STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225548	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41456 Based on observations and interviews, the facility failed to provide a dignified dining experience for the residents on the 2 East unit. Specifically, the facility failed to serve all residents seated at the same table at the same time. Findings Include: Review of the facility policy titled, Quality of Life - Dignity, dated August 2009, indicated the following: -Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. During the breakfast meal on the 2 East unit on 10/21/24, the following was observed: -Two residents were seated at a table. The first resident was served breakfast at 8:30 A.M. The second resident was served breakfast at 8:54 A.M., 24 minutes later. -Three residents were seated at a table. The first resident was served breakfast at 8:11 A.M. The third resident was served breakfast at 8:34 A.M., 23 minutes later. During the lunch meal on the 2 East unit on 10/21/24, the following was observed: -Four residents were seated at a table. The first resident was served lunch at 12:18 P.M. The fourth resident was served lunch at 12:36 P.M., 16 minutes later. -Four residents were seated at a table. The first resident was served lunch at 12:14 P.M. The fourth resident was served lunch at 12:41 P.M., 27 minutes later. -Three residents were seated at a table. The first resident was served lunch at 12:21 P.M. The fourth resident was served lunch at 12:48 P.M., 27 minutes later. -Six residents were seated at a table. The first resident was served lunch at 12:21 P.M. The fourth resident was served lunch at 12:42 P.M., 21 minutes later. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Four residents were seated at a table. The first resident was served lunch at 12:16 P.M. At 12:21 P.M. a resident who had not yet been served, attempted to reach towards the tray of the resident already served. This resident was not served her meal until 12:34, 18 minutes later. The last resident at the table was not served lunch until 12:43. -A nurse entered the dining room and began to administer insulin to a resident. The nurse did not ask the resident if it was okay to have the medicine administered while in the dining room. During the breakfast meal on the 2 East unit on 10/22/24, the following was observed: -Three residents were seated at a table. The first resident was served breakfast at 8:14 A.M. The third resident was served breakfast at 8:23 A.M., 9 minutes later. - Three residents were seated at a table. The first resident was served breakfast at 8:10 A.M. The third resident was served breakfast at 8:21 A.M., 11 minutes later. During the lunch meal on the 2 East unit on 10/22/24, the following was observed: -Five residents were seated at a table. The first resident was served lunch at 12:14 P.M. The fifth resident was served lunch at 12:20 P.M., however, the meal sat in front of him/her and he/she was not assisted with his/her lunch until 12:30, 10 minutes later. During the breakfast meal on the 2 East unit on 10/23/24, the following was observed: -Five residents were seated at a table. The first resident was served breakfast at 8:13 A.M. The third resident was served breakfast at 8:37 A.M., 24 minutes later. -Four residents were seated at a table. The first resident was served breakfast at 8:18 A.M. The third resident was served breakfast at 8:28 A.M., 10 minutes later. During an interview on 10/23/24 at 9:41 A.M., the Director of Nursing said all residents seated at a table should be served meals at the same time. The Director of Nursing said the unit should have a dining plan with appropriate meal truck ordering so the meal trays come to the floor correctly. The Director of Nursing also said nurses should not be giving medication in the dining room during a meal, and if it is necessary, the nurse should ask the resident if it is okay to do so.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to inform one Resident (#94) out of a sample of 30 residents in advance of the risks and benefits of proposed treatment. Specifically, the facility failed to obtain a psychotropic consent prior to administering a psychotropic medication. Findings include: A review of the facility policy titled 'Psychoactive medication informed consent procedure' with a review date of January 2024 indicated the following: 1. When a physician orders any psychoactive medication, i.e.: antianxiety medication, the licensed nurse must complete the Psychoactive Medication Informed Consent Form, the form must indicate the resident's name, the physician, the date, diagnosis, the reason for medication and expected benefits to the resident. 2. The nurse must indicate what type of psychoactive medication are ordered by checking the appropriate box. This form is to be reviewed with the resident or legal responsible party including each specific medication side effects. Resident # 94 was admitted to the facility in April 2024 with diagnoses including anxiety, depression and Post Traumatic Stress Disorder (PTSD). A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental status (BIMS) score of 9 out of a possible 15 indicating moderate cognitive impairment. During an interview on 10/22/24 at 9:24 A.M., Resident #94 said his/her son recently passed away. A review of Resident #94's September 2024 Medication Administration Record (MAR) indicated the following: -8/24/24 Ativan 0.5 milligrams tablet (Lorazepam) one tablet every 6 hours as needed. Stop Date 9/7/24. A review of Resident #94's October 2024 physician's orders indicated the following: -Ativan 0.5 milligrams tablet (Lorazepam) one tablet by mouth every 6 hours as needed. Order date 9/7/24, discontinued 10/23/24. A review of the September and October 2024 (Medication Administration Record), documentation and PRN (as needed) results report indicated that the Ativan 0.5 milligrams was utilized on the following days. -9/1/24, 9/3/24, 9/4/24, 9/5/24, 9/6/24, 9/7/24, 9/8/24, 9/14/24, 9/15/24, 9/16/24, 9/27/24, 9/28/24, 9/30/24, 10/1/24 and 10/3/24. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 10/22/24 at 9:05 A.M., Unit Manager #2 said Resident #94's son passed away this past September, the Ativan was prescribed to help with his/her grief. She said a consent to administer the psychotropic medication should have been obtained from the responsible party prior to administering the medication. The Unit Manager reviewed the record and said there was no indication that a verbal consent was obtained or that a written consent was mailed out to the responsible party. During an interview on 10/23/24 at 9:14 A.M., the Social Worker said the Resident has an activated health care proxy, she said she did not mail out any written consents or obtain verbal consent prior to the psychotropic medication being administered. She said written or verbal consents should be obtained from responsible parties prior to the administering psychotropic medication.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review, policy review, and interview, the facility failed to ensure Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were consistently documented in the medical record for one Resident (#105), out of a total sample of 30 residents. Findings include: Review of the facility policy titled Advanced Directives, revised 12/16, indicated, Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. Resident #105 was admitted to the facility in September 2024 with diagnoses that included end stage renal disease, diastolic congestive heart failure, acute respiratory failure, and type 2 diabetes. Review of Resident #105's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Review of Resident #105's physician order, dated 9/16/24, indicated MOLST (Medical Orders for Life-Sustaining Treatment): Do Not Intubate and Ventilate. Review of Resident #105's advanced directives care plan, dated 9/18/24, indicated Resident is a Full Code. Review of Resident #105's nursing progress note, dated 9/29/24, indicated Dialysis is questioning code status for patient. Per nursing chart does not have a MOLST on file or any other form of advanced directives. During an interview on 10/22/24 at 1:45 P.M., the Director of Nurses (DON) and and the surveyor reviewed Resident #105's medical record and were unable to locate a MOLST form. The DON said the Resident's physician order should be full code. During an interview on 10/22/24 at 1:51 P.M., Nurse #1 said Resident #105 should have MOLST form in place if their order reads as Do Not Intubate and Ventilate.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to keep one Resident (#20) free from abuse and neglect out of a total sample of 30 Residents. Specifically, the facility failed to prevent abuse by neglecting to complete incontinence care for Resident #20. Findings include: Review of the facility policy titled, Abuse Prevention Policies and Procedures, dated 4/2017 indicated the following: -To promote prevention, protection, prompt reporting and interventions in response to alleged, suspected or witnessed abuse/neglect/exploitation of any resident. Resident #20 was admitted to the facility in August 2022 with diagnoses including unspecified dementia, severe, with other behavioral disturbances and major depression disorder. Review of Resident #20 most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated Resident #20 had severe cognitive impairment. The MDS also indicated Resident #20 was dependent on staff for all toileting tasks. On 10/21/24 at approximately 11:38 A.M., a family member approached staff and asked if Resident #20 could be changed, as he/she appeared to have an incontinence episode. Unit Manager #1 responded by placing a towel over the Resident's lap and was not taken to the bathroom or changed. At 12:22 P.M., 44 minutes later, the family member again approached the nursing staff stating Resident #20 was drenched and needed to be changed. The staff did not attempt to take the Resident to the bathroom and offer incontinence care. The Resident was taken to the bathroom after 1:00 P.M., an hour and a half after the first report of him/her needing incontinence care. During an interview on 10/21/24 at approximately 12:30 P.M., Unit Manager #1 said staff was never told Resident #20 needed incontinence care. During interviews on 10/21/24 at approximately 12:35 P.M., and on 10/22/24 at 11:28 A.M., the Family Member said she did in fact tell the staff that Resident #20 needed to be changed and Unit Manager #1 said she would put a towel over Resident #20's lap to cover it. The Family Member said the staff have told her residents are not allowed to go to the bathroom or have incontinence care during the lunch hour and residents are often eating lunch with wet briefs. Review of Resident #20's last incontinence assessment dated [DATE] indicated the Resident has total incontinence for more than a year, has no control of his/her bladder and is incontinent multiple times in a 24-hour period. Review of Resident #20's skin integrity care plan indicated the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide incontinent care every two hours and as needed. -Toilet every two hours and as needed. Review of Resident #20's self-care care plan indicated the following: -Provide maximum assistance with 1 helper for toilet use (includes incontinent care) During an interview on 10/21/24 at 2:10 P.M., the Director of Nursing said if a resident has known incontinence the staff should change them immediately, even if a meal was taking place on the unit. The Director of Nursing said a resident should not have to sit for any length of time with a wet brief. During an interview on 10/23/24 at 9:59 A.M., the Administrator said neglect is a type of abuse and would need to be a purposeful refusal of care for it to be neglect. During an interview on 10/23/24 at 1:25 P.M., both the Administrator and Director of Nursing said staff not changing a resident's incontinence brief when asked is a purposeful act and could be classified as neglect.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to keep one Resident (#3) free from restraints, out of a total sample of 30 residents. Findings include: A physical restraint, as defined in the State Operations Manual, Appendix PP - Guidance to surveyors for Long Term Care Facilities, is any manual method, physical or mechanical device, equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff. Review of the facility policy titled, Device/Restraints Policy & Procedure, dated 10/10/2000, indicated the following: -Purpose: to ensure each resident attains/maintains the highest practicable well-being in an environment that improves functional status and ability. The resident has the right to be free from any physical and chemical restraints imposed for purpose of discipline or convenience and not required to treat the resident medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time. -Physical Restraints are defined as any manual method or physical or mechanical device material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. -physical restraints include, but are not limited to leg restraints, arm restraints, hand mitts, soft ties or vest, lap cushions, and lap trays the resident cannot remove easily. Also included as restraints or facility practices that meet the definition of a restraint such as: placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of bed. -The Device/Physical Restraint Assessment will include the medical justification, risk factor and potential complication. This form is forwarded to the licensed nursing staff to review with the resident and next of kin or responsible party. The restrained policy is reviewed and authorization is obtained. In the event the resident is confused and unable to sign the authorization, a verbal authorization will be obtained from the next of kin or legal guardian until written authorization is obtained. -The team will assure the process is complete and the restraint will be added on to the residence care plan and ADL guide/kardex. The Device/Physical Restraint Assessment form is then filed in the residence chart. -There must be written, signed, and dated physicians orders for devices/physical restraints, and all orders must be reviewed and signed with each required physician visit. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 was admitted to the facility in December 2018 with diagnoses including dementia. Review of Resident #83's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #3 requires assistance with all mobility tasks. Throughout all days of survey, Resident #3's bed was observed to be against the wall, inhibiting the Resident's ability to get out of bed on the left side of the bed. Review of Resident #3's medical record indicated the Resident has had several falls out of bed. Review of Resident #3's fall care plan indicated a fall intervention to have the bed the long way against the wall, implemented in June 2024. Review of Resident #3's medical record failed to indicate a restraint assessment had been completed. During an interview on 10/22/24 at 9:37 A.M., Unit Manager #1 said the Resident was just transferred to this unit a month ago and the Resident's bed was put against the wall because the other unit had positioned the bed that way. During an interview on 10/22/24 at 10:06 A.M., the Director of Nursing said Resident #3's bed was positioned against the wall because he/she had sustained numerous falls in the facility. The Director of Nursing said she did not think of that as a restraint however said it would limit the Resident's ability in one direction and get out of bed on that side of the bed. The Director of Nursing said a restraint assessment had never been completed for Resident #3's bed positioning.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) Assessments were accurately completed to reflect the status of one Resident (#106) out of a total sample of 30 residents. Specifically, the facility failed to document Resident #106 discharged home. Findings Include: Resident #106 was admitted the facility in August 2024 with diagnoses that included chronic kidney disease, hypertension, anxiety, and arthritis. Review of Resident #106's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she was discharged to a short term general hospital. Review of Resident #106's social services note, dated 9/6/24, indicated Resident discharged as planned this day accompanied by his/her friend. He/she has declined VNA (visiting nursing) services. During an interview on 10/23/24 at 8:11 A.M., Social Services said Resident #106 discharged home. During an interview on 10/23/24 at 9:22 A.M., the MDS Nurse said Resident #106 discharged home and the MDS is coded as he/she discharged to a hospital which is a mistake.

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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** 43846 Based on observations, record review and interview the facility failed to develop a comprehensive resident centered care plan for two Residents (#48, #94) out of a total sample of 30 residents. Specifically, 1. For Resident #48, the facility failed to develop a comprehensive pacemaker care plan, 2. For Resident #94, the facility failed to develop a comprehensive person centered history of Opioid abuse care plan. Findings include: Resident #48 was admitted to the facility in December 2021 with diagnoses that included hypertensive heart and chronic kidney disease with heart failure, paroxysmal atrial fibrillation, and presence if cardiac pacemaker. Review of Resident #48's most recent Minimum Data Set (MDS), dated [DATE], he/she scored a 15 out of 15 of the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. Review of Resident #48's nursing progress note, dated 7/24/24, indicated Pt (patient) readmitted from the hospital where he/she had a pacemaker placed. Review of Resident #48's pacemaker care plan, dated 7/25/24, indicated make and model, date of insertion, site of insertion, rate set, cardiologist and phone number were left blank. During an interview on 10/23/24 at 8:34 A.M., Nurse #4 said she is unsure if the Resident has a pacemaker. During an interview on 10/23/24 at 10:10 A.M., the Director of Nurses said the pacemaker care plan should have specifics on how the pacemaker is monitored and what the paced rate is of the pacemaker. 43807 2. Resident # 94 was admitted to the facility in April 2024 with diagnoses including a history of opioid dependence, anxiety, depression and Post Traumatic Stress Disorder (PTSD). A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental status (BIMS) score of 9 out of a possible 15 indicating moderate cognitive impairment. During an interview on 10/22/24 at 9:24 A.M., Resident #94 said he/she recently lost his/her son to a drug overdose. (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 social history version 2 dated 2/13/23 indicated the following psychosocial assessment: -history of substance abuse-opioid. A review of Resident #94's care plan failed to indicate a personalized history of opioid dependence care plan. During and interview and medical review on 10/23/24 at 9:04 A.M., the Social Worker reviewed Resident #94's care plan and said a personalized history of opioid dependence care plan should be developed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADLs) for seven dependent Residents (#73, #83, #20, #95, #60, #104, and #97) out of a total sample of 30 Residents. Specifically, the facility failed to: 1) Provide incontinence care timely and in accordance with the plan of care for Resident #73, #83, #20, #95, #60, #104. 2) Provide supervision/assistance while eating for Resident #95. 3) Provide showers for Resident #97. Finding Included: Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, last revised 3/18, indicated: Policy Statement: -Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care. c. Elimination (toileting). d. Dining (meals and snacks). 1 a. Resident #73 was admitted to the facility in July 2021 with diagnoses including dementia. Review of Resident #73's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) and staff assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #73 was dependent on staff for all toileting tasks. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 from approximately 8:00 A.M. to 1:18 P.M., Resident #73 was observed in a reclining chair and was not provided incontinence care. On 10/22/24 at 1:18, Resident #73 was provided incontinence care with the surveyor present. The surveyor observed Resident #73's peri area to be reddened and the incontinence brief that had been removed was wet with urine. During an interview on 10/22/24 at 1:10 P.M., Certified Nursing Assistant (CNA) #2 said Resident #83 is completely incontinent of bowel and bladder and would not him/herself know if he/she needed to be changed/provided care. CNA #2 said she had not yet provided any incontinent care to Resident #83 since he/she had gotten out of bed this morning prior to breakfast, approximately 5 hours ago. Review of Resident #73's latest bowel and bladder assessment dated [DATE], indicated the Resident has been incontinent for over a year, has no control of his/her bladder and is incontinent multiple times in a 24-hour period. Review of Resident #73's incontinence care plan indicated the following: -Check and change every two hours. During an interview on 10/22/24 at 2:08 P.M., the Director of Nursing (DON) said the policy of the facility is to provide incontinence care to residents every two hours or as needed. The DON said Resident #83 occasionally has a reddened peri area and that sitting in a wet brief could be a cause of reddened skin. 1 b. Resident #83 was admitted to the facility in February 2022 with diagnoses including dementia. Review of Resident #83's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #83 is dependent for all toileting tasks. On 10/22/24 from approximately 8:00 A.M. to 1:15 P.M., Resident #83 was observed in the dining room and was not provided incontinence care. Review of Resident #83's latest bowel and bladder assessment dated [DATE], indicated the Resident has been incontinent for over a year and is incontinent multiple times in a 24-hour period. Review of Resident #83's skin integrity care plan indicated the following: -Check and change every two hours. During an interview on 10/22/24 at 1:18, Certified Nursing Assistant (CNA) #5 said Resident #83 is incontinent throughout the day. CNA #5 said Resident #83 had not been checked or changed yet since he/she had gotten up for breakfast, over 5 hours ago. During an interview on 10/22/24 at 2:08 P.M., the Director of Nursing (DON) said the policy of the facility is to provide incontinence care to residents every two hours or as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 c. Resident #20 was admitted to the facility in August 2022 with diagnoses including unspecified dementia, severe, with other behavioral disturbances and major depression disorder. Review of Resident #20 most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated Resident #20 had severe cognitive impairment. The MDS also indicated Resident #20 was dependent on staff for all toileting tasks. On 10/22/24 from approximately 8:00 A.M. to 1:15 P.M., Resident #20 was observed sitting in the hallway of the unit and was not provided incontinence care. Review of Resident #20's last incontinence assessment dated [DATE] indicated the Resident has total incontinence for more than a year, has no control of his/her bladder and is incontinent multiple times in a 24-hour period. Review of Resident #83's incontinence care plan indicated the following: -Toilet every two hours and PRN (as needed). During an interview on 10/22/24 at 1:25 P.M., Certified Nursing Assistant #2 said she had not yet provided incontinence care to Resident #20 since he/she had gotten out of bed prior to breakfast, approximately five hours earlier. During an interview on 10/22/24 at 2:08 P.M., the Director of Nursing (DON) said the policy of the facility is to provide incontinence care to residents every two hours or as needed. 45343 1 d. Resident #95 admitted to the facility in August 2023 with diagnoses that included dysphagia (difficulty swallowing), gastro reflux, Parkinson's, and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/31/24, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #95 is dependent for toileting and is frequently incontinent of bowel and bladder, is not on a urinary or bowel toileting program, and at risk for developing pressure ulcers. On 10/22/24 from approximately 8:00 A.M. to 1:15 P.M., Resident #95 was observed in the dining room and was not provided incontinence care. Review of Resident #95's care plan indicated the following: -Bowel and Bladder Incontinence, Alteration in Elimination, With No potential for Retraining, effective date 7/19/23. Interventions dated 7/19/23 included: Toilet every two hours and PRN (containment program). Provide incontinent care with toileting. Observe for red/open areas when providing incontinent care. Adult briefs when out of bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Skin Breakdown, At Risk for, related to impaired bed mobility and B&B (bowel and bladder) incontinence, effective date 9/12/23. Interventions dated 9/12/23 included: Weekly skin checks. Provide skin care per facility protocol [NAME] a day and as needed. Provide incontinent care every two hours and as needed. During an interview on 10/22/24 at 1:01 P.M., CNA #1 said Resident # 95 is unable to report when he/she needs to use the bathroom, that the Resident was toileted when we got him/her up for breakfast, and that there is no set toileting schedule on the unit. CNA #1 said she was ready to start afternoon rounds and provide continence care for those who need it. During an interview on 10/22/24 at 2:08 P.M., the director of nursing said residents should be toileted every 2 hours or as needed. 1 e. Resident #60 admitted to the facility in August 2019 with diagnoses that included traumatic subdural hematoma and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/11/24, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #60 is dependent for toileting and is frequently incontinent of bowel and bladder, is not on a urinary or bowel toileting program, and at risk for developing pressure ulcers. On 10/22/24 from approximately 8:00 A.M. to 1:15 P.M., Resident #60 was observed in the dining room and was not provided incontinence care. Review of Resident #60's care plan indicated the following: -Bladder and Bowel Incontinence, Alteration in Elimination, Resident is incontinent and toileted, effective date 6/28/22. Interventions dated 6/28/22 included: Provide incontinence care with toileting. Observe for re/open areas when providing incontinence care. Adult briefs when out of bed. -Skin breakdown, at risk for, related to incontinence of bowel and bladder, effective date 9/12/23 and interventions that include: Observe skin daily for red and open areas. Weekly skin assessments. Provide skin care per facility protocol twice daily and as needed. Encourage fluids with meals and nourishment pass. Encourage high protein foods. Dietician consults PRN. Dietary supplements as ordered. Apply moisture barrier to arms and legs daily. During an interview on 10/22/24 at 1:01 P.M., CNA #1 said Resident # 60 is able to report when he/she needs to use the bathroom and that there is no set toileting schedule on the unit. CNA #1 said she was ready to start afternoon rounds and provide continence care for those who need it. During an interview on 10/22/24 at 2:08 P.M., the director of nursing said residents should be toileted every 2 hours or as needed. 1 f. Resident #104 admitted to the facility in September 2023 with diagnoses that included dementia, psychosis, and anxiety disorder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 9/24/24, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #104 is dependent for toileting and is frequently incontinent of bladder and always incontinent of bowel, is not on a urinary or bowel toileting program, and at risk for developing pressure ulcers. On 10/22/24 from approximately 8:00 A.M. to 1:15 P.M., Resident #104 was observed in the dining room and was not provided incontinence care. Review of Resident #104's Care plan indicated the following: Bladder and Bowel Incontinence Alteration in Elimination with No potential for Retraining, effective date 9/20/24, and interventions that include: Resident will be free for s/sx (signs/symptoms) UTI r/t (related to) incontinence daily through next review. Toilet every two hours and PRN (containment program). Provide incontinent care with toileting. Observe for re/open areas when providing incontinent care. Adult briefs when out of bed. -At risk for skin breakdown d/t (due to) bowel and bladder incontinence, effective date 9/13/24, and interventions that include: Apply house lotion after each incontinence. Notify MD/NP any changes in skin. Wear adult attends. Weekly skin checks. During an interview on 10/22/24 at 1:01 P.M., CNA #1 said Resident # 104 is unable to report when he/she needs to use the bathroom, that the Resident was toileted when we got him/her up for breakfast, and that there is no set toileting schedule on the unit. CNA #1 said she was ready to start afternoon rounds and provide continence care for those who need it. During an interview on 10/22/24 at 2:08 P.M., the director of nursing said residents should be toileted every 2 hours or as needed. 2. Resident #95 admitted to the facility in August 2023 with diagnoses that included dysphagia (difficulty swallowing), gastro reflux, Parkinson's and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/31/24, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #95 is dependent for all self-care activities and requires supervision/touching assistance for self-feeding. On 10/21/24 at 12:26 P.M., 1:06 P.M., and 1:10 P.M., 10/22/24 at 8:22 A.M., 8:33 A.M., and 8:43 A.M., 12:31 P.M., and 12:42 P.M., and 10/23/24 at 8:25 A.M., 8:35 A.M., 8:48 A.M., and 8:55 A.M., Resident #95 was observed sitting in the dining room eating his/her meals, with multiple episodes of coughing. There was no staff observed providing assistance or cueing with self-feeding and no beverages provided during his/her meal. During a record review on 10/21/24 at 4:30 P.M., Resident #95's care plan indicated the following: -Eating: Resident will feed with minimum assistance and setup only and no assistive device. Effective date 7/19/23. -Nutrition: Encourage fluid intake. Effective date 7/19/23. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #95"s Kardex (a form indicating level of assistance a resident requires) indicated the following: Eating: Resident requires supervision for eating with reminders to alternate liquids and solids. Review of Resident #95's Speech Language Pathology discharge summary dated 7/10/24 indicated the following supervision level: How often does the patient require supervision/assistance at mealtime d/t (due to) swallow safety? 91-100% of the time. During an interview on 10/23/24 at 9:00 A.M., CNA #3 said we normally help when we see him/her struggling. CNA #3 was asked why Resident #95 does not receive a drink during his/her meals, he said we don't provide him/her with a drink until after he/she is done eating because he/she pours his/her drink on their food. During an interview on 10/23/24 at 9:08 A.M., Unit Manager #1 said we setup his/her meal and he/she can feed himself, and we will assist if he/she is having difficulties eating. Unit Manager #1 said Resident #95 is not provided a drink during his/her meal because he/she pours their drink on their food. During an interview on 10/23/24 at 9:50 A.M., the Director of Nursing said she would expect Resident #95 would be provided the level of assistance indicated on his/her care plan for self-feeding. 3. Resident #97 admitted to the facility in September 2023 with diagnoses that included Post-traumatic Stress Disorder, Type 2 Diabetes, asthma, and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #97 is dependent for all self-care activities and does not display any behaviors impacting daily care. On 10/21/24 at 7:56 A.M., Resident #97 was observed in the dining room unshaven with greasy matted hair. On 10/22/24 at 8:59 A.M., Resident #97 was observed lying in bed eating breakfast. Resident #97 was dressed, unshaven with greasy matted hair. On 10/22/24 at 10:54 A.M., Resident #97 was observed in the dining room, unshaven with greasy matted hair. On 10/23/24 at 8:51 A.M., Resident #97 was observed lying in bed dressed, unshaven with greasy matted hair. Review of Resident #97's ADL care plan indicated the following: -Bathing: one-person dependent, effective date 11/17/23. Review of the shower schedule for the unit indicated Resident #97 is scheduled to have a weekly shower on Tuesdays on the 3 P.M. to 11 P.M. shift, and on Saturdays 7 A.M. to 3 P.M. shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 9:11 A.M., Unit Manager #1 said if Resident #97 refuses care she is notified, and it will be documented in a nursing note. Unit Manager #1 said she was not aware that Resident #97 had refused care. Unit Manager #1 said Resident #97 can be combative at times and if he/she refuses care it should be documented. During an interview on 10/23/24 at 9:50 A.M., the Director of Nursing said if a resident is refusing care staff should reapproach the resident later, and if the resident continues to refuse care the nurse should be notified. The Director of Nursing said she would expect the nurse to document a resident's refusal of care. Review of Resident #97's medical record failed to indicate Resident #97 refused care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to ensure one Resident (#54) was utilizing a left hand orthotic to prevent a worsening contracture, out of a total sample of 30 residents. Findings include: Resident #54 was admitted to the facility in October 2023 with diagnoses including dementia and left-hand contracture. Review of Resident #54's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 6 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #54 is dependent on staff for all functional tasks. On 10/21/24 at 11:48 A.M., Resident #54 was observed sitting in the dining room with his/her left hand in a closed, fisted position. The Resident was not wearing a splint. During an interview on 10/21/24 at 11:53, Resident #54's son-in-law said the Resident has a left-hand contracture and has a left-hand splint he/she is supposed to wear daily, however, it has been awhile since he has seen the Resident wear the splint. On 10/22/24 at 9:00 A.M. and approximately 1:15 P.M., Resident #54 was observed out of bed in his/her reclining chair. The Resident's left hand was in a closed, fisted position and he/she was not wearing a splint. On 10/23/24 at 10:23 A.M., Resident #54 was observed sitting in the dining room with his/her left hand in a closed, fisted position. The Resident was not wearing a splint. Review of Resident #54's physician orders indicated the following order: -Pt (patient) to wear easy care comfort splint left hand day shift. check skin before and after application. initiated 4/12/24. Review of the problem area/strength section of Resident #54's skin integrity care plan indicated the Resident had a left had splint to the left hand that he/she should wear at all times except for when care is being provided. During an interview on 10/23/24 at 8:53 A.M., the Occupational Therapist said Resident #54 has a left-hand contracture and was given a left-handed splint and is to wear it daily. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 10:56 A.M., Certified Nursing Assistant (CNA) #4 said she was unaware if Resident #54 had an order to wear a splint and if it should be put on when morning care was completed. CNA #4 said equipment like splints are usually listed on a resident's Kardex (a form indicating all the needs of a resident) so staff know of any special needs. CNA #4 and the surveyor observed Resident #54's Kardex together and the splint was not listed as a need for the Resident. During an interview on 10/23/24 at 10:57 A.M., Unit Manager #1 said Resident #54 has an order for a left-hand splint and the splint should be worn during the day time hours. Unit Manager #1 was unaware Resident #54 had not worn his/her splint for the past three days. During an interview on 10/23/24 at 11:48 A.M., the Director of Nursing said all orders need to be followed as written.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to ensure fall prevention interventions were in place for three Residents (#83, #43 and #3) out of a total sample of 30 residents. Specifically, 1) For Resident #83, the facility failed to follow fall prevention interventions which may have prevented a fall, 2) For Resident #43, the facility failed to have a fall mat in place and 3) For Resident #3, the facility failed to have a bed alarm in place. Findings include: Review of the facility policy titled, Quality Assurance & Performance Improvement Falls Policy & Procedures, dated 12/2023, indicated the following: -Purpose: To promote resident safety and an environment free from falls to the extent possible in consideration of the resident's right to maintain autonomy and make individual choices. -The licensed nurse must implement interventions to promote resident safety based on the resident's risk factors. If identified as high risk, the resident may be placed on the falling star program. 1. Resident #83 was admitted to the facility in February 2022 with diagnoses including dementia. Review of Resident #83's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #83 needs assistance with all mobility tasks. On 10/21/24 at 8:00 A.M., Resident #83 was observed with significant bruising to his/her face. Resident #83 said he/she fell but was unable to remember any details from the fall. Review of Resident #83's fall investigations and fall risk care plans indicated the following: -On 2/17/24, Resident #83 was found to be on the floor next to his/her bed. A new care plan intervention for a bed alarm was implanted on 2/17/24. -On 5/27/24, Resident #83 fell while sitting in his/her wheelchair and the wheelchair tipped over. At the time of this fall, Resident #83 had a care plan intervention of a chair alarm, initiated on 11/6/24. The fall investigation report indicated the Resident did not have an alarm in his/her chair at the time of this fall. A new care plan intervention for the Resident to sit in a regular chair, not a wheelchair when in the dining room was implemented on 5/27/24. -Throughout all days of survey, Resident #83 was observed sitting in his/her wheelchair and not in a regular dining room chair. -On 7/29/24, Resident #83 fell while attempting to ambulate by him/herself. The falls investigation indicated there was no alarm in place at time of the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 10/16/24, Resident #83 fell while trying to transfer by him/herself. The fall investigation indicated the Resident's wheelchair alarm was not plugged in at the time of the fall. The Resident was found to have a large bump on his head, a hand abrasion and significant pain leading to the need to be sent out to the hospital. During an interview on 10/23/24 at 1:50 P.M., the Director of Nursing (DON) said Resident #83 has had multiple falls while at the facility. The DON said the nursing staff complete a fall investigation which includes an assessment after each fall to find the root cause of the fall. The DON said the nursing staff implements a new fall intervention after each fall in order to prevent falls and these interventions should always be in place and followed. 2. Resident #43 was admitted to the facility in December 2023 with diagnoses including Alzheimer's Disease. Review of Resident #43's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated the Resident had severe cognitive impairment. The MDS also indicated the Resident required assistance for all mobility tasks. On 10/21/24 at 7:44 A.M., Resident #43 was observed lying in bed with both legs off the right side of the bed with both feet inches from touching the floor. There was no fall mat on the floor next to the right side of the bed. Review of Resident #43's medical record indicated he/she had sustained multiple falls at the facility. Specifically, Resident #43 had falls out of bed on 1/2/24, 2/1/24, and 4/9/24. Review of Resident #43's fall risk care plan indicated the following intervention: -Fall mat to right side of bed. Throughout all days of survey, a fall mat was never observed on the right side of Resident #43's bed. During an interview on 10/23/24 at 8:08 A.M., Nurse #7 and Unit Manager #1 were both unaware Resident #43 had a care plan intervention for a fall mat on the right side of his/her bed. During an interview on 10/23/24 at 9:10 A.M., the Director of Nursing said Resident #43 has had multiple falls out of bed and is supposed to have a fall mat to the right side of the bed. The Director of Nursing was unaware Resident #43 did not have his/her fall mat in place. 3. Resident #3 was admitted to the facility in December 2018 with diagnoses including dementia. Review of Resident #3's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #3 requires assistance with all mobility tasks. (continued on next page)

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	225548	A. Building B. Wing	10/23/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's medical record indicated he/she had sustained multiple falls at the facility. Specifically, Resident #3 had falls out of bed or when attempting to get out of bed on 4/5/24, 5/6/24, 5/19/24, 7/25/24 and 9/22/24. Review of Resident #3's fall risk care plan indicated the following intervention: -Bed sensor alarm, initiated on 5/28/24. Review of Resident #3's physician orders indicated the following order: - Bed sensor alarm to bed every shift. Check placement and functioning. On 10/21/24 at 10:11 A.M., Resident #3 was observed lying in bed without a bed alarm. On 10/22/24 at 9:00 A.M., Resident #3 was observed lying in bed without a bed alarm. On 10/23/24 at 9:22 A.M., Resident #3 was observed lying in bed without a bed alarm. During an interview on 10/22/24 at 9:32 A.M., Nurse #5 looked at Resident #3's physician orders and said the Resident had an order for a bed alarm. Nurse #5 then entered Resident #3's room and observed the bed without a bed alarm. During an interview on 10/22/24 at 9:33 A.M., Unit Manager #1 said she was not aware Resident #3 had an order for a bed alarm and that the bed alarm was not in place. During an interview on 10/23/24 at 11:48 A.M., the Director of Nursing said Resident #3 had a history of falling at the facility. The Director of Nursing said Resident #3 was ordered a bed alarm as a fall prevention intervention. The Director of Nursing was unaware Resident #3 did not have the ordered bed alarm on his/her bed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to provide appropriate treatment and services for an indwelling Foley catheter (urinary catheter which remains in the bladder to provide continuous urine drainage. A balloon inflated at the catheter's distal end prevents it from slipping out of the bladder after insertion) for one Resident (#50), out of a total sample of 30 residents. Specifically, for Resident #50, the facility failed to ensure a physician's order was obtained for the Foley catheter to be in place and changing/inserting the Foley catheter included catheter size/type and balloon size. Findings include: Resident #50 was readmitted to the facility in October 2024 with diagnoses that included sepsis due to methicillin resistant staphylococcus aureus, pressure ulcer of sacral region stage 4, acute kidney failure, and major depressive disorder. Review of Resident #50's Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS further indicated the Resident had an indwelling catheter. On 10/22/24 at 7:29 A.M., the surveyor observed Resident #50 in bed with a Foley catheter in place. Review of Resident #50's physician orders failed to indicate an order for the Foley catheter to be in place and the size of the catheter and the balloon. Further review of the orders failed to indicate an order to change the Foley catheter. Review of Resident #50's indwelling catheter care plan, dated 9/18/24, failed to indicate the size of the catheter and the balloon. Review of Resident #50's nursing progress note, dated 10/21/24, indicated Foley replaced with 16 FR (french), 10 CC balloon. During an interview on 10/23/24 ay 8:15 A.M., Nurse #3 said Resident #50 does have a Foley catheter in place and said a physician order should be in place with the size of the catheter and balloon. Nurse #50 said there should also be an order in place to change the Foley. During an interview on 10/23/24 at 8:33 A.M., Nurse #4 said she changed Resident #50's Foley catheter yesterday but did not have an order to do so. Nurse #4 said she made her best judgement call on picking what size catheter she should insert into the Resident. During an interview on 10/23/24 at 10:41 A.M., the Director of Nurses (DON) said if a resident has a Foley catheter then there should be orders for the Foley to be in place with a catheter size and balloon size. The DON said there should also be a physician order to change the Foley catheter as needed with the Foley size and balloon size.

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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** 43846 Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC: a flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV]), consistent with professional standards of practice for one Resident (#50), out of a total sample of 30 residents. Specifically, for Resident #50, the facility failed to obtain a baseline measurement for the external length of Resident #50's PICC from when it was placed to ensure the PICC had not migrated (moved from the heart to another area, which could have a significant impact on treatment, or cause serious harm) per facility policy. Findings include: Review of the facility policy titled Central Vascular Access Device Dressing Change, dated 2024, indicated The Nurse is responsible and accountable for obtaining and maintaining competence with infusion therapy within his or her scope of practice. Upper arm circumference with PICC, and external catheter length measurements must still be completed as part of the initial assessment. Length of external catheter us obtained upon admission, during dressing changes. Review of the Lippincott Manual of Nursing Practice, 11th Edition, dated 2021, included the following for documentation relative to PICC line migration and dressing changes: -Use a sterile measuring tape or incremental markings on the catheter to measure the external length of the catheter from hub to skin entry to make sure that the catheter hasn't migrated. Resident #50 was readmitted to the facility in October 2024 with diagnoses that included sepsis due to methicillin resistant staphylococcus aureus, pressure ulcer of sacral region stage 4, acute kidney failure, and major depressive disorder. Review of Resident #50's Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. On 10/22/24 and 10/23/24 Resident #50 was observed to have a PICC line in his/her left arm, the PICC line dressing was not dated. Review of Resident #50's nursing admission assessment and nursing admission note, dated 10/16/24, failed to indicate that the Resident returned with a PICC Line or any measurements for the PICC line. Review of Resident #50's nursing progress notes from 10/16/24 to 10/23/24 failed to indicate measurements for his/her PICC Line. Review of Resident #50's physician order, dated 10/20/24, indicated change PICC Line dressing to left upper arm every day on 3 to 11 shift weekly on Wednesdays. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #50's nursing progress note, dated 10/22/24, indicated this am (A.M.) resident iv dressing was changed for left arm. During an interview on 10/22/24 at 7:45 A.M., Nurse #1 said she changed the Residents PICC line dressing earlier today because the dressing was lifting off. During an interview and observation on 10/23/24 at 8:14 A.M., the surveyor and Nurse #3 observed Resident #50 in bed with a PICC line in his/her left arm, the PICC line dressing was not dated. Nurse #3 said the dressing should be dated and said that PICC line measurements should be obtained upon admission and with each dressing change and written in a nursing progress note. During an interview on 10/23/24 at 11:45 A.M., the Director of Nurses (DON) said a PICC line dressing should always be dated. The DON said when a resident admits with a PICC line baseline measurements are suppose to be obtained and written in a nurses note and should be measured with each dressing change.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to ensure a person-centered plan of care was developed for Trauma-Informed Care for four Residents (#12, #94, #82, #97), who were admitted with the diagnosis of Post-Traumatic Stress Disorder (PTSD), out of a total sample of 30 residents. Findings include: Review of the facility policy titled Post Traumatic Stress Disorder Screen Assessment Procedure, dated 1/24, indicated The PTSD screen is a 5-item screen designed to identify individuals with probable PTSD. Those screening positive require further assessment, preferably with a structured interview, and care planning. To be completed by Social Services or clinical designee on admission and annually thereafter. 1. Resident #12 admitted to the facility in June 2024 with diagnoses that included Post-traumatic Stress Disorder, heart failure, acute respiratory failure with hypoxia, and chronic kidney disease. Review of Resident #12's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS further indicated the Resident has a diagnosis of PTSD. Review of Resident #12's medical record failed to indicate a plan of care for PTSD or an assessment for PTSD. During an interview on 10/23/24 at 9:19 A.M., the Social Worker said a personalized PTSD care plan should be developed for a Resident who has PTSD. During an interview on 10/23/24 at 11:43 A.M., the Director of Nurses said a PTSD assessment should be completed on admission with a mood interview and then build a plan of care with triggers from the assessment. 43807 2. Resident # 94 was admitted to the facility in April 2024 with diagnoses including anxiety, depression and a history of Post Traumatic Stress Disorder (PTSD). A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental status (BIMS) score of 9 out of a possible 15 indicating moderate cognitive impairment. Further review of the MDS indicated Resident #94 has a diagnosis of PTSD. During an interview on 10/22/24 at 9:24 A.M., Resident #94 said he/she recently lost his/her son to a drug overdose, and he/she is a veteran who served in the Vietnam war. A review of the Social history version 2 dated 2/13/23 indicated a psychosocial assessment that stated Resident #94 has a history of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the medication management behavioral health progress notes dated 9/26/24 indicated the following: Chief complaint/History of present illness: medical evaluation for management of depression and PTSD (recent loss of his/her son). A review of Resident #94's care plan indicated the following non-personalized PTSD care plans initiated 4/9/24 and 6/4/24 respectively. -Psychotropic medication, resident requires the use of, secondary to the diagnosis of depression and PTSD. -Resident is at risk for psychological decline as evidenced by diagnosis of PTSD. During an interview and record review on 10/23/24 at 9:04 A.M., the Social Worker reviewed the Resident's PTSD care plan and said it should be personalized with the Resident's history of serving in the Vietnam war and the recent loss of his/her son. 3. Resident #82 was admitted to the facility August 2023 with diagnoses including depression. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated Resident #82 has a PTSD diagnosis. A review of the Primary Care PTSD Screen dated 9/25/24 indicated Resident #82 answered yes to exposure to traumatic events and having nightmares. A review of the occupational therapy medical history progress notes with dates of service 12/12/23-2/8/24 indicated the following: Prior medical history, multiple war injuries from Vietnam war including shot near chest and stabbed in the abdomen by bayonet, with titanium sternum, PTSD. [sic] A review of Resident #82's care plan failed to indicate a personalized PTSD care plan. During an interview and record review on 10/23/24 at 9:19 A.M., the Social Worker reviewed the Resident's care plan and said a personalized PTSD care plan should be developed. 45343 4. Resident #97 admitted to the facility in September 2023 with diagnoses that included Post-traumatic Stress Disorder, Type 2 Diabetes, and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #97 has an active diagnosis of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #97's medical record failed to indicate a plan of care for PTSD or an assessment for PTSD. During an interview on 10/23/24 at 11:40 A.M., Unit Manager #1 said she was unsure who assesses residents for PTSD, and she assumed social work. She said all residents are discussed by the interdisciplinary team during our care plan meeting, and if it was deemed necessary a care plan would be developed with triggers. During an interview on 10/23/24 at 9:19 A.M., the Social Worker said a personalized PTSD care plan should be developed for a Resident who has PTSD. During an interview on 10/23/24 at 11:43 A.M., the Director of Nurses said a PTSD assessment should be completed on admission with a mood interview and then build a plan of care with triggers from the assessment.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record reviews, policy reviews and interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental, and psychosocial well-being for two Residents (#105, #20) out of a total sample of 30 residents. Specifically, 1. For Resident #105, the facility failed to ensure a psychiatric consult was completed as ordered. 2. For Resident #20, the facility failed to follow a behavioral health recommendation. Findings include: 1. Resident #105 was admitted to the facility in September 2024 with diagnoses that included end stage renal disease, diastolic congestive heart failure, acute respiratory failure, and type 2 diabetes. Review of Resident #105's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Review of Resident #105's physician order dated 9/21/24, indicated a psychiatric consult related to depression. Review of Resident #105's physician progress note, dated 9/20/24, indicated 12. Major depression. The patient does believe that he/she has some level of depression . I will obtain a psychiatric consult. During a medical record review with Nurse #1 on 10/22/24 at 8:32 A.M., Nurse #1 said there are no psychiatric notes in Resident #105's chart and said that she thinks because he/she is a short term resident they were not signed up for psychiatric services. During an interview on 10/22/24 at 8:33 A.M., Social Services said the Psychiatric Nurse Practitioner (NP) comes in weekly and if her notes are not in the chart then the Resident hasn't been seen. During an interview on 10/22/24 8:58 A.M., the Director of Nurses said Resident #105's psychiatric consult should have completed by now and was not. 41456 2. Resident #20 was admitted to the facility in August 2022 with diagnoses including unspecified Dementia, severe, with other behavioral disturbances and major depression disorder. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20 most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, which indicated Resident #20 had severe cognitive impairment. The MDS also indicated Resident #20 was dependent on staff for all functional tasks. On the morning of 10/21/24 at 7:42 A.M., Resident #20 was observed sitting in the hallway and was heard screaming. Review of Resident #20's nursing notes indicated the following: -On 8/24/24: Resident with increased behaviors this AM, yelling out, throwing food and fluids. -On 9/18/24: (The Resident) will often yell out repeatedly and this annoys other residents. -On 10/7/24: Increased restlessness/agitation/yelling out 3-7pm. -On 10/8/24: Threw tray on ground both yesterday lunch and this AM breakfast ten threw (his/her) juice at another resident. Redirection not effective started yelling and swearing. -On 10/8/24: Resident behavior at dinner. Threw tray which broke glass dish. Verbally abusive to resident sitting across from (him/her). Multiple attempts to give medication, however only took small amount, attempted to [NAME] in ice cream juice and dinner with no success. Talking with resident did not help. -On 10/10/24: Pushed breakfast tray away refuses to eat. -On 10/15/24: Resident has poor appetite and is refusing medication. (He/she) has frequent calling out and is redirected with little effect. Resident was resistive with incontinent care and pm care. Review of the behavioral health note dated 10/16/24 indicated the following: -Chief Complaint: Medication evaluation for management of anxiety and depression. -HPI (History of Present Illness): Per staff, pt (patient) has anxiety, verbal and physical aggression, yelling behavior, and throws things. Per staff, pt has delusions and agitation. -Clinical Assessment: Would consider tapering down Zoloft (an antidepressant) dose, as patient is currently on high dose and some patient with dementia might develop agitation in high dose of SSRI (selective serotonin reuptake inhibitors) or SSRI itself. It also appeared, Zoloft has not been effective for this patient, would consider a slow taper off the Zoloft, likely consider increasing Trazodone (an antidepressant) in the future. -Plan/Recommendations: With PCP (Primary Care Physician) approval: Recommend stopping Zoloft 200 mg (milligrams) po (by mouth) daily and start Zoloft 175 mg po daily. Review of Resident #20's medical record failed to indicate the physician was notified of this recommendation and that the recommendation was implemented. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the behavioral notes since the recommendation was made and not implemented, indicated Resident #20 continued to demonstrate daily behaviors including verbal and physical behaviors towards others and rejection of care During an interview on 10/23/24 at 11:01 A.M., Unit Manager #1 said the Psychiatric Nurse Practitioner comes to the building weekly to see any resident who is exhibiting behaviors or needs psychiatric care. Unit Manager #1 said the recommendations made by the Psychiatric Nurse Practitioner are read by both the Director of Nursing and herself and are expected to be put in place immediately. Unit Manager #1 said she was unaware of the recommendation by the Psychiatric Nurse Practitioner for medication changes and the recommendation had not yet been relayed to the physician or put in place. During an interview on 10/23/24 at approximately 11:30 A.M., the Director of Nursing said the Unit Managers are expected to relay all behavioral health recommendations to the physician so the recommendation can be implemented immediately. The Director of Nursing was unaware of Resident #20's medication change recommendation or that it was never relayed to the physician so that it could be implemented.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41456 Based on observations and interviews, the facility failed to provide a palatable meal to the residents on the 2 East and 2 [NAME] Units. Findings include: Based on the facility policy titled, Daily Food Temperature Check - Adult Day Health, dated 2/2016, indicated the following: -The temperatures will be monitored daily and recorded weekly to assure that all meals be served to the participants within the proper temperature range (41 degrees to 140 degrees). On 10/21/24 at 8:55 A.M., a test tray was conducted on the 2 East Unit with the following findings: -Pureed pancakes: 105 degrees Fahrenheit, tasted luke warm, not hot and were bland in taste. The pancakes were a thick, gummy consistency which became stuck on the surveyors teeth and the surveyor needed to chew them. -Pureed eggs: 98 degrees Fahrenheit, tasted cool not hot and were powdery, watery and bland in taste. -Oatmeal - 100 degrees Fahrenheit, tasted luke warm not hot and bland in taste. -Coffee - 110 degrees Fahrenheit, tasted warm not hot. During an interview on 10/21/24 at 9:00 A.M., Unit Manager #1 looked at the food the surveyor was testing and when asked, said the pureed food did not look appetizing and she wouldn't dare eat it. Unit Manager #1 said the pureed food is supposed to be smooth and easy to swallow and at times does not appear so. On 10/23/24 at 8:37 A.M., a test tray was conducted on the 2 East Unit with the following findings: -Pancake: 104 degrees Fahrenheit, tasted cool not hot and had a gummy consistency. -Coffee - 141 degrees Fahrenheit, tasted hot. On 10/23/24 at 8:33 A.M., a test tray was conducted on the 2 [NAME] Unit with the following findings: -Sausages-115 degrees Fahrenheit, tasted warm and not hot. -Waffles-46 degrees Fahrenheit, tasted cool and not hot. -Coffee-61 degrees Fahrenheit, tasted warm and not hot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225548	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Oatmeal-64 degrees Fahrenheit, tasted warm and not hot. During an interview on 10/23/24 at 3:24 P.M., the Food Services Director said hot food should be served at above 150 degrees Fahrenheit, and cold food should be served at below 50 degrees Fahrenheit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225548	A. Building B. Wing	10/23/2024

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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** 41456 Based on observations, record review and interviews, the facility failed to ensure accurate medical record were kept for two Residents (#53 and #3), out of a total sample of 30 residents. Findings include: 1. Resident #54 was admitted to the facility in October 2023 with diagnoses including dementia and left-hand contracture. Review of Resident #54's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 6 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #54 is dependent on staff for all functional tasks. Review of Resident #54's physician orders indicated the following order: -Pt (patient) to wear easy care comfort splint left hand day shift. check skin before and after application. initiated 4/12/24. On 10/21/24 at 11:48 A.M., Resident #54 was observed sitting in the dining room with his/her left hand in a closed, fisted position. The Resident was not wearing a splint. During an interview on 10/21/24 at 11:53, Resident #54's son-in-law said the Resident has a left-hand contracture and has a left-hand splint he/she is supposed to wear daily, however, it has been awhile since he has seen the Resident wear the splint. On 10/22/24 at 9:00 A.M. and approximately 1:15 P.M., Resident #54 was observed out of bed in his/her reclining chair. The Resident's left hand was in a closed, fisted position and he/she was not wearing a splint. On 10/23/24 at 10:23 A.M., Resident #54 was observed sitting in the dining room with his/her left hand in a closed, fisted position. The Resident was not wearing a splint. Review of the Treatment Administration Record indicated nursing had marked the order as complete, indicating Resident #54 wore his/her left-hand splint on 10/21/24, 10/22/24 and 10/23/24. During an interview on 10/23/24 at 10:57 A.M., Unit Manager #1 said Resident #54 has an order for a left-hand splint and the splint should be worn during the daytime hours. Unit Manager #1 was unaware Resident #54 had not worn his/her splint for the past three days. Unit Manager #1 said orders should not be signed off as complete if not done. During an interview on 10/23/24 at 11:48 A.M., the Director of Nursing said orders should not be marked as complete if not done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225548	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Tewksbury	10 Erlin Terrace Tewksbury, MA 01876

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #3 was admitted to the facility in December 2018 with diagnoses including dementia. Review of Resident #3's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #3 requires assistance with all mobility tasks. Review of Resident #3's physician orders indicated the following order: - Bed sensor alarm to bed every shift. Check placement and functioning. On 10/21/24 at 10:11 A.M., Resident #3 was observed lying in bed without a bed alarm. On 10/22/24 at 9:00 A.M., Resident #3 was observed lying in bed without a bed alarm. On 10/23/24 at 9:22 A.M., Resident #3 was observed lying in bed without a bed alarm. Review of the Treatment Administration Record indicated the nurses had checked the order as completed for 10/21/24 and 10/22/24 indicating the bed alarm was in place. During an interview on 10/22/24 at 9:32 A.M., Nurse #5 looked at Resident #3's physician orders and said the Resident had an order for a bed alarm. Nurse #5 then entered Resident #3's room and observed the bed without a bed alarm. During an interview on 10/22/24 at 9:33 A.M., Unit Manager #1 said she was not aware Resident #3 had an order for a bed alarm. Unit Manager #1 said orders should not be signed off as complete if not done. During an interview on 10/23/24 at 11:48 A.M., the Director of Nursing said orders should not be marked as complete if not done.