continued to say that the night nurse should not have left them at Resident #38's bedside and should not have documented that the Resident took the medication when he/she did not. During an interview on 11/20/24 at 10:31 A.M., the Director of Nursing (DON) said Resident #38 should not have had medications at the bedside without staff present and staff should not be documenting that Resident #38 took medication when he/she did not. 3. Resident #62 was admitted to the facility in June 2021 with diagnoses including end stage renal disease and type 2 diabetes mellitus. Review of Resident #62's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 14 out of 15 indicating intact cognition. The MDS further indicated that Resident #62 currently receives dialysis treatment. The surveyor made the following observation: - On 11/19/24 at 10:04 A.M., Resident #62 was sitting on his/her bed. The Resident had a dialysis shunt on his/her right arm. During an interview on 11/20/24 at 12:11 P.M., Resident #62 said his/her dialysis shunt has been on his/her right arm for about four years. Review of Resident #62's physician's order dated 5/14/21 indicated the following: - Dialysis patient: Receives Dialysis at [an outside] facility. Do not take BP (blood pressure) on left arm with fistula/shunt. Send to dialysis on Tuesday/Thursday/Saturday The physician's order indicated the incorrect arm where the dialysis shunt is located, Resident #62's dialysis shunt is located on his/her right arm. Review of Resident #62's Kardex (a nursing care card) indicated the following under the Resident Care section: - No BP or blood draws in left arm due to fistula even though this is not functional (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62's hemodialysis care plan indicated the following interventions dated 7/22/21: - No BP No BP or blood draws in left arm due to fistula even though this is not functional - Observe for bleeding at dialysis access site. Review of Resident #62's physician's orders, Kardex and care plans indicated that his/her dialysis shunt is located on his/her left arm despite the shunt being located on his/her right arm. Review of Resident #62's Blood Pressure Vitals log indicated that the Resident has his/her blood pressure readings taken on his/her right arm 22 times since March 2024. Review of Resident #62's Medication Administration Record for November 2024 indicted that staff signed off on the physician's order for not taking the Resident's blood pressure on his/her left arm where the fistula is located, despite it being on Resident #62's right arm. During an interview on 11/21/24 at 10:31 A.M., Unit Manager #1 said she has worked in the facility since March 2024 and Resident #62 has always had his/her dialysis shunt on his/her right arm since then. Unit Manager #1 continued to say that Resident #62's medical record is incorrect since the Resident's dialysis shunt is on his/her right arm, not left. Unit Manager #1 said nursing staff should have identified the discrepancy with the order. During an interview on 11/21/24 at 12:48 P.M., the Director of Nursing (DON) said blood pressure readings should not be taken on the same arm where a dialysis port is located as it can cause clotting around the dialysis port. The DON continued to say she has worked in the facility for two years and does not remember Resident #62's dialysis port being on his/her other arm. The DON then said staff should be correctly documenting where Resident #62's dialysis shunt is located, and the physician's order was inaccurate.

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F 0865 Level of Harm - Actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on interview and document review, the facility failed to develop, implement, and maintain a Quality Assurance and Performance Improvement (QAPI) program which addressed the full range of care and services, was comprehensive and data-driven, and focused on indicators of outcomes of quality of life, quality of care, and services to residents in the facility. Specifically, the facility failed to ensure an ongoing QAPI program was implemented, maintained and addressed concerns related to pressure ulcers and wounds in the facility. As a result of this failure, three Residents (#264, #97, #103) developed pressure injuries that worsened, became infected, required hospitalization , required intravenous antibiotics with surgical intervention and for one of the three Residents, resulted in death. Findings include: Review of the facility policy titled QAPI - Program Design and Scope, dated and revised [DATE], last reviewed [DATE], indicated the following: Policy: - The facility will have a QAPI program that is ongoing, comprehensive, and capable of addressing the full range of care and services it provides. - At a minimum, the QAPI program will: - Address all systems of care and management practices - Include clinical care, quality of life and resident choice - Utilize the best available evidence to define measure indicators of quality and facility goals that reflect the processes of care and facility operations that have been shown to be predictive of desired outcomes for residents - Reflect the complexities, unique care, and services that the facility provides. Procedure: - The facility will ensure QAPI programs address systems of care and management practices. Systems of care are the processes in place to achieve an expected clinical outcome. For example, the system for prevention of pressure ulcers also involves the system for ensuring adequate nutrition, as well was the systems for identification of changes in condition and infection prevention. Review of the facility policy titled Quality Assurance & Performance Improvement (QAPI) Plan for the Facility 2024 signed by the Facility Executive Director on [DATE] and the Medical Director on [DATE] indicated the following: (continued on next page)

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F 0865 Level of Harm - Actual harm Residents Affected - Some	- Purpose: The QAPI program is to utilize an ongoing, data driven, proactive approach to advance the quality if life and quality of care for all residents at our facility. QAPI principles will drive our facility decisions to promote excellence in all resident and staff-related areas. All facility associates will be encouraged to be involved in identifying opportunities for improvement, partake in QAPI teams, imbed QAPI activities in all core processes and providing ongoing feedback. - Governance and Leadership: The governing body is ultimately responsible for overseeing the QAPI Committee. The Executive Director has direct oversight responsibility for all functions of the QAPI committee and reports directly to the governing body. The QAPI Committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction. Review of the Facility's Facility Assessment Tool indicated that the last time the Wound Care Manual Policies were reviewed by the QAPI Committee was on [DATE]. Review of the facility's QAPI plan indicated monthly documentation titled Medical Director Oversight Committee (MDOC) Meeting Minutes completed by the Medical Director of the facility which included the following discussion points: - Dated and signed by the Medical Director and Executive Director [DATE]: - Based on the topics reviewed in QAPI, are there additional quality of care areas that should be reviewed? This was checked yes with the following documentation Assessment documentation, communication, timely intervention. - Are there any compliance or regulatory concerns? This was checked yes with the following documentation Documentation. - Are there any opportunities or changes needed to education programs for staff? This was checked yes with the following documentation orientation enhancement. - Are there any issues based on consultant reports (pharmacy, nutrition, wound), this was check off yes with the following documentation Dressings & compliance. - Dated and signed by the Medical Director and Executive Director on [DATE]: - Based on the topics reviewed in QAPI, are there additional quality of care areas that should be reviewed? This was checked yes with the following documentation Lab services. - Are there any opportunities or changes needed to education programs for staff? This was checked yes with the following documentation documentation. - Any concerns with Event Management Program (e.g. incident reports, falls, skin tears)? This was checked yes with the following documentation thoroughness of investigation and immediate implementation of new interventions. - Dated and signed by the Medical Director and Executive Director on [DATE]: (continued on next page)

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F 0865 Level of Harm - Actual harm Residents Affected - Some	- Are there any issues based on consultant reports (pharmacy, nutrition, wound)? This was checked yes with the following documentation Wounds - staging, documentation. - Any concerns with Event Management Program (e.g., incident reports, falls, skin tears)? This was checked yes with the following documentation need improved detail and investigation root cause. Further review of the facility's QAPI plan failed to indicate any documentation of a QAPI plan relating to the care and services of pressure wounds or skin injuries which included data-driven information, monitoring of pressure ulcer wounds or indicators of outcomes. On the morning of [DATE], the facility presented the surveyor with an audit of pressure ulcers for the facility. The audit revealed that there were four residents with nine in-house acquired pressure ulcers. During Resident #264, #97 and #103's stay in the facility, the physician did not evaluate the effectiveness of treatments ordered for a skin condition resulting in worsening pressure injuries, infection, hospitalization , surgical intervention and for one of the three residents, resulted in death. Resident #264 developed multiple pressure ulcers at the facility, specifically a sacral pressure ulcer that worsened in presentation of size and symptoms of infection which included gangrene and necrosis. The wound worsened at the facility despite being treated with antibiotics for multiple infections and eventually required hospitalization on [DATE] where the Resident underwent surgical debridement due to osteomyelitis of the coccygeal and ultimately died on [DATE] as a result of neglect. Resident #97 developed a Stage 4 pressure injury to the sacrum and development of osteomyelitis requiring antibiotics treatment, surgical debridement, and multiple hospitalization s. Resident #97 then developed two Stage 2 pressure injuries, one Deep Tissue Injury, and failed to arrange a wound clinic follow up for deteriorating wounds. Resident #103 was admitted with a sacral pressure ulcer wound that worsened in the facility. Despite documentation of a worsening wound and signs of infection in the wound, treatment and interventions in the place for the wound remained the same, eventually resulting in hospitalization from [DATE] through [DATE] for worsening wounds, treatment with intravenous (IV) antibiotics and multiple surgical debridements for osteomyelitis (A bone infection) and the need for ileostomy formation for fecal diversion away from the wound. Resident #103 was discharged back to the facility with Negative Pressure Wound Therapy (a medical technique used to accelerate wound healing by applying negative pressure to the wound site) for wound management. During an interview on [DATE] at 8:43 A.M., the Regional Director of Clinical Services said we have a QAPI process for the wounds in the facility and the wound nurses provide data for QAPI and it allows us to track what is going on in the facility. The Clinical Regional Nurse continued to say QAPI is the biggest tool for monitoring wound progress and treatment and that she will review QAPI discussions after the fact. During an interview on [DATE] at 10:45 A.M., the Director of Nursing said the governing body of the facility is involved with wound care in the facility and if there were any issues, we would identify them in QAPI. (continued on next page)

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F 0865 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at 10:49 A.M., the Nursing Home Administrator (NHA) said she has noticed trends with wounds in the facility. During an interview on [DATE] at 11:43 A.M., with the NHA, the QAPI program was reviewed. The NHA said she looks for patterns and trends of what is going on in the facility for what to include in QAPI to improve the quality of the facility. The NHA said any plans that are put in place as a result of QAPI are monitored over time to see what is effective and if they are not improving, we discuss as a team and these results should be in the QAPI plan. When asked what has the facility been working on this part year for QAPI the NHA did not mention that wound care has been a part of QAPI this year. The NHA continued to say the facility's wound nurses have not been a part of QAPI. The surveyor and the NHA reviewed the attendance sheets for each month of QAPI and the wound care nurses were not in attendance. The surveyor showed the NHA the Medical Director Oversight Committee (MDOC) Meeting Minutes that was in the QAPI plan. When asked if there has been any follow up to the identified concerns, especially related to wounds in the facility, the NHA said no, and the Medical Director's concerns should have been addressed with follow up QAPI plans. The surveyor asked the NHA if there was any other documentation in the QAPI plan related to pressure ulcers or skin wounds and the NHA said there was not. Review of the QAPI plan indicated that the NHA did not follow up with the Medical Director's identified concerns including the identification or any improvement actitivies relating to wounds in the facility. Further review of the QAPI plan did not reveal any other information about wounds or pressure ulcers in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48671 Based on observations and interview the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, 1. Review of the infection control program line listings, the facility failed to indicate the monitoring, tracking, and analyzing of infections in the facility. 2. The facility failed to ensure the use of Enhanced Barrier Precautions during a wound dressing treatment. Findings Include: Review of the facility policy titled Antibiotic Stewardship dated as reviewed 5/19/23, Indicated the following: -The program will be managed and overseen by the Infection Preventionist. 3. Action b. Assessment of residents suspected of having an infection. The facility will utilize the McGeer Criteria when considering initiation of antibiotics. 1. Review of the infection control program failed to indicate the monitoring, tracking, and analyzing of infections in the facility. The facility did not have any documentation of monthly line listings indicating the tracking of antibiotics and failed to provide documentation of signs and symptoms of infections related to antibiotic selection and continuations. During an interview on 11/25/24 at 11:16 A.M., the Infection Preventionist (IP) said she will review the use of antibiotics on admission and at the end of the month when she runs a report to see how many residents were treated with antibiotics. The IP then said she will compare the report with any cultures or labs that were done at the end of each month. The IP said staff will tell her if a resident has a fever or needs an X-ray but she does not track signs and symptoms of infections daily. Review of the Infection Control report printed by the Infection Preventionist dated 11/21/24 showed the use of antibiotics prescribed in the facility from 1/2/24 to 11/12/24 but failed to include active monitoring system and documentation of active infections and antibiotic use. The report contained past details of the prescribed antibiotics. The IP said she does not keep a monthly line listing of active signs and symptoms to track infections or antibiotic use because she will run the antibiotic report at the end of the month for reporting and will review the medical record to see if any labs or cultures were ordered. The IP said she will report infections during the quartely QAPI meeting but not monthly and said outbreaks are discussed monthly if needed. The IP said there have been no outbreaks in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Merrimack Valley	80 Boston Road Billerica, MA 01862

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the QAPI Program Data Collection form indicated: Data Analysis Frequency for Infection Prevention Surveillance Reports and Outcome Surveillance Reports are reviewed annually. The IP was unable to provide the survey team with line listings, monthly tracking of infections, or antibiotic usage within the facility for the month of November and said she would not have that data until she looks at the antibiotic report the end of the month because she does not track the data daily. During the survey, there were three identified wound infections within the facility with no active infection control monitoring or documentation. The IP was unaware of the wound infections requiring IV [intravenous] and oral antibiotic therapy for osteomyelitis. During an interview on 11/26/24 at 10:11 A.M. the Director of Nurses (DON) said she expects the facility to follow infection control guidelines for tracking and evaluating infections and said the infection preventionist should be aware of current infection in the facility. 49880 2. Review of facility policy titled Enhanced Barrier Precautions, dated as reviewed 6/3/24, indicated the following: -The facility should use Enhanced Barrier Precautions (EBP) as an additional Multi Drug Resistant Organism (MDRO)mitigation strategy for residents that meet the following criteria, during high- contact resident care activities. -EBP are indicated for residents with any of the following: wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. -Examples of high- contact resident care activities requiring gown and glove use include: wound care: any skin opening requiring a dressing. During an observation on 11/25/24 at 1:25 P.M., the surveyor entered a resident room to observe wound care. There was a sign on the doorway indicating Enhanced Barrier Precautions to be used. Nurse #1 was in the process of providing wound care to the resident. Nurse #1 had gloves on but was not utilizing a gown as indicated on the sign for EBP outside of the resident's room. During an interview on 11/25/24 at 1:27 P.M., Nurse #1 said that she should be wearing a gown for wound care but that she forgot to put it on. During an interview on 11/26/24 at 8:03 A.M., the Director of Nurses said that she would expect that staff wear a gown while performing a dressing change.