STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225549	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brigham Health and Rehabilitation Center	77 High Street Newburyport, MA 01950

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review, interview and policy review, the facility failed to ensure residents were treated with dignity for one Resident (#28) out of a total sample of 17 residents. Specifically, for Resident #28, the facility failed to provide assistance with removal of unwanted chin hair. Findings include: Review of the facility policy titled Promoting/Maintaining Resident Dignity, dated 3/4/24, indicated that it is the practice of this facility to protect resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality. Further review of the policy indicated that residents are to be groomed and dressed according to resident preference. Resident #28 was admitted to the facility in March 2021 with diagnoses including heart disease, kidney disease and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #28 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderately impaired cognition. Further review of the MDS indicated that the section indicating how Resident #28 completes personal hygiene is blank. Review of the facility document titled MDS Kardex Report indicated that Resident #28 is totally dependent for personal hygiene. Review of Resident #28's current Activity of Daily Living (ADL) care plan, indicated for his/her personal hygiene: the Resident is an extensive assist to totally dependent of 1 staff with personal hygiene and oral care. Further review of the care plan failed to indicate Resident #28 refuses care. Review of the progress notes dated August 2024 and September 2024 failed to indicate Resident #28 refuses care. On 9/10/24 at 7:50 A.M. and 12:30 P.M., the surveyor observed Resident #28 with chin hair approximately 1 inch long. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 7:48 A.M., the surveyor observed Resident #28 with chin hair approximately 1 inch long. On 9/12/24 at 8:30 A.M., the surveyor observed Resident #28 with chin hair approximately 1 inch long. During an interview on 9/10/24 at 7:50 A.M. Resident #28 said he/she doesn't like the chin hair and wants it removed. During an interview on 9/12/24 at 8:34 A.M., Certified Nurse Aide (CNA) #3 said that it is the CNAs that are responsible for removing chin hair. CNA #3 said she didn't have time to remove Resident #28's chin hair yesterday.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44095 Based on record review and interview, the facility failed to provide an accurate estimated cost of services to resident's or their representatives, for two out of two resident records reviewed, to ensure they were informed of their potential financial liabilities of the cost of items and services provided in addition to the daily per diem room rate. Findings include: The SNF ABN (CMS-10055) notice is administered to a Medicare recipient when the facility determines that the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all of the Medicare benefit days for that episode. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. Review of the notices provided to two residents who came off their Medicare Part-A Benefit, who remained at the facility, were provided Advanced Beneficiary Notices that did not include an accurate estimated cost of services. During an interview on 9/11/24 at 7:56 A.M., the Business Office Manager said the ABN notices did not have the cost breakdown for services. During an interview on 9/11/24 at 7:57 A.M., the Administrator said the ABN notices should have the cost breakdown for services but did not.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44095 Based on observations and interviews, the facility failed to ensure residents on two of two units experienced a homelike dining experience. Findings include: Review of the facility policy titled, Promoting/Maintaining Resident Dignity During Mealtimes, dated 3/4/24, indicated that it is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident. On 9/10/24 between 8:00 A.M., to 9:00 A.M., the surveyors observed Residents on the first floor and second floor being served hot coffee in Styrofoam cups, hot cereal was served in in Styrofoam bowls, and plastic cutlery was utilized for residents. On 9/10/24 at 12:17 P.M., the surveyor observed on the first floor 6 of 6 residents being served their lunch meals on trays in the main dining room and 5 of 6 residents being served their lunch meals on trays with plastic cups and plastic cutlery in the secondary dining area on the first floor. On 9/11/24 at 8:16 A.M., the surveyor observed on the first floor 3 of 8 residents being served their breakfast meal on trays in the dining room, 8 of 8 residents had items being served in Styrofoam bowls and Styrofoam cups. On 9/11/24 at 8:36 A.M., the surveyor observed on the second floor 7 of 7 residents being served their breakfast meal on trays in the dining room, and 7 of 7 residents had items served items in Styrofoam bowls and cups. During Resident Group meeting on 9/11/24 at 10:36 A.M., 1 of 4 residents said they think there are not enough staff to wash the plates, so the kitchen uses paper and Styrofoam products, 4 of 4 residents said they wished to be served their meals off the trays with actual dishes. During an interview on 9/12/24 at 9:39 A.M., Certified Nurse Assistant #4 said that residents complain about the food being served in Styrofoam. During an interview on 9/12/24 at 11:02 A.M., Nurse #2 said Styrofoam use on the trays is an ongoing issue because of staffing issues in the kitchen. During an interview on 9/12/24 at 8:47 A.M., the Food Service Director said that the kitchen should not be using paper and Styrofoam products during meal times. The Food Service Director said that residents should not be served their meals on trays in the dining rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/12/24 at 12:09 P.M., Administrator #1 said that paper products and Styrofoam should not be used on resident trays. Administrator #1 said that staff should serve residents on the linens provided on tables and not on their trays during mealtime.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to provide a notice of transfer and failed to send a copy of the notice to the Ombudsman for one Resident (#30) and the facility failed to send a copy of the transfer notice to the Ombudsman for one Resident (#22) out of a total sample of 17 residents who were transferred to the hospital. Findings include: A review of the facility policy titled 'Transfer and Discharge (including AMA)', revised in March 2024, indicated the following: - Transfer and discharge include movement of a resident outside of the certified facility whether that bed is in the same physical place or not. 12. Emergency Transfers/Discharges initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident. (g) Provide a notice of transfer to the resident and representative as indicated. (h) The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman. 1.) Resident #30 was admitted to the facility in July 2024 with diagnoses including dementia. A review of the most recent Minimum Data Set (MDS) dated [DATE], did not indicate a Brief Interview for Mental Status Score. A review of the cognition care plan, revised on 7/29/24, indicated that Resident #30 had impaired cognition due to developmental delays and traumatic brain injury. A review of Resident #30's nurse progress notes, dated 8/19/24 and 8/21/24, respectively indicated the following: - Resident was sent out to hospital this evening at 6pm due to critically low H&H (hematocrit and hemoglobin). Resident has been non-compliant with transfusion/lab draw on Friday 8/16. Resident informed 7-3 nurse that he/she was feeling terrible weak and wanted to be sent for a transfusion. NP (Nurse Practitioner) spoke with resident and confirmed he/she wanted to be sent out. Hospital was called and given report via 2nd floor nurse. Staff made aware, will follow up tomorrow with NP 8/20. [sic] - Pt (patient) came back from the hospital on a stretcher escorted by two EMT (emergency medical technician) personnel. He/she was sent out on the 19th for anemia related complications (H & H 6,1). [sic] (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility census indicated that Resident #30 was at the hospital from 8/19/24 to 8/21/24. A review of Resident #30's medical record failed to indicate that a notice of transfer was issued to the Resident and a copy sent to the ombudsman. During an interview on 9/12/24 at 12:44 P.M., the Regional Nurse and the Director of Nurses (DON) #2 said Resident #30 was not issued a transfer notice prior to the hospital transfer on 8/19/24. They said transfer notices should be issued to residents or resident representatives prior to emergency transfers to the hospital. They both said a copy of the transfer notice should be sent to the ombudsman. 44095 2.) Resident #22 was admitted to the facility in January 2024 with diagnoses including combined systolic and diastolic heart failure, pleural effusion, atrial fibrillation, and pulmonary hypertension. Review of the Minimum Data Set (MDS) assessment, dated 4/9/24, indicated that Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #22's nursing note, dated 4/12/24 indicated: - Note Text: Ok to transfer to hospital for evaluation - fall this morning 6am in own bedroom. Review of Resident #22's nursing note, dated 4/12/24 indicated: - Note Text: This nurse received report from hospital that resident would be admitted for hypokalemia, and congestive heart failure. On 9/10/24 and 9/11/24 the surveyor reviewed the electronic health record and the paper medical record. The surveyor was unable to locate documentation to support the facility staff notified the ombudsman of Resident #22's transfer. The surveyor requested the documents from the Regional Nurse on 9/11/24 at 11:30 A.M. During an interview on 9/12/24 at 12:01 P.M., the Regional Nurse said she was unable to find documentation to support the ombudsman was notified of Resident #22's transfer.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interview, the facility failed to provide a bed hold policy for two Residents (#30 and #22) out of a sample of 17 residents. Specifically, the facility failed to provide a facility bed hold policies to the Residents or Resident Representatives before Resident #30 and Resident #22 were transferred to the hospital. Findings include: A review of the facility policy titled 'Transfer and Discharge (including AMA)', revised in March 2024, indicated the following: - Transfer and discharge include movement of a resident outside of the certified facility whether that bed is in the same physical place or not. 12. Emergency Transfers/Discharges initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident. (g) Provide the facility's bed hold policy to the resident and representative as indicated. 1.) Resident #30 was admitted to the facility in July 2024 with diagnoses including dementia. A review of the most recent Minimum Data Set (MDS) dated [DATE] did not indicate a Brief Interview for Mental Status Score. A review of the cognition care plan, revised on 7/29/24, indicated Resident #30 had impaired cognition due to developmental delays and traumatic brain injury. A review Resident #30's nurse progress notes, dated 8/19/24 and 8/21/24, respectively indicated the following: - Resident was sent out to the hospital this evening at 6pm due to critically low H&H (hematocrit and hemoglobin). Resident has been non-compliant with transfusion/ lab draw on Friday 8/16. Resident informed 7-3 nurse that he/she was feeling terrible weak and wanted to be sent for a transfusion. NP (Nurse Practitioner) spoke with resident and confirmed he/she wanted to be sent out. Hospital was called and given report via 2nd floor nurse. Staff made aware, will follow up tomorrow with NP 8/20. [sic] - Pt (patient) came back from the hospital on a stretcher escorted by two EMT (emergency medical technician) personnel. He/she was sent out on the 19th for anemia related complications (H & H 6,1). [sic] A review of the facility census indicated that Resident #30 was at the hospital from 8/19/24 to 8/21/24. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #30's medical record failed to indicate that a bed hold policy was issued to the Resident or the Resident representative. During an interview on 9/12/24 at 12:44 P.M., the Regional Nurse and the Director of Nurses (DON) #2 said Resident #30 was not issued a facility policy for bed hold prior to the hospital transfer on 8/19/24. They said bed hold policies should be issued to Residents or Resident Representatives prior to emergency transfers to the hospital. 44095 2.) Resident #22 was admitted to the facility in January 2024 with diagnoses including combined systolic and diastolic heart failure, pleural effusion, atrial fibrillation, and pulmonary hypertension. Review of the Minimum Data Set (MDS) assessment, dated 4/9/24, indicated that Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #22's nursing note, dated 4/12/24 indicated: Note Text: Ok to transfer to hospital for evaluation - fall this morning 6am in own bedroom. Review of Resident #22's nursing note, dated 4/12/24 indicated: Note Text: This nurse received report from hospital that resident would be admitted for hypokalemia, and congestive heart failure. On 9/10/24 and 9/11/24 the surveyor reviewed the electronic health record and the paper medical record. The surveyor was unable to locate documentation to support Resident #22 was provided the bed hold policy. The surveyor requested the documents from the Regional Nurse on 9/11/24 at 11:30 A.M. During an interview on 9/12/24 at 12:01 P.M., the Regional Nurse said she was unable to find documentation to support Resident #22 was provided the bed hold policy.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48990 Based on record review and interviews, the facility failed to ensure a Minimum Data Set (MDS) discharge assessment was encoded and transmitted timely for one Resident (#40) out of 17 total sampled residents. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual indicated a discharge MDS assessment must be completed within 14 days after the discharge date . Resident #40 was admitted to the facility in April 2024 with diagnoses including pancreatitis and skin cancer. Review of the Minimum Data Set (MDS) assessment, dated 4/18/24, indicated Resident #40 was recently admitted to the facility. Review of the Nurse Practitioner progress note, dated 5/22/24, indicated Resident #40 was discharged home. Review of Resident #40's medical record failed to indicate an MDS discharge assessment was encoded or transmitted as required. During an interview on 9/12/24 at 10:23 A.M., Director of Nursing (DON) #1 said all MDS's should be coded and transmitted according to RAI (Resident Assessment Instrument) guidelines and Resident #40 should have had an MDS discharge assessment encoded and transmitted by the MDS Nurse. During an interview on 9/12/24 at 11:33 A.M., the MDS Nurse said Resident #40 never had a discharge assessment encoded or transmitted but should have.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observation, interview and record review, the facility failed to accurately code in the Minimum Data Set (MDS) for two Residents (#10 and #49) of 17 total sampled residents. Specifically: 1.) For Resident #10, the use of anticoagulant and antiplatelet medications were inaccurately coded in the MDS. 2.) For Resident #49, the discharge location was incorrectly coded in the MDS. Findings include: 1.) Resident #10 was admitted to the facility in December 2021 with diagnoses including a history of stroke and congestive heart failure. Review of the Minimum Data Set (MDS) assessment, dated 7/12/24, indicated Resident #10 was taking anticoagulant and antiplatelet medications. Review of Resident #10's Medication Administration Record (MAR), dated 7/1/24 to 7/12/24, failed to indicate that Resident #10 was administered anticoagulant or antiplatelet medications during the seven day lookback period for the MDS, dated [DATE]. During an interview on 9/12/24 at 10:23 A.M., Director of Nursing (DON) #1 said the MDS should be coded by the MDS Nurse according to RAI (Resident Assessment Instrument) guidelines and if an anticoagulant or antiplatelet medication was not administered, it should not have been coded that it had been. During an interview on 9/12/24 at 11:33 A.M., the MDS Nurse reviewed the Medication Administration Record (MAR) with the surveyor and said Resident #10 did not receive any anticoagulant or antiplatelet medications during the seven day lookback period for the MDS, dated [DATE]. The MDS Nurse said this MDS was coded inaccurately. 36797 2.) Resident #49 was admitted to the facility in August 2024 with diagnoses including hip fracture and malnutrition. Review of Resident #49's MDS, dated [DATE], indicated the Resident was discharged to an acute care hospital. Review of Resident #49's nurses progress note, dated 8/5/24, indicated that the Resident was discharged to another long term care facility. Review of the Social Services progress note, dated 8/13/24, indicated that Resident #49 was discharged to another long term care facility. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 9/12/24 at 11:33 A.M., the MDS Nurse said that if a resident is discharged to another nursing home that should be correctly reflected on the MDS. The MDS nurse then said that Resident #49's MDS was coded incorrectly.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 48990 Based on record review and interviews, the facility failed to ensure that its staff completed a Preadmission Screening and Resident Review (PASRR - a federal and state required process that is used to identify evidence of serious mental illness (SMI) and/or intellectual or developmental disabilities in all individuals seeking admission to a nursing facility), in a timely manner after the expected length of stay exceeded 30 days for one Resident (#14) with SMI, out of 17 sampled residents. Findings include: Review of the facility policy titled Resident Assessment - Coordination with PASARR [sic] Program, dated 3/4/24, indicated: 9. If a resident who was not screened due to an exception and the resident remains in the facility longer than 30 days: e. The facility must screen the individual using the State's Level I screening process to the appropriate state-designated authority for Level II PASARR [sic] evaluation and determination. Resident #14 was admitted to the facility in August 2024 with diagnoses including bipolar disorder and depression. Review of the PASRR Level I Screening, dated 8/2/24, indicated the Resident had a positive SMI screen, but a Level II PASRR Evaluation (used to confirm if the individual has SMI and, if so, whether the individual requires a nursing facility level of care and specialized services) was not indicated at that time due to Exempted Hospital Discharge (maximum 30 calendar days). Further review indicated if the nursing facility determined that the Resident's stay would exceed the 30 day exemption period, the nursing facility must complete Section G on the form and submit Level I Screening to the Department of Mental Health (DMH) no later than the 25th calendar day from admission. Review of the clinical record on 9/11/24, which was 40 days after Resident #14's admission, did not indicate another PASRR Level I was ever completed once the nursing facility determined the Resident would exceed the 30 day exemption period. During a telephone interview on 9/11/24 at 12:01 P.M., the Admissions Liaison said she was responsible for PASRR Level I's only upon admission. The Admissions Liaison said she looked in the PASRR portal and there were no additional PASRRs completed for Resident #14 since 8/2/24, but there should have been another submitted before the 25th calendar day from admission since Resident #14 exceeded the 30 day exemption. The Admissions Liaison said she was not aware of who was responsible because she works remotely but knew the previous person responsible had resigned. During an interview on 9/12/24 at 10:55 A.M., the Social Worker said she was a consultant that came in once a week to help. The Social Worker said nobody had been completing PASRRs in the facility after admission because there is nobody in the facility who has access to the PASSR portal. The Social Worker said she told the Administrator multiple times, but they never got her access. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/24 at 1:05 P.M., The Administrator said he was unaware the PASRRs were not being completed but should be.

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F 0655 Level of Harm - Minimal harm or potential for 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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review, policy review, and interview, the facility failed to ensure staff developed and implemented a baseline care plan within 48 hours of the resident's admission, which included the instructions needed to provide effective and person-centered care to the resident which meet professional standards of quality care for three Residents (#25, #47 and #49), in a total sample of 17 residents. Specifically, the facility failed to ensure: 1. For Resident #25, a baseline care plan was developed for the Resident's dialysis treatment. 2. For Resident #47, a baseline care plan was developed. 3. For Resident #49, a baseline care plan was developed. Findings include: Review of the facility policy titled Comprehensive Care Plans dated 3/4/24, failed to indicate that a baseline care plan would be developed to ensure the minimum healthcare information necessary to properly care for each resident upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision and assistance with Activities of Daily Living. 1.) Resident #25 was admitted to the facility in August 2024 with diagnoses including end stage kidney disease, pneumonia and fracture. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #25 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderately impaired cognition. Further review indicated Resident #25 required moderate assistance for most activities of daily living. Review of the doctor's orders dated August 2024 and September 2024 failed to indicate a doctor's order for hemodialysis. Review of the medical record failed to indicate that a baseline care plan was developed within the required 48 hours of admission, including the development of a dialysis care plan. During an interview on 9/10/24, at 12:45 P.M., Nurse #4 said that there should have been a care plan created on admission that includes how to care for the Resident including the days, times and place the Resident is scheduled to go to dialysis. During an interview on 9/10/24 at 1:45 P.M., Nurse #6 said that Resident # 25 has a Central Venous Catheter (CVC) for dialysis access. Nurse #6 said that she would expect that there would be a doctor's order to monitor the CVC site for infection and drainage and that a baseline care plan would have been developed to include those interventions. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) Resident #47 was admitted to the facility in August 2024 with diagnoses including post-traumatic stress disorder (PTSD), hemiplegia and diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review of the MDS indicated Resident #47 required assistance with most activities of daily living. Review of the medical record failed to indicate that a baseline care plan was developed within the required 48 hours of admission. During an interview on 9/10/24 at 4:38 P.M., Director of Nursing #1 said that he was unable to locate a baseline care plan. 3.) Resident #49 was admitted to the facility in August 2024 with diagnoses including hip fracture and malnutrition. Review of the medical record failed to indicate a baseline care plan was created within 48 hours of admission. During an interview on 9/10/24 at 12:33 P.M., Nurse #5 said that she could not locate a baseline care plan in the medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48990 Based on observations, interviews, and record review, the facility failed to ensure staff developed and implemented a comprehensive person-centered care plan for four Residents (#4, #23, #25 and #47), out of a total sample of 17 residents. Specifically: 1.) For Resident #4, the facility failed to implement a fall care plan intervention to keep a urinal within reach and failed to develop a fall care plan intervention for fall mats. 2.) For Resident #23, the facility failed to develop personalized mood, behavior, and substance abuse care plans. 3.) For Resident #25, the facility failed to develop a comprehensive care plan for dialysis and antidepressant medication. 4.) For Resident #47, the facility failed to develop a comprehensive care plan for post-traumatic stress disorder (PTSD) and the use of psychotropic medication. Findings include: Review of the facility policy titled Comprehensive Care Plans, dated 3/4/24, indicated: - It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 1.) Review of the facility policy titled Fall Prevention Program, dated 3/4/24, indicated: 8. Each resident's risk factors and environmental hazards will be evaluated when developing the comprehensive care plan. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised if needed. Resident #4 was admitted to the facility in December 2021 with diagnoses including vascular dementia and adult failure to thrive. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/25/24, indicated Resident #4 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. This MDS also indicated Resident #4 had two falls since the previous MDS, dated [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/24 at 8:18 A.M., the surveyor observed Resident #4 in bed with one fall mat under the bed, not fully in position. Only approximately one third of the fall mat was extended out from the left side of the Resident's bed. There was no urinal visible in his/her room. On 9/11/24 at 7:28 A.M., the surveyor observed Resident #4 in bed with one fall mat stored fully under his/her bed. No portion of the fall mat was extended to the area next to the Resident's bed. There was no urinal visible in his/her room. On 9/11/24 AT 8:20 A.M., the surveyor observed Resident #4 in bed eating breakfast. The fall mat had been moved and propped upright on the wall in the Resident's room. There was no urinal visible in his/her room. On 9/12/24 at 7:26 A.M., the surveyor observed Resident #4 in bed with one fall mat under the bed, not fully in position. Only approximately one third of the fall mat was extended out from the left side of the Resident's bed. There was no urinal visible in his/her room. During an interview on 9/12/24 at 7:29 A.M., Resident #4 said he/she used to have a urinal, but it's been gone for a long time. Resident said he/she would like to have the urinal again because then he/she wouldn't have to wait to go to the bathroom. Review of Resident #4's plan of care related to falls, revised 7/9/24, indicated: -Keep Urinal within reach. Review of Resident #4's plan of care related to falls, revised 7/9/24, failed to indicate use of fall mats. Review on Resident #4's physician's orders failed to indicate the use of fall mats. Review of Resident #4's medical record failed to indicate fall mats had been implemented or were in use. Further review of medical record failed to indicate any rationale for urinal not being within reach or any refusal of urinal. During an interview on 9/12/24 at 7:31 A.M., Certified Nurse Assistant (CNA) #3 said she cared for Resident #4 regularly on day shift. CNA #3 said Resident #4 had a history of falling out of bed. CNA #3 said Resident #4 should have two fall mats in place when in bed, not just one, but is not sure where the other one went. CNA #3 said a nurse a while back had told her in report that Resident #4 needed fall mats when in bed. CNA #3 said there is no urinal in the room. CNA #3 said this is because staff should never give Resident #4 a urinal because then he/she might use it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/12/24 at 8:44 A.M., Nurse #5 said Resident #4 should have a fall mat on the left side of his/her bed whenever he/she is in bed. Nurse #5 said Resident #4 does not use a urinal. Nurse #5 said CNAs should be instructed on specific interventions necessary, such as fall mats and use of urinal, during shiftly report. Nurse #5 visualized Resident #4's care plan and said, based on the care plan, the Resident should have a urinal within reach to prevent falls. Nurse #5 said if this intervention was no effective or no longer necessary, the care plan should have been updated, but was not. Nurse #5 said there was not an intervention for fall mats, but there should have been one added because fall mats should not be used without either a physician's order or a care plan intervention. Nurse #5 said nurses are expected to check and update the care plan for interventions each shift, but it's not realistic because they don't have enough time with staffing levels in the facility. Nurse #5 said instead the nurses rely on shift report to communicate specific interventions, but that often doesn't happen either because of time constraints related to staffing levels. During an interview on 9/12/24 at 10:11 A.M., the Director of Nursing (DON) #1 said Resident #4's care plan should always be followed. DON #1 said fall mats should not have been used because they were determined to be a risk for Resident #4's roommate. DON #1 said the urinal should have been within Resident #4's reach because Resident #4's past falls were related to toileting needs. DON #1 said if interventions were not effective or no longer needed the care plan should have been updated but was not. DON #1 said Resident #4's care plan should always be followed but was not. 43807 2.) Resident #23 was admitted to the facility in July 2024 with diagnoses including borderline personality disorder, suicidal ideations, major depression disorder and opioid abuse. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating intact cognition. A review of Resident #23's behavioral health medication management progress note dated 9/4/24 indicated the following: -Chief Complaint: follow up medication/mood management: Target Symptoms: Anxiety, Depression, Tearfulness, Suicidal and Homicidal ideation (history of present illness) HPI: Problem: Resident has a history of major depressive disorder, borderline personality d/o, suicidal ideation's, opioid abuse and autism is seen for a follow up visit. He/she is here s/p hospitalization for weakness and falls; did have a laminectomy 2 weeks prior to that. Troponin was elevated but stabilized then sent to rehab. He/she has chronic back and leg pain since 2012 when his/her SI thoughts started, previously admitted to psych for it and has hx ECT treatment as well. Since 2012, his/her SI thoughts have been gradually worsening. Recently he/she asked staff to give him/her more pills so he/she would overdose. Talked about a gun with staff another time. Sent to ER last visit for worsening depression and suicidal ideation, had plans to self-harm and also harm the doctor who he/she blames for not doing his/her surgery right. Said he/she would go to garden center, buy [NAME] glove seeds/digitalis, plans to grow them, then process/ferment them, then ingest. He/she additionally reported that he/she will be finding the license plate of the doctor who did his/her surgery and turn the Dr's car into a traveling bomb. [sic] (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Substance Use / Addiction History: Opiates, Marijuana. -A review of Resident #23's progress note dated 9/4/24 indicated that a Certified Nurse's Assistant (CNA) reported the Resident was playing with his/her feces and had feces smeared on his/her hand and sheet. [sic] A review of Resident #23's care plan failed to indicate a history of homicidal ideation, opiate and marijuana abuse care plan with personalized interventions was developed. The care plan also failed to indicate the Resident's feces smearing behavior with personalized interventions. Further review of the mood care plan initiated on 8/6/24 indicated Resident #23 has a history of making suicidal statements, wanting to overdose on digitalis, but failed to indicate the Resident has a history of asking staff for more pills so he/she could overdose. During an interview on 9/12/24 at 9:21 A.M., the Social Worker said the Resident has a history of suicidal ideations, homicidal ideations, smearing feces, opioid abuse and marijuana abuse. The Social Worker there should be personalized care plans developed addressing Resident #23's mood and behavior. 36797 3.) Resident #25 was admitted to the facility in August 2024 with diagnoses including end stage kidney disease, pneumonia, and fracture. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #25 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderately impaired cognition. Further review indicated Resident #25 required moderate assistance for most activities of daily living. Review of the physician's orders dated August 2024 and September 2024 failed to indicate a physician's order for hemodialysis. Further review indicated an order for the antidepressants Mirtazapine 7.5 mg (milligrams) daily and Fluoxetine 60 mg daily. Review of the current care plan failed to indicate complete interventions for hemodialysis, including days, times and location of treatments. Further review failed to indicate how to care for the dialysis access site. Further review failed to indicate the use of antidepressant medications. During an interview on 9/10/24, at 12:45 P.M., Nurse#4 said that there should be a care plan that includes the days, times and place the Resident is scheduled to go to dialysis as well as how to care for the dialysis access site. During an interview on 9/10/24 at 1:45 P.M. Nurse #6 said that Resident # 25 has a Central Venous Catheter (CVC) for dialysis access, and she would expect that there would be a care plan to monitor the CVC site for infection and drainage. 4.) Resident #47 was admitted to the facility in August 2024 with diagnoses including post-traumatic stress disorder (PTSD), hemiplegia and diabetes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review indicated Resident #47 required assistance with most activities of daily living. Review of the physician's orders dated August 2024 and September 2024 indicated the following orders: 1. Zyprexa (an anti-psychotic) 5 mg (milligrams). 2. Trazodone (an anti-depressent) 50 mg. Review of the care plan dated 8/6/24, indicated a focus for alteration/risk for alteration in mood and/or behavioral status AEB (as evidenced by)/Related to: Depression, history of suicidal ideation's, PTSD. Further review failed to indicate a care plan for psychotropic medication use. During an interview on 9/10/24 at 4:38 P.M., Director of Nursing (DON) #1 said that he was unable to locate a psychotropic medication use care plan. During an interview on 9/12/24 at 8:50 A.M., DON #1 said that the care plan should include the specific psychotropic medications used with their corresponding potential side effects, and resident specific interventions. The DON then said that the care plan was not complete.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observation, record review and staff interview, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team for two Residents (#14 and #47) out of a total sample of 17 residents. Specifically: 1.) For Resident #14, the facility failed to update the comprehensive care plan to indicate a new change in advanced directives from full code to do not resuscitate (DNR) and failed to ensure the entire comprehensive care plan was reviewed and revised by an interdisciplinary team following the completion of a comprehensive assessment. 2.) For Resident #47, the facility failed ensure the entire comprehensive care plan was reviewed and revised by an interdisciplinary team following the completion of a comprehensive assessment. Findings include: Review of the facility policy titled Comprehensive Care Plans, dated 3/4/24, indicated: - The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set). Review of the facility policy titled Residents' Rights Regarding Treatment and Advanced Directives, dated 3/4/24, indicated: - Decisions regarding advanced directives and treatment will be periodically reviewed as part of the comprehensive care planning process. 1.) Resident #14 was admitted to the facility in August 2024 with diagnoses including adult failure to thrive and malnutrition. Review of Resident #14's most recent Minimum Data Set (MDS) assessment, dated 8/6/24, indicated the assessment was completed on 8/14/24. Review of Resident #14's advanced directives care plan, dated as last revised 8/13/24, indicated the target date for goal review was overdue. The care plan further indicated: - No MOLST. - Resident #14 has not made any advance directives: Assume full code. - Discuss/Confirm Advance Directives and/or Living will decisions on admission, at least quarterly and PRN (as needed) with change in prognosis. Review of Resident #14's physician's order, dated 8/16/24, indicated: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident is a DNR/DNI (do not intubate). During an interview on 9/11/24 at 11:43 A.M., Nurse #5 said the nurses on the floor were responsible for updating all care plans since the MDS nurse and social worker had resigned. Nurse #5 said it was difficult to keep up with care plan updates because they didn't have enough time with staffing levels in the facility. Nurse #5 said Resident #14 advanced directives specified he/she was a full code on admission but the Resident opted to change his/her code status to DNR on 8/16/24. Nurse #5 said Resident #14's care plan should have been updated to reflect his/her current wishes for DNR on 8/16/24, but it was not done. During an interview on 9/12/24 at 10:08 A.M., Director of Nursing (DON) #1 said Resident #14's advanced directives care plan should have been updated immediately when his/her code status changed to DNR. During an interview on 9/12/24 at 1:10 P.M., the Social Worker said she was a consultant that came in once a week to help the facility. The Social Worker said she was not involved in the care plan process and was not aware of who was. The Social Worker said she did not hold any care plan meetings in over a month. During an interview on 9/12/24 at 1:14 P.M., Director of Nursing (DON) #2 and the Regional Nurse said the Social Worker and the MDS Nurse should have been responsible for care plan meeting coordination. DON #2 and the Regional Nurse said the comprehensive care plan should be reviewed and revised during a care plan meeting within seven days after the completion date of every comprehensive or quarterly MDS. They said since Resident #14's comprehensive MDS was completed on 8/14/24, there should have been a care plan meeting to review and revise the care plan to reflect their current status by 8/21/24. They said that the Resident #14's care plan relating to advanced directives should have been revised immediately, but also reviewed during the care plan meeting that should have been held by 8/21/24. DON#2 and the Regional Nurse said if a care plan meeting was held to review and revise the care plan it would be in the binder titled Care Plan Sign In but they would not be surprised if it was missed because they did not have an MDS Nurse at the time and the consultant Social Worker was only in once a week. Review of binder titled Care Plan Sign In failed to indicate a care plan meeting invitation was sent or a care plan meeting was held for Resident #14 on or after 8/14/24. Review of Resident #14's care plan indicates that no revisions were made after 8/13/24. Further review of the care plan indicated the care plan review was overdue and should have been completed by 8/21/24. 36797 2.) Resident #47 was admitted to the facility in August 2024 with diagnoses including post-traumatic stress disorder (PTSD), hemiplegia and diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review indicated Resident #47 required assistance with most activities of daily living. Further review indicated the MDS assessment was completed on 8/14/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #47's active plan of care dated as last revised 8/6/24, indicated the target date for all goal reviews were overdue. The care plan was scheduled to be reviewed 7 days after the completion of the MDS and was not. The care plan further indicated: a. 12 separate problem focus's related to high-risk medication use indicated the following: Secondary to DX (diagnosis)/indication for use of (choose etiologies and identify DX, symptoms for use of each high-risk med (medication). Further review of the 12 separate problem focus's failed to indicate that the name of the medication, the diagnoses associated with the medication, or the symptoms for use, had been filled in. b. all 12 of the goals for the corresponding problem focuses listed above, were the same and did not include any specific goals related to any specific medications. Further review indicated that all 12 goals for each problem focus were overdue. During an interview on 9/10/24 at 4:38 P.M., Director of Nursing (DON) #1 said that he was unable to locate any specific/complete psychotropic medication use care plans. During an interview on 9/12/24 at 8:50 A.M., DON #1 said that the care plan should include the specific psychotropic medications used with their corresponding potential side effects, and resident specific interventions. The DON said that the care plan had not been reviewed/revised timely as all the goals indicated the care plan was overdue for review.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44095 Based on record review and interviews, the facility failed to provide services that met professional standards of quality for one Resident (#19) out of a sample of 17 Residents. Specifically, for Resident #19 the facility failed the ensure nursing implemented an air mattress setting according to the physician's order. Findings include: Resident #19 was admitted to the facility in November 2020 with diagnoses including dementia, dysphagia, and osteoarthritis. Review of the facility policy titled, Use of Support Surfaces, dated as 3/4/24, indicated that support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. 5. Except for the facility's standard mattresses and wheelchair cushions, support surfaces will be utilized in accordance with physician orders. 6. Support surfaces will be utilized in accordance with manufacturer recommendations (including considerations for contraindications) 7. For powered devices, or those requiring air, the licensed nurse will check each shift and as needed for proper functioning and/or inflation. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated that Resident #19 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. On 9/10/24 at 7:32 A.M., 9/10/24 at 8:10 A.M., 9/10/24 at 2:34 P.M., 9/10/24 at 4:43 P.M., 9/11/24 at 6:58 A.M., 9/11/24 at 8:32 A.M., and on 9/12/24 at 2:05 P.M., the surveyor observed Resident #19 in his/her bed with the air mattress set to 150. Review of Resident #19's physician's order, dated 5/1/24, indicated: - Low air loss mattress at a setting of 140, three times a day for monitoring; comfort measures. Review of Resident #19's physician's order, dated 7/2/24, indicated: - Low air loss mattress at a setting of 130, check every shift to maintain setting at 130, three times a day for monitoring/prevention. Review of Resident #19's plan of care related to skin breakdown, dated as revised 8/23/24, indicated: - I have a pressure relieving air mattress on my bed and a cushion on my wheelchair, 5/9/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the air mattress settings indicated the following settings, 100, 150, 200, 250, and 325. Further review of the air mattress there was no ability for nursing to set the air mattress to 130 or 140. During an interview on 9/12/24 at 9:36 A.M., Certified Nurse Assistant (CNA) #4 said CNA's do not adjust air mattress settings. During an interview on 9/12/24 at 11:00 A.M., Nurse #2 said she should verify the physician's order and set the air mattress to the physician's order. During an interview on 9/12/24 at 12:02 P.M., the Regional Nurse said nursing should implement the physician's order for air mattress settings and should set air mattress settings according to the manufacture's guidelines.

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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. 44095 Based on observation, record review, and interview, for one Resident (#34) out of a total sample of 17 residents, the facility failed provide services and treatment for a resident who was assessed to have a reduction in range of motion of his/her left hand. Findings include: Review of the facility policy titled, Brace and Splint Program, dated as revised January 2020, indicated the facility will ensure that any resident with a limited range of motion receives treatment and services to increase range of motion and prevent further decrease in range of motion. The facility will ensure that the resident reaches and maintains his or her highest level of range of motion and to prevent avoidable decline of range of motion. - If a resident enters the facility with a brace or splint, or if there is evidence of a decrease in range of motion and/or contractures are evident a physician's order will be obtained for a therapy evaluation. - If it is determined that a brace or splint is appropriate/needed a physician's order will be obtained and will define the following information: a. Where the splint/brace is to be worn b. When the splint/brace is to be worn c. Why the splint/brace is to be worn d. Who will apply the splint/brace (nursing or therapy) -A care plan will be developed that has measurable objectives and interventions that include the following: a. A scheduled program of applying and removing the appliance that includes: scheduled hours to be worn and when skin will be inspected for signs and symptoms of pressure areas, irritation rashes etc. and will be reported to charge nurse and attending physician. b. Communicate individualized interventions to the direct care providers. Provide specific directions and training as needed (e.g., correct splint application, range of motion techniques, skin integrity). Update Care Plan and Resident Care Guide as needed. - The splint/brace application and removal will be documented in the clinical record as will the skin inspection after removal. - Any issues with the splint/brace will be communicated to the physician (e.g. skin issues, discomfort etc.) and follow up therapy evaluation ordered as needed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Goals and interventions will be modified as needed and communicated to the direct care providers. Resident #34 was admitted to the facility in May 2024 with diagnoses including dysphagia and hemiplegia and hemiparesis following a cerebral infarction. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/15/24, indicated that Resident #34 had a functional limitation in range of motion on one side in the upper extremity and one in the lower extremity. On 9/10/24 at 7:23 A.M., the surveyor observed a left-hand splint with a palm protector on Resident #34's nightstand. Resident #34 was unable to fully open his/her right hand. On 9/10/24 at 9:24 A.M., Resident #34 had just finished receiving care from two certified nurse assistants. Resident #34 was not wearing a left-hand splint with palm protector. On 9/10/24 at 12:15 P.M., 9/10/24 at 2:15 P.M., 9/10/24 at 4:45 P.M., 9/11/24 at 6:47 A.M., the surveyor observed Resident #34 without a left-hand splint and palm protector. On 9/11/24 at 7:59 A.M., the surveyor observed CNA #2 finish care for Resident #34. CNA #2 said that she was not aware that Resident #34 required a left-hand splint. CNA #2 said that Resident #34 has limited range of motion and pain in his/her left hand. Review of Resident #34's Occupation Therapy note, dated 8/27/24, indicated: Resident tolerates gentle stretches to left hand and wrist prior to application of a hand/wrist splint with palm protector. Nursing educated on schedule and left upper extremity (LUE) positioning. Pain = No pain present, per Resident verbal and nonverbal communication. Patient and Caregiver Training: LUE hand/wrist splint with palm protector application, wearing schedule and LUE positioning. Response to Session Interventions: complaint with skilled services Review of Resident #34's Occupational Therapy Discharge Summary, dated as 8/27/24, indicated but was not limited to the following: Short term goal #5 met on 8/27/24: Patient will tolerate nursing application of left hand/wrist splint daily. Discharge level: Patient tolerates 8+ hours with application by nursing. Short term goal #6 met on 8/27/24: Patient will tolerate nursing application of left hand/wrist splint. Assessment and Summary of Skilled Services: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skilled interventions provided: Training with nursing for left hand/wrist splint with palm protector application, wearing schedule and repositioning. Discharge recommendations: left upper extremity hand/wrist splint with palm protector. Review of Resident #34's plan of care and active physician's orders on 9/11/24 failed to include any documentation to support a splint wearing schedule. During an interview on 9/11/24 at 10:12 A.M., Nurse #2 (who typically works the day and evening shift) said she was not aware that Resident #24 requires a left-hand splint. During an interview on 9/12/24 at 7:27 A.M., Nurse #3 (who typically works the evening and night shift) said that Resident #34 requires a splint. Nurse #3 said she thinks the splint is worn at night and would apply the splint based on the physician's orders. During an interview on 9/11/24 at 1:33 P.M., the Occupational Therapist said that she worked with Resident #34 for contracture management. The OT said when she finished with Resident #34 on 8/27/24 he/she was able to tolerate wearing a left-hand splint with palm guard for over 8 hours during the day shift. The OT said she completed training with nursing and nursing should have obtained and implemented physician's orders for the splint use but did not. During an interview on 9/12/24 at 11:52 A.M., the Regional Nurse said that nursing should have implemented a plan of care and splint wearing scheduled based on the OT's recommendations for the left upper extremity hand/wrist splint with palm protector.

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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** 43807 Based on observation, record review and interview, the facility failed to ensure the size of an indwelling urinary catheter was documented in the physician's orders for one Resident #23 out of a sample of 17 Residents. Findings include: A review of the facility policy titled 'Catheter Care' with a revision date of 3/4/24 indicated the following: -It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care. Resident #23 was admitted to the facility in July 2024 with diagnoses including retention of urine. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating intact cognition. Further review of the MDS indicated Resident #23 had an indwelling catheter. On 9/10/24 at 9:24 A.M., and 9/11/24 at 9:09 A.M., Resident #24 was observed in bed with a Foley (urinary) catheter in place. A review of the Nurse's progress note dated 8/25/24 indicated the following: Complaints of penile/vaginal discomfort with urinary catheter. Light brown foul smelling penile discharge noted. This writer irrigated catheter with 60 ccs ns (normal saline) and cleaned surrounding areas well. Drained a total of 600 ml (milliliters) of clear, dark yellow urine throughout shift. Fluids encouraged. [sic] A review of Resident #23's September physician's orders indicated the following: - Foley Catheter care every shift three times a day. The physician's order failed to indicate the size of the Foley catheter and balloon. A review of the indwelling catheter care plan created on 8/6/24 failed to indicate the size of the Foley catheter and balloon. During an interview and observation on 9/11/24 at 9:29 A.M., Nurse #2 said she had no idea what Resident #23's catheter size was, she said it should be in the physician's order and care plan but wasn't. Nurse #2 said the size should be documented because the wrong catheter size could cause pain for the Resident. The surveyor and Nurse #2 observed the catheter size, 16 French (Fr) 10 Milliliters (ml). The Resident said this particular catheter size was comfortable. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/11/24 at 9:45 A.M., the Regional Nurse said Foley catheter sizes should be documented in the physician's orders.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44095 Based on observation, record review and interview for one Resident (#19) of 17 sampled residents the facility failed to ensure acceptable parameters of nutritional status were maintained. Specifically, for Resident #19, a resident with weight loss, the facility failed consistently provide fortified foods and nutritional supplements. Findings include: Resident #19 was admitted to the facility in November 2020 with diagnoses including dementia, dysphagia, and osteoarthritis. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated that Resident #19 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. This MDS indicated Resident #19 was dependent on staff for eating and had experienced weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and received a mechanically altered diet. On 9/10/24 at 8:58 A.M., the surveyor observed Resident #19's breakfast tray which included the following: - Cream of wheat with cinnamon, regular apple juice, eggs, and pureed bread. Review of Resident #19's tray ticket on 9/10/24 at 8:58 A.M., indicated the following for breakfast: - 8 ounce chocolate shake - 6 ounce fortified juice - 6 ounce fortified milk - Super Cereal (fortified cereal with condensed milk, butter, and brown sugar) - Yogurt The staff member assisting Resident #19 with his/her meal said there was no chocolate shake, no fortified juice, no fortified milk, no super cereal, and no yogurt, on his/her tray. On 9/11/24 at 8:28 A.M., the surveyor observed Resident #19's breakfast tray which included the following: - Oatmeal, regular apple juice, eggs, and pureed bread. Review of Resident #19's tray ticket on 9/11/24 at 8:28 A.M., indicated the following for breakfast: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8 ounce chocolate shake - 6 ounce fortified juice - 6 ounce fortified milk - Super Cereal - Yogurt The staff member assisting Resident #19 with his/her meal said there was no chocolate shake, no fortified juice, no fortified milk, no super cereal, and no yogurt, on his/her tray. Review of Resident #19's physician's order, dated 3/28/24, indicated: - fortified shakes on all meal trays, three times a day. Review of Resident #19's plan of care related to nutrition, dated as revised 5/9/24, indicated: - trialing high calorie smoothie, super mashed potato at lunch, 12/9/23. - Weigh as ordered and document findings, 5/9/24. Review of Resident #19's plan of care related to skin breakdown, dated as revised 8/23/24, indicated: - Give me any nutritional supplements I am ordered to help with my skin, 5/1/24. Review of Resident #19's weights in the electronic health record indicated the following: 4/4/24 142 pounds (lbs) 4/8/24 142 lbs 4/11/24 142 lbs 5/2/24 131.6 lbs 5/6/24 132 lbs 6/4/24 130 lbs 7/8/24 129 lbs 7/15/24 129 lbs 8/8/24 127 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/11/24 125 lbs Review of Resident #19's, Dietary/Nutrition Note, dated 7/11/24, indicated the following: He/she has had a 13-pound weight loss over past 3 months. He/she has been observed and reported poor oral intake he/she takes fortified nutrition shakes at all meals and boost between meals. Plan: - serve diet as ordered. - continue supplements between meals. Review of Resident #19's daily tray tickets indicated the following: Breakfast - 8 ounce chocolate shake - 6 ounce fortified juice - 6 ounce fortified milk - Super Cereal - Yogurt Lunch - 8 ounce chocolate shake - 6 ounce fortified juice Dinner - 8 ounce chocolate shake - 6 ounce fortified juice. During an interview on 9/12/24 at 9:38 A.M., Certified Nurse Assistant (CNA) #4 said that Resident #19 has a poor appetite, and he/she loves liquids. CNA #4 said the Resident #19 used to get a fortified shake on his/her meal trays, but CNA #4 has not seen a fortified shake in a few months. CNA #4 said fortified milk and juice has not been served in a while and they would have an F on the top of the drink. CNA #4 said that yogurt is rarely provided. During an interview on 9/12/24 10:59 A.M., Nurse #2 said that shakes between meals require a physician's order. Nurse #2 said the kitchen was sending shakes on Resident #19's tray, but the kitchen has not in a while. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/24 at 8:43 A.M., Dietary Staff #1 said on 9/10/24 and 9/11/24 she did not prepare any fortified milk or juices for resident meal trays, she did not prepare super cereal or super mashed potatoes. Dietary Staff #1 said there was no yogurt to serve residents. Dietary Staff #1 said that she was aware that Resident #19 required a fortified shake on his/her meal trays, and she did not make or provide the shake. During an interview on 9/12/24 at 8:45 A.M., the Food Service Director said that the Dietary Staff #1 should prepare and provide fortified foods from the kitchen. During an interview on 9/12/24 at 10:32 A.M., the Dietitian said that the kitchen should be providing fortified food and supplements on Resident #19's tray. The Dietitian said she was not aware that kitchen was not providing Resident #19's fortified shake on his/her meal tray but should have been. The Dietician reviewed her note from 7/11/24 and said she was not aware that Resident #19 did not have an order for shakes between meals, but she should have one. The Dietitian said these interventions are in place for weight loss and maintaining good nutritional status. During an interview on 9/12/24 at 12:08 P.M., the Regional Nurse said that the kitchen should provide fortified foods and supplements for Resident #19's weight loss.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 44095 Based on observation, record review, and interview the facility failed to adhere to professional standards for the administration of enteral feeding (nutrition taken through a tube directly to the stomach) for one Resident (#34) out of a total sample of 17 residents. Specifically, for Resident #34 the facility failed to administer enteral feedings in accordance to manufactures guidelines (product exceeded the expiration date). Findings include: Review of the facility policy titled, Care and Treatment of Feeding Tubes, dated as 3/4/24, indicated it is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. 9. Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided: p. Ensuring that the selection and use of enteral nutrition is consistent with manufacturer's recommendations. r. Ensuring that the product has not exceeded the expiration date. Resident #34 was admitted to the facility in May 2024 with diagnoses including dysphagia and hemiplegia and hemiparesis following a cerebral infarction. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/15/24, indicated that Resident #34 had a tube feeding. On 9/10/24 at 7:47 A.M., the surveyor observed one bottle of Jevity 1.2 dated 9/6/24 at 9:00 P.M., in Resident #34's room. There were about 800 milliliters (mls) missing from the bottle. Review of the Jevity manufacture's guidelines, indicated the following: - Hang product up to 48 hours after initial connection when clean technique and only one new feeding set is used, Otherwise, hang no longer than 24 hours. Review of Resident #34's plan of care related to tube feeding, dated 8/23/24, indicated: - I am dependent with tube feeding and water flushes. See physician orders for current feeding orders. Review of Resident #34's physician's order, dated 7/25/24, indicated: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Jevity at bedtime for weight management and nutrition Jevity 1.2 cals at 55 ml starting at 9:00 P.M. ending at 1:00 A.M. (over 4 hours). (220 mls) Review of Resident #34's Dietary/Nutrition Note, dated 8/29/24, indicated: - plan going forward is to reduce tube feeding to 4 hours over night up at 9:00 P.M., down at 1:00 A.M. During an interview on 9/11/24 at 6:45 A.M., Nurse #1 said that she worked the overnight shift Monday 9/9/24 into Tuesday 9/10/24. She said she disconnected the tube feeding around 1:00 A.M. on 9/10/24, that was dated 9/6/24, Nurse #1 said she leaves the Jevity bottle up to use the next day since there is still feeding available to use. During an interview on 9/12/24 at 11:55 A.M., the Regional Nurse said nursing should change the bottle of Jevity daily and follow the manufactures' guidelines.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48990 Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care and services for two Residents (#2 and #22), out of a total sample of 17 residents. Specifically: 1.) For Resident #2, the facility failed to ensure a bilevel positive airway pressure (BiPAP) machine, which is a device which assists with breathing, was repaired after identifying it was unable to be utilized because it was broken. 2.) For Resident #22 the facility failed to ensure nursing consistently provided respiratory care in accordance with professional standards of practice. Findings include: 1.) Review of the facility policy titled Noninvasive Ventilation (CPAP), BiPAP, AVAPS, Trilogy TM), undated, indicated: - Replace equipment immediately when it is broken or malfunctions. Resident #2 was admitted to the facility in August 2017 with diagnoses including sleep apnea (a respiratory condition in which your breathing stops and restarts many times while you sleep) and asthma. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated Resident #2 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #2 required non-invasive mechanical ventilator, which includes BiPAP. On 9/10/24 at 8:07 A.M., the surveyor observed Resident #2 being awoken from sleep by staff because his/her breakfast arrived. There was a BiPAP machine on a dresser across the room, not near Resident #2's bed. Resident #2 said he/she had not used the BiPAP in a few weeks because it was broken, but staff knew and had told him/her they called to get it fixed. Resident #2 said he/she sleeps better when using the BiPAP and said he/she had not been sleeping well without it. During a follow up interview on 9/11/24 at 7:29 A.M., Resident #2 said he/she had not been able to wear the BiPAP again last night and had not received an update on when it would be fixed by from staff. There was a BiPAP machine on a dresser across the room, not near Resident #2's bed. Review of Resident #2's active physician's order, initiated 9/16/21, indicated: - Bi-PAP settings 12 cm Exp, 18 cm Inspiratory @ (at) bedtime, every evening and night shift for Asthma, O2 (oxygen) Dep (dependency). Review of Resident #2's active plan of care related to asthma and sleep apnea, dated as reviewed 7/30/24, indicated: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brigham Health and Rehabilitation Center	77 High Street Newburyport, MA 01950

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- BIPAP at night: see MD (physician) order. During an interview on 9/11/24 at 7:37 A.M., Nurse #7 said she noticed Resident #2's BiPAP was broken a few weeks ago and was unable to be used safely. Nurse #7 said she told the Director of Nursing (DON) #1 but was not sure if the call for repair had been made. Nurse #7 said the medical record should have reflected that the BiPAP was broken, unable to be used, and what the outcome or plan was. Review of Resident #2's medical record failed to indicate the BiPAP was broken, any repair had been requested or made, or that there were any changes in the plan of care regarding BiPAP use. During an interview on 9/12/24 at 12:31 P.M., Certified Nurse Aide (CNA) #3 said she cares for Resident #2 frequently on day shift and was not aware the BiPAP was broken but had not seen it in place in the morning during the last few weeks when she started her shift. During an interview on 9/11/24 at 9:05 A.M., the Director of Nursing (DON) #1 said he was told Resident #2's BiPAP was broken a few weeks ago, but never called for repair or ensured the plan of care was updated or changed when the Resident was unable to use the BiPAP. 44095 2.) Review of the facility policy titled, Oxygen Administration, 3/4/24, indicated oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Resident #22 was admitted to the facility in January 2024 with diagnoses including combined systolic and diastolic heart failure, pleural effusion, atrial fibrillation, and pulmonary hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/2/24, indicated that Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 9/10/24 at 7:34 A.M., 9/10/24 at 12:18 P.M., 9/10/24 at 2:20 P.M., 9/10/24 at 4:46 P.M., 9/11/24 at 9:50 A.M., the surveyor observed Resident #22 being administered oxygen at 2 liters per minute (LPM) via nasal cannula. Review of Resident #22's physician's order, dated 4/16/24, indicated: - Oxygen at 1 liter per minute (@ 1L/MIN) via nasal cannula to maintain oxygen (O2) saturations (sats) above 90%, every shift for CHF exacerbation, maintain O2 sats above 90%. Review of Resident #22's physician's order, dated 8/8/24, indicated: - Oxygen @ 2 L/min continuous at bedtime (QHS), at bedtime for Oxygen Therapy 2L QHS. Review of Resident #22's nursing notes dated 9/10/24 at 4:18 P.M., and 9/10/24 at 10:31 P.M., indicated Resident #22 received oxygen at 2 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/24 at 9:35 A.M., Certified Nurse Assistant (CNA) #4 said that Resident #22 requires oxygen administration. CNA #4 said she does not adjust oxygen settings and she is not aware of Resident #22 adjusting his/her own oxygen settings. During an interview on 9/12/24 at 11:05 A.M., Nurse #2 said that Resident #22 requires continuous oxygen at 2 LPM, and the flow rate is based on the physician's orders. Nurse #2 said that she is not aware of Resident #22 adjusting his/her own oxygen settings. During an interview on 9/12/24 at 11:59 A.M., the Regional Nurse said nursing should implement physician's orders for oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on interview and record review, the facility failed to develop a plan of care for dialysis and failed to ensure staff implemented dialysis care and services consistent with professional standards of practice for one Resident (#25), out of 17 sampled residents. Specifically, the facility failed to provide ongoing communication between the nursing facility and dialysis facility. Findings include: Resident #25 was admitted to the facility in August 2024 with diagnoses including end stage kidney disease, pneumonia, and fracture. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #25 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderately impaired cognition. Further review indicated Resident #25 required moderate assistance for most activities of daily living. Review of the physician's orders dated September 2024 failed to indicate a physician's order for hemodialysis. Review of the dialysis communication book indicated 3 undated Dialysis Communication Forms (DCF). Further review indicated DCF's dated 8/15/24, 9/7/24 and 9/10/24 (only three dated communication forms out of a possible 12). On 9/10/24, at 12:44 P.M., Nurse #4 said that Resident #25 went out to dialysis at 10:00 A.M. The surveyor and Nurse #4 observed Resident #25's dialysis communication book at nurse's station with the DCF dated 9/10/24 still in the communication book. Nurse #4 then said that Resident #25 should have the book with him/her as that is how the facility and the dialysis center communicate needs, changes, and concerns. Nurse #4 then said that Resident #25 goes to dialysis 3 times a week. Nurse #4 said that there should be a communication form completed each time the Resident goes to dialysis. Nurse #4 said she was not aware of which type of dialysis access Resident #25 had. During an interview on 9/10/24 at 1:45 P.M., Nurse #6 said that Resident # 25 has a CVC (Central Venous Catheter) for dialysis access, and she would expect that there would be a physician's order to monitor the CVC site for infection and drainage.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview the facility failed to ensure a plan of care was developed for Trauma-Informed Care for one Resident (#47), who was admitted to the facility with the diagnosis of Post-Traumatic Stress Disorder (PTSD), out of a total 17 sampled residents. Findings include: Review of the facility policy titled Trauma Informed Care dated 3/4/24, indicated that the facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event . Further review indicated that the facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. Resident #47 was admitted to the facility in August 2024 with diagnoses including post-traumatic stress disorder (PTSD), hemiplegia, and diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review of the MDS indicated Resident #47 required assistance with most activities of daily living. Review of the care plan dated 8/6/24, indicated an incomplete PTSD care plan, with a focus for alteration/risk for alteration in mood and/or behavioral status AEB (as evidenced by)/ Related to: Depression, history of suicidal ideation's, PTSD. Further review of the care plan failed to indicate what the potential Resident specific triggers were for PTSD and failed to indicate what interventions would mitigate or decrease the effect of the trigger for PTSD. During an interview on 9/12/24, at 8:50 A.M., Director of Nursing (DON) #1 said that Resident #47's PTSD care plan was not complete, and resident centered. The DON said that the PTSD care plan should include the triggers and the interventions required to help the Resident once a PTSD episode has been triggered. During an interview on 9/12/24 at 11:43 A.M., the MDS Nurse said that care plans are to be resident specific with resident specific interventions.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48990 Based on record review and interview, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to meet the facility-determined minimum for certified nurse assistant (CNA) staff on the weekends. Findings Include: During the Resident Group interview on 9/10/24 at 1:00 P.M., the Resident Group expressed concern about certified nurse assistant (CNA) staffing. The Resident Group said they do not feel there is enough CNAs, and they often must wait too long for their call lights to be answered. On 9/11/24 at 1:50 P.M., the Chief Nursing Officer (CNO) said there was no facility assessment for the facility. The CNO gave the surveyor a list of current staffing needs for direct care staff. The CNO said this does not include any supervisors. The CNO said the following staffing was determined to be necessary based on the facility needs since at least April 1, 2024: *Nurses - 7-3: 2 - 3-11: 2 - 11-7: 2 *CNAs - 7-3: 5 - 3-11: 4.5 - 11-7: 2 During offsite preparation, the CASPER Payroll-Based Journal (PBJ) Staffing Data Report submitted by the facility for fiscal year (FY) Quarter 3, 2024 (April 1 - June 30) was reviewed. The facility's report triggered that the facility reported excessively low weekend staffing. Review of the weekend staff schedule, dated April 1, 2024 to June 30, 2024, indicated that the facility was staffed below their determined minimum necessary CNAs for 20 weekend shifts. On these days there were no additional nurses scheduled who could assist with CNA duties. The weekend staff schedules indicated the following staffing during this quarter: - Sunday April 7th, 2024: only 4 CNAs on 7-3, but should be 5. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Sunday April 7th, 2024: only 1 CNA on 11-7, but should be 2. - Saturday April 13th, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday April 14th, 2024: only 3 CNAs on 7-3, but should be 5. - Saturday April 20th, 2024: only 2 CNAs on 7-3, but should be 5. - Saturday April 20th, 2024: only 4 CNAs on 3-11, but should be 4.5. - Sunday April 21st, 2024: only 2 CNAs on 3-11, but should be 4.5. - Sunday May 5th, 2024: only 3 CNAs on 3-11, but should be 4.5. - Saturday May 11th, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday May 12, 2024: only 4 CNAs on 3-11, but should be 4.5. - Sunday May 19, 2024: only 4 CNAs on 3-11, but should be 4.5. - Saturday June 1, 2024: only 4 CNAs on 3-11, but should be 4.5. - Sunday June 2, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday June 2, 2024: only 4 CNAs on 3-11, but should be 4.5. - Saturday June 8, 2024: only 4 CNAs on 3-11, but should be 4.5. - Sunday June 9, 2024: only 4 CNAs on 7-3, but should be 5. - Saturday June 15, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday June 16, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday June 16, 2024: only 4 CNAs on 3-11, but should be 4.5. - Sunday June 23, 2024: only 4 CNAs on 7-3, but should be 5. Further review of the weekend staff schedules, dated July 1, 2024 to September 1, 2024, continued to indicate the facility was staffed below their determined minimum necessary CNAs on 16 weekend shifts. On these days there were no additional nurses scheduled who could assist with CNA duties. The weekend staff schedules indicated the following staffing: - Saturday July 6, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday July 7, 2024: only 3 CNAs on 7-3, but should be 5. - Sunday July 7, 2024: only 3 CNAs on 3-11, but should be 4.5 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Saturday July 13, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday July 14, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday July 14, 2024: only 3 CNAs on 3-11, but should be 4.5. - Sunday July 14, 2024: only 1 CNA on 11-7, but should be 2. - Sunday July 21, 2024: only 4 CNAs on 7-3, but should be 5. - Sunday July 21, 2024: only 4 CNAs on 3-11, but should be 4.5 - Saturday July 27, 2024: only 4 CNAs on 3-11, but should be 4.5 - Saturday August 10, 2024: only 4 CNAs on 7-3, but should be 5. - Saturday August 10, 2024: only 4 CNAs on 3-11, but should be 4.5. - Saturday August 10, 2024: only 1 CNA on 11-7, but should be 2. - Sunday August 11, 2024: only 3 CNAs on 7-3, but should be 5. - Saturday August 31, 2024: only 4 CNAs on 3-11, but should be 4.5 - Sunday September 1, 2024: only 4 CNAs on 3-11, but should be 4.5. During an interview on 9/12/24 at 1:32 P.M., CNA #5 said the CNAs do the best they can, but they often can't get to everything when they are short staffed. CNA #5 said the facility's CNA staffing was the worst during April 2024 to June 2024 on the weekends. CNA #5 said it has gotten better since the facility started with a new agency, but they still struggle at times. CNA #5 said even with fully staffed ratios it's hard to get everything needed done. During an interview on 9/12/24 at 1:36 P.M., CNA #6 said CNA staffing was really bad on weekends during April 2024 to June 2024, but it's getting better. CNA #6 said it was often because the CNAs from an agency they used to have would call out, but it's been getting better since they changed staffing agencies. During an interview on 9/12/25 at 8:39 A.M., Nurse #5 said there is often not enough CNAs scheduled to support the nurses across all shifts. Nurse #5 said it's been better since the facility changed staffing agencies, but the nurses still can't get all required duties completed because there aren't enough CNAs. Nurse #5 said its specifically hard to get their documentation, paperwork, and care plans updated, even when the suggested staffing ratios are met and that she had often expressed this to management. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/12/24 at 7:31 A.M., the scheduler said the staffing ratios the CNO gave the surveyor were accurate and had been the needed staffing ratios since at least April 2024. The scheduler said sometimes staff complains there isn't enough staff, and the facility will attempt to get more staff when the acuity is higher, but the ratios given were the minimum needed. The scheduler said she was aware that the facility triggered for low weekend staffing and it sounds accurate that during that time there were at least 20 weekend shifts without enough CNA staff working because they couldn't replace the call outs or just didn't have enough CNAs. During an interview on 9/12/24 at 10:01 A.M., the Director of Nursing (DON) #1 said he was aware the facility triggered for low weekend staffing during the quarter of April 1, 2024 to June 30, 2024. DON #1 said during that quarter there was insufficient staffing on the weekends, and they hired more staff and changed staffing agencies. DON #1 said even with those changes it's still difficult to staff CNAs at times.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 48990 Based on observations and interviews, the facility failed to post nurse staffing information, which included the date, facility name, total number of hours worked for licensed and unlicensed staff, and the resident census number, on a daily basis in a prominent place readily accessible to residents and visitors. Findings include: Review of the facility policy titled Nurse Staffing Posting Information, dated 3/4/24, indicated: 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility Name b. The current date c. Facility's current resident census d. The total number and the actual hours worked by the follow categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides 2. The facility will post the Nurse Staffing Sheet at the beginning of the shift. 3. The information posted will be in a prominent place readily available to residents and visitors. On 9/10/24 at 7:02 A.M., upon entering the reception area of the facility, the surveyor was unable to locate nurse staffing information. During subsequent observations made upon entrance to the reception area on 9/10/24 at 3:35 P.M. and 9/12/24 at 9:55 A.M., the surveyor was unable to locate nurse staffing information. During an interview on 9/12/24 at 10:55 A.M., the Scheduler said she was responsible for posting nurse staffing information at the beginning of her shift in the reception area. The Scheduler said she forgot to post it today (9/12/24). The Scheduler said nurse staffing information is not posted on days she doesn't work, and since she was off on 9/10/24, it was not posted on 9/10/24. The Scheduler said the nurse staffing information is not posted on weekends because there isn't anyone else that was assigned the responsibility to do it. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 9/12/24 at 10:01 A.M., the Director of Nursing (DON) #1 said nurse staffing information should be posted daily every morning at reception, even on weekends.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43807 Based on interviews and record review, the facility failed to provide Substance Abuse Services for one Resident (#47) out of a sample of 17 Residents, and additionally failed to provide Substance Abuse Services for 6 additional Residents identified by the Social Worker. Findings include: A review of the facility policy titled 'Safety for Residents with Substance Abuse Disorder' with a revision date of 3/4/24 indicated the following: -It is the policy of this facility to create an environment that is free of accident hazards as possible, for residents with a history of substance use disorder. -Substance use disorder is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. 7. The facility will make an effort to prevent substance use which may include providing substance use treatment services, such as behavioral health services, medication-assisted treatment (MAT), alcoholic/narcotics anonymous meetings, working with the resident and the family, if appropriate, to address goals related to their stay in the nursing home, and increased monitoring and supervision. Resident #47 was admitted to the facility in August 2024 with diagnoses including bipolar disorder, post traumatic stress disorder and borderline personality disorder. A review of the 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. Review of the medical record indicated Resident #47's most recent behavioral medication management progress note. The progress note dated 8/14/24 indicated the Resident has a history of using substances such as heroin and alcohol. During an interview on 9/12/24 at 11:19 A.M., Resident #47 said he/she has a history of ingesting heroin and alcohol. He/she said he/she last ingested heroin and alcohol eight months ago. The Resident said he/she participated in Alcoholic Anonymous (AA)/ Narcotics Anonymous (NA) meetings in the community, so he/she wanted to continue those services while in the facility. The Resident said no one in the facility has offered AA/NA services until today. During an interview on 9/12/24 at 9:21 A.M., the Social Worker said the facility does not offer any AA/NA services for residents with a history of substance use. She provided the surveyor a list of six additional Residents in the facility with a history of alcohol, narcotics and marijuana use. The Social worker said none of these residents have been offered AA/NA services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review, policy review and interview, the facility failed to ensure recommendations from the Monthly Medication Reviews (MMRs) conducted by the consultant pharmacist were addressed and acknowledged by the physician in a timely manner for two Residents (#33 and #47) out of a total sample of 17 residents. Findings Include: Review of the facility policy titled Documentation and Communication of Consultant Pharmacist Recommendations dated 10/1/19, indicated that comments and recommendations concerning medication therapy are communicated in a timely fashion. Further review indicated that in the event that a problem requiring the immediate attention of the prescriber, the responsible prescriber is contacted by the consultant pharmacist or the facility, and the prescriber response is documented on the consultant pharmacist review record or elsewhere is the medical record. 1.) Resident #33 was admitted to the facility in April 2023 with diagnoses including but not limited to dementia and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #33 is severely cognitively impaired and is totally dependent for activities of daily living. Review of the Federal Drug Association (FDA) document Reference ID: 4029608, indicated that the initial Ativan dose for the elderly should not exceed 2 mg. Review of the doctor's order dated September 2024 indicated a new order for Ativan (an anti-anxiety, benzodiazepine medication) 5 mg. (milligrams) PRN (as needed) dated as initiated 7/26/24. Review of the MMR dated 8/18/24, indicated a request to the doctor for clarification of the Ativan dose. Review of the medical record failed to indicate the doctor was made aware of the MMR recommendation and failed to indicate a response to the MMR. 2.) Resident #47 was admitted to the facility in August 2024 with diagnoses including post-traumatic stress disorder (PTSD), hemiplegia and diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review indicated Resident #47 required assistance with most activities of daily living. Review of the doctor's orders dated August 2024 indicated an order for Zetia (a cholesterol lowering medication) 10 mg. Give 10 mg by mouth one time a day for Diabetes. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MMR dated 8/18/24, indicated a request to the doctor for clarification of the of the diagnosis for the use of the medication Zetia. During an interview on 9/10/24 at 4:38 P.M., Director of Nursing #1 (DON) said that the pharmacist reviewed all residents on 8/18/24. DON #1 then said that he was unable to locate any of the MMR's from 8/18/24, or any of the responses by the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to indicate the duration of a PRN (as needed) psychotropic medication for one Resident (#23) out of a sample of 17 residents. Specifically, the facility failed to indicate the duration of a PRN (as needed) antipsychotic medication. Findings include: A review of the facility policy titled 'Use of Psychotropic Medication', with a revision date of 3/4/24, indicated the following: - PRN orders for all psychotropic drugs shall be used only when the medications is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). - If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration of the PRN order. Resident #23 was admitted to the facility in July 2024 with diagnoses including borderline personality disorder, suicidal ideations, major depression disorder and opioid abuse. A review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating intact cognition. A review of Resident #23's September 2024 physician's orders indicated the following: - Olanzapine oral tablet (an antipsychotic medication) 5 milligrams, give 1 tablet by mouth every 24 hours as needed for agitation. Start date 8/27/24. A review of the September Medication Administration Record (MAR) indicated the PRN Olanzapine was administered on 9/5/24. A review of the Behavioral health note, dated 9/4/24, indicated the following recommendation made by the Psychiatric Nurse Practitioner. - Recommend discontinuing PRN Zyprexa; antipsychotics can't be PRN unless scheduled. During a telephone interview on 9/16/24 at 1:07 P.M., the Psychiatric Nurse Practitioner said she made the recommendation for the PRN Zyprexa to be discontinued or scheduled if the Resident required the antipsychotic medication. She said after writing the recommendation, she emailed the Director of Nurses (DON) #1 after her visit on 9/4/24. She said she has a list of facility staff recipients' emails that get a copy of her progress notes after her visit, so she expects any recommendations she makes to be reviewed as soon as possible. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/24 at 9:32 A.M., DON #1 said psychiatric recommendations made by the Psychiatric Nurse Practitioner should be reviewed within 24 hours and if the physician is in agreement with the recommendations, they should be addressed within the same time period. DON #1 said PRN antipsychotics should have a stop date of 14 days, and if the PRN antipsychotic needs to be extended beyond the 14 days, there should be a rationale documented in the medical record by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36797 Based on observation, policy review and interview, the facility failed to ensure nursing staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically, the facility failed to properly secure the medication room on two of two units. Findings include: Review of the facility policy titled Medication Storage, dated 3/4/24, indicated that all drugs and biological's will be stored in locked compartments (i.e. medication rooms). Further review of the policy indicated that only authorized personnel will have access to the keys to the locked compartments. On 9/10/24 at 8:33 A.M., the surveyor observed the medication room on the first floor open. The surveyor also observed that no staff were present within eyesight of the open medication room. On 9/11/24, at 7:51 A.M., the surveyor observed the medication room on the second floor open. The surveyor also observed that no staff were present within eyesight of the open medication room. During an interview on 9/11/24 at 8:11 A.M. Nurse #1 said she left the medication room open after she went in to get masks. Nurse #1 said that it was a mistake to leave the door unlocked and open. Nurse #1 said the medication door should never be left open.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on record reviews and interviews the facility failed to ensure they provided laboratory services to meet the needs of its residents. Specifically, the facility failed to: 1.) Maintain a current Clinical Laboratory Improvement Amendment (CLIA) certificate appropriate for the level of testing performed within the facility, and 2.) For Resident #19 the facility failed to obtain an albumin level (a test that can help determine liver disease or kidney disease, or if the body is not absorbing enough protein). Findings include: 1.) On [DATE] at 8:30 A.M., during the entrance conference the surveyor requested the facility's CLIA certificate. Review of the facility policy titled, Laboratory Testing Waivers, dated [DATE], indicated the facility will ensure that laboratory services are provided to its residents in a manner that meets State and Federal regulations. 1. An application for a Clinical Laboratory Improvement Amendments (CLIA) will be made through the appropriate State agency for services that are categorized as waived under their requirements, i.e. bedside glucose testing 2. An agreement to provide laboratory services will be maintained with an off-site qualified laboratory to provide all other lab services. 3. The facility will assume responsibility to obtain services that meet professional standards and timeliness of the services. During an interview on [DATE] at 12:05 P.M., the Administrator #1 said that the facility did not have a current CLIA certificate but should. The Administrator #1 provided the surveyor with a CLIA certificate dated as expired [DATE] and the following document titled CLIA Laboratory User Fees dated [DATE], which indicated the payment was due by [DATE], for a CLIA renewal certificate period [DATE] to [DATE]. During an interview on [DATE] at 1:00 P.M. the Regional Nurse said there were 7 residents who required blood glucose monitoring. The Regional Nurse said the CLIA certificate should have been renewed but was not. 2.) Resident #19 was admitted to the facility in [DATE] with diagnoses including dementia, dysphagia, and osteoarthritis. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Laboratory Services and Reporting, dated [DATE], indicated the facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. 1. The facility must provide or obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services. 6. All laboratory reports will be dated and contain the name and address of the testing laboratory and will be filed in the resident's clinical record. Review of Resident #19's physician's order, dated [DATE], indicated: - Check Albumin level next lab day [DATE]. On [DATE] at 12:30 P.M., the surveyor was unable to locate the results of the albumin level from [DATE] in the electronic health record or in the paper medical record. The surveyor requested the results from the facility. During an interview on [DATE] 10:01 A.M., Director of Nursing (DON) #1 said that Resident #19's albumin level was not obtained but should have been. During an interview on [DATE] at 12:04 P.M., the Regional Nurse said that they were unable to locate the results of the lab from [DATE]. The Regional Nurse said that nursing should have notified the laboratory service provider to perform the test but did not.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 43807 Based on observations, interviews and facility assessment review, the facility failed to have sufficient number of staff to effectively carry out the function of food and nutrition services. Findings include: A review of the Facility assessment dated /completed on 9/12/24 indicated the following: -Dietary-270 hours. On 9/10/24 at 7:08 A.M., the surveyor observed [NAME] #1 in the kitchen preparing breakfast for the residents. During an interview on 9/10/24 at 7:10 A.M., [NAME] #1 said there should be at least three staff in the kitchen on each shift, he said he is trying to get a Dietary staff to come in and work with him. [NAME] #1 said they have not had a Food Service Director for a while, he said one was hired but she is still in orientation. On 9/11/24 at 7:32 A.M., the surveyor observed Dietary staff #1 and Dietary staff #3 in the kitchen preparing breakfast. During an interview on 9/11/24 at 7:35 A.M., Dietary staff #1 said they never have enough staff in the kitchen. She said they should at least have three staff on each shift. On 9/11/24 at 11:25 A.M., the surveyor observed Dietary Staff #4 and [NAME] #2 in the kitchen preparing lunch. During interviews on 9/11/24 at 11:30 A.M., Dietary staff #4 and [NAME] #2 said they should have three staff working in the kitchen on each shift, but they never do. During a schedule review and interview on 9/12/24 at 1:20 P.M., the surveyor and Dietary staff #1 reviewed the 6:00 A.M.-2:00 P.M. August and September 2024 Dietary staff and [NAME] schedule. Dietary staff #1 said the following Dietary staff and Cooks worked on the following days: -8/18/24-Dietary staff #1 and [NAME] #1. -8/20/24-Dietary staff#1 and Dietary staff #6. -8/21/24-Dietary staff #1 and Dietary staff #6. -8/22/24-Dietary staff #1 and Dietary staff #6. -8/23/24-Cook #1 and Dietary staff #6. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/24/24-Dietary staff #1 and #Cook #1. -8/25/24-Dietary staff #1 and #Cook #1. -8/27/24-Cook #1 and Dietary staff #6. -8/28/24-Dietary staff #1 and Dietary staff #6. -9/1/24-Dietary staff #1 and [NAME] #1. -9/3/24- [NAME] #2 and Dietary Staff #6. -9/7/24- [NAME] #1 and Dietary staff #6. -9/10/24-Cook #1 and Dietary staff #3. -9/11/24-Dietary staff #1 and Dietary staff #3. During the Resident Council meeting held on 9/11/24 at 10:36 A.M., one out of the thirteen residents who attended the Resident council meeting said the kitchen does not have enough staff to wash dishes, as a result the meals are served on styrofoam dishes. During an interview on 9/11/24 at 11:35 A.M., the Food Services Director said the kitchen should have a total of three staff, 2 Dietary staff and one [NAME] on each shift. During an interview on 9/12/24 at 12:53 P.M., the Regional Nurse and the Administrator said the kitchen should be staffed with three staff on each shift according to the facility assessment. During a telephone interview on 9/17/24 at 12:24 P.M., the Administrator said there should be two Dietary staff and one [NAME] during each shift in the kitchen. He said the Dietary staff can work as Dietary staff or Dishwasher, but the [NAME] should always remain a cook. He said the facility assessment hours are divided as follows, [NAME] hours-120 hours, Dietary staff hours-150 hours, a total of 270 hours, not including the Food Services Director's 40 hours.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 44095 Based on observations, staff interviews, and record review, the facility failed to ensure that staff accommodated food preferences for four Residents (#17, #14, #2, and #10), out of a total sample of 17 residents. Specifically, 1.) For Resident #17, the facility failed to honor the Resident's preferences and served the Resident foods that he/she disliked, including eggs. 2.) For Resident #14, the facility failed to honor the Resident's preferences and served the Resident foods that he/she disliked, including eggs. 3.) For Resident #2, the facility failed to honor the Resident's preferences and served the Resident foods that he/she disliked, including ham. 4.) For Resident #10, the facility failed to honor the Resident's preferences. Findings include: Review of the facility policy titled Menus and Adequate Nutrition, dated 3/4/24, indicated: - The purpose of this policy is to assure menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs, while using established guidelines. 4. Menus must reflect input from residents and resident groups: 1. Resident Preferences, including likes and dislikes will be documented in the resident's chart, and shall be reviewed when planning menus. Review of the facility policy titled Food Preference Record, dated January 2013, indicated: - Obtain the following information and record in the appropriate section on the form: allergies, beverage preferences at each meal, dislikes by food group. - Complete the Food Preference Record by interviewing a family member or responsible party if the resident is unable to be interviewed. - Transfer appropriate information to the computerized diet system in the kitchen. 1.) Resident #17 was admitted to the facility in November 2017 with diagnoses including dementia and dysphagia. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 8/14/24, indicated that Resident #17 had a severe cognitive impairment, rarely/never understood. This MDS indicated Resident #17 required a mechanically altered diet and was dependent for eating. On 9/10/24 at 8:58 A.M., 9/11/24 at 8:28 A.M., and on 9/12/24 8:20 A.M., the surveyor observed nursing feeding Resident #17 eggs for breakfast. Review of Resident #17's on 9/10/24 at 8:58 A.M., 9/11/24 at 8:28 A.M., and on 9/12/24 8:20 A.M., diet slip indicated: - dislikes eggs. During an interview on 9/12/24 at 8:22 A.M., Nurse #2 was assisting Resident #17 with his/her breakfast. Nurse #2 was feeding Resident #17 scrambled eggs. Nurse #2 reviewed the diet slip and said that Resident #17 has a dislike listed as eggs. During an interview on 9/12/24 at 9:50 A.M., Certified Nurse Assistant #4 said she has been caring for Resident #17 for years and Resident #17 should not get eggs because he/she doesn't like them. During an interview on 9/12/24 at 8:42 A.M., the Food Service Director said the kitchen should honor Resident #17's food preferences. She said the diet aide calling out the food preferences during the food tray line should follow Resident preferences. During an interview on 9/12/24 at 12:15 P.M., the Clinical Nurse said nursing should review the diet slips for dislikes. 48990 2.) Resident #14 was admitted to the facility in August 2024 with diagnoses including adult failure to thrive and malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/6/24, indicated Resident #14 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. On 9/11/24 at 8:29 A.M., the surveyor observed Resident #14 sitting in front of his/her breakfast tray. Resident #14 said he/she was very upset because his/her tray is wrong. Resident #14 said his/her tray is always wrong and no matter how many times he/she tells staff, it never gets better. The menu slip on Resident #14's breakfast tray indicated it should contain oatmeal, 2 creamers, 2 coffees, and orange juice. The menu slip indicated Resident #14 disliked eggs. This breakfast tray contained scrambled eggs, one cup of coffee, one creamer. Resident #14 said he/she hates the eggs served at the facility and does not want them. The meal tray failed to have oatmeal, second creamer, the second cup of coffee, and orange juice on it. Resident #14 said every day he/she goes to remind staff about the oatmeal, two cups of coffee, and two creamers before the tray comes because it never comes. Resident #14 said it takes over an hour to get the oatmeal and coffee when he/she requests it. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 9/11/24 at 11:28 A.M., Resident #14 said his/her food preferences are rarely honored. Resident #14 said that some of his/her preferences for breakfast, such as oatmeal and having two coffees, are listed on his/her meal slip because of multiple past complaints to staff. Resident #14 said staff never asks what he/she would like for a meal and is never offered an alternative. Resident #14 said he/she has not received what was indicated on the menu slip for any meals for over a week. Resident #14 said the oatmeal he/she was missing this morning took over an hour to come and it was cold, so he/she didn't eat it. Resident #14 said he/she is not eating enough because they send him/her things he/she doesn't like. Resident #14 said he/she wished the facility would allow him/her to be involved in his/her menu plan. On 9/12/24 at 8:36 A.M., the surveyor observed Resident #14 sitting in front of his/her breakfast tray. The menu slip on Resident #14's breakfast tray indicated it should contain 2 coffees and 2% milk. The breakfast tray contained one cup of coffee and fat-free milk. Resident #14 said his/her tray was incorrect because it was missing the second cup of coffee and had fat-free milk instead of skim milk. Resident #14 said he/she prefers to have two cups of coffee because one isn't enough, and it takes over an hour to get the second cup if he/she has to request it. On 9/12/24 at 12:18 P.M., the surveyor observed Resident #14 sitting in front of his/her lunch tray. The menu slip failed to indicate a selection for lunch meal. The lunch meal tray contained spaghetti with red sauce, spinach, garlic bread, and peaches. Resident #14 said he/she had told staff many times in the past that he/she didn't want spaghetti because it had no nutritional value. Resident #14 said he/she heard some other residents were being served ham and asked the surveyor to ask the staff to order him/her the ham because it's one of his/her favorites and needed more protein in his/her diet. Resident #14 said staff never asked what meal he/she would like, but wished they would have. During an interview on 9/11/24 at 12:08 P.M., Certified Nurse Assistant (CNA) #3 said menus are determined based on what the residents select with a staff member comes to complete menu selection with each resident. CNA #3 said each resident should receive what they order, but they often don't because the kitchen is missing a lot of items. During an interview on 9/11/24 at 12:35 P.M., The Activities Director said the kitchen had been responsible for completing the menu selection for the past two months, but she had not seen it being done in weeks. The Activities Director said she often hears that residents are upset because the receive incorrect or missing food or beverages. The Activities Director said sometimes staff must call multiple times and the food orders still doesn't come. During an interview on 9/12/24 at 8:42 A.M., Nurse #5 said the nurses are responsible for checking menu slips to ensure the correct items are on each resident's tray. Nurse #5 said if it doesn't match, they are supposed to call down to the kitchen. Nurse #5 said activities staff is responsible for meeting with each resident for menu selection, and that is how specific food preferences are communicated to the kitchen. Nurse #5 said resident meal preferences should be honored. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/12/24 at 9:05 A.M., the Food Service Director (FSD) and Dietary Staff #1 said activities is responsible for menu selection, but they don't have time so it's not being done. The FSD and Dietary Staff #1 said all items listed on the menu slips should be available except in rare cases. The FSD and Dietary Staff #1 said coffee, creamers, and oatmeal have been available and are not sure why they were not provided to the Resident. The FSD and Dietary Staff #1 said residents should not be served items listed on their ticket as dislikes such as eggs. The FSD and Dietary Staff #1 said food preferences need to be honored, and without the menu selection the kitchen isn't aware of what preferences residents have but should be. During an interview on 9/12/24 at 10:25 A.M., the Director of Nursing (DON) #1 said meal preferences should be honored and that meals served should match what is on the menu slip. DON #1 said each resident should have been involved in their menu selection for every meal. During an interview on 9/12/24 at 10:50 A.M., the Dietitian said she had noticed menu slips not matching what was served the residents. The Dietitian said residents should not be served items listed on their ticket as dislikes such as eggs. The Dietitian said meals served should match what is on the menu slip and meal preferences should be always honored to the best of the facilities ability, not just for medically necessary reasons. 3.) Resident #2 was admitted to the facility in August 2017 with diagnoses including sleep apnea (a respiratory condition in which your breathing stops and restarts many times while you sleep) and asthma. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated Resident #2 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 9/11/24 at 8:23 A.M., the surveyor observed Resident #2 sitting on the side of his/her bed and said he/she had just finished eating breakfast. Resident #2 said he/she didn't get yogurt, banana, tea or diet ginger ale, but instead got a thickened yellow colored liquid that he/she did not want to drink. On 9/11/24 at 8:25 A.M., the surveyor observed Resident #2's breakfast tray in the hallway adjacent to his/her room with a menu slip on it indicating his/her name. The menu slip on Resident #2's breakfast tray indicated it should contain a yogurt, banana, tea and diet ginger ale. The tray did not show any packaging or evidence that those items were on the plate but did contain a full glass of a thickened yellow colored liquid. During a follow up interview on 9/11/24 at 11:21 A.M., Resident #2 said he/she has repeatedly asked to be served a banana every morning because he/she is worried about his/her potassium level but hasn't been served a banana in over a month even though it's on his/her slip. Resident #2 also said he/she has asked staff for yogurt repeatedly because he/she really likes it but hasn't been served yogurt for over a month. Resident #2 said his/her menu slip often does not match what he/she is served, and when he/she asks staff for it often doesn't come. Resident #2 said they always send the standard menu option. Resident #2 said the staff hasn't asked about menu selection for in at least 3 weeks but wishes that the facility would start doing it again because his/her meal preferences are not being honored. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brigham Health and Rehabilitation Center	77 High Street Newburyport, MA 01950

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at 8:11 A.M., the surveyor observed Resident #2 sitting in front of his/her breakfast tray. The menu slip indicated Resident #14's tray should contain a banana. The meal tray failed to include a banana. Resident #2 said he/she really wanted the banana and nobody could give him/her a reason as to why he/she never gets a banana. On 9/12/24 at 12:25 P.M., the surveyor observed Resident #2 sitting in front of his/her lunch tray which did not contain a plate of food and only beverages. Resident #2 said he/she had to send the lunch meal back because it was ham, and he/she can't eat ham. Resident #2 showed the surveyor the menu slip on the tray he/she was served, which indicated dislikes ham. Resident #2 said he/she had not been asked which meal he/she would like for lunch, but would have selected the spaghetti, which was the alternative, and was waiting for it to arrive. During an interview on 9/11/24 at 12:08 P.M., Certified Nurse Assistant (CNA) #3 said menus are determined based on what the residents select with a staff member comes to complete menu selection with each resident. CNA #3 said each resident should receive what they order, but they often don't because the kitchen is missing a lot of items. During an interview on 9/11/24 at 12:35 P.M., The Activities Director said the kitchen had been responsible for completing the menu selection for the past two months, but she had not seen it being done in weeks. The Activities Director said she often hears that residents are upset because the receive incorrect or missing food or beverages. The Activities Director said sometimes staff must call multiple times and the food orders still doesn't come. The Activities Director said yogurt is available, but often not sent. The Activities Director said bananas have not been readily available and there have been numerous complaints about that. During an interview on 9/12/24 at 8:42 A.M., Nurse #5 said the nurses are responsible for checking menu slips to ensure the correct items are on each resident's tray. Nurse #5 said if it doesn't match, they are supposed to call down to the kitchen. Nurse #5 said activities staff is responsible for meeting with each resident for menu selection, and that is how specific food preferences are communicated to the kitchen. Nurse #5 said resident meal preferences should be honored. During an interview on 9/12/24 at 9:05 A.M., the Food Service Director (FSD) and Dietary Staff #1 said activities is responsible for menu selection, but they don't have time so it's not being done. The FSD and Dietary Staff #1 said all items listed on the menu slips should be available except in rare cases. The FSD and Dietary Staff #1 said bananas, yogurt, and diet ginger ale have been available and are not sure why they were not provided to the Resident. The FSD and Dietary Staff #1 said residents should not be served items listed on their ticket as dislikes such as ham. The FSD and Dietary Staff #1 said food preferences need to be honored, and without the menu selection the kitchen isn't aware of what preferences residents have but should be. During an interview on 9/12/24 at 10:25 A.M., the Director of Nursing (DON) #1 said meal preferences should be honored and that meals served should match what is on the menu slip. DON #1 said each resident should have been involved in their menu selection for every meal. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/12/24 at 10:50 A.M., the Dietitian said she had noticed menu slips not matching what was served the residents. The Dietitian said residents should not be served items listed on their ticket as dislikes such as ham. The Dietitian said meals served should match what is on the menu slip and meal preferences should be always honored to the best of the facilities ability, not just for medically necessary reasons. 4.) Resident #10 was admitted to the facility in December 2021 with diagnoses including a history of stroke and congestive heart failure. Review of the Minimum Data Set (MDS) assessment, dated 7/12/24, indicated Resident #10 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 9/11/24 at 7:43 A.M., the surveyor observed Resident #10 eating breakfast. Resident #10 said his/her tray is always wrong and his/her food preferences are not honored. The menu slip on Resident #10 breakfast tray indicated it should contain a banana, cheerios, and yogurt. The breakfast tray failed to have a banana, cheerios, or yogurt on it. On 9/12/24 at 8:25 A.M., the surveyor observed Resident #10 eating breakfast. The menu slip on Resident #10 breakfast tray indicated it should contain a banana and wheat toast. The breakfast tray failed to have a banana and wheat toast on it. During a follow up interview on 9/12/24 at 11:34 A.M., Resident #10 said every tray he/she had received in the past week has been either incorrect or missing an item. Resident #10 said he/she has not filled out a menu selection form for over a month, and even then, he/she did not get the correct items. Resident #10 said when he/she asks for yogurt and bananas he/she is told they are too expensive. On 9/12/24 at 12:19, the surveyor observed Resident #10 with a lunch tray in front of him/her. Resident #10 said he/she didn't have an option to choose what he/she would like for lunch and received spaghetti so he/she ate it, and it was okay, but wished he/she was able to choose what he/she would like to eat. During an interview on 9/11/24 at 12:08 P.M., Certified Nurse Assistant (CNA) #3 said menus are determined based on what the residents select with a staff member comes to complete menu selection with each resident. CNA #3 said each resident should receive what they order, but they often don't because the kitchen is missing a lot of items. During an interview on 9/11/24 at 12:35 P.M., the Activities Director said the kitchen had been responsible for completing the menu selection for the past two months, but she had not seen it being done in weeks. The Activities Director said she often hears that residents are upset because the receive incorrect or missing food or beverages. The Activities Director said sometimes staff must call multiple times and the food orders still doesn't come. The Activities Director said yogurt and cheerios are available, but often not sent. The Activities Director said bananas have not been readily available and there have been numerous complaints about that. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/12/24 at 8:42 A.M., Nurse #5 said the nurses are responsible for checking menu slips to ensure the correct items are on each resident's tray. Nurse #5 said if it doesn't match, they are supposed to call down to the kitchen. Nurse #5 said activities staff is responsible for meeting with each resident for menu selection, and that is how specific food preferences are communicated to the kitchen. Nurse #5 said resident meal preferences should be honored. During an interview on 9/12/24 at 9:05 A.M., the Food Service Director (FSD) and Dietary Staff #1 said activities is responsible for menu selection, but they don't have time so it's not being done. The FSD and Dietary Staff #1 says all items listed on the menu slips should be available except in rare cases. The FSD and Dietary Staff #1 said bananas, yogurt, and cheerios have been available and are not sure why they were not provided to the Resident. The FSD and Dietary Staff #1 said food preferences need to be honored, and without the menu selection the kitchen isn't aware of what preferences residents have but should be. During an interview on 9/12/24 at 10:25 A.M., the Director of Nursing (DON) #1 said meal preferences should be honored and that meals served should match what is on the menu slip. DON #1 said each resident should have been involved in their menu selection for every meal. During an interview on 9/12/24 at 10:50 A.M., the Dietitian said she had noticed menu slips not matching what was served the residents. The Dietitian said meals served should match what is on the menu slip and meal preferences should be always honored to the best of the facilities ability, not just for medically necessary reasons.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 44095 Based on observation, interviews, and record review, the facility failed to ensure that the physician ordered therapeutic diet was followed for one Resident (#34), in a total sample of 17 residents. Findings include: Review of the facility policy titled, Therapeutic Diet Orders, dated 3/4/24, indicated the facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. 1. Each resident's nutritional status is assessed by the interdisciplinary team in accordance with assessment policies. 2. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations, such as, but not limited to: a. Inadequate nutrition b. Nutritional deficits c. Weight loss d. Medical conditions such as diabetes, renal disease, or heart disease e. Swallowing difficulty 3. Therapeutic diets are provided only when ordered by the attending physician or a registered or licensed dietitian who has been delegated to write diet orders, to the extent allowed by state law. Should the attending physician delegate the prescribing of therapeutic diets, he or she will supervise the dietitian and remain responsible for the resident's care. 4. The reason for a therapeutic diet is to be documented in the medical record and/or indicated on the resident's comprehensive plan of care. All diet orders are to be communicated to the dietary department in accordance with facility procedures. 5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. Resident #34 was admitted to the facility in May 2024 with diagnoses including dysphagia (difficulty swallowing) and hemiplegia and hemiparesis following a cerebral infarction. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 8/15/24, indicated that Resident #34 had a tube feeding (a tube that goes directly into the stomach through the abdomen to administer liquid food) and was on a mechanically altered diet. Review of Resident #34's plan of care related to alteration in nutrition, dated as revised 6/3/24, indicated: - Diet as ordered Review of Resident #34's physician's order, dated 7/16/24, indicated: - Diet Modification order: Speech Language Pathologist (SLP) to recommend upgrade to Dysphagia Advanced solids; cleared to have bread/dry items. Continue thin liquids. Review of Resident #34's physician's order, dated 7/25/24, indicated: - Regular diet, dysphagia advanced texture, Thin Liquids consistency, for diet upgrade Review of Resident #34's diet resident detail on 9/10/24 at 4:49 P.M., indicated the following texture as Mech Soft On 9/10/24 at 4:49 P.M., the surveyor observed Resident #34 eating his/her evening meal. The following was provided to Resident #34: - breaded fish, ground up - Coleslaw, whole - French fries, whole crinkle cut - pineapple tidbits, whole During an interview on 9/11/24 at 9:30 A.M. Dietary Staff #1 said that about 2 weeks ago the kitchen changed food vendors and the kitchen staff had not been provided breakdowns for meals for the therapeutic diets. Dietary Staff #1 said she just goes with what she thinks residents should get based off memory of the old therapeutic diets. During an interview on 9/11/24 at 9:36 A.M., the Food Service Director said she only has the menus, and she did not have therapeutic diet breakdowns. During an interview on 9/11/24 at 2:00 P.M. the Chief Nursing Officer (CNO) provided the surveyor with a therapeutic breakdown for the evening meal on 9/10/24. The CNO said dietary should follow the therapeutic diets as ordered by the physician. The menu breakdown indicated Resident #34 should have received the following for dinner on 9/10/24: - soft plain baked minced fish mixed with lemon sauce, not breaded ground fish. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- carrots soft, minced, and drained, not coleslaw. - mashed potatoes, not French fries. - pureed fruit, not pineapple tidbits. During a follow up interview on 9/12/24 at 8:46 A.M., the Food Service Director said dietary staff should follow diet as ordered. During an interview on 9/12/24 at 11:57 A.M., the Regional Nurse said that the kitchen should follow therapeutic diets as ordered by the physician.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 44095 Based on observations, interviews, and review of the meal truck delivery schedule, the facility failed to offer a nourishing evening snack when there was greater than 14 hours between dinner and breakfast service. Findings include: Review of the facility policy titled, Frequency of Meals, dated 3/4/24, indicated the facility will ensure that each resident receives at least three meals daily without extensive time lapses. 1. The facility has scheduled three regular meal times, comparable to normal mealtimes in the community, per day and has scheduled three regular snack times. 3. There will be no more than 14 hours between an evening meal and breakfast the following day, unless a nourishing snack is served at bedtime; then, up to 16 hours may elapse between an evening meal and breakfast the following day if the resident council agrees to this meal time span. 5. Nutritious snacks and convenience foods (i.e., canned soups, peanut butter, crackers, cereal, and fruit) shall be available on the nursing units for those residents who request food outside scheduled meal and snack times. On 9/10/24 at 4:48 P.M., the surveyor observed the final food tray passed by facility staff from Cart #4 for the evening meal. Review of the Meal Truck Deliver Log, dated as current, indicated the following: -Dinner Start Time: 4:45 P.M., 2nd Floor Cart #1 at 4:55 P.M., 2nd Floor Cart #2 at 5:05 P.M., 1st Floor Cart #3 at 5:15 P.M., 1st Floor Cart #4 at 5:25 P.M., -Breakfast Start Time: 7:30 A.M., (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2nd Floor Cart #1 at 7:40 A.M., 14 hours and 45 minutes between a substantial evening meal and breakfast the following day. 2nd Floor Cart #2 at 7:50 A.M., 14 hours and 45 minutes between a substantial evening meal and breakfast the following day. 1st Floor Cart #3 at 8:00 A.M., 14 hours and 45 minutes between a substantial evening meal and breakfast the following day. 1st Floor Cart #4 at 8:10 A.M., 14 hours and 45 minutes between a substantial evening meal and breakfast the following day. During a Resident Group Meeting for the 2nd Floor held on 9/10/24 at 12:58 P.M., 4 of 4 residents said they sometimes were provided with an evening snack when they asked for it. Residents said there are no sandwiches, or peanut butter. Residents said that there are less snack choices since the change of ownership. During a Resident Group Meeting for the 1st Floor held on 9/11/24 at 10:36 A.M., 4 of 4 residents said they sometimes were provided with an evening snack when they asked for it. Residents said there are no sandwiches, or peanut butter. Review of the Food Committee Notes, dated 8/21/24, indicated the following: - Snacks need more soft cookies choices. On 9/10/24 at 10:00 A.M., the surveyor observed in the 1st Floor snack kitchenette to have no soft cookies and no peanut butter. During an interview on 9/12/24 at 11:04 A.M., Nurse #2 (who works the day and evening shifts) said dinner is served on the first floor unit before 5:00 P.M., Nurse #2 said the residents often complain about the lack of snack choices. During an interview on 9/12/24 at 8:07 A.M., Nurse #3 (who typically works the evening and overnight shift) said snacks include, crackers, peanut butter, and supplement shakes. Nurse #3 said that the kitchenette is not always stocked. During an interview on 9/12/24 at 8:53 A.M., the Food Service Director said there needs to be no more than 14 hours between a sustainable evening meal and breakfast the following the day. The Food Service Director said that the evening meal on 9/11/24 started at 4:30 P.M., and she would need to adjust the times. During an interview on 9/12/24 at 10:35 A.M., the Dietician said that the kitchen should follow the tray line delivery times and there should be substantial evening snacks available for residents when there is greater than 14 hours between dinner and breakfast the following day. During an interview on 9/12/24 at 12:11 P.M., the Administrator said meals should be served after 5:00 P.M. and there should be a substantial evening snack available on the units.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 44095 Based on observations, record review, and interviews, the facility failed to provide adaptive equipment for one Resident (#19) of 17 sampled residents. Specifically, the facility failed to ensure Resident #19 was consistently provided with a lip plate for use during his/her meals. Findings include: Review of the facility policy titled, Adaptive Feeding Equipment, dated 3/4/24, indicated that residents requiring assistance in feeding are potential candidates for a restorative dining program or adaptive utensil use, as determined by the occupational therapist. Any staff member may refer a resident for a program evaluation. 5. The dietary department should be notified of residents needing adaptive feeding equipment; the equipment is stored and maintained in the dietary department. Appropriate utensils should be placed on the resident's food tray, at each meal, and returned to the dietary department, on the food tray, for sanitization. Resident #19 was admitted to the facility in November 2020 with diagnoses including dementia, dysphagia, and osteoarthritis. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated that Resident #19 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of 15. This MDS indicated Resident #19 had experienced weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and received a mechanically altered diet. On 9/10/24 at 8:35 A.M., and 9/11/24 at 8:32 A.M., the surveyor observed Resident #19 being served breakfast without a lip plate. Review of Resident #19's physician's order, dated 4/14/23, indicated: - Lip plate on all meal trays. During an interview on 9/12/24 at 9:37 A.M., Certified Nurse Assistant (CNA) #4 said that the kitchen supplies Resident #19 his/her lip plate. During an interview on 9/12/24 at 11:02 A.M., Nurse #2 said that Resident #19's lip plate is provided by the kitchen. During an interview on 9/12/24 at 8:41 A.M., the Food Service Director said the lip plate should be provided by the kitchen. During an interview on 9/12/24 at 12:03 P.M., the Regional Nurse said the kitchen should provide Resident #19's lip plate.

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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. 43807 Based on observations, interviews and policy review, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to label and date food in the refrigerator, store food in the freezer with dates opened and expiration dates and failed to store food directly off the floor. Findings include: A review of the facility policy titled 'Storage' effective November 2013 indicated the following: -Policy-To store food in a safe manner. -Dry Storage 4. Store products on shelves no less than six inches from the floor. -Refrigerator Storage 1. Store perishable foods in the refrigerator. 6. Label products with delivery date indicating month and year the product was received. 8. Label all leftovers with recipe name and date (month, day, and year) of storage. -Freezer Storage 5. Label products with delivery date indicating month and year the product was received. On 9/10/24 at 7:20 A.M., the surveyor observed the following in the refrigerator in the kitchen: -Five heads of lettuce wrapped in plastic placed directly on the refrigerator shelf, and on top of a food container with leftovers, not labeled or dated. -Tomatoes and cabbages placed in aluminum trays, not labeled, or dated. -An unidentified Styrofoam bowl covered with leftovers, not labeled or dated. -Left over Tuna in an aluminum bowl, covered in saran wrap, not labeled, or dated. -Sliced tomatoes in an aluminum bowl, covered in saran wrap, not labeled, or dated. -Left over doughnut placed in a plastic bag, not labeled, or dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A water jug with sliced yellow lemons, not labeled or dated. On 9/10/24 at 7:20 A.M., the surveyor observed the following in the dry food storage: -Four packs of ginger ale on the floor. -2 boxes of frozen bread on the floor. -1 box of dinner rolls on the floor. -1 box of canned potato sweet cuts on the floor. -1 box of canned halved apricot cuts on the floor. -6 large cans of black beans on the floor. -1 box of ground coffee on the floor. On 9/10/24 at 7:41 A.M., the surveyor observed the following in the freezer in the dry food storage room: -A bag of frozen French toast in an open bag, not labeled or dated. -A bag of frozen steak fries in an open bag, not labeled or dated. -A bag of frozen cookie dough, in an open bag, not labeled or dated. During an interview and observation on 9/11/24 at 8:00 A.M., Dietary staff #1 and the surveyor walked through the kitchen and the dry food storage room. Dietary staff #1 said that she had to throw out all the food and vegetables in the refrigerator that was not labeled and dated, she said all the leftovers in the refrigerator should be labeled and dated, all the vegetables should be placed in labeled and dated containers. Dietary staff #1 said the dry food storage room should not have any food on the floor, she said the cartons of food on the floor were deliveries that no one put away. Dietary staff #1 said the frozen food in the freezer should have labels and dates and the bags containing the food should not be left open. During an interview on 9/11/24 at 12:23 P.M., the Food Services Director said all left overs, vegetables and frozen food should be labeled and dated. She said the dry storage room should not have containers of food on the floor.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brigham Health and Rehabilitation Center	77 High Street Newburyport, MA 01950

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 44095 Based on record review and interview the facility failed to annually conduct, review, and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Findings include: Review of the facility policy titled, Facility Assessment, dated as 3/4/24, indicated this facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. The purpose of this policy is to establish responsibilities and procedures for the facility assessment process. 4. The Administrator is responsible for ensuring the completion of the facility assessment and maintaining all documents that pertain to the assessment. The Administrator serves as the leader of the facility assessment process, or may designate someone to lead the process. 10. The facility assessment will be reviewed and updated as necessary and at least annually, whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment. Additionally, the facility will consider specific staffing needs for each shift (e.g., day, evening, night, weekend shifts) and for each resident unit in the facility based on changes to resident population. Any changes to the assessment will be documented, along with a revision history. On 9/10/24 at 8:30 A.M., during the facility entrance conference the surveyor requested a copy of the facility assessment. On 9/11/24 at 9:00 A.M., the surveyor requested the facility assessment from Administrator #1. During an interview on 9/11/24 at 12:00 P.M., Administrator #1 said he was unable to locate the facility assessment. Administrator #1 provided the surveyor a copy of the facility assessment dated [DATE], and said he was unable to locate any other facility assessments. During an interview on 9/12/24 at 12:50 P.M., Administrator #2 said she was responsible to conduct the facility assessment review, but she did not. Administrator #2 said she was employed by the facility for about 10 weeks and that facility assessments are required annually. Administrator #2 said she did not have access to any previous facility assessments during her time as the Administrator. Administrator #2 said that the Director of Operations was aware she did not have any previous copies of facility assessments and that she was unable to complete the facility assessment. During an interview on 9/12/24 at 1:15 P.M., the Director of Operations said that Administrator #2 was supposed to complete the facility assessment update, but she did not. The Director of Operations said that facility assessments are required to be completed annually but one was not completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on record review and interview the facility failed to ensure they maintained complete and accurate medical records for four Residents (#22, #2, #28, and #23) out of a total sample of 17 residents. Specifically: 1.) For Resident #22, the facility failed to document weights in the Electronic Health Record (EHR). 2.) For Resident #2, the facility nurses documented a broken BiPAP was being used, when it was not. 3.) For Resident #28, the facility failed to document services provided each shift by the Certified Nurse Aide (CNA). 4.) For Resident #23, the facility failed to document weights in the medical record. Findings include: Review of the facility policy titled Documentation in Medical Record, undated, indicated: - Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. - Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. - Documentation shall be completed at the time of services, but no later than the shift in which the assessment, observation, or care service occurred. - False information shall not be documented. A review of the facility policy titled 'Weight Monitoring' with a revision date of 3/4/24 indicated the following: -A weight monitoring schedule will be developed upon admission for all residents. -Newly admitted residents-monitor weight weekly for 4 weeks. 1.) Resident #22 was admitted to the facility in January 2024 with diagnoses including combined systolic and diastolic heart failure, pleural effusion, atrial fibrillation, and pulmonary hypertension. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 7/2/24, indicated that Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #22's weights recorded in the Electronic Health Record (EHR) indicated the following: - 8/8/24 143.6 pounds. Review of Resident #22's physician's order, dated 9/3/24, indicated: - Record weights on Mondays, Wednesdays, and Fridays x (times) 2 weeks every day shift (7:00 A.M. to 3:00 P.M.) for monitoring for 2 weeks. Review of Resident #22's Medication Administration Record, dated September 2024, indicated nursing implemented the physician's orders on the following dates 9/4/24, 9/6/24, and 9/9/24. However, there was no documentation to support that nursing staff documented Resident #22's weight in the EHR. During an interview on 9/12/24 at 9:36 A.M., Certified Nurse Assistant (CNA) #4 said Resident #22 is weighed Monday, Wednesday and Friday. CNA #4 said she reports these weights to the nurse on duty. CNA #4 said that monthly weights are reported on the weight sheet and then given to the nurse, but weekly or daily weights are verbally provided to the nurse. During an interview on 9/12/24 at 11:05 A.M., Nurse #2 said Resident #22 has an order for weights on Monday Wednesday and Friday, she said CNA's will obtain the weights and the nurse will put the weight value in the weight tab in the EHR. Nurse #2 said there would be no paper documentation of weights. During an interview on 9/12/24 at 12:00 P.M., the Regional Nurse said that weights should be documented in the EHR under the weights tab. 48990 2.) Resident #2 was admitted to the facility in August 2017 with diagnoses including sleep apnea (a respiratory condition in which your breathing stops and restarts many times while you sleep) and asthma. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated Resident #2 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #2 required non-invasive mechanical ventilator, which includes BiPAP. On 9/10/24 at 8:07 A.M., the surveyor observed Resident #2 being awoken from sleep by staff because his/her breakfast arrived. There was a BiPAP machine on a dresser across the room, not near Resident #2's bed. Resident #2 said he/she had not used the BiPAP in a few weeks because it was broken, but nursing staff knew and had told him/her they called to get it fixed. Resident #2 said he/she sleeps better when using the BiPAP and said he/she had not been sleeping well without it. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 9/11/24 at 7:29 A.M., Resident #2 said he/she had not been able to wear the BiPAP again last night and had not received an update on when it would be fixed by from staff. There was a BiPAP machine on a dresser across the room, not near Resident #2's bed. Review of Resident #2's active physician's order, initiated 9/16/21, indicated: - Bi-PAP settings 12 cm Exp, 18 cm Inspiratory @ (at) bedtime, every evening (3:00 P.M. to 11:00 P.M.) and night shift (11:00 P.M. to 7:00 A.M.) for Asthma, O2 (oxygen) Dep (dependency). Review of Resident #2's Treatment Administration Record (TAR), dated September 2024, indicated the physician's order for Bi-PAP settings 12 cm Exp, 18 cm Inspiratory @ bedtime, every evening and night shift for Asthma, O2 Dep was documented as implemented on the following shifts: - 9/1/24: evening shift. - 9/2/24: evening shift. - 9/3/24: evening shift and night shift. - 9/4/24: evening shift and night shift. - 9/5/24: evening shift. - 9/6/24: evening shift. - 9/7/24: evening shift and night shift. - 9/8/24: evening shift and night shift. - 9/9/24: evening shift. - 9/10/24: evening shift. During an interview on 9/11/24 at 7:37 A.M., Nurse #7 said she noticed Resident #2's BiPAP was broken a few weeks ago and was unable to be used safely. Nurse #7 said she told the Director of Nursing (DON) #1 but was not sure if the call for repair had been made. Nurse #7 said the medical record should have reflected that the BiPAP was broken, unable to be used, and what the outcome or plan was. Nurse #7 said she documented that the BiPAP as not implemented on 9/1/24, 9/2/24, 9/5/25, 9/6/24, 9/9/24, and 9/10/24 because it was broken on all these dates. Nurse #7 said the other evening and night shift nurses should not have documented it as implemented because it was broken and physically unable to be used. During an interview on 9/11/24 at 9:05 A.M., the Director of Nursing (DON) #1 said he was told Resident #2's BiPAP was broken a few weeks ago, but never called for repair or ensured the plan of care was updated or changed when the Resident was unable to use the BiPAP. DON #1 said since the BiPAP was broken and unable to be used, it should not have been documented as implemented. 36797 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) Resident #28 was admitted to the facility in March 2021 with diagnoses including heart disease, kidney disease and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #28 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating moderately impaired cognition. During an interview on 9/12/24 at 8:30 A.M., Certified Nurse Aide (CNA) #3 said that the CNA's document the services they provide to each resident in the computer each shift. CNA #3 then said that the CNA documentation is located on the form titled Alpha Daily GG (CNA) - V2 and the top of the page indicates the date and shift being documented on. Review of the medical record indicated that for the month of August 2024 CNAs documented the services they provided to Resident #28 only 13 out of 93 shifts. During an interview on 9/12/24 at 8:49 A.M., Director of Nursing (DON) #1 said that it is the expectation that CNA's document the services they provide to each resident at the end of each shift. DON #1 then said that he was not able to locate a policy for CNA documentation. During an interview on 9/12/24 at 9:02 A.M., CNA #3 said that there is not enough time to complete all the tasks required of her because there are only two CNAs to care for 24 residents. CNA #3 then said that she has 12 residents to care for including getting them bathed, dressed, getting them up, assisting with two meals and toileting residents every two hours. CNA #3 said she also has three showers to give today. CNA #3 said there is just no time to document before the end of the shift. 43807 4.) Resident #23 was admitted to the facility in July 2024 with diagnoses including type 2 diabetes mellitus. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating intact cognition. A review of Resident #23's census indicated he/she was out on a Medical Leave of Absence MLOA) on 8/2/24 - 8/3/24 and 8/7/24 -8/14/24. A review of Resident #23's initial weights physician's order dated 7/31/24 indicated the following: -Vital signs & Weights monthly, everyday shift every Tuesday for monitoring and prevention. A review of Resident #23's August Medication Administration Record (MAR) indicated the following: -Staff weighed the Resident on 8/20/24 and 8/27/24 (a week apart). Review of the medical record failed to indicate these weights were documented in the electronic medical record. -A review of Resident #23's physician's orders dated 8/16/24 indicated the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Obtain patient's weight weekly times 4 weeks in the morning every Monday for monitoring until 9/16/24. Further review of the MAR did not indicate any weights were done based on this physician's order. A review of Resident #23's August TAR (Treatment Administration Record) indicated the following: -Weigh weekly x4 weeks every day shift every Sunday for 4 weeks. Weight change of 3 lbs (pounds) or more, notify MD. [sic] Staff signed off that they weighed the Resident on 8/18/24 and signed off code 9 (see Nurse's notes) on 8/25/24. Further review of the electronic medical record failed to indicate the documented weight taken on 8/18/24, and no Nurse's progress note concerning weights in the medical record on 8/25/24. A review of Resident #23's weights indicated the following listed weights struck out in error: -8/29/24 195.0 lbs Standing -8/2/24 120.0 lbs Standing -8/1/24 195 lbs Standing -7/31/24 195 lbs Standing During an interview and record review on 9/12/24 at 10:23 A.M., the Dietician and the surveyor reviewed Resident #23's medical record together, she said she had no idea why all of the Resident's weights were struck out in error. The Dietician said if a weight is struck out in error, the Resident should be reweighed to get an accurate weight and the weight should be documented in the electronic medical record. She said Resident #23 has a history of refusing weights but there was no indication in the medical record that the Resident refused to be weighed. The Dietician said since there were no documented weights in the medical record, the Resident had not been weighed since admission. She said all newly admitted residents should be weighed weekly for four weeks and then a decision is made with the physician how often they need to be weighed after the four weeks.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 44095 Based on interviews and review of the Health Care Facility Reporting System (HCFRS-State agency reporting system), the facility failed to provide written notice to the State Agency when a change in the facility's Administrator occurred. Findings include: Review of HCFRS indicated: - Change in facility administrator occurred on 6/21/24, which indicated Administrator #2 was the current Administrator. During an interview on 9/10/24 at 8:30 A.M., Administrator #1 said he started on 9/9/24. Further review of HCFRS failed to indicate the State Agency was notified when Administrator #1 assumed the role as Administrator of the facility. During an interview on 9/12/24 at 12:50 P.M., Administrator #2 said her last day was 9/6/24. During an interview on 9/12/24 at 3:13 P.M., the Chief Nursing Officer said that the change in Administrator should have been reported to the State Agency but was not.