STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225568	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Brook Rehabilitation and Healthcare Center	90 West Street Wilmington, MA 01887

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. 48990 Based on observations, interviews and record review, the facility failed to ensure a dignified existence was maintained for two Residents (#471 and #117) out of 27 total sampled residents. Specifically, 1.) For Resident #471, the facility failed to provide a privacy bag for a urinary catheter drainage bag. 2.) For Resident #117, the facility failed to provide a privacy bag for a urinary catheter drainage bag. Findings include: Review of the facility policy titled Resident Rights, revised January 2022, indicated: - Federal and state law guarantee certain basic rights to all residents of this facility. These rights include the resident's right to privacy and confidentiality. 1.) Resident #471 was admitted to the facility in September 2024 with diagnoses including benign prostatic hyperplasia with lower urinary tract symptoms, brain cancer, and hemiplegia affecting the right dominant side. Review of Resident #471's medical record indicated there was no Minimum Data Set (MDS) data available. Review of Resident #471's assessment titled Brief Interview for Mental Status (BIMS) Evaluation, dated 9/16/24, indicated Resident #471 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #471's active physician's orders, initiated 9/13/24, indicated: - Privacy bag for foley cath (urinary catheter) drainage bag, every shift. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 7:54 A.M., the surveyor observed Resident #471 sitting in a wheelchair. His/her urinary catheter drainage bag was observed clipped to the bottom of the wheelchair. There was no privacy bag on the urinary catheter drainage bag and clear, yellow urine was observed. Resident #471 said staff do not offer any type of privacy cover for the urinary catheter drainage bag but would be interested in having one. The following additional observations were made by the surveyor: - On 9/17/24 at 10:12 A.M., Resident #471 was observed talking with staff in the hallway with a urinary catheter drainage bag clipped to the front arm rest of his/her wheelchair. There was no privacy bag on the urinary catheter drainage bag and clear, yellow urine was observed. - On 9/17/24 at 2:16 P.M., Resident #471 was observed in bed with a urinary catheter drainage bag attached to the bedframe. The urinary catheter drainage bag did not have a privacy bag, and the clear, yellow urine was visible from the hallway. Review of Resident #471's plan of care, dated 9/13/24, failed to indicate rejection of care or refusal of privacy bag for his/her urinary catheter drainage bag. During an interview on 9/19/24 at 10:50 A.M., Certified Nurse Assistant (CNA) #3 said urinary catheter drainage bags should always have a privacy bag. During an interview on 9/19/24 at 12:33 P.M., Nurse #3 said urinary catheter drainage bags should always have a privacy bag because the urine should not be visible to others. During an interview on 9/19/24 at 9:43 A.M., The Director of Nursing (DON) said urinary catheter drainage bags should always have a privacy bag, even when in bed, because the urine should not be visible to others. 2.) Resident #117 was admitted to the facility in June 2024 with diagnoses including Parkinson's disease and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the Minimum Data Set (MDS) assessment, dated 7/31/24, indicated Resident #117 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS also indicated Resident #117 had an indwelling urinary catheter. Review of Resident #117's active physician's orders, initiated 8/5/24, indicated: - Privacy bag for suprapubic cath (urinary catheter) drainage bag, every shift. On 9/17/24 at 7:54 A.M., 9/17/24 at 8:19 A.M., and 09/17/24 10:02 AM, the surveyor observed Resident #117 in bed with a urinary catheter drainage bag attached to the bedframe. The urinary catheter drainage bag did not have a privacy bag, and the clear, yellow urine was visible from the hallway. During an interview on 9/17/24 at 7:56 A.M., Resident #117 said staff do not offer any type of privacy cover for the urinary catheter drainage bag but would be interested in having one. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #117's plan of care, last revised 8/28/24, failed to indicate rejection of care or refusal of privacy bag for his/her urinary catheter drainage bag. During an interview on 9/19/24 at 10:50 A.M., Certified Nurse Assistant (CNA) #3 said urinary catheter drainage bags should always have a privacy bag. During an interview on 9/19/24 at 12:33 P.M., Nurse #3 said urinary catheter drainage bags should always have a privacy bag because the urine should not be visible to others. During an interview on 9/19/24 at 9:43 A.M., The Director of Nursing (DON) said urinary catheter drainage bags should always have a privacy bag, even when in bed, because the urine should not be visible to others.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48990 Based on observation, interviews and record review, the facility failed to ensure the interdisciplinary team was involved in determining whether the self-administration of medications was clinically appropriate for one Resident (#78), out of 27 total sampled residents. Specifically, the facility failed to assess if it was clinically appropriate for Resident #78 to self-administer an injection prior to the Resident self-administering the injection. Findings include: Review of the facility policy titled Self Administration of Medications, revised January 2023, indicated: - Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication. - The staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident upon request. - In addition to general evaluation of decision-making capacity, the nurse will perform a more specific skill assessment, this can be accomplished on paper or through the EHR (electronic health record) system. - The EMAR (electronic medication administration record)/MAR (medication administration record) must identify meds that are self-administered. - If residents are determined to be able to self-administer Resident/Representative will complete a consent for Self-Administration. Resident #78 was admitted to the facility in October 2023 with diagnoses including diabetes and hyperlipidemia. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/6/24, indicated Resident #78 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #78's physician order, dated 7/31/24, indicated: - Trulicity Subcutaneous Solution Pen-Injector 1.5 ml (milliliter)/0.5 mg (milligram), which is an injectable medication used to treat diabetes, Inject 0.5 milliliter subcutaneously one time a day every Wed (Wednesday). Review of Resident #78's medical record failed to indicate any assessment of the Resident's mental and physical abilities by the staff, nurse, or practitioner to determine whether self-administering the trulicity injection was clinically appropriate. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #78's physician's orders and September 2024 Medication Administration record (MAR) failed to indicate the trulicity injection may be self-administered. Review of medical record failed to indicate a consent for self-administration was completed. On 9/18/24 at 9:38 A.M., the surveyor observed Nurse #2 prepare and administer medications to Resident #78 with the Assistant Director of Nursing (ADON) present. Nurse #2 said Resident #78 liked to self-administer the trulicity injection. Nurse #2 handed the injection to the Resident who injected the medication into his/her abdomen. Resident #78 said he/she always self-administered the trulicity injection. Review of Resident #78's nursing progress note, dated 9/18/24, indicated: - Self administered injection w/ (with) good technique and little instruction. During an interview on 9/18/24 at 9:50 A.M., the Assistant Director of Nursing (ADON) said any resident who self-administers medication needs to be assessed to determine if it is clinically appropriate and a consent must be obtained prior to self-administration. The surveyor and ADON reviewed the medical record together and were unable to locate that a self-administration of medication assessment was completed or that a consent for medication self-administration was completed by the Resident/Resident Representative. The ADON said these should have been completed but were not. During an interview on 9/19/24 09:43 A.M., the Director of Nursing (DON) said Resident #78 should have had an assessment completed to determine if self-administration of medication was clinically appropriate and consent for medication self-administration should have been obtained prior to the Resident self-administering the trulicity injection.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48990 Based on record review and interview, the facility failed to transmit Minimum Data Set (MDS) data to the Centers for Medicare and Medicaid Services (CMS) System timely for two Resident (#18 and #99), out of 27 total sampled residents. Specifically: 1.) For Resident #18, the facility failed to transmit an MDS discharge assessment within 14 days after completion. 2.) For Resident #99, the facility failed to transmit an MDS discharge assessment within 14 days after completion. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual indicated an MDS discharge assessment must be transmitted within 14 days after the MDS completion date. 1.) Resident #18 was admitted to the facility in April 2024 with diagnoses including low back pain and repeated falls. Review of facility census indicated Resident #18 was discharged from the facility on 5/10/24. Review of medical record indicated the MDS discharge assessment, dated 5/10/24, was completed 5/14/24, but was never transmitted. During an interview on 9/19/24 at 9:43 A.M., the Director of Nursing (DON) said all MDS assessments should be transmitted timely by an MDS Nurse as required by RAI guidelines. During an interview on 9/19/24 at 8:06 A.M., MDS Nurse #1 said the MDS discharge assessment that was completed for Resident #18 was never transmitted but should have been. 2.) Resident #99 was admitted to the facility in April 2024 with diagnoses including adult failure to thrive and repeated falls. Review of facility census indicated Resident #99 was discharged from the facility 5/6/24. Review of medical record indicated the MDS discharge assessment, dated 5/6/24, was completed 5/16/24, but was never transmitted. During an interview on 9/19/24 at 9:43 A.M., the Director of Nursing (DON) said all MDS assessments should be transmitted timely by an MDS Nurse as required by RAI guidelines. During an interview on 9/19/24 at 8:06 A.M., MDS Nurse #1 said the MDS discharge assessment that was completed for Resident #99 was never transmitted but should have been.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 50338 Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS) for one Resident (#92) out of 27 total sampled residents. Specifically, the facility inaccurately coded the MDS to indicate the Resident was comatose or in a persistent vegetative state. Findings include: Resident #92 was admitted to the facility in April 2023 with diagnosis including traumatic subdural hemorrhage. Review of the most recent MDS assessment, dated 9/6/24, indicated Resident #92's hearing, speech, vision, cognitive patterns, mood, activity preferences and pain had not been assessed. On 9/17/24 7:49 A.M., the surveyor observed Resident #92 in bed. Resident #92 was able to answer questions appropriately, follow commands and was watching a show on his/her electronic device. Review of nurse practitioner #1's progress note, dated 8/12/24, indicated Resident #92 had started to be more interactive with more speaking. Further review of the nursing clinical assessment, dated 9/4/24, indicated Resident #92 had short term memory loss, was oriented to person and place, coherent, usually made self understood and understands others, speech was improving and the Resident used words and phrases. During an interview on 9/19/24 at 8:11 A.M., Nurse #7 said Resident #92 had improved since admission and was able to communicate. Nurse #7 said the Resident could be understood, understands when spoken to, and can spell words out if unable to say the word. During an interview on 9/19/24 at 8:15 A.M., Certified Nursing Aide (CNA) #5 said Resident #92 was able to speak and understands what is being said to him/her. During an interview on 9/19/24 at 10:08 A.M., the MDS Nurse #2 said she didn't know how nursing assessed that Resident #92 was in a coma/vegetative state, but it's the nursing clinical evaluation assessment that populates the MDS. The MDS nurse said the coding of the MDS would depend on the look back period as Resident #92's cognition and awareness fluctuated. The MDS nurse said that if the Resident was coded as being in a coma or vegetative state that all interview questions would be grayed out or skipped. During an interview on 9/19/24 at 2:17 P.M., the Director of Nursing (DON) said that Resident #92 was not in a vegetative state and that Resident has improved since admission. The DON said the MDS should reflect Resident #92's status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for one Resident (#48) out of a total sample of 27 residents. Specifically, the facility failed to a.) implement weekly weights as care planned, and b.) develop a care plan for Resident #48's history of suicide attempts. Findings Include: Review of the facility policy, titled Care Plan - Comprehensive, indicated, but was not limited to, the following: - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. - Facility utilizes and electronic health record for resident care plans (sic.). - The comprehensive, person-centered care plan will: o Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. o Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights to refuse. o Incorporate identified problem areas. o Incorporate risk factors associated with identified problems. o Reflect currently recognized standards of practice for problem areas and conditions. - Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change. Review of the facility policy, titled Weights Assessment and Interventions, revised May 2019, indicated, but was not limited to, the following: - Monthly weights will be obtained each month or as ordered by the physician. - Weights will be recorded in the medical record (electronic medical record where available) for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #48 was admitted to the facility in March 2024 with diagnoses of heart failure (inability of the heart to maintain adequate blood circulation), renal insufficiency, anxiety disorder, depression, and post-traumatic stress disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #48 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had moderate cognitive impairment. a. Review of Resident #48's care plans indicated the Resident had decreased/alteration in cardiac output related to CHF and hypertension (high blood pressure, defined as repeatedly elevated blood pressure) with the following intervention: Weekly wts (weights), initiated 3/20/24. Review of Resident #48's Weights and Vitals Summary indicated the following weight readings: 7/24/24 - 150 lbs. (pounds) 8/27/24 - 189.4 lbs. 9/4/24 - 192 lbs. 9/11/24 - 192 lbs. 9/18/24 - 188 lbs. Further review of Resident #48's Weights and Vitals Summary indicated that weekly weights were not obtained on the weeks of 7/31/24, 8/7/24, 8/14/24, or 8/21/24, and that the Resident had gained a clinically significant 39.4 lbs. during that time period (26.2% of the Resident's total body weight gained in one month). Review of the Dietitian follow-up note, dated 8/28/24, indicated that Resident #48 had experienced a significant weight gain and that the Resident was placed on diuretic therapy due to increased edema. Review of Resident #48's medical record failed to indicate the Resident had refused to be weighed. During an interview on 9/18/24 at 11:39 A.M., Nurse #3 said certified nursing aides (CNAs) will obtain weights which the nurse then enters into the resident's electronic health record. Nurse #3 said that residents at risk for fluid retention, such as those who have CHF, should be weighed weekly and that she would expect a care plan for weekly weights to be followed. Nurse #3 said that Resident #48 was at risk for weight gain and fluid retention. During an interview on 9/18/24 at 12:20 P.M., the Registered Dietitian (RD) said that CNAs obtain weights which are then entered by the nurse into the electronic health record. The RD said that she would defer to the Nurse Practitioner (NP) for the required frequency of weighing a resident with CHF, and that weight refusals should be documented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/19/24 at 11:10 A.M., the NP said she would have expected Resident #48 to be weighed weekly throughout the Resident's entire admission. The NP said that the Resident's diuretic needed to be increased recently due to fluid retention, and that the risk of not weighing a resident as often as needed was that the Resident could accumulate fluid. During an interview on 9/18/24 at 1:38 P.M., the Director of Nursing (DON) said that she would expect weights to be recorded in the electronic health record according to the frequency outlined in a resident's care plan. b. Review of Resident #48's active diagnoses indicated the following diagnosis: Personal history of suicidal behavior. Review of the physician note, dated 8/2/24, indicated the Resident had a history of two suicide attempts related to severe depression around the time of his/her gastric bypass surgery. Review of Resident #48's medical record indicated the Resident had gastric bypass surgery in 2020. Review of Resident #48's care plans failed to indicate that a care plan addressing Resident #48's history of suicide attempts was developed. During an interview on 9/18/24 at 11:36 A.M., Nurse #3 said she was currently assigned to Resident #48 and that she was unaware of Resident #48's history of suicide attempts. Nurse #3 said she would expect a care plan to be developed specific to the Resident's history of suicide attempts. During an interview on 9/18/24 at 11:36 A.M., the Social Worker (SW) said she would expect a resident with a history of suicide attempts to have a care plan developed which specifically addresses the history of suicide attempts; the SW said she was unaware of Resident #48's history of suicide attempts. During an interview on 9/18/24 at 1:41 P.M., the Director of Nursing (DON) said she would expect a resident with a history of suicide attempts to have a care plan developed which specifically addresses the history of suicide attempts.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observations, interviews, and record review the facility failed to provide services that met professional standards of quality to two Residents (#473 and #14) out of a total sample of 27 residents. Specifically, 1.) For Resident #473, the facility failed to implement a skin graft wound treatment as ordered by the physician. 2.) For Resident #14, the facility failed to arrange a follow up urology appointment. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1.) Resident #473 was admitted to the facility in September 2024 with diagnoses including diabetes and soft tissue disorder. Review of Resident #473's medical record indicated a there was no Minimum Data Set (MDS) data available. Review of Brief Interview for Mental Status (BIMS) Evaluation, dated 9/16/24, indicated Resident #473 was cognitively intact as evidenced by a score of 14 out of 15. Review of the Clinical Admission assessment, dated 9/13/24, indicated Resident #473 had the following wounds: - Left posterior thigh skin graft. - Left thigh skin graft. - Left inguinal region skin graft. Review of Resident #473's active physician's order, initiated 9/13/24, indicated: - Prescribed treatment: (Wounds with soap and water, pat dry, apply triple-antibiotic to wounds and cover with xeroform (non-adhesive dressing). Secure wound dressing with gauze tape, gauze pads, and/or tap [sic]. Daily or PRN (as needed) when soiled (Location: Left leg wounds). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 10:20 A.M., the surveyor observed Nurse #2 perform a wound dressing change on the Resident #473's left leg skin graft wounds. After removing the previous dressing, Nurse #2 cleansed three left leg wounds with normal saline. Nurse #2 then applied xeroform to the three left leg wounds and covered with gauze. During this wound dressing change, Nurse #2 did not apply the triple-antibiotic cream as ordered by the physician. During an interview on 9/17/24 at 2:06 P.M., Nurse #2 and the surveyor reviewed Resident #473's active physician's treatment orders for the three skin graft wounds on his/her left leg. Nurse #2 said she should have applied triple-antibiotic cream to the wound but did not. Nurse #2 said that based on the physician's order in place she should have cleansed the wounds with soap and water, not normal saline. During an interview on 9/19/24 at 9:43 A.M., the Director of Nursing (DON) said physician's orders must be followed as ordered. The DON said Nurse #2 should have applied triple-antibiotic cream during the dressing change and should have washed the wounds with soap and water instead of normal saline. 36876 2. Resident #14 was admitted to the facility in August 2022 with diagnoses including neuromuscular dysfunction of the bladder, obstructive and reflux uropathy, and schizoaffective disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #14 was unable to participate in the Brief Interview for Mental Status Exam and staff assessed him/her as having severely impaired cognitive skills. The MDS also indicated he/she is dependent on staff for activities of daily living and utilized an indwelling catheter. Review of the clinical record indicated Resident #14 was hospitalized in March 2024. Review of the discharge hospital paperwork, dated 4/3/24, indicated: Will need out-patient follow up with urology for management of neurogenic bladder and chronic foley. Review of the clinical record failed to indicate an appointment with urology had been arranged. During an interview on 9/19/24 at 9:56 A.M., Nurse Supervisor #1 said she would look into when Resident #14 had been seen by urology. The facility was unable to provide evidence that Resident #14 had been seen by urology since his/her hospitalization . On 9/19/24 at approximately 3:00 P.M., the Director of Nursing (DON) told the surveyor that Resident #14 has an appointment on 9/25/24 with the urologist for follow up. The DON said that the appointment had been made that day, (9/19/24); approximately five months after Resident #14's hospital discharge.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, record review and interviews, the facility failed to ensure quality of care was provided according to facility protocol and professional standards of practice for one Resident (#101), out of a total sample of 27 residents. Specifically, the facility failed to ensure physician orders were in place for a skin tear. Findings include: Resident #101 was admitted to the facility in August 2024 with diagnoses including muscle wasting and atrophy, end stage renal disease. Review of Resident #101 Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was moderately cognitively impaired. On 9/17/24 at 1:00 P.M., the surveyor observed Resident #101 sitting in his/her wheelchair. His/her left elbow had a dressing that was saturated with bloody drainage, and the dressing was undated. The Resident said he/she got the skin tear at an outside hospital during transportation. On 9/19/24 at 9:00 A.M., the surveyor and Nurse #3 observed Resident #101's left elbow. Nurse #3 removed the dressing covering the skin tear, (the dressing was undated), and underneath was a xeroform gauze covering the skin tear which was open with bloody drainage. Review of the medical record failed to indicate treatment orders were in place for the skin tear. Review of a nurse progress note, dated 9/16/24, indicated the following: Wound doctor seen this shift, left elbow resolved discontinue dressing orders. Review of care plan with focus of skin tear, dated revised 9/3/24, indicated the following interventions: Apply treatment as ordered by MD (physician). Position left arm on a pillow. During an interview on 9/19/24 at 9:05 A.M., Nurse #3 said the Resident should have treatment orders in place for the left elbow as it was still open with drainage. During an interview on 9/19/24 at 9:33 A.M., the Assistant Director of Nursing read the progress note, dated 9/16/24, and said the wound treatment orders for Resident #101 should not have been discontinued. She further said dressing treatments should be applied with physician orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50338 Based on observations, interviews, and record review for one Resident (#39), out of 27 total sampled residents, the facility failed to provide the necessary treatment to promote healing of a pressure ulcer. Specifically, the facility failed to obtain a physician's order for wound treatment of a pressure ulcer on Resident #39's left hip. Findings include: Resident #39 was admitted to the facility in March 2023 with diagnoses including anoxic brain damage (occurs when the brain's oxygen supply is completely cut off). Review of the most recent Minimum Data Set (MDS) assessment, dated 9/5/24, indicated the Brief Interview for Mental Status (BIMS) should not be conducted as Resident #39 is rarely/never understood. The MDS indicated Resident #39 was at risk of pressure ulcers, currently had unhealed pressure ulcers, and received pressure ulcer care. Review of the current physician's order did not include any treatments related to pressure ulcers for Resident #39. Review of Resident #39's Treatment Administration Record (TAR) dated 9/1/24 through 9/19/24, failed to include a treatment for pressure ulcers for Resident #39. Review of Resident #39's Wound Physician's evaluation and management summary, dated 9/4/24, indicated a stage two pressure wound of the left hip partial thickness. The dressing treatment plan included alginate calcium, covered with gauze dressing. The measurements were: -length- 4.7 centimeters (cm). -width- 1.8 cm. -depth-0.2 cm. Review of Resident #39's Wound Physician's evaluation and management summary, dated 9/9/24, indicated a stage two pressure ulcer of the left hip partial thickness. The dressing treatment plan included alginate calcium, covered with gauze dressing. The measurements were: -length- 12.8 cm. -width- 3.5 cm. -depth-0.2 cm. Review of Resident #39's Wound Physician's evaluation and management summary, dated 9/16/24, indicated a stage two pressure ulcer of the left hip partial thickness. The dressing treatment plan included alginate calcium, covered with gauze dressing. The measurements were: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-length-2 cm. -width-1 cm. -depth-0.2 cm. On 9/19/24 at 9:29 A.M., the surveyor observed Nurse #5 doing wound care for Resident #39. Resident #39 had a dressing on his/her left hip. Nurse #5 removed that dressing, cleansed the wound and applied alginate calcium covered with a gauze dressing. During an interview on 9/19/24 at 9:45 A.M., the surveyor asked Nurse #5 how she knew what treatment was required to Resident #39's pressure ulcer and she indicated the copy of the wound physician's recommendation. During an interview on 9/19/24 at 10 A.M., the surveyor and Nurse #5 reviewed the attending physician's orders and were not able to find an active order for the treatment of the Resident's left hip pressure ulcer. Nurse #5 said the Director of Nursing usually makes rounds with the wound physician and any recommendations are communicated to nursing so they can obtain an order from the attending physician. Nurse #5 said the recommendation from wound physician should have been confirmed with attending physician and transcribed as a physician's order for Resident #39. During an interview on 9/19/24 at 2:15 P.M., the Director of Nursing said she would expect that orders recommended by the Wound Physician and ordered by the attending Physician would be put into the electronic health record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation, record review and interview, the facility failed to ensure the environment was free from accident hazards for one Resident (#93) out of a total sample of 27 residents. Specifically, the facility failed to implement an intervention intended to prevent further falls after Resident #93 had sustained multiple falls. Findings include: Review of the facility policy, titled Fall Prevention and Management, revised January 2022, indicated, but was not limited to, the following: - The interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Resident #93 was admitted to the facility in March 2024 with diagnoses of cancer and malnutrition. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #93 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Review of Resident #93's fall incident reports indicated the Resident had fallen attempting to self-transfer in his/her room on 3/20/24, 4/24/24, and 9/3/24. Review of Resident #93's falls care plan indicated the Resident was at risk for injuries related to fall history due to experiencing a fall in the last month, decreased mobility, and impaired balance normal progression of disease process with unavoidable and/or predictable decline, use of assistive devices recent fall, with the following intervention: Keep walker within resident's reach while in bed (sic.), initiated on 4/30/24. On 9/18/24 at 8:20 A.M., the surveyor observed Resident #93 in bed, the Residents walker was folded and leaning against the wall out of reach of the Resident. On 9/18/24 at 10:57 A.M., the surveyor observed Resident #93 in bed, the Residents walker was folded and leaning against the wall out of reach of the Resident. On 9/18/24 at 12:18 A.M., the surveyor observed Resident #93 in bed, the Residents walker was folded and leaning against the wall out of reach of the Resident. On 9/19/24 at 8:32 A.M., the surveyor observed Resident #93 in bed, the Residents walker was folded and leaning against the wall out of reach of the Resident. During an interview on 9/19/24 at 10:40 A.M., Certified Nursing Aide (CNA) #5 said Resident #93 was at risk for falls and that the Resident had fallen in the past attempting to self-transfer. (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 9/19/24 at 10:42 A.M., Nurse #6 said Resident #93 has had multiple falls attempting to self-transfer. Nurse #6 said he would expect care-plan interventions for fall prevention to be implemented. During an interview on 9/19/24 at 11:21 A.M., Nurse #7 said Resident #93 utilizes his/her walker to transfer into his/her wheelchair, and that the Resident has fallen attempting to self-transfer in the past. Nurse #7 said she would expect care plan interventions for fall prevention to be implemented. During an interview on 9/19/24 at 11:54 A.M., the Director of Nursing (DON) said she would expect care plan interventions for fall prevention to be implemented.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, record reviews, and interviews, the facility failed to maintain professional standards in the management and caring for urinary catheter devices for 4 Residents (#30, #103, #108 and #471). Specifically, 1. For Resident #30, the facility failed to empty urinary drainage bag as ordered. 2. For Resident #103, the facility failed to empty urinary drainage as ordered and maintain urinary drainage bag off the floor. 3. For Resident #108, the facility failed to empty urinary drainage bag as ordered. 4. For Resident #471, the facility failed ensure urinary catheter drainage bags and tubing were not stored directly touching the floor. Findings include: Review of the facility policy titled 'Catheter Drainage Bag', dated January 2023, indicated: -The purpose of this procedure are to prevent the drainage bag from becoming full and allowing urine to flow back into the bladder, to measure output, and to obtain sterile specimen. -Empty the urinary drainage bag at least every eight hours or more often if needed to keep the bag from becoming full. -Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage. 1. Resident #30 was admitted to the facility with diagnoses including malignant neoplasm of kidneys except renal pelvis, infection and inflammatory reaction due to indwelling urethral catheter and hematuria (blood in urine). Review of Resident #30's Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated the Resident had an indwelling catheter. On 9/17/24 at 8:54 A.M., the surveyor observed Resident #30 laying in his/her bed. The urinary drainage bag had 1200 (ML)milliliters of urine in it. The Resident said that the staff does not empty the drainage bag frequently. Review of Resident #30's current physician orders indicated the following: -Foley catheter care every shift. -Measure output from indwelling catheter every shift. (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 the current Treatment Administration Record (TAR) indicated the night shift documented the catheter had been emptied a total of 600 milliliters on 9/17/24 Review of the care plan with a focus of indwelling urinary catheter, dated revised 7/5/24, indicated the following intervention: Provide catheter care per policy. During an interview on 9/19/24 at 9:04 A.M., Nurse #3 said the urinary catheters are emptied at the end of the shift. When asked if the drainage bag should contain 1200 milliliters at the beginning of the shift Nurse #3 said no. During an interview on 9/19/24 at 9:26 A.M., the Assistant Director of Nursing said urinary catheters should be emptied every shift as ordered and as needed if the resident is on a diuretic. 2. Resident #103 was admitted to the facility in July 2024 with diagnoses including urinary retention, obstructive and reflux uropathy and hematuria (blood in urine). Review of Resident #103's Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 9 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was moderately cognitively impaired. The MDS further indicated the Resident had an indwelling urinary catheter. On 9/17/24 at 8:18 A.M., the surveyor observed Resident #103 laying in his/her bed the urinary drainage bag was lying on the floor. On 9/19/24 at 9:19 A.M., the surveyor observed Resident #103 laying in his/her bed, the drainage bag had 600 ml of bloody urine. Review of Resident #103 current physician orders indicated the following: -Check placement of urinary drainage bag to assure it is hanging below the level of the bladder every shift. -Foley catheter care every shift. Review of the current Treatment Administration Record (TAR) indicated the night shift documented an output of 450 ml for the overnight shift on 9/19/24. Review of care plan with focus of indwelling urinary catheter, dated revised 9/18/24, indicated the following intervention: Provide catheter care per policy. During an interview on 9/19/24 at 9:23 A.M., Nurse #2 said the Resident's catheter should be emptied every shift, and the catheter should be maintained off the floor to prevent infections. She also said the hematuria in the urinary drainage bag was ongoing and that the Resident was being followed by urology. During an interview on 9/19/24 at 9:26 A.M., the Assistant Director of Nursing said urinary catheters should be emptied every shift as ordered and as needed if the resident is on a diuretic. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #108 was admitted to the facility in April 2024 with diagnoses including neuromuscular dysfunction of bladder and urinary retention. Review of Resident #108's Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated the Resident had an indwelling catheter. On 9/17/24 at 8:02 A.M., the surveyor observed Resident #108 laying in his/her bed, the urinary drainage bag was hooked to the bed rail and had approximately 600 ml of urine. The Resident said that the staff does not empty his/her catheter and at times his/her parent will empty the catheter when they come to visit the Resident. On 9/18/24 at 7:07 A.M., the surveyor observed the Resident laying in his/her bed and his/her urinary drainage bag had 1200 ml of urine. On 9/18/24 at 1:03 P.M., the surveyor and Nurse #4 observed Resident #108's foley catheter, the Resident had a 16 French 10 ml catheter size. Nurse #4 said the catheter size should match the physician orders. On 9/19/24 at 8:58 A.M., the surveyor observed the Resident laying in his/her bed the urinary drainage bag had approximately 800 ml of urine. Review of current physician orders indicated the following: -Foley catheter care every shift. -Foley catheter 14 French 10 ml continuous drainage bag every shift Review of care plan with focus of indwelling urinary catheter, dated revised 4/16/24, indicated the following interventions: Provide catheter care per policy. Change catheter per policy/medical director (MD) orders. During an interview on 9/19/24 at 9:04 A.M., Nurse #3 said catheters should be emptied every end of shift. During an interview on 9/19/24 at 9:26 A.M., the Assistant Director of Nursing said urinary catheters should be emptied every shift as ordered and as needed if the resident is on a diuretic. During an interview on 9/19/24 at 12:26 P.M., the Director of Nursing said the Resident had been in and out of the hospital and the staff should have ensured that the Resident's catheter was the same as the orders. 48990 4. Review of the facility policy titled Catheter Guidelines, revised January 2023, indicated: Be sure the catheter tubing and drainage bag are kept off the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #471 was admitted to the facility in September 2024 with diagnoses including benign prostatic hyperplasia with lower urinary tract symptoms, brain cancer, and hemiplegia affecting the right dominant side. Review of Resident #471's assessment titled Brief Interview for Mental Status (BIMS) Evaluation, dated 9/16/24, indicated Resident #471 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #471's active physician's orders, initiated 9/15/24, indicated: - Foley Catheter (urinary catheter)12 FR (french size) /10 ML (milliliter) continuous to drainage bag. May Reinsert for dislodgment or malfunctioning, every shift. Review of Resident #471's plan of care related to indwelling urinary catheter, revised 9/15/24, indicated: Provide catheter care per policy. On 9/17/24 at 7:54 A.M., the surveyor observed Resident #471 sitting in a wheelchair. His/her urinary catheter drainage bag was observed attached to the bottom of the wheelchair with the bottom of the bag resting directly on the floor. There was no barrier between the urinary drainage bag and the floor. Resident #471 said staff provides all urinary catheter care, including drainage bag management, because his/her hands shake and can't manage it him/herself. On 9/18/24 at 6:48 A.M., the surveyor observed Resident #471 in bed with a urinary catheter drainage bag attached to the bedframe. The bed was in a low position with the urinary catheter drainage bag and tubing directly on the floor without a barrier. On 9/18/24 at 9:01 A.M., the surveyor observed Resident #471 self-propelling wheelchair in the hall using his/her feet. His/her urinary catheter drainage bag was observed attached to the bottom of the wheelchair and was dragging along the floor without a barrier. During an interview on 9/19/24 at 10:50 A.M., Certified Nurse Assistant (CNA) #3 said urinary catheter drainage bags and tubing should never be directly touching the floor. CNA #3 said she often finds urinary catheter bags on the floor and was unaware of expectations for what to do if they are found on the floor but is worried about the risk of infection. CNA #3 said Resident #471 is physically unable to lower the bed or manage urinary catheter drainage bag/tubing by him/herself because of dexterity in hands. During an interview on 9/19/24 at 12:33 P.M., Nurse #3 said urinary catheter drainage bags should never directly touch the floor because of the risk for infection. Nurse #3 said if for any reason the urinary catheter drainage bag or tubing needed to be touching the floor, a barrier should be placed between the urinary catheter drainage bag/tubing and the floor. During an interview on 9/19/24 at 9:43 A.M., The Director of Nursing (DON) said urinary catheter drainage bags or tubing should never be directly touching floor without a barrier to protect from infection.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 48990 Based on record review and interview, the facility failed to maintain acceptable parameters of nutrition status for one Resident (#77) out of a total sample of 27 residents. Specifically, the facility failed to implement the Dietitian's recommendation for increasing the frequency of Resident #77's nutritional supplement. Findings include: Review of the facility policy titled Nourishments - Supplements, revised January 2023, indicated: - To prevent or respond to unplanned and unfavorable weight loss and malnutrition, the Dietitian will assess the nutritional status of all residents and recommends supplements as needed with the Physicians approval. - Refusal or poor intake acceptance should be reported to the Physician and Dietitian for further evaluation. Resident #77 was admitted to the facility in August 2024 with diagnoses including protein calorie malnutrition, diabetes, and dependent on dialysis chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/27/24, indicated Resident #77 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The MDS also indicated Resident #77 had significant weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months and received greater than 51% of total calories by tube feeding. On 9/17/24 at 8:15 A.M., the surveyor observed Resident #77 in his/her room with a tube feeding pole in the corner of the room. Resident #77 said he/she now eats by mouth. Review of Resident #77's plan of care related to nutrition, revised 9/13/24, indicated: - Goal: Resident will not lose weight below [sic] 155. - Supplements a/o (as ordered). Review of Resident #77's Weight Summary report indicated the following weights: - 8/27 112.8 lbs. (pounds) - 8/28 113.0 lbs. - 9/4 102.5 lbs. - 9/9 115.3 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/19: 110.4 lbs. Review of Dietitian progress note, dated 9/10/24, indicated: Met with Resident to discuss regarding his refusal to accept the TF (tube feeding). Rec (recommend) Nepro 240ml three times a day and explained to Resident that it is important that he/she should consume the Nepro. Review of Resident #77's physician's order, initiated 9/10/24, indicated: Nepro Oral Liquid (Nutritional Supplements), Give 240 ml (milliliters) by mouth two times a day. Review of Resident #77's Medication Administration Record (MAR), dated 9/10/24 to 9/19/24, failed to indicate that Nepro 240 ml was ever increased to three times a day. Review of Resident #77's medical record, dated 9/10/24 to 9/19/24, failed to indicate a rationale for why Nepro 240 ml was not increased to three times a day. During an interview on 9/19/24 at 10:50 A.M., Nurse #5 said Resident #77's tube feeding was recently discontinued and his/her nutritional status is followed by the Dietitian. During an interview on 9/19/24 at 10:21 A.M., the Dietitian said she evaluated Resident #77 on 9/10/24 because she was notified, he/she was refusing tube feeding. The Dietitian said, in collaboration with the physician, his/her tube feeding was discontinued and Nepro 240 ml was supposed to be increased to three times a day. The Dietitian said, based on her assessment, Resident #77 needed to have the increased nutritional supplement. The Dietitian said she discussed this with the physician, who approved the increased frequency of Nepro 240ml to three times a day, and she was supposed to enter the physician order herself but forgot. During an interview on 9/19/24 at 11:15 A.M., the Director of Nursing (DON) said nutritional supplements that are recommended and approved by a physician should be input by the Dietitian. The DON said the Dietitian should have input the physician order for increased frequency of Nepro 240 ml to three times on 9/10/24 but did not.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48990 Based on observation, interview, and record review, the facility failed to provide care and maintenance of a peripherally inserted IV (intravenous) catheter (a thin flexible tube that is inserted into a vein for delivery of medication, blood or fluids directly into the bloodstream), consistent with professional standards of practice for one Resident (#70), out of a total sample of 27 residents. Specifically, for Resident #70, the facility failed consistently flush the peripheral IV catheter and failed to monitor the peripheral IV site for complications. Findings include: Review of the facility policy titled Peripheral Catheter Flushing, revised January 2023, indicated: - Specific flush orders must be documented. - Flushing is performed to ensure and maintain catheter patency. - A physician's order is required to flush a peripheral catheter. The order must include the flushing agent, the amount, and the frequency. Resident #70 was admitted to the facility in March 2024 with diagnoses including heart failure and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/13/24, indicated Resident #70 had moderate cognitive impairment evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. On 9/17/24 at 2:21 P.M., the surveyor observed Resident #70 with a peripheral IV catheter port in his/her left forearm. Resident #70 said he/she received IV fluids a few days ago. Resident #70 said staff had not flushed the peripheral IV catheter port since the fluids were discontinued a few days ago. Review of nursing progress note, dated 9/13/24, indicated a peripheral IV catheter was inserted into Resident #70's left forearm. Review of Resident #70's Medication Administration Record (MAR), dated 9/13/24, 9/14/24, and 9/15/24, indicated the following physician's order was implemented: -Peripheral IV: D5 1/2 NS (an IV fluid used for hydration) at 75 ml (milliliters)/hr (hour) x (times) 1.5 L (liters). Review of nursing progress note, dated 9/15/24, indicated peripheral IV fluids (D5 1/2 NS) were completed on 9/15/24. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of medical record, dated 9/13/24 to 9/17/24, failed to indicate any physician's orders to flush Resident #70's peripheral IV catheter or to monitor the peripheral IV catheter site for complications. During an interview on 9/18/24 at 1:26 P.M., Nurse #4 reviewed Resident #70's physician's orders with the surveyor. Nurse #4 said there should have been a physician's order put in place to monitor the peripheral IV site for complications when it was inserted on 9/13/24 but was not. Nurse #4 also said that after the IV fluids were completed on 9/15/24, there should have been a physician's order to flush the peripheral IV catheter to maintain patency, but there was not. Nurse #4 said a physician's order is needed to flush peripheral IV catheters. Nurse #4 said Resident #70's peripheral IV catheter should have been flushed when not infusing IV fluids from 9/15/24 to 9/17/24 but was not. During an interview on 9/19/24 at 9:43 A.M., the Director of Nursing (DON) said there should always be an order in place to monitor peripheral IV catheter sites for complications and should be monitored at least shiftly. The DON said if a peripheral IV catheter is not actively infusing IV fluids, then there needs to be an order to flush the peripheral IV catheter to maintain patency. The DON said peripheral IV catheter ports should be flushed at least twice daily when not infusing IV fluids. The DON said Resident #70 should have had physician's orders to flush and monitor the peripheral IV catheter but did not.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observations, interviews and record review, the facility failed to provide respiratory care consistent with professional standards of practice for one Resident (#372) out of 27 total sampled residents. Specifically, for Resident #372, the facility failed to ensure the oxygen filter was cleaned as ordered. Findings include: Review of the facility policy titled 'Oxygen Administration' dated October 2022, indicated the following but not limited to: -Check the physician order. If it is unclear, clarification must be obtained. -Do not operate a concentrator without a filter or with a dirty filter. Resident #372 was admitted to the facility in August 2024 with diagnoses including chronic obstructive pulmonary disease (COPD) with hypoxia and hypercapnia and was dependent on oxygen. Review of Resident #372 Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. The MDS further indicated the Resident is on oxygen therapy. On 9/17/24 at 7:54 A.M., the surveyor observed Resident #372 lying in his/her bed wearing a nasal oxygen cannula oxygen in his/her nasal. The oxygen concentrator was set at a flow rate of 1.5 liters per minute, the tubing was dated 9/17/24, and the Resident said he/she was being weaned off the oxygen. The surveyor observed the concentrator filter to be visibly dirty with a thick layer of dust on it. Review of the current physician order, dated 9/5/24, indicated the following: -Oxygen at 0.5-2 Liters/Minute via nasal cannula continuous to maintain oxygen saturation at or greater than 89%. Oxygen every shift. -Change o2 (oxygen) tubing and bottle weekly and PRN. Rinse o2 filter with H2O pat dry and replace. Initial tubing and bottle at time of change place tubing in dated plastic bag when not in use. Every night shift every sat COPD and as needed COPD. During an interview on 9/19/24 at 9:09 A.M., Nurse #3 said oxygen tubing and filters are changed weekly per the orders. During an interview on 9/19/24 at 12:27 P.M., the Director of Nursing said the oxygen filters are to be cleaned weekly.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to: 1. ensure physicians orders for dialysis treatment and post dialysis weights were obtained for one Resident (#77) and 2. failed to ensure post dialysis weights were obtained after treatment for two 2 Residents (#117 and #372) out of a total of 27 sampled residents. Findings include: Review of facility's Dialysis Management policy, dated as revised October 2022, indicated the following but not limited to: -Facility will establish open communication with the Resident's Dialysis Center utilizing a dialysis communication book' completing the dialysis communication form. -Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provisions of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered. -On return from the dialysis center the nurse will review the communication returning from dialysis center. The nurse should review specifically, pre and post vital signs, treatment tolerance, any meds given and any new orders for resident care. According to the National Kidney Foundation: Normal weight without any extra fluid in your body is called dry weight. Extra fluid can be dangerous and cause extra strain on your body, including your heart and lungs. When you have kidney failure, your body depends on dialysis to get rid of the extra fluid and wastes that build up in your body between treatments. If you have too much extra fluid in your body, you may need longer or more frequent hemodialysis treatments. There is a limit to how much fluid can safely be removed during each dialysis treatment. 1. Resident #77 was admitted to the facility in August 2024 with diagnoses including acute kidney failure and type 2 diabetes. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #77 was cognitively intact and required assistance with bathing, dressing and toileting. The MDS also indicated Resident #77 received dialysis treatment. Review Resident #77's care plans indicated he/she received dialysis treatment three days a week. Review of Resident #77's physicians orders indicated: -Monitor right chest wall hemodialysis every shift, 8/25/24 -Weight every week for 4 weeks one time every day 7 days to monitor weight, 8/25/24 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no active orders for Resident #77 to receive dialysis treatment or for post dialysis weights to be obtained. Review of Resident #77's weights indicated he/she had been weighed twice in the month of August 2024 and three times from 9/1/24 through 9/19/24. During an interview with Nurse #3 on 9/19/24 at 12:19 P.M., she said that when residents are on dialysis, they have physicians orders and weights are supposed to be obtained before and after treatment. Nurse #3 said that weights are logged both in the electronic record and Dialysis communication binder. The surveyor was unable to locate a communication binder for Resident #77. During an interview with the Director of Nursing on 9/19/24 at approximately 2:30 P.M., she said that residents who are receiving dialysis treatment should have physicians orders in place and weights should be obtained. The DON said she was not aware that Resident #77 had no physicians orders for dialysis treatment and weights were not being obtained. 2. Resident #117 was readmitted to the facility in July 2024 with diagnoses including dependence on renal dialysis and type two diabetes. Review of the Minimum Data Set Assessment, dated 7/31/24, indicated he/she was cognitively intact and required assistance with activities of daily living. The MDS also indicated he/she received dialysis treatment. Review of Resident #117's physicians orders indicated: -Access port for Dialysis is located L (left) chest wall, 8/12/24 -Dialysis [Center], Dialysis days M-W-F (Monday, Wednesday, Friday) 8/12/24 -Dialysis log vital signs and weight one time a day every Mon, Wed, Fri for pre dialysis vital signs before dialysis please follow schedule, 8/12/24 -Dialysis log vital signs and weight one time a day every Mon, Wed, Fri for post dialysis vital signs (weight on dialysis day should be post-dialysis dry weight), 8/12/24 Review of Resident #117's weights indicated he/she was weighed four times in August 2024 and twice from 9/1/24 through 9/19/24. During an interview with Nurse #3 on 9/19/24 at 12:19 P.M., she said that when residents are on dialysis, they have physicians orders and weights are supposed to be obtained before and after treatment. Nurse #3 said that weights are logged both in the electronic record and dialysis communication binder. The surveyor and Nurse #3 reviewed Resident #117's dialysis communication binder and all pages were blank. Nurse #3 said that the binder may be new as the previous one may have been misplaced. During an interview with the Director of Nursing on 9/19/24 at approximately 2:30 P.M., she said she was not aware weights were not being obtained for Resident #117. 46339 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #372 was admitted to the facility in August 2024 with diagnoses including end stage renal disease and dependence on dialysis. Review of Resident #372's Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 14 out of a possible 15 on the Brief Interview for Mental Status indicating he/she was cognitively intact. The MDS further indicated that the Resident was on dialysis. Review of Resident #372 current physician order indicated the following: -Dialysis log vital signs and weight one time a day every Monday, Wednesday and Friday for pre dialysis vital signs and one time a day every Monday, Wednesday and Friday for post dialysis vital signs. (weight on dialysis day should be post dialysis dry weight) Review of the Medication Administration Record (MAR) for September indicated the following documented post dialysis weights: 9/6/24-251.5 lbs (pounds) 9/13/24- 252 lbs Review of the dialysis communication book indicated the following weights in kilograms (kg): 9/6/24 - 115. Kg (253.2) lbs. 9/13/24 -115.6 kg (254.1) lbs. During an interview on 9/19/24 at 9:09 A.M., Nurse #3 said post dialysis weights should be calculated by multiplying by 2.2 from kilograms to pounds. During an interview on 9/19/24 at 9:51 A.M., the Assistant Director of Nursing said post dialysis weights should be entered accurately in the medical records.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48990 Based on observations, interviews, and record review for one Resident (#89) out of four residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. One out of four nurses observed made two errors out of 32 opportunities resulting in a medication error rate of 6.25%. Specifically, Nurse #1 administered the incorrect form of aspirin and administered the incorrect dose of calcium plus vitamin d3. Findings include: Review of the facility policy titled Medication Administration, revised October 2022, indicated: - The medication nurse shall assure that the correct medication is administered by checking the physician's order and the medication label. Resident #89 was admitted to the facility in September 2022 with diagnoses including heart failure and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/13/24, indicated Resident #89 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. During the medication pass observation on 9/18/24 at 7:58 A.M., the surveyor observed Nurse #1 prepare and administer the following medications to Resident #89: - One aspirin 81 oral tablet enteric coated. - One calcium 600 mg (milligrams)/10 mcg (micrograms) vitamin d3 tablet. Review of Resident #89's physician orders indicated: - Aspirin 81 Oral Tablet Chewable, give 81 mg in the morning. - Calcium 600+D3 Oral Tablet 600-5 mg-mcg, give 1 tablet one time a day. During an interview on 9/18/24 at 1:15 P.M., Nurse #1 said he administered enteric coated aspirin instead of the chewable form. Nurse #1 said he knew it wasn't the ordered form but was unaware that medications needed to be in the form ordered by the physician. Nurse #1 said he administered the incorrect dose of calcium plus vitamin d3. Nurse #1 said he administered calcium 600 mg/10 mcg but should have administered calcium 600 mg/5 mcg. During an interview on 9/19/24 at 9:43 A.M., the Director of Nursing (DON) said the medication form and dose administered needs to match the physician's order. The DON said Nurse #1 should not have administered the incorrect form of aspirin because Resident #89's order indicated chewable form instead of enteric coated form. The DON said Nurse #1 should not have administered the incorrect dose of calcium 600 mg/10 mcg because the physician's order was for calcium 600 mg/5 mcg.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observations and interviews, the facility failed to ensure staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically, 1.) The facility failed to ensure medications were dated once opened and discarded as appropriate according to manufacturer's guidelines. 2.) The facility failed to ensure medications were not prepared in advance and stored in original, labeled containers in the medication cart. 3.) The facility failed to properly secure medication carts on one of three units 4.) The facility failed to ensure unauthorized nurses did not have access to medication cart. Findings include: Review of the facility policy titled Medication Storage [sic], revised [DATE], indicated: - All medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by the facility policy. - Medications will be stored in the original, labeled containers received from the pharmacy. - Multi-dose vials which have been opened or accessed (e.g., needle punctured) should be dated and discarded within 28 days unless the manufacturer specifies a differed (shorter or longer) date for the opened vial. - Expired, discontinued and/or contaminated medications will be removed from the medication storage area and disposed of in accordance with facility policy. 1a.) On [DATE] at 8:10 A.M., the surveyor observed the following on the Concord Unit medication cart #2: - Fluticasone propionate and salmeterol inhaler, dated [DATE], which was 55 days prior to observation. - One bottle of proheal liquid protein, undated. - One open vial of lantus 100u (units)/ml (milliliter) insulin, undated. - One bottle of atropine 1% sublingual drops, undated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:13 A.M., Nurse #1 said the resident currently used the fluticasone propionate and salmeterol inhaler that was dated [DATE], but it should have been discarded within 30 days after opening based on manufacturers guidelines. Nurse #1 said proheal liquid protein was not dated but should have been because it needs to be discarded 60 days after opening. Nurse #1 said the lantus insulin vial and the atropine drops were not dated but should have been because they need to be discarded 28 days after opening. During an interview on [DATE] at 9:43 A.M., the Director of Nursing (DON) said all inhalers and medications with shortened expiry dates once opened must be dated so they can be discarded according to manufacturer's guidelines. The DON said fluticasone propionate and salmeterol inhaler should have been discarded within 30 days after opening. The DON said proheal liquid protein should have been dated because it needs to be discarded 60 days after opening. The DON said insulin vials and atropine drops should have been dated because they need to be discarded 28 days after opening. 1b.) On [DATE] at 8:20 A.M., the surveyor observed the following on the [NAME] Unit medication cart #2: - One bottle of proheal liquid protein, undated. - One open vial of lantus 100u (units)/ml (milliliter) insulin, dated [DATE], which was 32 days prior to observation. - One lupinhaler, with a capsule preloaded, unlabeled, stored directly on the bottom of the medication cart drawer not in a box. During an interview on [DATE] at 8:24 A.M., Nurse #3 said proheal liquid protein was not dated, but should have been because it needs to be discarded 60 days after opening. Nurse #1 said insulins need to be discarded 28 days after opening. Nurse #1 said the lantus insulin vial should have been discarded on [DATE] but was still being used by the resident. Nurse #3 said the lupinhaler should not have a capsule preloaded because there is not expiration date on the capsule. Nurse #3 said the lupinhaler should be labeled with the resident's name and stored in a box for infection control purposes. During an interview on [DATE] at 9:43 A.M., the Director of Nursing (DON) said all medications with shortened expiry dates once opened must be dated so they can be discarded according to manufacturer's guidelines. The DON said proheal liquid protein should have been dated because it needs to be discarded 60 days after opening. The DON said insulin vials and atropine drops should have been dated because they need to be discarded 28 days after opening. The DON said the lupinhaler should be labeled with the resident's name and stored in a box for infection control purposes. 2a.) On [DATE] at 8:13 A.M., the surveyor observed the following on the Concord Unit medication cart #2: - Three unsealed clear pill packet sleeves containing crushed medications. Each clear pill packet sleeve was labeled a resident name written in black marker. During an interview on [DATE] at 8:13 A.M., Nurse #1 said he had prepared and crushed the medications in advance and was planning on administering to the residents later. Nurse #1 said he wasn't supposed to prepare medications in advance. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:43 A.M., the Director of Nursing (DON) said medications should only be prepared immediately before administering and should never be prepare or pre-poured and stored in the medication cart to administer later. 2b.) On [DATE] at 8:10 A.M., the surveyor observed the following on the Concord Unit medication cart #2: - One unknown, unlabeled pill stored in an orange prescription bottle with a label indicating haloper dec inj (haloperidol decanoate injection, which is an injectable antipsychotic medication) 50 mg (milligrams)/ml (milliliter). During an interview on [DATE] at 8:13 A.M., Nurse #1 said he did not know what that pill was, but it was not a haloperidol decanoate injection. Nurse #1 said the unknown pill should not have been stored in that orange prescription bottle, and should have been stored in the original, labeled container. During an interview on [DATE] at 9:43 A.M., the Director of Nursing (DON) said pills should always be stored in the original, labeled containers, and the unknown pill should not have been in that orange prescription bottle. 3a.) On [DATE] at 8:20 A.M., the surveyor observed Andover Unit medication cart unlocked in the hallway. The nurse was not within sight line of the medication cart. During an interview on [DATE] at 8:22 A.M., Nurse #4 said she should have locked her medication cart before walking away. During an interview on [DATE] at 2:49 P.M., the Director of Nursing (DON) said medication carts should never be left unlocked if unattended. 3b.) On [DATE] at 12:31 P.M., the surveyor observed Andover Unit medication cart unlocked in the hallway. The nurse was not within sight line of the medication cart. During an interview on [DATE] at 12:33 P.M., Nurse #3 said she should have locked her medication cart before walking away. Nurse #3 said medication carts should always be locked if unattended. During an interview on [DATE] at 2:49 P.M., the Director of Nursing (DON) said medication carts should never be left unlocked if unattended. 4.) On [DATE] at 9:27 A.M., the surveyor observed the Assistant Director of Nursing (ADON) preparing and administering medications for a resident from the Andover unit medication cart #2. The ADON said she borrowed the medication cart keys from Nurse #2, who was down the hall in another resident's room. The ADON said she was not authorized to administer medications from this medication cart because she never completed the narcotic count or signed out the medication cart from Nurse #2 but should have before administering medications from the medication cart. On [DATE] at 9:30 A.M., Nurse #2 came back to the medication cart and retrieved the keys from the ADON. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:43 A.M., the Director of Nursing (DON) said only nurses who have completed the narcotic count in order to sign out the medication cart should have access to administer medications from the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225568	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Brook Rehabilitation and Healthcare Center	90 West Street Wilmington, MA 01887

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation, policy review, and interview, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure food was labeled in the unit kitchenette refrigerators, and that dented cans were not accepted into storage/circulation. Findings include: Review of the facility's undated policy titled Food Storage (Dry, Refrigerated, and Frozen), indicated, but was not limited to, the following: Dented cans are set aside in a separate labeled area of the storeroom to avoid using them and discarded according to vendor procedure. Review of the facility's undated policy titled Food from Outside indicated, but was not limited to, the following: - Residents have the right to have foods brought in by family and friends. Due to the potential for foodborne illness or interfere with nutritional treatment, family members and/or visitors who bring food in from the outside will be educated on safe food handling practices and the importance of diet order compliance. Food or beverage that is brought in from the outside will be monitored by nursing staff for spoilage, contamination and safety. - Food brought by family/visitors that is left with the resident to consume later will labeled (sic.) and stored in a manner that it is clearly distinguishable from the facility-prepared food. (label will identify resident name, room number, item, date received and discard date). o All refrigerated food shall be discarded within 48 hrs. (hours) o Perishable foods should be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the discard date. - The nursing staff will discard perishable foods on or before the discard date. Resident and/or family should be notified when food is being discarded. On 9/17/24 at 7:17 A.M., the surveyor observed a significantly dented can of pumpkin and a significantly dented can of mandarin oranges on the can rack in the kitchen. On 9/17/24 at 7:53 A.M., the surveyor made the following observations in the Concord unit kitchenette refrigerator: - Two water bottles, opened and filled with a green liquid undated and unlabeled. - A white plastic bag containing two containers of food, the white plastic bag was labeled with a resident name but the food was undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 8:01 A.M., the surveyor made the following observations in the [NAME] unit kitchenette refrigerator: - Two undated plastic pitchers of cranberry juice. - One undated plastic pitcher of apple juice. - One undated plastic pitcher of orange juice. On 9/17/24 at 11:21 A.M., the surveyor made the following observations in the Andover unit kitchenette refrigerator: - Two undated containers of resident food. During an interview on 9/17/24 at 7:17 A.M., the cook said that dented cans should not go on the can rack and should instead be placed in the office. During an interview on 9/17/24 at 7:55 A.M., Nurse #6 said that all food in the kitchenette refrigerators should be dated and discarded after three days. Nurse #6 said that the bottles of green liquid were brought in for a resident by family members. During an interview on 9/17/24 at 11:03 A.M., the Food Service Director (FSD) said dented cans should be set aside in the office to be returned as they pose a risk for botulism if consumed (a rare but serious illness caused by a toxin that attacks the nervous system and can lead to paralysis and death). The FSD said that juice and resident food in the unit kitchenette refrigerators should be dated and discarded after three days.

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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. 48990 Based on observations, record review, and interviews the facility failed to implement the infection prevention and control program. Specifically, the facility failed to ensure staff performed appropriate hand hygiene after removing gloves during wound care. Findings include: Review of the facility policy titled Hand Washing, revised December 2019, indicated: 6. Use an alcohol-based hand rub, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: after removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. a. Perform hand hygiene before and after glove use. On 9/17/24 at 10:20 A.M., the surveyor observed Nurse #2 perform wound care for a Resident with three left leg wounds in bed with a large amount of bloody drainage completely covering an area of approximately two feet by 1 foot of the bed sheets/bed sheet protector and the Resident's left leg. Certified Nurse Assistant (CNA) #4 assisted with positioning the Resident during wound care. Nurse #2 and CNA #4 did not perform any hand hygiene during the wound care observation. The following observations were made: - After removing the soiled dressing from the Resident's wound, Nurse #2 removed her soiled gloves to reach into her pocket and did not perform hand hygiene prior to applying a new pair of gloves. - CNA #4, who had been elevating the Resident's left leg where there was bloody drainage, also removed her soiled gloves and did not perform hand hygiene prior to applying a new pair of gloves. - Nurse #2 continued to cleanse the wound before she removed her soiled gloves to use an electronic tablet to take a photograph of the wound without performing hand hygiene. - Nurse #2 then handed the electronic tablet to CNA #4, who removed her gloves to assist with taking photographs using the electronic tablet, without performing hand hygiene. - Nurse #2 and CNA #4 then applied a new pair of gloves without performing hand hygiene. - Nurse #2 cleansed another area of the wound, and then removed one glove, which was visibly soiled with blood, to touch the electronic tablet, and then applied a new glove without performing hand hygiene. - CNA #4 also removed soiled gloves to use the electronic tablet again and did not perform any hand hygiene before applying a new pair of gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nurse #2 applied part of the dressing and removed her soiled gloves to open another dressing package and did not perform any hand hygiene before applying a new pair of gloves. - Nurse #2 applied another portion of the dressing and then used her gloved hands to reach into a plastic bag, being used for discarded wound dressing supplies, to push down on soiled dressings and soiled gauze to make more room. Nurse #2 then used the same soiled gloves to cleanse another area of the wounds, without changing gloves or performing hand hygiene. - Nurse #2 then removed her soiled gloves and did not perform any hand hygiene before applying a new pair of gloves. - Nurse #2 applied another dressing and then removed her soiled gloves and did not perform any hand hygiene before applying a new pair of gloves. During an interview on 9/19/24 at 12:44 P.M., Certified Nurse Assistant (CNA) #4 said she should have performed hand hygiene after removing her gloves while assisting the nurse with the Resident's wound care observed with the surveyor but did not. During an interview on 9/17/24 at 2:06 P.M., Nurse #2 said she should have performed hand hygiene after removing her gloves during the Resident's wound care observed by the surveyor but did not because she forgot to bring sanitizer into the room. During an interview on 9/19/24 at 9:43 A.M., the Director of Nursing (DON) said hand hygiene should be performed every time gloves are removed and before new gloves applied during wound care.