STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225562	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Milford LLC	10 Veterans Memorial Drive Milford, MA 01757

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43935 Based on observation and interview, the facility failed to ensure one Resident's (#3) dignity was maintained, out of a total sample of 18 residents. Specifically, the facility failed to provide Resident #3 with a privacy bag for his/her indwelling suprapubic catheter (a tube inserted through the urinary tract into the bladder, connected to a drainage bag) drainage bag. Findings include: Resident #3 was admitted to the facility in June 2021 with diagnoses including: neuromuscular dysfunction of the bladder and diabetes mellitus with neuropathy. Review of the Minimum Data Set assessment, dated 10/24/24, indicated the Resident was moderately cognitively impaired scoring 8 out of 15 on the Brief Interview for Mental Status. Review of the current Physician's Orders for Resident #3 indicated but was not limited to the following: Suprapubic (SP) tube 16 French with 10 milliliter balloon to bedside straight drainage for neurogenic bladder (6/2/21) Empty catheter drainage bag at least once every eight hours to when it becomes 1/2 to 2/3 full every shift (6/2/21) Review of the current care plans in place for the Resident indicated but were not limited to the following: FOCUS: Resident requires SP catheter due to neurogenic bladder INTERVENTIONS: Provide privacy and comfort The surveyor made the following observations of Resident #3's catheter drainage bag: (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	12/3/24 at 9:08 A.M., Catheter drainage bag visible from the doorway/hallway, not covered to provide privacy and dignity 12/4/24 at 7:39 A.M., Catheter drainage bag visible from the doorway/hallway, not covered to provide privacy and dignity 12/4/24 at 9:52 A.M., Catheter drainage bag visible from the doorway/hallway, not covered to provide privacy and dignity 12/5/24 at 7:28 A.M., Catheter drainage bag visible from the doorway/hallway, not covered to provide privacy and dignity During an interview on 12/5/24 at 7:59 A.M., Nurse #2 said the catheter drainage bag should have been kept in a privacy bag at all times when hanging in an area that can be seen. During an interview on 12/5/24 at 10:02 A.M., Certified Nurse Aide (CNA) #2 said the CNAs were responsible for ensuring catheter drainage bags were either hanging under the wheelchairs or on the lower edge of the bed frames and were kept in a privacy bags. She said the privacy bags were switched between the bed and chair and were in place to ensure people cannot see the urine and cause any potential embarrassment to the resident with the catheter. During an interview on 12/5/24 at 10:07 A.M., Nurse #3 said residents with any type of urinary catheters have privacy bags over their catheter drainage bags to maintain their dignity and ensure the urine is not in view of any passersby. She said the facility provides one privacy bag and the CNA is to switch it between the chair and bed for the residents to help prevent any potential dignity issues. During an interview on 12/5/24 at 10:09 A.M., Unit Manager #1 said the Resident should have his/her catheter drainage bag in a privacy bag at all times and the urine should not be visible from the doorway or hallway. She said the facility was out of privacy bags at this time and they were awaiting a delivery. She said regardless the drainage bag should have been hung on the interior part of the room to maintain the Resident's privacy and dignity and that did not happen in this instance. During an interview on 12/5/24 at 4:36 P.M., the Staff Development Coordinator said the staff are to ensure residents with catheters have their drainage bags not in plain view and either in a privacy bag or hanging in a manner that they are not visible to help preserve the resident's dignity and privacy. She said based on the surveyor's observations of Resident #3's drainage bag, that did not occur.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 42742 Based on a resident group meeting, Resident Council Minutes, and interview, the facility failed to ensure staff promptly addressed and resolved grievances brought forward during Resident Council Meetings held on 9/29/24 and 10/18/24. Findings include: Review of the facility's policy titled Resident Council, undated, indicated but was not limited to the following: The purpose of the resident council is to provide a forum for: a. residents, families, and resident representatives to have input in the operation of the facility; b. discussion of concerns and suggestions for improvement; and c. disseminating information and gathering feedback from interested residents. -A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. Review of Resident Council Minutes, dated 9/29/24, indicated the following grievance/complaint was brought forward: -Residents complained that evening snacks were not being offered at times. Review of the Resident Council Departmental Response Form, dated 9/29/24, indicated the form was signed by the Administrator as complete on 9/30/24. Further review of the form failed to indicate the Administrator, or his designee provided any follow up to the Resident Council regarding efforts the facility made to address their grievance brought forward during the 9/29/24 Resident Council Meeting. Review of Resident Council Minutes, dated 10/18/24, indicated the following grievance/compliant was brought forward: -Residents complained that there were too many agency staff and staff were not speaking English. Review of the Resident Council Departmental Response Form, dated 10/18/24, indicated that the form was signed by the Administrator as complete on 10/18/24, the same day. Further review of the form failed to indicate the Administrator, or his designee provided any follow up to the Resident Council regarding their grievances brought forward during the 10/18/24 Resident Council Meeting. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a resident group meeting held on 12/4/24 at 1:29 P.M., 11 residents were in attendance representing two of three units. Ten of 11 residents said their complaint from September of not being offered evening snacks is unresolved and continues to be a problem. Five out of 11 residents said their complaint from October of staff not speaking English is unresolved and has gotten worse. During an interview on 12/5/24 at 11:11 A.M., the Activities Director (AD) said she facilitates the monthly resident council meetings and writes the minutes. She said resident council is another forum for residents to express their concerns. She said if resident concerns are not resolved during the meeting, then she'll complete the Department Response Form, write who is responsible for addressing the issue and come up with a plan. She said she did not follow up on the residents' concerns regarding evening snacks, too many agency staff, and staff not speaking English, but should have. She said she assumed it was okay and didn't put it in her discussion of old business at the next monthly meetings. The AD said the grievance process was not followed for the grievances brought forward during the 9/29/24 and 10/18/24 Resident Council Meetings. During an interview on 12/5/24 at 12:00 P.M., the Administrator said he is the grievance official, and all grievances come to him for review to ensure issues are resolved as soon as possible and signed in a timely manner. The Administrator said resident council grievances follow the same process as other grievances. He said he investigated the complaints brought forward during the 9/29/24 and 10/18/24 Resident Council meetings. However, he was unable to provide the surveyor with documented evidence that resolutions to the complaints were provided to the group. He said the grievances brought forward during the resident council meetings should have been reviewed at the next month's meetings, but if the AD said she didn't do it, then it wasn't done.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observation, interview, and record review, the facility failed to notify the Physician and/or responsible party of recommendations or changes in condition for four Residents (#65, #13, #58, and #70), out of a total sample of 18 residents. Specifically, the facility failed: 1. For Resident #65, to notify the Physician of treatment recommendations and orders to initiate a 40-day Vancomycin (antibiotic) taper due to a diagnosis of Enterocolitis due to Clostridium Difficile (C. diff - an infection of the large intestine often resulting in diarrhea or loose stools) for 19 days after a hospitalization resulting in a decline in the Resident's stage IV pressure injury (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) on the sacrum; 2. For Resident #58, to notify the Physician of his/her significant weight loss; 3. For Resident #70, to notify the Physician of his/her significant weight loss; and 4. For Resident #13, to notify his/her Guardian of a fall that required transfer to the hospital. Findings include: Review of the facility's policy titled Change in a Resident's Condition, Acute Care Transfer and Notification, dated 2024, indicated but was not limited to: - Should a change in condition be suspected or noted, the nurse(s) shall be promptly alerted, shall promptly assess the resident, notify his or her Attending Physician of changes in the resident's medical/mental condition and/or status asking for orders/guidance and/or initiate life sustaining supportive measures accordingly to one's presenting condition in accordance with one's advance directives, and notify the resident's representative appropriately. - The Nurse Supervisor/Charge Nurse shall be notified of a change in a resident's condition, presentation, disposition or routine that may serve as an early warning sign of clinical events by staff or other concerned parties. Those may include but are not limited to: (g) a need or request to alter the resident's medical treatment, (k) Instructions to notify the Physician of changes in the resident's condition. 1. Resident #65 was admitted to the facility in June 2024 with diagnoses including C. diff, pressure ulcer of sacral region, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 9/26/24, indicated Resident #65 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Further review of the MDS assessment indicated he/she was being treated for a stage IV pressure ulcer and had a medical diagnosis of C. diff. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #65's nursing progress note, dated 7/29/24, indicated Resident #65 was seen by physician who recommended a transfer to the hospital due to a change in medical status. Review of the Hospital Discharge Summary, dated 7/31/24, indicated but was not limited to the following: - Resident had diarrhea on the overnight of 7/29/24. - Resident tested positive for C. diff on 7/30/24. - The Resident was seen by Infectious Disease (ID) during the hospitalization . - ID recommended Fidaxomicin (antibiotic) 200 milligrams (mg) twice a day for five days (7/30/24 to 8/4/24), then 200 mg every 48 hours for 20 days. - ID also alternatively recommended a 40-day Vancomycin (antibiotic) taper instead of the Fidaxomicin. - The recommendation for the 40-day Vancomycin taper included: 125 mg by mouth four times a day for 10 days, followed by 125 mg by mouth twice a day for 10 days, followed by 125 mg by mouth once daily for 10 days, followed by 125 mg by mouth once every other day for 10 days. Review of Resident #65's nursing progress note, dated 7/31/24, indicated the Resident returned to the facility from the hospital on this date and a Vancomycin taper was recommended for the treatment of C. diff. The nursing progress note indicated the antibiotic treatment options needed to be reviewed with the in-house Physician. Review of nursing progress notes from 7/31/24 to 8/18/24 failed to indicate the antibiotic recommendations were reviewed and/or implemented with the in-house physician. Review of physician progress notes from 7/31/24 to 8/18/24 failed to indicate the antibiotic recommendations from the Resident's hospital discharge on 7/31/24 were reviewed or implemented. Review of Resident #65's Physician's Orders failed to indicate an order for the 40-day Vancomycin taper or Fidaxomicin taper were implemented following his/her return from the hospital on 7/31/24. Review of the Certified Nursing Assistant (CNA) Documentation Survey Report for the task of Bowel Continence, dated August 2024, indicated Resident #65 was incontinent of large/medium loose stools on the following dates/shifts: - 8/1/24: Night shift - 8/2/24: Night shift - 8/3/24: All shifts - 8/4/24: Night shift (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	- 8/5/24: All shifts - 8/6/24: Day shift - 8/7/24: Day shift - 8/8/24: Day/Evening shifts - 8/9/24: All shifts - 8/10/24: Day shift - 8/11/24: Night shift - 8/13/24: Evening shift - 8/15/24: Day shift - 8/16/24: Day/Evening shifts Review of the Wound Consultant Documentation, dated 8/9/24, indicated but was not limited to the following: - Resident had been hospitalized since last wound evaluation. - Wound measurements increased, mild odor noted. - Wound status: worsening. Review of the Wound Consultant Documentation, dated 8/16/24 indicated but was not limited to the following: - Wound measurements increased. - Increased odor and drainage. - Wound status: worsening. During an interview on 12/5/24 at 11:58 A.M., Wound Consultant #1 said Resident #65 has been followed for a chronic stage IV sacral pressure ulcer since being admitted to the facility. Wound Consultant #1 said Resident #65 has a history of recurrent C. diff. Wound Consultant #1 said in her experience when Resident #65 has C. diff he/she typically has large, loose stools which would require dressing changes of the chronic stage IV sacral pressure ulcer. Wound Consultant #1 said large amounts of loose stool would negatively impact the wound healing process. During an interview on 12/5/24 at 12:35 P.M., the Physician said loose stools and C. diff would have a negative impact on the Resident's wound status. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #65's nursing progress note, dated 8/18/24, indicated that the Resident was transferred to the hospital for abnormal test results. Review of the Hospital Discharge Summary, dated 8/19/24, indicated but was not limited to the following: - Resident had a history of recent C. diff (discharged [DATE]). - Resident presented to the hospital with decubitus ulcer pain and diarrhea. - Resident still has diarrhea, unfortunately the Vancomycin was stopped. - ID suggested a 40-day Vancomycin taper during last hospitalization [DATE] to 7/31/24. - Communication with the nursing facility indicated there was a misunderstanding by the facility on placing the Resident on the Vancomycin taper. - Communicated with them that when leaving the hospital this time the Resident should definitely be on a 40-day taper of Vancomycin. - ID recommendation for the 40-day Vancomycin taper included: 125 mg by mouth four times a day for 10 days, followed by 125 mg by mouth twice a day for 10 days, followed by 125 mg by mouth once daily for 10 days, followed by 125 mg by mouth once every other day for 10 days. Review of the medical record indicated Resident #65 was placed on the recommended 40-day Vancomycin taper on 8/19/24, 19 days after it was initially recommended. During an interview on 12/5/24 at 12:35 P.M., the Physician said when a resident returns from the hospital the facility typically will call him or a nurse practitioner (NP) to review the discharge medications and recommendations. The Physician said he almost always accepts the recommendations for medications and treatments from the hospital discharge. The Physician said he reviewed each of his residents' medical records when evaluating him/her in the facility. The Physician said he does not recall being notified of recommendations for a 40-day Vancomycin taper after Resident #65's hospitalization from [DATE] to 7/31/24. The Physician said he would have addressed the recommendations and documented them in his progress notes. During an interview on 12/9/24 at 8:26 A.M., Unit Manager (UM) #1 said when a resident returns from the hospital the discharge summary is reviewed by the nurse. UM #1 said all discharge medications and recommendations would then be reviewed by the physician or NP either in the facility, if they were present, or by phone. UM #1 reviewed Resident #65's hospital discharge summary from 7/31/24 and said the Vancomycin taper was not listed on the discharge medication list from the hospital. UM #1 said the hospital discharge summary does clearly indicate the recommendation for a Fidaxomicin or Vancomycin taper to be initiated due to the Resident's diagnosis of C. diff. UM #1 said the hospital discharge summary recommendations should have been reviewed with the physician or NP so they could be implemented. UM #1 said no Vancomycin taper was started until Resident #65 returned from the hospital on 8/19/24. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/9/24 at 11:20 A.M., the Director of Nursing (DON) said when a resident returns from the hospital the discharge summary is reviewed by the nurse. The DON said all discharge medications and recommendations would then be reviewed by the physician or NP either in the facility, if they were present, or by phone. The DON said she reviewed Resident #65's medical record and noted the 40-day Vancomycin taper was not implemented when he/she returned from the hospital on 7/31/24 as it should have been. The DON said the hospital discharge summary should have been reviewed and clarified with the Physician. The DON said there should not have been a delay in starting the 40-day Vancomycin taper for Resident #65. 48695 2. Resident #58 was admitted to the facility in September 2024 with diagnoses including obesity and pleural effusion (fluid builds up in the pleural space, the thin cavity between the lungs and the chest wall). Review of Resident #58's Minimum Data Set (MDS) assessment, dated 9/26/24, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #58's Registered Dietitian's notes indicated but was not limited to: - 11/21/24: Resident #58 continues to trigger for significant weight loss over 180 days. Resident #58 down approximately 13 pounds. - 10/22/24: Reweight obtained 10/18 of 354.8 pounds which verifies weight loss. - 10/18/24: Weight on 10/14 reordered in electronic medical 358.6 pounds. Weight on 10/9 410.9 pounds. This reflects a weight loss of 43 pounds in 5 days. Further review of Resident #58's medical record failed to indicate his/her Physician or Physician Extender had been notified of his/her weight loss. During an interview on 12/9/24 at 9:50 A.M., Resident #58 said he/she had lost about 99 pounds since his/her hospitalization and facility admission. Resident #58 said he/she was happy with weight loss. During an interview on 12/5/24 at 10:36 A.M., Nurse #11 said if it was identified that a resident had a weight loss the nurse would notify the Dietitian and if the Dietitian made a recommendation the nurse would notify the Physician. Nurse #11 said if the Physician had been notified then it would be documented in the medical record in a nurse's note. During an interview on 12/5/24 at 10:40 A.M., Unit Manager (UM) #2 said the Dietitian was notified for all significant weight loss. UM #2 said the Dietitian would make recommendations, if appropriate, and then the doctor would be called to approve the recommendation. UM #2 said the Physician would often be verbally notified of changes in resident conditions. UM #2 said the nurses do not document Physician notification anywhere. UM #2 said there is not a system in place to notify the Physician of a significant weight loss and there should be a process for Physician notification, but there isn't one in place. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/5/24 at 11:06 A.M., the Dietitian said she did not notify the physician if a resident had a significant weight loss. The Dietitian said her expectation was for the nurses to notify the physician of a significant weight loss. During an interview on 12/5/24 at 11:30 A.M., Physician #1 said he was not aware of Resident #58's significant weight loss. Physician #1 said regardless of if a resident is on prescribed weight loss regimen or had an unplanned weight loss he should be notified of all weight loss. During an interview on 12/9/24 at 3:40 P.M., the Director of Nursing (DON) said the Physician should have been notified of Resident #58's weight loss and the notification should have been documented in his/her medical record but was not. 3. Resident #70 was admitted to the facility in August 2024 with diagnoses including heart failure and obesity. Review of Resident #70's MDS assessment, dated 10/21/24, indicated he/she had a mild cognitive deficit as evidenced by a BIMS score of 10 out of 15. Further review of Resident #70's MDS assessment indicated he/she had a five percent weight loss and he/she was not on a prescribed weight loss regimen. Review of Resident #70's Registered Dietitian's notes indicated but was not limited to: -12/3/24: Resident #70 continues to trigger for significant weight loss. Review of Resident #70's care plan titled Resident #70 is at nutritional risk, last revised 10/21/24, indicated but was not limited to: - Intervention: Weight a/o (as ordered) and alert the dietitian and physician to any significant loss or gain, revision date 8/8/24 During an interview on 12/5/24 at 10:32 A.M., Physician #1 said he was not aware of Resident #70's significant weight loss. Physician #1 said regardless of if a resident is on prescribed weight loss regimen or had an unplanned weight loss he should be notified of all weight loss. During an interview on 12/5/24 at 10:36 A.M., Nurse #11 said if it was identified that a resident had a weight loss the nurse would notify the Dietitian and if the Dietitian made a recommendation the nurse would notify the Physician. Nurse #11 said if the Physician was notified then it would be documented in the medical record in a nurse's note. During an interview on 12/5/24 at 10:40 A.M., UM #2 said the Dietitian was notified for all significant weight loss. UM #2 said the Dietitian would make recommendations, if appropriate, and then the doctor would be called to approve the recommendation. UM #2 said the Physician would often be verbally notified of changes in resident conditions. UM #2 said the nurses do not document Physician notification anywhere. UM #2 said there is not a system in place to notify the Physician of a significant weight loss and there should be to a process for Physician notification, but there isn't one in place. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/5/24 at 11:06 A.M., the Dietitian said she did not notify the physician if a resident had a significant weight loss. The dietitian said her expectation was for the nurses to notify the physician of a significant weight loss. During an interview on 12/9/24 at 3:40 P.M., the DON said the Physician should have been notified of Resident #70's weight loss and the notification should have been documented in his/her medical record but was not. 50740 4. Resident #13 was admitted to the facility in September 2023 with diagnoses including dementia, fracture of the second cervical vertebra (a broken bone in the neck), and mild cognitive impairment. Review of Resident #13's MDS assessment, dated 9/10/24, indicated that the Resident was severely cognitively impaired as evidenced by a BIMS score of 6 out of 15. Review of Resident #13's medical record indicated that a guardian was appointed by the Court on 8/13/24. Review of the facility's fall incident report completed for Resident #13 on 10/30/24 indicated that the Resident sustained an unwitnessed fall and was transported to the hospital for evaluation. The report failed to indicate that the Resident's guardian was notified of the fall or subsequent transfer. Review of a progress note written for Resident #13, dated 10/20/24 7:00 P.M., indicated that the Resident was found on the floor in the dining room and complained of right hip pain, right-sided head pain, and back pain. The progress note indicated the provider was notified and an order was obtained to send the Resident to the emergency department for evaluation. The progress note failed to indicate that the Resident's guardian was notified of the fall or subsequent transfer. Review of an eINTERACT Change in Condition Evaluation completed for Resident #13 on 10/31/24 indicated the Resident returned from the hospital with no new orders and the physician was aware. The Evaluation indicates that the name of family/healthcare agent notified was self. The Evaluation failed to indicate that the Resident's guardian was notified. During an interview on 12/5/24 at 1:09 P.M., the DON reviewed the Resident's record and said that there is no documentation that facility staff notified Resident #13's guardian of the fall and transfer to the hospital. The DON said that the Resident's guardian should have been notified of the fall and transfer. During a telephonic interview on 12/5/24 at 2:52 P.M., Resident Representative #1 said that he was not notified of the Resident's fall and transfer to hospital. Refer to F684

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42742 Based on grievance book review and interview, the facility failed to ensure that staff documented all the steps of the grievance resolution and/or reasonable attempts were made to provide a satisfactory resolution for five Residents' (#29, #278, #277, #47, and #72) grievances filed. Findings include: Review of the facility's policy titled Resident and Family Concerns and Grievances Policy and Procedure, dated 2024, indicated but was not limited to the following: Purpose: -To provide for the prompt resolution of medical and non-medical grievances while maintain confidentiality, in accordance with applicable federal and state statutes and regulations. Filing of Grievances: -Residents or their family members, guardian, or representative may voice a grievance to the Facility staff in person, by telephone, or via written communication. -The facility shall provide the attached Grievance Report Form to facilitate the voicing of a grievance if requested by the resident or family member. Investigation of Grievances: Responses to and Resolution of Grievances: -The facility will follow up with the resident or their family members, guardian, or representative within 72 hours of the filing of the grievance. -The facility will advise the resident of the outcome of the grievance investigation and shall make reasonable efforts to contact the resident's family members to advise them of the outcome of the grievance investigation. -The facility will provide the resident with a written grievance decision, which shall include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. -The facility will document all steps of the grievance resolution in the facility's records, including whether or not the resident/family was satisfied with the resolution. The documentation will be kept for a minimum of 3 years. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 12:00 P.M., the Administrator said he is the grievance official, and all grievances come to him for review to ensure issues are resolved as soon as possible and signed in a timely manner. During a subsequent interview on 12/5/24 at 12:29 P.M., the Administrator and Consultant Staff #1 reviewed the Grievance Book with the surveyor as follows: a. A grievance form, dated 10/7/24, indicated that Resident #29 reported to the Administrator that an agency Certified Nursing Assistant (CNA) ignored a request in the hallway to get him/her a chair. The Resident stated the CNA continued to walk away. The Resident further stated, agency staff are lousy. The grievance was signed as complete on 10/7/24 by the Administrator. Further review of the grievance form failed to indicate that an investigation was conducted regarding agency staff including pertinent findings or conclusions, a statement as to whether the grievance was confirmed or not, any corrective action taken or to be taken by the facility in response, or that a resolution provided to the Resident. The Administrator said Resident #29 has a certain pattern of accusatory behavior, comments, and complaints of which the majority are not accurate. He said it doesn't mean they don't follow through with a complaint, but he considered this a comment not a complaint. The Administrator said he asked the Resident about the incident but did not document it. b. A grievance form, dated 10/15/24, indicated that Resident #278 reported to the Administrator that he/she had some cheese packages that were left in the unit's refrigerator but were now missing. The action taken included to have the family member bring a receipt for its replacement and would be reimbursed by the facility. The grievance was confirmed and signed as complete by the Administrator on 10/15/24. Further review of the grievance failed to indicate follow up on whether or not the Resident was reimbursed, and if he/she was satisfied with the resolution. The Administrator said the Resident was okay with not being reimbursed for the missing cheese packets and that was the resolution, but he did not document this on the grievance form. c. Review of an email sent by Resident #277 to the Administrator, dated 10/20/24, indicated he/she had been subjected to a roommate who had been talking loudly, yelling, singing, and cursing so he/she had not received a full night's sleep since he/she came to the unit six weeks prior. The Resident stated nothing was done and could have been easily rectified, but it was ignored and compounded by threats to send him/her to a psychiatric ward. Review of the Administrator's email response to Resident #277, dated 10/21/24, indicated he would follow up on his/her comment and address the issue. A grievance form, dated 10/21/24, indicated that Resident #277 reported to the Administrator that his/her roommate was making noise during the night and why the roommate wasn't moved to another room when the Resident first complained about it to staff. The grievance indicated the Resident was offered a room change and denied the request expecting the roommate to be moved. The form indicated based on staff's observation, the roommate does not make noise too often and unit managers confirmed that the Resident's comment was not accurate. The grievance was confirmed and signed as complete by the Administrator on 10/21/24. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The grievance form failed to indicate a formal investigation was completed with a summary of pertinent findings and conclusions. The Administrator said he could not get satisfaction with this Resident regardless and the roommate was not making noise, he/she was just speaking softly before falling asleep. He said the Resident declined a room change and just wanted a private room and was told that that wasn't the right way to do it. The Administrator said he confirmed the Resident's grievance and felt he did a formal investigation. He said to the lay reader it may not be clear, but to him the investigation was adequate. The Administrator could not provide the names of the staff he spoke to, and no further documentation was provided to the surveyor. d. A grievance form, dated 10/24/24, indicated that Resident #47's son reported to the Administrator that the Resident had developed a bed sore within the past two weeks from lying on his/her back. The form indicated that the unit manager was going to do a skin assessment and was adding the Resident to wound rounds for assessment. The grievance was signed as complete on 10/25/24 by the Administrator. Further review of the grievance failed to indicate documentation of all the steps of the grievance resolution including a statement as to whether the grievance was confirmed or not confirmed, and whether or not the resident/resident's son was satisfied with the resolution. The Administrator said the form should have indicated whether or not the grievance was confirmed. He said there was no summary of the corrective actions taken or documentation of a resolution. The Administrator said the purpose of the grievance form is to serve as a reminder that more information can be accessed in the record but could not provide documentation to the surveyor of pertinent findings, a conclusion, and a resolution. Consulting Staff #1 was present for the interview and said the documentation should be on the grievance form in the event the Administrator is not there. e. A grievance form, dated 10/30/24, indicated that Resident #47's daughter-in-law reported to the Administrator that the Resident should be a two-person assist for care. The form indicated rehab would evaluate the Resident. The grievance was signed as complete on 10/30/24 by the Administrator. Further review of the grievance failed to indicate documentation of all the steps of the grievance resolution including a summary of pertinent findings and whether or not the resident/resident's son was satisfied with the resolution. During an interview on 12/5/24 at 2:29 P.M., the Administrator said he can follow up to see if the rehab evaluation was done because it isn't documented on the form. He said there wasn't a follow up summary done or documentation of whether or not the Resident/representative was satisfied with the resolution. He said the old rule was, if you didn't document it, you didn't do it. f. A grievance form, dated 11/20/24, indicated in the summary of the grievance that Resident #72's sister reported that the Resident's colostomy bag had not been changed for the past three days. The form indicated the colostomy bag was changed as ordered by the physician. The grievance was signed as completed on 11/20/24 by the Administrator. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the grievance failed to indicate documentation of all the steps of the grievance resolution including the steps taken to investigate the grievance, a summary of pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and whether or not the Resident/Resident's sister was satisfied with the resolution. The form also did not indicate who the Resident's sister reported to or when. During an interview on 12/4/24 at 3:15 P.M., Resident #72 said he/she has a hard time changing the colostomy bag and needs staff's help to do it but said he/she has to tell them how to do it. The Resident said if it isn't done right there would be a blow out of liquid stool on the side which has happened before. The Resident said there is mostly agency staff, and they don't know how to do it. The Resident said staff were changing it every few days, just not right. He/she said the Administrator never came in to speak with him directly about the grievance filed and was never provide a resolution. The Resident said it's gotten a little better but still sometimes must wait three or four hours for the bag to be changed. The Administrator said he confirmed the colostomy bag was being changed but did not confirm it was being changed late, so he asked staff to date the bag when changed. He said he asked the Unit Manager who said it was being done after checking the documentation. The Administrator said he didn't document if it was confirmed or not because there were multiple issues on the same grievance form. He said he did meet face to face with the Resident to discuss his/her concerns but did not document it. He said there is no documentation of a resolution because he didn't confirm the grievance. g. A grievance form, dated 11/26/24, indicated that Resident #72's sister reported to the Administrator that two Saturdays ago when his/her friend sat on the Resident's bed, the bed was wet. The form indicated specific staff would be called in for a statement. The form also indicated the Administrator was unable to verify and signed the form as completed on 11/26/24. Further review of the grievance failed to indicate documentation of all the steps of the grievance resolution including a summary of pertinent findings or conclusions from the identified staffs' statements, any corrective action taken or to be taken by the facility as a result of the grievance, a resolution, and whether or not the Resident/Resident's sister was satisfied with the resolution. The Administrator said he documented that he interviewed the staff but didn't get statements from them because no one remembered the incident. He said he did not document this on the form or as part of the investigation. He said there was no corrective action because it could not be confirmed. He said there was no documentation of satisfaction or dissatisfaction because no one remembered what happened or knew a cause for the bed being wet. The Administrator said the form should still have something documented that it was discussed and what the findings were.

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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 43935 Based on document review and interview, the facility failed to accurately complete a Level 1 Preadmission Screening and Resident Review (PASARR) for one Resident (#18) with a severe mental illness, out of a total sample of 18 residents. Findings include: Resident #18 was admitted to the facility in October 2023 with diagnoses including: bipolar disorder and post-traumatic stress disorder (PTSD). Review of the hospital discharge summary, dated 10/31/23, indicated a discharge diagnosis of bipolar disorder. Review of the admission Minimum Data Set (MDS) assessment for Resident #18 indicated under Section I (Active Diagnoses) that the Resident had both bipolar disorder and PTSD coded as active diagnoses. Review of the MDS assessment, dated 10/24/24, indicated the Resident continued to have Active Diagnoses of bipolar disorder and PTSD. In addition, there was a diagnosis of schizoaffective disorder coded on Section I of the October 2024 MDS. Review of the most recent PASARR for Resident #18, completed on 10/18/23, indicated but was not limited to the following: - PASARR was completed prior to admission by the facility MDS Nurse - Section B (Screen for serious mental illness) indicated under question 4A, the Resident did not have any diagnoses of serious mental illness including: bipolar disorder or PTSD Review of the psychiatric evaluation for Resident #18, dated 9/26/24, indicated but was not limited to the following: Diagnoses: bipolar disorder (2016), PTSD (2020) During an interview on 12/5/24 at 9:17 A.M., the Director of Social Services said the Resident had a complicated psychiatric history including diagnoses of PTSD and bipolar disorder. On review of the PASARR, she said the PASARR was completed incorrectly and does not reflect the Resident's mental illnesses, as it should. She also said that typically a resident with Resident #18's history and diagnoses would also have a Level 2 PASARR completed and this Resident does not have that since the Level 1 PASARR was completed incorrectly. During an interview on 12/5/24 at 10:59 A.M., the MDS nurse said she completed the PASARR for Resident #18. She reviewed the PASARR and said the Resident's PASARR was completed incorrectly and did not match the Resident's known active diagnoses as reflected on the MDS at the time of admission or currently.

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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. 48695 Based on observation, interview, and record review, the facility failed to follow professional standards of practice for two Residents (#13 and # 58), out of a total sample of 16 residents. Specifically, the facility failed: 1. For Resident #58, to ensure medications were administered by a nurse and not by a Certified Nursing Assistant (CNA); and 2. For Resident #13, to ensure a physician's order for Trazodone (antidepressant) was complete and included the strength of the medication ordered. Findings include: 1. Review of the National Library of Medicine (NLM), dated 1/2022, indicated but was not limited to: - Nursing assistants (NAs), also called nursing aides, are important members of the health care team. NAs work under the supervision of licensed practical/vocational nurses (LPNs/VNs) and registered nurses (RNs). - NAs provide basic care and help patients* with activities of daily living. They typically perform the following tasks[1]: - Clean and bathe patients - Help patients use the toilet and dress - Turn, reposition, and transfer patients between beds and wheelchairs - Listen to and record patients' health concerns and report that information to nurses - Measure patients' vital signs, such as temperature - Serve meals and help patients eat Review of the Nursing License Requirements and Scope of Practice in Massachusetts, undated indicated but was not limited to: - CNA- considered dependent practitioners, CNAs must work under the direct supervision of a licensed nurse. Typical CNA tasks include hygiene activities such as bed baths, feeding patients, and helping them ambulate. Certified medication aides may also administer medications. Review of the facility's Certified Nursing Assistant Job Descriptions, undated, indicated but was not limited to: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Special Nursing Care Functions: -Turn all medications found in the resident's room/possessions over to the Nurse Supervisor/Charge Nurse. Resident #58 was admitted to the facility in September 2024 with diagnoses including sciatica (pain that radiates along the sciatic nerve and runs down one or both legs from the lower back). Review of Resident #58's Minimum Data Set (MDS) assessment, dated 12/17/24, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had frequent pain. On 1/13/25 at 12:37 P.M., and 2:07 P.M., the surveyor observed a bottle of Lidocaine Pain Relief Cream Plus Menthol (an anesthetic cream, used to prevent and treat pain). During an interview on 1/13/25 at 12:37 P.M., Resident #58 said he/she uses the Lidocaine Pain Relief Cream Plus Menthol for his/her back pain. Resident #58 said a visitor brought the cream in over the weekend and the nursing staff helped him/her to put it on his/her lower back. Resident #58 said he/she was unable to apply the Lidocaine Pain Relief Cream to his/her lower back in the morning and asked CNA #1 to apply it to his/her lower back. Resident #58 said CNA #1 applied the Lidocaine Pain Relief Cream to his/her lower back in the morning. During an interview on 1/13/25 at 12:51 P.M., Nurse #1 said CNAs are not able to administer medications to residents. Nurse #1 said all medications and medicated creams should be administered by nurses. During an interview on 1/13/25 at 2:04 P.M., CNA #1 said Resident #58 had asked her to apply the Lidocaine Pain Relief Cream to his/her lower back while providing morning care. CNA #1 said the cream belonged to Resident #58 and she had applied the cream as he/she had requested. CNA #1 said she was not aware of what the cream was for. During an interview on 1/13/25 at 2:11 P.M., Unit Manager (UM) #1 said medications should only be administered by nurses and CNAs should not administer any medications or medicated creams. During an interview on 1/13/25 at 2:32 P.M., the Director of Nursing (DON) said medications should only be administered by nurses. The DON said CNA #1 was not certified to administer medications and should not have. 34145 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered nurse and Practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered nurse and practical nurse incorporate into the plan of care and implement prescribed medical regimens. A nurse licensed by the Board shall not administer any prescription drug or non-prescription drug to any person in the course of nursing practice except as directed by an authorized prescriber. A nurse licensed by the Board shall document the handling, administration, and destruction of controlled substances in accordance with all federal and state laws and regulations and in a manner consistent with accepted standards of practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling #9324, titled Accepting, Verifying, Transcribing and Implementing Orders, dated as last revised 4/11/2018, indicated but was not limited to the following: - It is the responsibility of the licensed nurse to ensure there is a proper patient care order from a duly authorized prescriber prior to the administration of any prescription or non-prescription medication or activity that requires which order in accordance with accepted standard of practice and in compliance with the Boards regulations. - Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. - The nurse is accountable for ensuring that any orders he or she implements are reasonable based on the nurse's knowledge of that particular patient's care. It is the responsibility and obligation of the nurse to question a patient care order that is deemed inappropriate by a nurse according to his/her educational preparation and clinical experience. Review of the facility' policy titled Medication and Treatment Orders, last revised July 2024, indicated but was not limited to: - Orders for medications must include: a. name and strength of the drug; b. number of doses, start and stop date; c. dosage and frequency of administration; d. route of administration; e. clinical condition or symptoms for which the medication is prescribed; and f. any interim follow-up requirements. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13 was admitted to the facility in September 2023 and had diagnoses including major depression, dementia with psychotic disturbance, and anxiety. Review of the MDS assessment, dated 12/10/24, indicated Resident #13 had severe cognitive impairment as evidenced by a BIMS score of 5 out of 15, and received psychotropic medication daily. Review of the medical record indicated the following Physician's Orders: - Trazodone HCl Oral tablet, give 0.5 tablet by mouth two times a day for mood, agitation and related symptoms (8/26/24) - Trazodone HCl Oral tablet, give one tablet by mouth at bedtime for mood, agitation and related symptoms (8/26/24) During an interview on 1/3/25 at 12:58 P.M., Nurse #1 reviewed Resident #13's medication orders and said the orders for Trazodone: give 0.5 tablet by mouth two times a day and give one tablet at bedtime was incomplete and should include the strength of the medication ordered. During an interview on 1/3/25 at 1:09 P.M., the DON said the orders for Trazodone: give 0.5 tablet by mouth two times a day and give one tablet at bedtime should include the dose of the medication and it does not. She reviewed the medical record and said the dose of Trazodone dropped off the order when the order was renewed in August 2024.

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on interview and record review, the facility failed to promote and manage the delivery of safe nursing care in accordance with accepted Standards of Nursing Practice by failing to identify and address a change in condition and provide necessary care and treatment for one Resident (#65), out of a total sample of 18 residents. Specifically, the facility failed to implement treatment recommendations and orders to initiate a 40-day Vancomycin (antibiotic) taper due to a diagnosis of Enterocolitis due to Clostridium Difficile (C. diff - an infection of the large intestine often resulting in diarrhea or loose stools) for 19 days after a hospitalization resulting a decline in the Resident's stage IV pressure injury (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) on the sacrum. Findings include: Resident #65 was admitted to the facility in June 2024 with diagnoses including C. diff, pressure ulcer of sacral region, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 9/26/24, indicated Resident #65 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Furthermore, the MDS assessment indicated he/she was being treated for a stage IV pressure ulcer and had a medical diagnosis of C. diff. Review of Resident #65's nursing progress note, dated 7/29/24, indicated Resident #65 was seen by the physician who recommended a transfer to the hospital due to a change in medical status. Review of the hospital Discharge Summary, dated 7/31/24, indicated but was not limited to the following: - Resident had diarrhea on the overnight of 7/29/24. - Resident tested positive for C. diff on 7/30/24. - The Resident was seen by Infectious Disease (ID) during the hospitalization . - ID recommended Fidaxomicin (antibiotic) 200 milligrams (mg) twice a day for five days (7/30/24 to 8/4/24), then 200 mg every 48 hours for 20 days. - ID also alternatively recommended a 40-day Vancomycin taper instead of the Fidaxomicin. - The recommendation for the 40-day Vancomycin taper included: 125 mg by mouth four times a day for 10 days, followed by 125 mg by mouth twice a day for 10 days, followed by 125 mg by mouth once daily for 10 days, followed by 125 mg by mouth once every other day for 10 days. (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 0684 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #65's nursing progress note, dated 7/31/24, indicated the Resident returned to the facility from the hospital on this date. Further review of the nursing progress note indicated a Vancomycin taper was recommended for the treatment of C. diff. The nursing progress note indicated the antibiotic treatment options needed to be reviewed with the in-house physician. Review of nursing progress notes, from 7/31/24 to 8/18/24, failed to indicate the antibiotic recommendations were reviewed and/or implemented with the in-house physician. Review of Physician progress notes, from 7/31/24 to 8/18/24, failed to indicate the antibiotic recommendations from the Resident's hospital discharge on 7/31/24 were reviewed or implemented. Review of Resident #65's Physician's Orders failed to indicate an order for the 40-day Vancomycin taper or Fidaxomicin taper were implemented following his/her return from the hospital on 7/31/24. Review of the Certified Nursing Assistant (CNA) Documentation Survey Report for the task of Bowel Continence, dated August 2024, indicated Resident #65 was incontinent of large/medium loose stools on the following dates/shifts: - 8/1/24: Night shift - 8/2/24: Night shift - 8/3/24: All shifts - 8/4/24: Night shift - 8/5/24: All shifts - 8/6/24: Day shift - 8/7/24: Day shift - 8/8/24: Day/Evening shifts - 8/9/24: All shifts - 8/10/24: Day shift - 8/11/24: Night shift - 8/13/24: Evening shift - 8/15/24: Day shift - 8/16/24: Day/Evening shifts Review of the Wound Consultant Documentation, dated 8/9/24, indicated but was not limited to the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	- Resident had been hospitalized since last wound evaluation. - Wound measurements increased, mild odor noted. - Wound status: worsening. Review of the Wound Consultant Documentation, dated 8/16/24, indicated but was not limited to the following: - Wound measurements increased. - Increased odor and drainage. - Wound status: worsening. During an interview on 12/5/24 at 11:58 A.M., Wound Consultant #1 said Resident #65 has been followed for a chronic stage IV sacral pressure ulcer since being admitted to the facility. Wound Consultant #1 said Resident #65 has a history of recurrent C. diff. Wound Consultant #1 said in her experience when Resident #65 has C. diff he/she typically has large, loose stools which would require dressing changes of the chronic stage IV sacral pressure ulcer. Wound Consultant #1 said large amounts of loose stool would negatively impact the wound healing process. During an interview on 12/5/24 at 12:35 P.M., the Physician said loose stools and C. diff would have a negative impact on the Resident's wound status. Review of Resident #65's nursing progress note, dated 8/18/24, indicated the Resident was transferred to the hospital for abnormal test results. Review of the Hospital Discharge Summary, dated 8/19/24, indicated but was not limited to the following: - Resident had a history of recent C. diff (discharged [DATE]). - Resident presented to the hospital with decubitus ulcer, pain and diarrhea. - Resident still had diarrhea, unfortunately the Vancomycin was stopped. - ID suggested a 40-day Vancomycin taper during last hospitalization [DATE] to 7/31/24. - Communication with the nursing facility indicated there was a misunderstanding by the facility on placing the Resident on the Vancomycin taper. - Communicated with them that when leaving the hospital this time the Resident should definitely be on a 40-day taper of Vancomycin. - ID recommendation for the 40-day Vancomycin taper included: 125 mg by mouth four times a day for 10 days, followed by 125 mg by mouth twice a day for 10 days, followed by 125 mg by mouth once daily for 10 days, followed by 125 mg by mouth once every other day for 10 days. (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 0684 Level of Harm - Actual harm Residents Affected - Some	Review of the medical record indicated Resident #65 was placed on the recommended 40-day Vancomycin taper on 8/19/24, 19 days after it was initially recommended. During an interview on 12/5/24 at 12:35 P.M., the Physician said when a resident returns from the hospital the facility typically will call him or a nurse practitioner (NP) to review the discharge medications and recommendations. The Physician said he almost always accepts the recommendations for medications and treatments from the hospital discharge. The Physician said he does not recall being notified of recommendations for a 40-day Vancomycin taper after Resident #65's hospitalization from [DATE] to 7/31/24. The Physician said he would have addressed the recommendations and documented them in his progress notes. During an interview on 12/9/24 at 8:26 A.M., Unit Manager (UM) #1 said when a resident returns from the hospital the discharge summary is reviewed by the nurse. UM #1 said all discharge medications and recommendations would then be reviewed by the physician or NP either in the facility, if they were present, or by phone. UM #1 reviewed Resident #65's hospital discharge summary from 7/31/24 and said the Vancomycin taper was not listed on the discharge medication list from the hospital. UM #1 said the hospital discharge summary does clearly indicate the recommendation for a Fidaxomicin or Vancomycin taper to be initiated due to the Resident's diagnosis of C. diff. UM #1 said the hospital discharge summary recommendations should have been reviewed with the physician or NP so they could be implemented. UM #1 said no Vancomycin taper was started until Resident #65 returned from the hospital on 8/19/24. During an interview on 12/9/24 at 11:20 A.M., the Director of Nursing (DON) said when a resident returns from the hospital the discharge summary is reviewed by the nurse. The DON said all discharge medications and recommendations would then be reviewed by the physician or NP either in the facility, if they were present, or by phone. The DON said she reviewed Resident #65's medical record and noted the 40-day Vancomycin taper was not implemented when he/she returned from the hospital on 7/31/24 as it should have been. The DON said the hospital discharge summary should have been reviewed and clarified with the Physician. The DON said there should not have been a delay in starting the 40-day Vancomycin taper for Resident #65.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observations, interviews, and record review, the facility failed to ensure two Residents (#65, #68), out of a total sample of 18 residents, received care and treatment to promote healing of pressure injuries. Specifically, the facility failed: 1. For Resident #65, to implement wound care orders per physician recommendations for a stage IV pressure injury (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) on the sacrum; and 2. For Resident #68, to implement orders for a change in treatment for the care of an unstageable pressure ulcer injury (full thickness tissue loss that is covered by a layer of dead tissue that prevents the stage from being determined) to the left heel. Findings include: Review of the facility's policy titled Prevention of Pressure Injuries, undated, included but was not limited to: - The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. - Review of the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. - Monitoring: (1) Evaluate, report and document potential changes in the skin; (2) Review the interventions and strategies for effectiveness on an ongoing basis. Review of the facility's policy titled Wound Care, undated, included but was not limited to: - The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. - The following information should be recorded in the resident's medical record: (1) the type of wound care given, (2) the date the wound care was given, (3) the name and title of the individual performing the wound care, (4) any change in the resident's condition, (5) all assessment date (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound, (6) any problems or complaints made by the resident related to the procedure, (7) if the resident refused the treatment and the reason(s) why, (8) the signature and title of the person recording the data. - Reporting: (1) notify the supervisor if the resident refuses the wound care, (2) report other information in accordance with facility policy and professional standards of practice. 1. Resident #65 was admitted to the facility in June 2024 with diagnoses of Enterocolitis due to Clostridium Difficile (C. diff - an infection of the large intestine often resulting in loose stools/diarrhea), osteomyelitis, stage IV pressure ulcer of the sacral region, and chronic kidney disease. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 9/26/24, indicated Resident #65 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Further review indicated that Section M: Skin Conditions of the MDS assessment indicated he/she was being treated for a stage IV pressure ulcer. The assessment also indicated Resident #65 was receiving pressure ulcer/injury care including application of non-surgical dressings and ointments. Review of Resident #65's comprehensive care plans indicated the Resident had a stage IV pressure injury to the sacrum with interventions to provide wound care per treatment order, measure ulcer on at (sic) regular interval and monitor for signs of infection. Review of Resident #65's medical record indicated he/she was hospitalized from 7/29/24 to 7/31/24. Review of the Hospital Discharge Summary indicated the Resident had a chronic sacral wound with osteomyelitis since January 2024. The Hospital Discharge Summary also indicated the Resident was positive for C. diff and required a Fidaxomicin (antibiotic) or Vancomycin (antibiotic) taper for the treatment of C. diff. Review of Resident #65's medical record failed to indicate an order for a Fidaxomicin or Vancomycin taper was obtained on 7/31/24 upon return from his/her hospitalization . Review of Resident #65's nursing Wound - Weekly Observation Tool, dated 7/31/24, indicated but was not limited to the following: - UM (Unit Manager) wound measurements on admission: Stage 4 pressure ulcer sacrum 7.5 centimeters (cm) x 8.0 cm x 0.3 cm, 25% slough (necrotic (dead) tissue that is green, yellow, tan, or brown and may be moist, loose, or stringy) and 75% granulation (pink-red moist tissue that fills an open wound, when it starts to heal), moderate amount serous sanguinous drainage (yellow serous fluid mixed with blood). - Visible Tissue overall impression - unchanged; granulation tissue, slough tissue - Visible Tissue Comments: 7.0 cm x 8.0 cm x 1.0 cm, 50% slough and 50% granulation. - Drainage: Moderate serous - Odor: NO - Treatment: Santyl (a medication used to treat and debride pressure ulcers), Alginate (fibrous, water insoluble dressing that forms a gel that absorbs drainage), Bfoam (bordered foam), once daily and PRN (as needed). - Evaluation: wound progress - improved Review of Resident #65's Physician's Orders indicated but were not limited to the following: - 7/31/24 to 8/9/24: cleanse with wound cleanser; Santyl, Alginate, border foam change daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record indicated Resident #65 was seen by the Consulting Wound Nurse Practitioner (NP) on 8/9/24. Review of the Consulting Wound NP's progress note from 8/9/24 indicated but was not limited to the following: - Per staff Resident had been hospitalized since last wound evaluation. - Wound measurements increased. - Mild odor noted. - Will switch to cleansing wound with 1/2 strength Dakins. - Duration: Area first evaluated on 3/27/24 - Etiology: Pressure - Stage/Severity: Stage IV - Wound Status: Worsening - Odor Post Cleansing: Mild - Size: 8.0 cm x 9.5 cm x 0.8 cm - Wound Base: 75% granulation, 25% slough - Exudate (Drainage): Moderate amount of yellow - Recommendations: cleanse with 0.25% Dakins (1/2 strength), apply Santyl, Calcium Alginate to base of the wound, secure with bordered foam. Change daily, PRN (as needed) for soiling, saturation or accidental removal. Review of Resident #65's Physician's Orders indicated the following: - 8/9/24 to 8/26/24: Sacral Dakims (sic), alginate, bordered foam; every day shift Further review of the Physician's Orders failed to include the Santyl portion of the treatment as recommended by the Consulting Wound NP on 8/9/24. Furthermore, the Physician's Orders failed to indicate the Dakin's strength or clarify calcium alginate versus an alginate dressing. Review of the August 2024 Treatment Administration Record (TAR) indicated the following treatment was completed daily to the sacrum between 8/9/24 and 8/16/24: - Sacral Dakims (sic), alginate, bordered foam; every day shift Further review of the August 2024 TAR failed to include the Santyl portion of the treatment as recommended by the Consulting Wound NP on 8/9/24. Furthermore, the TAR failed to indicate the Dakin's strength or clarify calcium alginate versus an alginate dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record indicated Resident #65 was seen by the Consulting Wound Nurse Practitioner (NP) on 8/16/24. Review of the Consulting Wound NP progress note from 8/16/24 indicated but was not limited to the following: - Per staff Resident went to the hospital yesterday due to abnormal labs and received one unit of packed red blood cells (PRBCs). - Wound measurements increased. - Increased odor and drainage. - Will switch treatment to Dakin moist gauze. - Recommend x-ray and labs to evaluate for osteomyelitis. - Duration: Area first evaluated on 3/27/24 - Etiology: Pressure - Stage/Severity: Stage IV - Wound Status: Worsening - Odor Post Cleansing: Malodorous - Size: 8.0 cm x 10.0 cm x 1.5 cm - Wound Base: 75% granulation, 25% slough - Exposed Tissue: Bone - Exudate (Drainage): Large amount of yellow - Recommendations: irrigate with wound cleanser, apply 1/2 strength Dakins moist gauze to base of wound, secure with silicone border foam. Change twice daily and PRN for soiling, saturation, or accidental removal. - Further Recommendations: X-ray of wound site and labs. Review of Resident #65's nursing progress notes, dated 8/16/24, indicated the Resident was seen by the Consulting Wound NP. The nursing progress notes further indicated the recommended labs and x-ray were reviewed with the NP and ordered. Review of Resident #65's telehealth NP progress note, dated 8/17/24, indicated a sacral x-ray was concerning for osteomyelitis. Further review of the telehealth NP progress note indicated the Resident was ordered to be transferred to the hospital for further follow-up. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #65's Hospital Discharge Summary, dated 8/19/24, indicated but was not limited to the following: - The Resident had a history of chronic osteomyelitis and chronic decubitus ulcer. - The Resident presented to the hospital with decubitus ulcer pain and diarrhea. - The Resident was positive for C. diff and a 40-day Vancomycin taper for treatment was never initiated as recommended on previous hospital discharge (7/31/24). - It was recommended for the Resident to begin the 40-day Vancomycin taper for treatment of C. diff upon discharge from the hospital on 8/19/24. - The Resident has a chronic decubitus ulcer and osteomyelitis. - A Computed Tomography Angiography of the Pulmonary Arteries (CTAP) completed on 8/17/24 demonstrated worsening soft tissue ulceration overlying the distal sacrum and coccyx with open bone exposure. The CTAP also showed increased fragmentation of the coccyx favoring chronic osteomyelitis. - The Resident was seen by Infectious Disease (ID) who suggested no antibiotics for now. - Wound treatment recommendations included: cleanse with normal saline and pat dry; paint periwound skin with 3M Vailon No String Barrier Film to protect and help Mepilex to better adhere to skin; cover with a piece of Exufiber Ag (silver) to absorb drainage, promote moist would healing and offer broad spectrum topical antimicrobial control through the use of sustained release silver; cover with Mepilex Border Sacrum; and change every other day and PRN (as needed). Review of Resident #65's medical record indicated he/she returned from the hospital on 8/19/24. Review of the medical record indicated the wound treatment recommendations as well as the 40-day Vancomycin taper were implemented. During an interview on 12/5/24 at 11:58 A.M., Wound Consultant #1 said Resident #65 has been followed for a chronic stage IV sacral pressure ulcer since being admitted to the facility. Wound Consultant #1 said Resident #65 has a history of recurrent C. diff. Wound Consultant #1 said in her experience when Resident #65 has C. diff he/she typically has large stools which would require dressing changes of the chronic stage IV sacral pressure ulcer. Wound Consultant #1 said large amounts of loose stool would negatively impact the wound healing process. During an interview on 12/5/24 at 12:35 P.M., the Physician said recommendations for medications and treatments from the Consulting Wound NP are reviewed with himself or his NP. The Physician said Consulting Wound NP recommendations are generally accepted by the providers. The Physician said he does not recall being notified of recommendations for a 40-day Vancomycin taper after Resident #65's hospitalization from [DATE] to 7/31/24. The Physician said loose stools and C. diff would have a negative impact on the Resident's wound status. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/9/24 at 8:26 A.M., Unit Manager (UM) #1 said the Consulting Wound NP rounds on Fridays with the other UM and herself. UM #1 said the Consulting Wound NP will typically undress and evaluate the wound. UM #1 said the Weekly - Wound Observation Tool is updated based on the Consulting Wound NP's observations and recommendations. UM #1 said if any treatment recommendations are changed, they are reviewed with the resident's Physician or NP and orders are updated in the electronic medical record. UM #1 reviewed Resident #65's medical record and said Resident #65's wound treatment orders from 8/9/24 to 8/16/24 did not match the recommendations made by the Consulting Wound NP. UM #1 said the order was missing the Consulting Wound NP's recommendation for Santyl. UM #1 said recommendations for a Fidaxomicin or Vancomycin taper for the treatment of C. diff was not implemented upon return from the hospital on 7/31/24. During an interview on 12/9/24 at 11:20 A.M., the Director of Nursing (DON) said she reviewed Resident #65's medical record and noted the 40-day Vancomycin taper was not implemented when he/she returned from the hospital on 7/31/24 as it should have been. The DON said there should not have been a delay in starting the 40-day Vancomycin taper for Resident #65. The DON reviewed the Consulting Wound NP's recommendations and documentation and said the orders from 8/9/24 to 8/16/24 did not include Santyl as recommended by the Consulting Wound NP. 49425 2. Resident #68 was admitted to the facility in May 2024 with diagnoses including cerebral vascular accident (damage to the brain from interruption of blood supply) and spinal fusion. Review of the MDS assessment, dated 9/3/24, indicated Resident #68 was cognitively intact as evidenced by a score of 15 out of 15 on the BIMS. Additionally, Resident #68 had two unstageable pressure ulcers/injuries which were receiving skin treatments and he/she was dependent on staff for assistance with bed mobility. Review of the comprehensive care plan indicated but was not limited to the following: - Resident has unstageable pressure ulcers to bilateral heels related to immobility - Administer treatments as ordered and monitor for effectiveness - Notify MD/NP and obtain treatment Review of the medical record indicated Resident #68 was followed by a Wound Care Nurse Practitioner at the facility. Review of the Wound Assessment Report, completed by the Consulting Wound NP, dated 11/22/24, indicated but was not limited to the following: -Unstageable Pressure Wound of the Left Heel - Treatment: Cleanse with normal saline (NS), apply Santyl, Calcium alginate, cover with abdominal (ABD) pad and rolled gauze. Change daily and as needed for soiling, saturation, or accidental removal. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Wound Care Specialist's progress note, dated 11/22/24, indicated but was not limited to the following: - Left heel wound no longer with eschar (thick adherent black dead tissue), slough, and granulation to wound bed. Will update treatment plan. - Wound Status: improving without complications. Review of the Wound Assessment Report, completed by the Consulting Wound NP, dated 12/06/24, indicated but was not limited to the following: - Unstageable Pressure Wound of the Left Heel - Treatment: Cleanse with NS, apply Santyl, Calcium alginate, cover with ABD pad and rolled gauze. Change daily and as needed for soiling, saturation, or accidental removal. Review of the Wound Care Specialist's progress note, dated 12/06/24, indicated but was not limited to the following: - Left heel wound continue with treatment plan. - Wound Status: improving without complications. Review of the November and December 2024 Physician's Orders and TARs indicated an order was implemented on 9/13/24 as follows: Left heel: Cleanse with NS and pat dry. Apply Iodosorb (ointment applied to wound bed to remove bacteria and slough). Cover with ABD pad and wrap with kling. Change daily and as needed for dislodgement. Further review of the Physician's Orders failed to include the wound treatment recommendations from 11/22/24. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound nurse practitioner. During an interview on 12/9/24 at 11:42 A.M., UM #1 said she rounds with the wound NP weekly on Fridays. She said the wound NP assesses and measures the wounds and provides treatment recommendations. She said she receives the recommendations verbally, and the wound NP follows up with faxing over a Wound Assessment Report and documenting the visit under progress notes in the Resident's medical record. UM#1 said then she implements the orders. She said the medical director defers treatment plans to the wound NP. UM#1 reviewed the Wound Assessment Report, dated 11/22/24, with the active physician order in the medical record and said the treatment was never changed as it should have been. She said she was not in the facility on 11/22/24, and someone else completed rounds with the wound NP, and must have missed the treatment change. UM#1 said the treatment order is incorrect and will notify the physician of the error. (continued on next page)

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Vantage at Milford LLC	10 Veterans Memorial Drive Milford, MA 01757

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/9/24 at 2:43 P.M., the DON said her expectation is for the facility staff member who rounds with the wound NP to initiate the recommendations the date received. She said the order was incorrect.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43935 Based on observation, document review, and interview, the facility failed to ensure it provided an environment free of potential safety hazards for two Residents (#38 and #18), out of a total sample of 18 residents. Specifically, the facility failed to: 1. For Resident #38, a. Ensure his/her emergency oxygen tank was stored in a holder to prevent it from potentially falling over and causing a hazard, and b. Provide him/her a lock box to secure his/her inhalers and keep them out of the reach of unauthorized users; and 2. For Resident #18, ensure his/her bedside inhaler, which he/she can self-administer, was secured and out of view or accessibility of other residents. Findings include: Review of the facility's policy titled Medication Labeling and Storage, undated, indicated but was not limited to the following: - medications are stored in an orderly manner in cabinets, drawers, boxes, carts or other holding areas to prevent the possibility of mixing up medications of several residents - compartments including drawers, boxes, cabinets, rooms, etc. containing biologicals or medications are locked when not in use - nursing staff are responsible for maintaining medication storage in a safe manner Review of the facility's policy titled Self-administration of Medications, dated as revised February 2024, indicated but was not limited to the following: - self-administered medications are stored in a safe and secure place, which is not accessible by other residents - if safe storage is not possible in the resident's room, the medication is stored on a central medication cart or in the medication room and the licensed nurse will transfer medications to the resident when the resident requests them 1a. Review of the National Fire Protection Association (NFPA) 99, Health Care Facilities Code, 2012 Edition Chapter 11: Gas Equipment, section 11.6.2.3 (11) states that freestanding oxygen cylinders shall be properly chained or supported in a proper cylinder stand or cart. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #38 was admitted to the facility in December 2021 and has diagnoses including: dyspnea (shortness of breath), dependence on supplemental oxygen, and chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block air flow and make it difficult to breathe). Review of the Minimum Data Set (MDS) assessment, dated 9/12/24, indicated the following: - Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the Resident is cognitively intact - Resident suffers from shortness of breath when lying flat - Resident uses oxygen therapy Review of the current Physician's Orders for Resident #38 indicated but were not limited to the following: - Oxygen at 4 liters by nasal canula continuously to maintain oxygen saturations greater than 92% (2/7/24) The surveyor made the following observations: - 12/3/24 at 9:31 A.M., E-tank (cylinder or tank of compressed oxygen approximately 3 feet tall) observed standing against the wall near the heater in the room, not secured in a cylinder stand or attached to the wall - 12/3/24 at 10:11 A.M., E-tank standing under the window in the room, not in a cylinder stand, secured or attached to the wall - 12/4/24 at 7:45 A.M., E-tank standing by the heater in the room, not in a cylinder stand, secured or attached to the wall - 12/4/24 at 9:54 A.M., E-tank (with indicator reading as full of oxygen), free standing in the room by the wall, not in a cylinder stand, secured or attached to the wall - 12/4/24 at 1:38 P.M., E-tank (full) standing by the wall, not in a cylinder stand, secured or attached to the wall During an interview on 12/4/24 at 1:38 P.M., Unit Manager (UM) #1 said the Resident is on continuous oxygen and has a backup cylinder in his/her room for when they leave the room. She said the oxygen E-tank should not be sitting directly on the floor and could be a safety hazard and should be stored in a cylinder stand or holder to prevent the potential of it falling over and causing a safety hazard. She said the oxygen E-tank was not currently stored in a secure way in the Resident's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/24 at 1:42 P.M., the Director of Maintenance observed the E-tank in the Resident's room. He said the oxygen cylinder should not be stored in the room without being in a cylinder holder or stand and having it free standing could result in the tank falling over and launch itself through a wall or into a resident or equipment; free standing it was a safety hazard. He said the E-tank was not stored properly at this time and it should be in a cylinder holder or attached to the Resident's wheelchair. He said the facility was not following the safety guidelines for oxygen storage. b. Review of the current Physician's Orders for Resident #38 indicated but were not limited to the following: - Advair HFA Inhalation aerosol 230-21 micrograms per actuation (mcg/act), 2 puffs inhaled orally two times a day for COPD (6/18/24) - Albuterol sulfate HFA Inhalation aerosol solution 108 mcg/act, 2 puffs inhaled orally every four hours as needed for shortness of breath (11/21/22) - Incruse Ellipta aerosol powder breath activated 62.5 mcg/act, 1 puff inhaled orally one time a day for COPD (12/6/22) - Resident may self-administer inhalers at the bedside (12/6/23) - Resident may administer some medications including his/her inhalers as he/she has shown knowledge of medications and risks (4/7/22) During an interview on 12/3/24 at 10:11 A.M., the Resident said he/she keeps their inhalers at the bedside and the facility is aware that they are there. The Resident said he/she has been given permission to keep them in his/her room and self-administer them. The Resident said he/she does not have a lock box or anywhere that he/she can secure their inhalers and therefore just keeps them on the overbed table at all times. During an interview on 12/4/24 at 8:13 A.M., Nurse #9 said the Resident self-administers one inhaler on her shift and it is kept at the bedside, typically on the overbed table. She said the Resident does not have a way to lock up the medications he/she keeps in his/her room, but there was some talk in the past about getting him/her a locking box to secure the medications. She said the Resident tells her when he/she takes the inhaler and she signs it off on the medication administration record. She said the Resident is mentally right on target and has no issues with knowing their inhalers and when or how to take them. The surveyor observed three inhalers (Advair, Albuterol, and Incruse) lying on the overbed table, not secured or inaccessible to others on: - 12/3/24 at 9:31 A.M. - 12/3/24 at 10:11 A.M. - 12/4/24 at 7:45 A.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/4/24 at 9:54 A.M. - 12/4/24 at 1:38 P.M. During an interview on 12/4/24 at 1:39 P.M., UM #1 said Resident #38 does not have a lock box or way to secure the inhalers that are stored at the bedside but should. She said medications at the bedside are supposed to be secured in a locked compartment to ensure other residents or anyone passing by doesn't have access to them. She said the policy indicates medications at the bedside are supposed to be secured and in locked compartments and the Resident's inhalers are not at this time. 2. Resident #18 was admitted to the facility in October 2023 with diagnoses including: COPD and Solitary pulmonary nodule (a non-cancerous mass in the lungs). Review of the MDS assessment, dated 12/12/24, indicated the following: - BIMS score of 15 out of 15 indicating the Resident is cognitively intact - Resident suffers from shortness of breath when lying flat Review of the current Physician's Orders for Resident #38 indicated but were not limited to the following: - Albuterol Sulfate inhalation aerosol powder breath activated 90 micrograms inhale orally 2 puffs every four hours as needed for shortness of breath (3/28/24) - May have Albuterol inhaler at the bedside to self-administer for rescue inhaler (3/28/24) During an interview on 12/3/24 at 10:11 A.M., Resident #18 said he/she keeps their rescue inhaler at the bedside and he/she has received permission to do so. The surveyor observed the Albuterol rescue inhaler lying on the overbed table, not secured or inaccessible to others on: - 12/3/24 at 10:11 A.M. - 12/5/24 at 8:14 A.M. - 12/5/24 at 4:11 P.M. - 12/6/24 at 7:26 A.M. - 12/6/24 at 8:40 A.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 8:14 A.M., the Resident said no one has come in to provide a lock box for the storage of his/her inhaler at this time, but it could be helpful to keep it safe from other residents. The Resident said he/she is told the medications need to be locked up when the staff ask him/her questions about how to take the medications and side effects but no one has ever provided a manner for the medications to be secured. The Resident said he/she assumes that he/she doesn't have to lock up the inhaler because it is a rescue inhaler and no one has ever made it possible to secure it. During an interview on 12/5/24 at 4:51 P.M., Nurse #10 said she knows the Resident well and provides care to them regularly. She said the inhaler is always at the bedside on the overbed table and she doesn't believe the Resident ever uses the inhaler and has never told her that he/she has. She said she thinks the inhaler is there more for the Resident's peace of mind. She said there is no box for the inhaler to be locked up. During an interview on 12/6/24 at 8:47 A.M., Nurse #6 said the Albuterol rescue inhaler is always sitting on the Resident's overbed table. She said she does not think the Resident uses the inhaler, but there is a doctor's order for the medication to be left at the bedside for self-administration. She said she believes for safety it is supposed to be locked or secured in a box or drawer, but it always sits on the table in front of the Resident. During an interview on 12/6/24 at 12:48 P.M., UM #1 said the process is for the Resident to have their self-administration medications locked up at the bedside for the safety of other residents. She said this Resident does not have a lock box and keeps the inhaler on their overbed table. She said the process for self-administration is not fully implemented since the medication is not secured. During an interview on 12/6/24 at 12:50 P.M., the Director of Nurses said that residents who have been assessed and have orders to self-administer their medications are supposed to have their medications secured in a lock box at the bedside. She was made aware of the surveyor's observations for both Resident #38 and Resident #18 and said the process was not followed as it should have been and the medications should be secured to ensure the safety of all the other residents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48695 Based on observation, interview, and record review, for two Residents (#330 and #64), of 18 sampled residents, the facility failed to provide indwelling catheter (a flexible tube inserted into the bladder to drain urine outside of the body) care consistent with professional standards related to infection control prevention. Specifically, the facility failed: 1. For Resident #330, to maintain/secure the Resident's Foley catheter drainage bag away from contaminated surfaces; and 2. For Resident #64, to ensure his/her catheter drainage bag was positioned in a manner to prevent potential complications. Findings include: Review of Centers for Disease Control and Prevention's Guidelines for Prevention of Catheter-Associated Urinary Tract Infections, page last reviewed November 2015, indicated but was not limited to: - Do not rest the catheter bag on the floor. Review of the facility's policy titled Catheter Care, Urinary, last revised August 2024, indicated but was not limited to: - Purpose: The Purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. - Infection Control: Be sure the catheter tubing and drainage bag are kept off the floor. - Maintaining Unobstructed Urine Flow: Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. 1. Resident #330 was admitted to the facility in November 2024 with diagnoses including dementia and neuromuscular dysfunction of the bladder. Review of Resident #330's Minimum Data Set (MDS) assessment, dated 11/26/24, indicated he/she had a severe cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15 and he/she had an indwelling catheter. Review of Resident #330's current Physician's Orders indicated but was not limited to: -Indwelling catheter 16 FR (French) with 10 cc (milliliter) balloon to bedside straight drainage (dated 11/20/24) -Empty catheter drainage bag at least once every eight hours to when it becomes 1/2 to 2/3 full every 8 hours and as needed (dated 11/20/24) (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-May use leg bag if desired when out of bed (dated 11/20/24) -Perform indwelling catheter care every shift and as needed (dated 11/20/24) -Change indwelling catheter when occluded or leaking as needed (dated 11/20/24) The surveyor observed Resident #330's catheter drainage bag in direct contact with the floor as follows: - 12/4/24 at 7:43 A.M. - 12/4/24 at 8:06 A.M. - 12/4/24 at 9:55 A.M. - 12/4/24 at 12:25 P.M. - 12/4/24 at 1:33 P.M. - 12/4/24 at 3:47 P.M - 12/4/24 at 4:20 P.M. - 12/5/24 at 7:49 A.M. During an interview on 12/5/24 at 7:49 A.M., Certified Nursing Assistant (CNA) #1 said catheter drainage bags should not be on the floor. CNA #1 said if a resident was in bed, then his/her catheter drainage bag should be hung on their bed frame, and if the resident was in their wheelchair, the catheter should be secured off the floor. During an interview on 12/5/24 at 7:50 A.M., Nurse #1 said catheter drainage bags should be secured off the floor. During an interview on 12/5/24 at 10:58 A.M. Unit Manager (UM) #2 said catheter drainage bags should always be kept below the resident's bladder and off the floor. During an interview on 12/5/24 at 12:28 P.M., the Occupation Therapy Assistant said Resident #330's catheter drainage bag should have been secured off the floor. During an interview on 12/9/24 at 3:40 P.M., the Director of Nursing (DON) said the expectation was for catheter drainage bags to be positioned below the resident's bladder and should not be in direct contact with the floor. 43935 2. Resident #64 was admitted to the facility in December 2023 with diagnoses including: cerebral infarction (stroke) and obstructive uropathy. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #64's BIMS, dated 9/12/24, indicated he/she was severely cognitively impaired with a score of 0 out of 15. Review of the current orders for Resident #64 indicated but were not limited to the following: -Foley catheter 22 French with 30 milliliter balloon: may change Foley as needed due to blockage (5/24/24) -Empty catheter drainage bag at least once every eight hours every shift (5/3/24) The surveyor made the following observations as follows: 12/3/24 at 9:20 A.M., Catheter drainage bag laying on the floor on the right side of the Resident's bed, while the Resident was in the bed. 12/3/24 at 1:14 P.M., Catheter drainage bag hanging off the right side of the Resident's bed, on the floor face down, while the Resident was in the bed. 12/3/24 at 2:27 P.M., Catheter drainage bag on the right side of the Resident's bed, lying on the floor face up, while the Resident was in the bed. 12/4/24 at 7:37 A.M., Catheter drainage bag hanging off the right side of the Residents bed on the upper 1/4 siderail, above the Resident's bladder level. 12/4/24 at 9:54 A.M., Catheter drainage bag hanging on the right upper 1/4 siderail of the Resident's bed, above the Resident's bladder level. During an interview on 12/5/24 at 7:59 A.M., Nurse #2 said residents with catheters are required to have their drainage bags kept off the floor for infection control reasons and the bag should be positioned below the bladder level at all times to prevent potential backflow of urine into the resident's bladder. During an interview on 12/5/24 at 10:02 A.M., CNA #2 said when the CNAs are providing care to residents with catheters, they are to make sure that the drainage bag is hung below the waist (bladder level) of the resident either on the edge of the bed frame or under the wheelchairs, and the bag may not touch the floor. During an interview on 12/5/24 at 10:07 A.M., Nurse #3 said residents with catheters are to have the drainage bags positioned below bladder level and the bags cannot be placed on the floor for infection control reasons. She said both the CNAs and Nurses are responsible for providing catheter care and ensuring the drainage bags are maintained in the appropriate manner. During an interview on 12/5/24 at 10:09 A.M., Unit Manager #1 said that Resident #64 should have had his/her drainage bag kept off the floor and positioned below bladder level at all times. She said having the drainage bag on the floor is a potential infection control issue for contamination and if the bag is positioned above the bladder it could result in the back flow of urine into the bladder causing potential complications. She said the process for positioning this Resident's catheter drainage bag does not appear to have been followed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 4:36 P.M., the Infection Preventionist said that residents with catheters are to have their drainage bags positioned below the bladder level to prevent potential back flow of urine into the bladder and complication. She said the drainage bag should never be placed on the floor as it could cause a potential complication with infections. She said based on the surveyor's observations the facility did not follow their process for ensuring Resident #64's catheter drainage bag was positioned in a manner to prevent complications.

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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. 50740 Based on document review and interview, the facility failed to ensure the monthly medication regimen review (MRR) for one Resident (#13), out of a total sample of 18 residents, was included in the medical record or readily available for review to indicate the Physician's response to the recommendations made by the Pharmacist. Findings include: Review of the facility's policy titled Pharmacy Consultant/Medication Orders, revised 2024, indicated but was not limited to the following: -The consulting pharmacist will ensure that a record of the observations and recommendations is made available in an easily retrievable to [sic] the Director of Nursing/Designee who is the process manager and who will ensure that the information is available to the nurses, prescribers, and the care planning team. -All recommendations received from the pharmacy consultant should be addressed prior to the next medication regimen review. -Recommendations will be acted upon and documented by the facility licensed nurse and/or the prescriber. Resident #13 was admitted to the facility in September 2023 with diagnoses including dementia, fracture of the second cervical vertebra (a broken bone in the neck), and mild cognitive impairment. Review of the medical record for Resident #13 indicated the Consultant Pharmacist had completed a MRR with recommendations to the physician as follows: 1/23/24: MD rec (recommendation) to reeval (re-evaluate) prn (as needed) trazodone (an antidepressant medication) 2/22/24: md rec for tsh (a laboratory test to evaluate thyroid function) 4/29/24: MD rec for lipid panel (a laboratory test to evaluate cholesterol levels in the blood) 5/22/24: MD rec to consider reduction of Pravachol (a medication used to lower cholesterol levels) 6/17/24: MD rec to consider reduction of Pravachol. 7/25/24: MD rec to consider reduction of Pravachol. 9/23/24: MD rec to reeval prn Ativan (an anti-anxiety medication) (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 Consultant Pharmacist Recommendation to Prescriber form for the MRR, dated 6/18/24, indicated that the Physician declined the Consultant Pharmacist's recommendation to consider a dose reduction of Pravachol for Resident #13. The facility failed to provide copies of the Review of the Consultant Pharmacist Recommendation to Prescriber forms for MRRs completed 1/23/24, 2/22/24, 4/29/24, 5/22/24, 7/25/24, and 9/23/24 indicating they were reviewed by the Resident's provider as requested by the surveyor. During an interview on 12/05/24 at 2:29 P.M., the Director of Nurses (DON) said the Resident's medical record was reviewed and only one of the requested MRR forms was found. The DON said the completed forms should be retained in the Resident's medical record.

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Vantage at Milford LLC	10 Veterans Memorial Drive Milford, MA 01757

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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. 34145 Based on record review and interview, the facility failed to ensure one Resident's (#13) drug regimen was free from unnecessary psychotropic medications, out of a total sample of 16 residents. Specifically, the facility failed to ensure the Physician or Nurse Practitioner documented a risk/benefit analysis for the continued use of the antidepressant medication Amitriptyline in response to the Pharmacist's recommendation to consider a safer alternative treatment. Findings include: Review of the facility's policy titled Psychoactive Medication Use, last revised 2024, indicated but was not limited to: - Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: antidepressants - Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. - Situations which may prompt an evaluation or re-evaluation of the resident include: an irregularity identified in the pharmacist's medication regimen review. Resident #13 was admitted to the facility in September 2023 and had diagnoses including major depression, dementia with psychotic disturbance, and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 12/10/24, indicated Resident #13 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15, and received psychotropic medication daily. Review of the medical record indicated the following Physician's Orders: - Amitriptyline HCl Oral tablet 25 milligrams (mg), give 1 tablet by mouth at bedtime for depression (2/26/24) Review of the consultant Pharmacist's Medication Regimen Review (MRR) documentation, dated 12/19/24 and signed by the physician as addressed on 12/19/24, indicated but was not limited to: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident is currently receiving Amitriptyline 25 mg at bedtime. This medication should be avoided in elderly patients because it is highly anticholinergic (blocks the action of acetylcholine (a neurotransmitter, or a chemical messenger. It transfers signals between certain cells to affect how your body functions), sedating, and can cause orthostatic hypotension according to the most recently published Beers criteria (a set of evidence-based guidelines that aim to identify and avoid potentially inappropriate medications in older adults). Please consider using a safer alternative. The following medications have been noted as alternatives for depression: Selective Serotonin Reuptake Inhibitors (SSRI) (except Paroxetine), Serotonin-Norepinephrine Reuptake Inhibitors (SNRI), bupropion, and alternatives for neuropathic pain: SNRI, gabapentin, capsaicin topical, pregabalin, lidocaine patch. If continuing, please document a risk/benefit analysis in the context of clinical condition, existing medication regimen, and related factors to keep this facility in compliance with current regulations. The physician wrote a check mark next to the following pre-printed response on the MRR: -The benefit of treating this condition with this medication outweighs the potential/actual risks; therefore, continue the current therapy. Continuation of therapy helps promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing, as identified by, and in collaboration with, the resident and/or representative. Review of December 2024 through January 2025 Medication Administration Record indicated the order for Amitriptyline was administered as ordered by the physician. Further review of the medical record failed to indicate Resident #13's physician documented a risk/benefit analysis in the context of the Resident's clinical condition, existing medication regimen and related factors in response to the Pharmacist's recommendation for a safer alternative. During an interview on 1/3/25 at 1:55 P.M., Unit Manager #1 reviewed Resident #13's medical record and said there was no evidence that either the Physician or Nurse Practitioner documented a risk/benefit analysis in the context of the Resident's clinical condition, existing medication regimen and related factors for the continued use of Amitriptyline in response to the Pharmacist's recommendation to consider a safer alternative treatment. During an interview on 1/3/25 at 2:30 P.M., Physician #1 reviewed Resident #13's medical record and said he only checked off a response on the MRR and neither he nor the Nurse Practitioner documented a risk/benefit analysis of continued use of the medication in response to the Pharmacist's recommendation to consider a safer alternative.

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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. 49425 Based on observation, interview, and record review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. For Resident #41, ensure a portable nebulizer device (turns liquid medicine into a mist that can be inhaled to treat lung conditions) and a bottle of Tums (antacid that treats heartburn, indigestion, and upset stomach) were not left unsecured in the Resident's room; 2. Ensure that once opened, a Lantus (long-acting insulin) pen was labeled with the date opened/date to be discarded; and 3. Ensure that once opened, Liquid Protein supplements were labeled with the date opened and/or date to be discarded. Findings include: Review of the facility's policy titled Self-Administration of Medications, dated as revised February 2024, indicated but was not limited to the following: -Medications are stored in a safe and secure place, which is not accessible by other residents. -Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. Review of the facility's policy titled Medication Labeling and Storage, undated, indicated but was not limited to the following: -Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Review of the facility's policy titled Insulin Storage, dated 2024, indicated but was not limited to the following: -Facility shall store insulin in accordance with pharmaceutical standards. -To ensure that your insulin remains effective, stable and undamaged you should discard your 'in use' insulin after 28 days, whether in a vial or cartridge. -Insulin has a 'use by' date as well as an expiration date. Insulins removed from the refrigerator and/or opened shall be dated as such with the use by date not to exceed 28 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #41 was admitted to the facility in July 2022 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD- lung condition causing airflow obstruction). Review of the Minimum Data Set (MDS) assessment, dated 11/7/24, indicated that Resident #41 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. During an observation with interview on 12/3/24 at 9:56 A.M., the surveyor observed the following in Resident #41's room: - a portable handheld nebulizer device, unsecured, uncovered, tucked in the elastic humidifier holder on the oxygen concentrator machine -a large bottle of Tums on the floor at the edge of Resident #41's bed, unsecured. Resident #41 said the staff are aware of the nebulizer device and have watched him/her use it. Resident #41 said his/her son brings in the Albuterol (treats wheezing, difficulty breathing) solution to refill the device, however he/she is uncertain how to clean or manage the device. Resident #41 said he/she keeps the bottle of Tums in his/her room in case he/she needs to use them, and no one from the facility has ever said he/she cannot obtain medications from his/her family. During an observation on 12/9/24 at 9:20 A.M., the surveyor observed the following in Resident #41's room: - a portable handheld nebulizer device, unsecured, uncovered, tucked in the elastic humidifier holder on the oxygen concentrator machine -a large bottle of Tums sticking out of a bag, next to the edge of the Resident's bed, unsecured. Review of Resident #41's active Physician's Orders indicated the following: -Albuterol Sulfate Nebulizer Solution 0.083% inhale orally via nebulizer every 4 hours as needed for shortness of breath/wheezing -Tums tablet chewable 500 milligrams (mg) one tablet by mouth every 8 hours as needed for heartburn Review of the Medication Administration Record (MAR) for the months of September, October, November, and December 2024 indicated Albuterol Sulfate nebulizer or Tums had not been administered. Review of the medical record indicated a Self-Administration of Medications assessment was completed on 11/15/24, indicating Resident #41 wished to self-administer inhaled/nebulized medications and had the ability to manage and maintain safe storage of the medication at the bedside. Further review of the assessment failed to indicate an assessment had been completed for the self-administration of any oral medications. Review of the comprehensive care plan indicated the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-may self-administer inhalers at bedside -monitor quantity of medications to validate Resident is taking medications -provide locked storage compartment for medications approved for unsupervised self-administration -Resident educated by nursing to ensure inhalers are locked in bedside drawers after use, verbalized understanding. During an interview on 12/5/24 at 2:04 P.M., Nurse #2 said she is not sure if residents may keep medications unlocked at the bedside. She said she would have to ask a nurse manager. During an observation with an interview on 12/5/24 at 2:10 P.M., Nurse #6 said Resident #41 may self-administer his/her Albuterol inhaler, he/she has a physician's order to do so. She said inhalers do not need to be in a locked container. The surveyor and Nurse #6 entered Resident #41's room and observed a portable handheld nebulizer device, not secured, uncovered, tucked in the elastic humidifier holder on the oxygen concentrator machine and a large bottle of Tums, sticking out of a bag, next to the edge of the Resident's bed. She said she was not aware of the Resident having a handheld nebulizer, or Tums in the room, she has never seen it before. Resident #41 said he/she uses the nebulizer throughout the day when he/she feels short of breath but has not taken any of the Tums in a long time. The Resident said the doctor put him/her on a different medication that he/she takes twice a day for heartburn. Resident #41 said he/she has never told anyone that he/she had the Tums in his/her room. During an observation on 12/9/24 at 8:04 A.M., the surveyor observed the following in Resident #41's room: -a portable handheld nebulizer device, unsecured, uncovered, tucked in the elastic humidifier holder on the oxygen concentrator machine. During an interview on 12/10/24 at 1:02 P.M., the Director of Nursing (DON) said Resident #41 should not have medications at the bedside which are not locked. She said her expectation would be for any residents who self-administer medications, to have an assessment completed, physician's order in place, and the medications to be stored in a locked container or drawer. 50740 2. On 12/4/24 at 12:50 P.M., the surveyor completed a review of the medication cart (High) on the Elm Unit with Nurse #5 and made the following observation: -One Lantus (a long-acting insulin) pen opened but not marked with the date opened/date to be discarded. During an interview on 12/4/24 at 12:52 P.M., Nurse #5 said that the insulin pen should have been labeled with the date opened/date to be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/4/24 at 9:06 A.M., the surveyor observed Nurse #6 administer Liquid Protein 30 milliliters (ml) to Resident #68. The bottle of Liquid Protein was opened prior to Nurse #6 using it. The bottle was not marked with the date opened. The surveyor and Nurse #6 reviewed the label on the bottle of Liquid Protein which indicated that the product had a three month shelf life from the date opened. During an interview on 12/4/24 at 9:16 A.M., Nurse #6 said that the bottle of Liquid Protein she had used during the medication pass should have been marked with the date it was opened but was not. On 12/4/24 at 12:50 P.M., the surveyor completed a review of the medication cart (High) on the Elm Unit with Nurse #5 and made the following observation: -One bottle of Liquid Protein, opened, not dated with the date opened or date to be discarded. During an interview on 12/4/24 at 12:52 P.M., Nurse #5 said no one told her the Liquid Protein needed to be labeled with the date opened. During an interview on 12/5/24 at 1:09 P.M., the DON said that the Liquid Protein should be marked with the date opened.

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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. 48362 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to properly label and date food products as well as maintain safe and clean equipment in three of three nourishment kitchenettes. Findings include: Review of the facility's policy titled Food Brought in for Patients/Residents, dated effective 5/1/23, indicated but was not limited to: - Food brought to residents by family or visitors will be handled and stored in a safe and sanitary manner. - Food may be stored in refrigerators outside of the Food and Nutrition Services Department on the nursing unit or in personal refrigerators in resident rooms. - Food items that require refrigeration must be labeled with resident's name and date the food was brought in. - Food items must be stored in a closed container to prevent contamination. - Food considered unsafe for consumption or beyond the expiration date will be discarded by staff upon notification to resident. - Food will be held in refrigerator for three (3) days following date on label and will be discarded by staff upon notification to resident. On 12/3/24 at 2:18 P.M., the surveyor made the following observations of the Cedar Unit nourishment kitchenette: - Two chocolate and two vanilla Premier Protein Shakes were located on the top shelf of the door to the refrigerator. No resident identification was listed on the bottles. - A bottle of Low Sodium V8 Juice was unopened located on the second shelf of the door to the refrigerator. No resident identification was listed on the bottle. On 12/3/24 at 2:30 P.M., the surveyor made the following observations of the Elm Unit nourishment kitchenette: - Food splatter and a dark brown/black substance were located on the top and sides inside of the microwave. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A package of Morning Star Farms Spicy Black Bean Patties was in the freezer. No resident identification was listed on the packaging. - A package of PictSweet Farms Frozen Roasting Vegetables (Broccoli, Carrots, Cauliflower) was in the freezer. No resident identification was listed on the packaging. - Multiple Tupperware containers with food products were in the freezer. The Tupperware containers were noted to have ice buildup on the inside of the containers and food products inside. The Tupperware containers had a resident identification but no use by date. On 12/3/24 at 2:46 P.M., the surveyor made the following observations on the Oak Unit nourishment kitchenette: - One single serving bottle of Coffee Milk, labeled with resident identification and a manufacturer's use by date of 11/27/24 in the refrigerator. - One single serving Friendly's Fudge Ice Cream Sundae with no resident identification was stored in the freezer. On 12/4/24 at 8:44 A.M., the surveyor made the following observations of the Elm Unit nourishment kitchenette: - Food splatter and a dark brown/black substance were located on the top and sides inside of the microwave. - A package of Morning Star Farms Spicy Black Bean Patties was in the freezer. No resident identification was listed on the packaging. - A package of PictSweet Farms Frozen Roasting Vegetables (Broccoli, Carrots, Cauliflower) was in the freezer. No resident identification was listed on the packaging. - Multiple Tupperware containers with food products were in the freezer. The Tupperware containers were noted to have ice buildup on the inside of the containers and food products inside. The Tupperware containers had a resident identification but no use by date. On 12/4/24 at 8:51 A.M., the surveyor made the following observations on the Oak Unit nourishment kitchenette: - One single serving bottle of Coffee Milk, labeled with resident identification and a manufacturer's use by date of 11/27/24 in the refrigerator. - A plastic Target bag containing several plastic Tupperware containers of food product with a use by date of 12/3/24 on the outside of the bag. The plastic Target bag did have resident identification. On 12/4/24 at 8:55 A.M., the surveyor made the following observations on the Cedar Unit nourishment kitchenette: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Two chocolate and two vanilla Premier Protein Shakes were located on the top shelf of the door to the refrigerator. No resident identification was listed on the bottles. - A bottle of Low Sodium V8 Juice was unopened located on the second shelf of the door to the refrigerator. No resident identification was listed on the bottle. On 12/5/24 at 2:34 P.M, the surveyor made the following observations on the Elm Unit nourishment kitchenette: - Food splatter and a dark brown/black substance were located on the top and sides inside of the microwave. - A package of Morning Star Farms Spicy Black Bean Patties was in the freezer. No resident identification was listed on the packaging. - A package of PictSweet Farms Frozen Roasting Vegetables (Broccoli, Carrots, Cauliflower) was in the freezer. No resident identification was listed on the packaging. - Multiple Tupperware containers with food products were in the freezer. The Tupperware containers were noted to have ice buildup on the inside of the containers and food products inside. The Tupperware containers had a resident identification but no use by date. On 12/5/24 at 2:36 P.M., the surveyor made the following observations on the Oak Unit nourishment kitchenette: - One single serving bottle of Coffee Milk, labeled with resident identification and a manufacturer's use by date of 11/27/24 in the refrigerator. - A plastic Target bag containing several plastic Tupperware containers of food product with a use by date of 12/3/24 on the outside of the bag. The plastic Target bag did have resident identification. On 12/5/24 at 2:38 P.M., the surveyor made the following observations on the Cedar Unit nourishment kitchenette: - One chocolate and two vanilla Premier Protein Shakes were located on the top shelf of the door to the refrigerator. No resident identification was listed on the bottles. - A bottle of Low Sodium V8 Juice was unopened located on the second shelf of the door to the refrigerator. No resident identification was listed on the bottle. On 12/9/24 at 9:49 A.M., the surveyor made the following observations on the Oak Unit nourishment kitchenette: - One single serving bottle of Coffee Milk, labeled with resident identification and a manufacturer's use by date of 11/27/24 in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 9:51 A.M., the surveyor made the following observations on the Elm Unit nourishment kitchenette: - Food splatter and a dark brown/black substance were located on the top and sides inside of the microwave. On 12/9/24 at 9:53 A.M., the surveyor made the following observations on the Cedar Unit nourishment kitchenette: - One chocolate and two vanilla Premier Protein Shakes were located on the top shelf of the door to the refrigerator. No resident identification was listed on the bottles. - A bottle of Low Sodium V8 Juice was unopened located on the second shelf of the door to the refrigerator. No resident identification was listed on the bottle. During an interview on 12/9/24 at 11:01 A.M., the Food Service Director (FSD) said she and her staff are responsible for stocking each unit's nourishment kitchenette in the morning and afternoon. The FSD said during stocking times dietary staff are looking to ensure food products stored in the refrigerators are properly labeled and are within expiration dates. The FSD said nursing staff are responsible for dating and labeling items brought in by residents' family members or visitors. The FSD said products should be labeled with the resident's name, the date the item was brought in and a discard date of three days later. The FSD and the surveyor reviewed the observations made in the nourishment kitchenettes on all three units. The FSD said items that were not labeled with an expiration date or resident identification should have been discarded. The FSD said items past the manufacturer's expiration should have been discarded. The FSD said the maintenance/housekeeping staff are responsible for cleaning the inside of the microwaves on each of the nourishment kitchenettes and said the microwave should be kept clean.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48362 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed: 1. For Resident #65, to ensure staff wore appropriate personal protective equipment (PPE) while providing care for the Resident who was on contact precautions due to Enterocolitis due to Clostridium Difficile (C. diff- an infection of the large intestine often resulting in diarrhea or loose stools); and 2. For Resident #327, to ensure staff wore appropriate PPE for enhanced barrier precautions (EBP) when providing gastrostomy care. Findings include: Review of the facility's policy titled Enhanced Barrier Precaution, dated as revised 2024, indicated but was not limited to: - Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. - In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. - Examples of infections requiring Contact Precautions include, but are not limited to: (b) diarrhea associated with Clostridium Difficile. - In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room. - While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). - Remove gloves before leaving the room and perform hand hygiene. - After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room. - Wear a disposable gown upon entering the Contact Precautions room or cubicle. - After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Signs - The facility will implement a system to alert staff to the type of precaution resident requires. - This facility typically utilizes a yellow precautions sign for the identification of Contact Precautions for staff and visitors. 1. Resident #65 was admitted to the facility in June 2024 with diagnoses including C. diff, pressure ulcer of sacral region, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 9/26/24, indicated Resident #65 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Further review of the MDS assessment indicated he/she was being treated for a stage IV pressure ulcer. Review of Resident #65's Physician's Orders indicated but were not limited to: - 9/5/24: Infection Precautions - contact due to C. diff infection. Review of Resident #65's comprehensive care plan indicated he/she has C. diff and had an intervention of contact precautions for all care related to C. diff. On 12/4/24 at 12:33 P.M., the surveyor observed that Resident #65 had a Contact Precautions Plus sign, undated, located on the wall outside his/her room, which indicated the following: - Before Entering: disinfect hands, put on gown (if clothes may come in contact with patient or environment), put on gloves. - Before Leaving: remove gown, remove gloves, soap and water wash. On 12/4/24 at 12:34 P.M., the surveyor made the following observations: - Certified Nursing Assistant (CNA) #3 was in Resident #65's room assisting him/her with their lunch meal. - CNA #3 was seated in a chair at Resident #65's bedside. - CNA #3 was not wearing gloves or a gown. On 12/4/24 at 12:37 P.M., the surveyor observed CNA #3 exit Resident #65's room with his/her lunch tray and perform hand hygiene with hand sanitizer from a wall dispenser outside of his/her room. During an interview on 12/4/24 at 12:42 P.M., CNA #3 said Resident #65 was on precautions. CNA #3 said she only needs to wear PPE when providing direct care to Resident #65. CNA #3 said she does not have to wear a gown or gloves every time she enters Resident #65's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225562	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Milford LLC	10 Veterans Memorial Drive Milford, MA 01757

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/24 at 9:55 A.M., Nurse #5 said Resident #65 was currently on precautions for their wound. Nurse #5 said staff are required to wear gowns and gloves only when providing direct care to the Resident. Nurse #5 said when not providing direct care, such as feeding the Resident, staff just need to follow standard precautions. During an interview on 12/9/24 at 10:01 A.M., Unit Manager (UM) #1 said Resident #65 is on contact precautions. UM #1 said staff should be wearing a gown and gloves each time they enter Resident #65's room. UM #1 and the surveyor reviewed the observations made by the surveyor on 12/4/24. UM #1 said the CNA should have worn a gown and gloves to assist the Resident with feeding. During an interview on 12/9/24 at 11:20 A.M., the Director of Nursing (DON) said Resident #65 was currently on contact precautions. The DON said staff should wear a gown and gloves each time they enter Resident #65's room. 48695 2. Resident #327 was admitted to the facility in September 2024 with diagnoses including severe protein calorie malnutrition and diabetes mellitus. Review of Resident #327's MDS assessment, dated 11/11/24, indicated he/she was cogitatively intact as evidenced by a BIMS score of 15 out of 15, and he/she had a feeding tube. Review of Resident #327's current Physician Orders indicated but was not limited to: - Infection precautions -enhanced barrier R/T (related to) Feeding Tube, dated 9/23/24 Resident #327 had an EBP sign, undated, from the Centers for Disease Control and Prevention (CDC) on the door to his/her room, which indicated but was not limited to the following: - Stop Enhanced Barrier Precautions - Everyone Must: - Clean their hands, including before entering and when leaving the room. - Providers and staff must also: - Wear gloves and a gown for the following High-Contact Resident Care Activities. - Dressing - Bathing/Showering - Transferring - Changing Linens - Providing Hygiene (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225562	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Milford LLC	10 Veterans Memorial Drive Milford, MA 01757

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy - Wound Care: any skin opening requiring a dressing On 12/4/24 at 7:47 A.M., the surveyor observed Nurse #1 administer medications to Resident #327 via his/her gastrostomy tube. Nurse #1 had gloves donned (on) but had failed to don (put on) a gown. On 12/4/24 at 1:35 P.M., the surveyor observed Nurse #1 perform hand hygiene and don of a gown prior to preparing and administering Resident #327's enteral feeding. Nurse #1 failed to don a gown. During an interview on 12/5/24 at 12:26 P.M., Nurse #1 said Resident #327 was on EBP for his/her gastrostomy. Nurse #1 said she had performed hand hygiene and donned gloves prior to administering Resident #327's medications and feeding via gastrostomy. Nurse #1 said she knew that she had to wear a gown when changing the dressing around Resident #327's gastrostomy, but she was not sure if she had to wear a gown to administer medication or feedings via gastrostomy. During an interview on 12/5/24 at 12:30 P.M., UM #2 said Resident #327 was on EBP related to their gastrostomy and staff should follow EBP and wear gown and gloves while providing high contact care and when providing medications or feedings via gastrostomy. UM #2 said Nurse #1 should have donned a gown when providing medications and a feeding via gastrostomy to Resident #327. During an interview on 12/9/24 at 3:40 P.M., the DON said it was the expectation for all staff to follow EBP. The DON said Nurse #1 should have donned a gown while she provided gastrostomy care to Resident #327.