STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225581	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Care Center	320 Pittsfield Road Lenox, MA 01240

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. 37400 Based on observation, interview and policy review, the facility failed to ensure that one Resident (#25) out of a total sample of 17 residents, was provided privacy and dignity when assisting with personal care. Specifically, the facility staff failed to: -provide appropriate clothing or covering for the Resident's private areas while he/she was being transported to and from the shower. Findings include: Review of the facility policy titled Resident Rights - Promoting and Maintaining Resident Dignity, effective 3/16/23, indicated it was the practice of the home to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. The policy also included the following: -All staff members are involved in providing care to residents to promote and maintain resident dignity respect resident rights. -Maintain resident privacy. Resident #25 was admitted to the facility in May 2018 with diagnoses including cognitive communication deficit, mood disorder, and resided on the St. Luke's Unit. Review of the Activity of Daily Living (ADL- skills required for basic needs like eating, bathing, toileting) Care Plan, initiated 6/6/18 included the following: -Required extensive physical assist of one staff with bathing/showering, revised 6/6/18 -Required extensive assist of one staff with dressing and undressing, revised 7/7/23 (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 4/10/24 at 10:32 A.M., the surveyor observed Resident #25 seated on a shower chair and dressed in a hospital gown being assisted by Certified Nurses Aide (CNA) #6 from his/her room to the shower room which was on the opposite end of the hallway. The surveyor observed that the Resident's legs, bare bottom and private parts were exposed as he/she was assisted down the hallway. CNA #6 brought the Resident into the shower room and closed the door. During an interview at the time, CNA #5, who was also in the hallway during the observation said she observed Resident #25 being assisted by CNA #6 down the hallway with only a hospital gown on. CNA #5 said the shower chairs have an opening were the Resident sits, so unless there was something used, like a blanket or towel, to cover the lower portion of the Resident's body, the lower body would be exposed. CNA #5 said there should have been some covering used on the Resident's lower extremities to provide privacy and dignity. CNA #5 further said that it would not only be upsetting for Resident #25 to have his/her private areas exposed, but also upsetting to the other residents who may have seen the exposed private areas. On 4/10/24 at 10:46 A.M., Nurse #7 entered the shower room where CNA #6 and Resident #25 were located. The surveyor observed Nurse #7 assisting Resident #25, who remained seated in the shower chair and was dressed in a hospital gown and had pants covering the lower portion of his/her legs, down the hallway back to his/her room. The surveyor observed that the Resident's bare bottom remained visible when seated on the shower chair as he/she was assisted down the hallway. The surveyor also observed multiple staff members in the hallway at the time the Resident was being transported back to his/her room with his/her private areas exposed. During an interview on 4/10/24 at 11:02 A.M., Nurse #7 said that she assisted CNA #6 with Resident #25 because there was another resident who required assistance. When the surveyor shared the observations with Nurse #7. Nurse #7 said that the Resident should have been covered with a blanket or a towel to ensure that he/she was not exposed when being assisted to and from his/her room to the shower room.

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F 0580 Level of Harm - Minimal harm or potential for 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. 37400 Based on observation, interview, record and policy review, the facility failed to ensure the Physician and the Resident Representative were notified of a change in skin condition for one Resident's (#60) out of a total sample of 17 residents. Specifically, the facility failed to notify the Physician and Resident Representative when Resident #60 was found bleeding from his/her left index finger and the Resident was on anticoagulant (medication that prevent blood from clotting) therapy. Findings include: Review of the facility policy titled Notification of Changes, dated 4/25/23, indicated the facility shall consult with the resident's physician when there are changes in the resident's condition or status, in order to obtain orders for appropriate treatment and monitoring. The policy also included the following: -The nurse will immediately attempt to notify the resident, resident representative and resident physician for the following: an accident involving the resident, which results in injury and may require medical physician intervention . -The nurse will notify the resident, resident's physician and the resident representative for non-immediate changes of condition on the shift the change occurs . -The nurse will document the notification, and record any new orders on the resident's medical record Resident #60 was admitted to the facility in January 2024 with diagnoses including Alzheimer's disease (progressive disease that destroys memory and other important mental functions), cognitive communication deficit (difficulty paying attention to conversation, remembering information, responding accurately) and Diabetes Mellitus (disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood). Review of the Minimum Data Set (MDS) Assessment, dated 1/22/24, indicated the Resident: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15. -required assistance from staff with activities of daily living (ADLs- functional daily tasks including eating, personal hygiene, dressing, toileting). -had a recent surgery for hip replacement. Review of the Diabetes Mellitus Care Plan, initiated 1/16/24, included the following intervention: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-check all of the body for breaks in skin and treat promptly as ordered by the Physician Review of the Anticoagulant Therapy Care Plan, initiated 1/16/24, included the following intervention: -daily skin inspection, report abnormalities to the Nurse Review of a Nurse's Note, dated 3/14/24, indicated the Resident was found at 6:00 A.M. with blood all over his/her hands. Upon closer inspection, the blood was observed coming from the Resident's left index finger. The area was cleansed with normal saline (mixture of sodium chloride and water), bacitracin (antibiotic ointment) and a bandage was applied. There was no indication in the Nurse's Note that the Physician or Resident Representative were notified of the bleeding area on the Resident's left index finger or that treatment orders were obtained. The surveyor observed Resident #60 on the following dates/times with an undated bandage on his/her left index finger: -4/7/24 at 9:39 A.M. -4/8/24 at 11:41 A.M. -4/9/24 at 8:38 A.M. During an interview on 4/9/24 at 2:06 P.M., Unit Manager (UM) #1 said there was no investigation or incident report that was completed related to the left index finger incident and there should have been. During an interview on 4/9/24 at 2:22 P.M., the Director of Nurses (DON) said she was not aware of the area on the Resident's left index finger until today when the surveyor brought it to her attention. The DON said if a skin tear, or bleeding was observed by the staff without any knowledge of why, then an incident report should be initiated. The DON further said part of the process of completing the incident report also instructs the staff to update the Resident/Resident Representative and the Physician. The DON said she spoke with the Nurse who documented the Resident's skin incident on 3/14/24, and was told that the Resident's Representative and the Physician were not notified of the event, as required. Refer to F684

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) Assessment was accurate for one Resident (#15) out of a total sample of 17 residents. Specifically, the facility failed to accurately code that Resident #15 had a pressure injury (localized damage to skin and/or underlying soft tissue, usually over a bony prominence or related to a medical or other device). Findings include: Resident #15 was admitted to the facility in October 2020 with diagnoses including Dementia and Diabetes. Review of Resident #15's medical record indicated the Resident developed a Stage 2 injury (partial thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) in November 2022 that was not deemed resolved until March 2024. Review of Section M0100: Determination of Pressure Ulcer Risk, of the MDS assessment dated [DATE] did not indicate that the Resident had a pressure injury. During an interview on 4/10/24 at 10:44 A.M., the MDS Nurse said Section M0100 of the MDS assessment dated [DATE], was coded incorrectly and should have indicated the Resident had a Stage 1 or greater pressure injury and the MDS Assessment required modification.

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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** 37400 Based on observation, interview, record and policy review, the facility failed to provide treatment and care in accordance with professional standards relative to monitoring and assessing the skin condition for two Residents (#60 and #15). The facility also failed to ensure care and services were provided that meet professional standards relative to a Central Venous Access Device (CVAD-long flexible tube that is inserted through one of the central veins found in the neck, chest or groin to allow access to the bloodstream to deliver medication) catheter used to administer Intravenous (IV) antibiotics for Resident #60. Specifically, the facility failed to: 1. For Resident #60, a. perform weekly skin assessments, notify and obtain orders from the Physician when a new skin area of concern was identified, and b. monitor a CVC access site relative to measuring and documenting the external catheter length (measured from the catheter exit site to the 0 mark or, if no 0 mark is present, to the suture flange. Each line is measured as 1 centimeter/cm) according to standards of practice. 2. For Resident #12, perform weekly skin assessments per facility policy and Physician's order, and implement a Nurse Practitioner (NP) recommendation relative to edema (swelling in parts of the body due to fluid trapped in the tissues, most often in feet, ankles, and legs). Findings include: Review of the facility policy titled Central Venous Access Device (CVAD) Catheter Dressing Change, effective January 2022, indicated the purpose of the policy was to provide specific intervals and technique for CVAD dressing changes. The policy also included the following: -The licensed nurse will have documented education and competency in the management of vascular access devices (VADs) and will practice according to state law. -The IV therapy order for care and maintenance is required. -VAD assessment should occur: at least every 2 hours during a continuous infusion; before, during and after medication administration; during dressing changes; at a minimum of once each shift, when not in use; at prescribed intervals if complications are observed. -With each site assessment of the VAD, presence of the following, at a minimum, should be included: erythema (redness); drainage; induration (thickening and hardening of the soft tissues of the body); tenderness; warmth; swelling, of the extremity (if applicable) and at the site, sutures, if present; external catheter length. Review of the facility policy titled Wound and Skin Care- Skin Assessment, effective 6/25/23, indicated it was the policy of the facility to perform a full body skin assessment as part of their systemic approach to pressure injury prevention and management. The policy also included the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, and after any newly identified pressure injury is noted. -Documentation of skin assessment: >include date and time of the assessment, your name and position title >document observations (i.e. skin conditions, how the resident tolerated the procedure .) >document the type of wound >describe the wound (measurements, color, type of tissue in the wound bed, drainage, odor, pain) >document if resident refused the assessment and why >document other information as indicated and appropriate 1. Resident #60 was admitted to the facility in January 2024 with diagnoses including Alzheimer's disease (progressive disease that destroys memory or other important mental functions), cognitive communication deficit (difficulty with paying attention to conversation, remembering information and responding accurately), Diabetes Mellitus (disease where there are elevated blood glucose [sugar] levels in the blood), status post joint replacement left hip, bacterial infection, and vascular access site (procedure that involves the insertion of a flexible and sterile thin plastic tube, or catheter, into the blood vessel). Review of the Minimum Data Set (MDS) Assessment, dated 1/22/24, indicated the Resident: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15. -required assistance from staff with activities of daily living (ADLs- functional daily tasks including eating, personal hygiene, dressing, toileting). -had a recent surgery for hip replacement. a. Review of Nursing Assessment, dated 1/16/24, indicated Resident #60 had the following skin impairments: -redness to groin -bruises on scrotum -red heels -left knee bruises -left hip bruises (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-left and right arm bruises -left hip had a surgical incision with 19 staples and non-pitting edema Review of the Potential for Pressure Injury Development Care Plan, initiated 1/16/24, indicated the Resident had a potential risk related to impaired mobility and included the following interventions: -follow facility policies/protocols for the prevention/treatment of skin breakdown Review of the Diabetes Mellitus Care Plan, initiated 1/16/24, included the following intervention: -check all of the body for breaks in skin and treat promptly as ordered by the Physician Review of the Anticoagulant Therapy Care Plan, initiated 1/16/24, included the following intervention: -daily skin inspection, report abnormalities to the Nurse Review of a Nurse's Note, dated 3/14/24 indicated the Resident was found at 6:00 A.M. with blood all over his/her hands. Upon inspection, the blood was observed coming from the Resident's left index finger. There was no indication in the Nurse's Note that the Physician or Resident Representative were notified of the area on the Resident's left index finger or that treatment orders were obtained for the area. Review of a Skilled Nurse's Note, dated 4/1/24, indicated the Resident had an abrasion on his/her left pointer finger .cleansed and a bandage was put on. Review of the Physician's Orders from January 2024 through April 2024 did not include an order to complete a weekly skin assessments for Resident #60. Further review of the clinical record indicated no documented evidence of weekly skin assessments, nor Physician's orders or assessments obtained for the area on the Resident's left index finger after the initial injury occurred on 3/14/24. On 4/7/24 at 9:39 A.M., the surveyor observed Resident #60 seated in the small dining area during breakfast. A bandage was observed on the Resident's left index finger. There was no date observed on the bandage. On 4/8/24 at 11:41 A.M., the Resident was observed seated in a wheelchair in his/her room. A undated bandage was observed on the Resident's left index finger. On 4/9/24 at 8:38 A.M., the surveyor observed the Resident seated in a wheelchair in the small dining room during breakfast. The Resident was dressed and an undated, discolored bandage was observed on his/her left index finger. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 1:10 P.M. and 1:24 P.M., the surveyor observed the Resident with Nurse #6. When the surveyor inquired about the bandage on the Resident's left index finger, Nurse #6 said that she assessed the Resident's finger today by pulling the bandage off the finger, that the area was not open, and Nurse #6 thought it was because he/she scratched or pulled at something. Nurse #6 attempted to pull the bandage off of the Resident's finger for the surveyor to observe the area and was unable to remove the bandage. Nurse #6 said there was no date on the bandage and there were no Physician's orders in place for a treatment to the area. On 4/9/24 at 2:06 P.M., the surveyor and Unit Manager (UM) #1 reviewed Resident #60's clinical record. UM #1 said skin assessments should be completed weekly on the Resident's shower days, documented in the Treatment Administration Record (TAR) and also on a weekly skin assessment form. UM #1 said that an incident report should have been completed when the Resident's finger was found to be bleeding, but one had not been completed. After reviewing the Resident's clinical record, UM #1 said weekly skin assessments had not been completed and should have been. On 4/9/24 at 2:22 P.M., the Director of Nurses (DON) said she was not aware of the area on Resident #60's left index finger until the surveyor brought it to her attention. The DON said any time there was a skin incident, an incident report should be initiated, the Physician and Resident Representative would be notified, and a treatment order would be put in place. The DON said that if the weekly skin assessments had been completed, the bandage on the Resident's finger would have been observed during those assessments, but this did not occur. The DON further said when the Nurse does the scheduled weekly skin assessment and they notice a new area or a bandage, they would assess the area, update the Unit Manager and the DON and ensure there was a treatment order in place. During a follow-up interview on 4/9/24 at 3:05 P.M., UM #1 said she assessed the Resident's left index finger, there was dried blood on the finger but no open areas were observed. UM #1 further said that there was no indication as to when the bandage on the Resident's finger was last changed. b. Review of the Hospital Discharge Summary, dated 3/22/24 indicated the following: -Resident removed Peripherally Inserted Central Catheter (PICC) line from right arm while at the nursing home, was sent to the hospital to have PICC line replacement for antibiotic administration -Resident had a right jugular (large vein located in the neck) PICC line placed by Interventional Radiology (IR) on 3/22/24 -Complete 6 weeks of Ampicillin (antibiotic) 2 grams (gm) every six hours as previously recommended by Infectious Disease (ID) -Under completed studies/procedures during hospitalization , listed the following: >Procedure: Central Venous Catheter (CVC or type of CVAD), insert tunneled WO port on 3/22/24 at 9:20 A. M. Review of the April 2024 Physician's orders included the following: -PICC/Midline for Intravenous (IV) Antibiotic, initiated 3/9/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PICC/Midline: have clamp at bedside at all times every shift, initiated 3/9/24 -Change dressing unless biopatch on gauze every 48 hours and as needed, initiated 3/9/24 -Change needless access device every 7 days and as needed, initiated 3/9/24 -Change transparent dressing every 7 days and as needed, initiated 3/9/24 -22 G PICC in right jugular, single lumen, insertion date 3/22/23, initiated 3/22/24 -Flush PICC line (right jugular PICC line) with 5 milliliters (ml) of normal saline before and after each medication and every 24 hours, initiated 3/22/24 -Ampicillin Sodium IV Solution Reconstituted 2 grams (gms), use 2 grams IV every 6 hours for infection of left hip until 4/12/24, initiated 3/22/24 Review of the IV Medication Care Plan, initiated 3/10/24 indicated the Resident will not have any complications related to IV therapy through the review period, and included the following interventions: -Evaluate patency of device prior to use -Monitor/Document site conditions every shift and as needed (PRN) -Monitor/Change/Document dressing per policy Review of the March 2024 Treatment Administration Record (TAR), indicated the following Physician's order which was discontinued on 3/24/24: -Measure and Document External Catheter Length every 7 days, initiated 3/10/24 Further review of the March 2024 TAR indicated NA was documented on 3/24/24 by the Nurse relative to external catheter length order. Review of the April 2024 TAR did not indicate any Physician's orders to monitor and document the External Catheter Length. Review of Resident #60's clinical record indicated no documented evidence that the External Catheter Length was determined upon re-admission to the facility from CVAD catheter placement on 3/22/24, or that any measurements were obtained since re-admission to the facility. On 4/7/24 at 11:35 A.M., the surveyor observed Resident #60 seated in a wheelchair in his/her room. The surveyor observed that an IV pole with a clear bag containing a clear fluid was hanging. The bag was labeled Ampicillin 2 gm/100 milliliter (ml) 0.9% NS, was dated 4/7/24 and was observed to be infusing via an IV pump set at 100 ml/hour. The IV tubing was dated 4/7/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 1:10 P.M., the surveyor observed Nurse #6 assess the CVAD catheter site for Resident #60. She said that prior to administering the IV antibiotics, she would check the insertion site to see if there was drainage, blood, or any discomfort from that area. Nurse #6 said she would than flush the IV line with 5 mls of normal saline before and after the antibiotic administration and than connect the medication for infusion. Nurse #6 said that the Registered Nurse (RN) would measure the external catheter length when changing the dressing weekly to ensure that it has not migrated (moved out of place) and that because she was an Licensed Practical Nurse (LPN), she was unable to do this task. The surveyor and Nurse #6 observed the Resident's access site located in his/her upper chest and a transparent dressing was observed that was dated 4/4/24. There was no redness or drainage observed around the insertion site. During an interview on 4/9/24 at 1:47 P.M., UM #1 said the external catheter length of the CVAD catheter should be obtained on admission to the facility after placement. She said that the nursing staff should be monitoring/assessing the CVAD catheter site for redness, infection, drainage and for any changes. UM #1 further said that prior to antibiotic administration, the access site should be assessed and the external catheter length should be measured. The UM reviewed the Resident's clinical records and said there were no current orders to measure the external catheter length and there should be. UM #1 said she was unsure what the external catheter length was initially when placed at the hospital on 3/22/24, and would have to look into this. During an interview on 4/10/24 at 11:12 A.M., Nurse #5 said Resident #60 had a CVAD catheter in place for IV antibiotic administration. Nurse #5 said that the external catheter length would be measured weekly when the dressing changes were completed. She further said that if the line was placed at the hospital, the information about the type of catheter placed and the external catheter length should be provided. She said the measurement should be documented and if there was a change from the previous measurement, the IV medication would not be administered and the Physician would be notified for further instructions. The surveyor and Nurse #5 reviewed Resident #60's current orders and Nurse #5 said there was no Physician's order in place to measure the external catheter length and there should be because there would be no way for the Nurses to review the previous measurements to ensure that the catheter remained in the correct place. Nurse #5 reviewed the Resident's progress notes and further said that the Resident's catheter dressing was changed the previous day and there should be an indication of what the external catheter length was at that time but nothing was documented. Nurse #5 said she was comfortable working with IVs and had received training from the agency she worked for about three years ago which included a competency, but had not received any training in the facility. During a follow-up interview on 4/10/24 at 12:24 P.M., UM #1 said on admission the resident orders would be reviewed and the information relative to a CVAD catheter if not received, would be requested from the hospital and would include initial measurements for the external catheter length. UM #1 further said this information had not been obtained for Resident #60. Refer to F726 44129 2. Resident #12 was admitted to the facility in February 2024 with diagnoses including Hypertension (high blood pressure), Polyneuropathy (nerve damage), muscle weakness and difficulty walking. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment dated [DATE] indicated the Resident had severe cognitive impairment as evidenced by a BIMS score of six out of a total possible score of 15. Further review of the MDS Assessment indicated the Resident was usually understood by others. Review of the April 2024 Physician's Orders indicated: -Complete weekly skin assessment and obtain weight every Thursday on the evening (3:00 P.M. - 11:00 P.M.) shift, initiated 2/29/24. Review of the Electronic Health Record (EHR) Assessments section indicated no weekly skin assessments were completed by the facility staff since 2/29/24. Review of Resident #12's Nursing Admission assessment dated [DATE] indicated the Resident had edema present in his/her lower extremities. Review of a Nursing Progress Note dated 3/1/24 indicated the Resident had bilateral lower extremity edema present. Review of the NP Progress Note dated 3/29/24 indicated: -Bilateral lower extremity chronic redness (pooling of blood in the legs often causing the skin to become irritated and inflamed), no evidence of infection. Keep legs elevated when seated. During an observation and interview on 4/7/24 at 11:05 A.M., the surveyor observed the Resident seated in a chair at his/her bedside with his/her feet resting on the floor. The surveyor observed both the Resident's lower legs were taut, reddened and with edema. The Resident told the surveyor that he/she was not aware of any treatments the facility had in place to alleviate his/her edema, such as elevating his/her legs, medication, or compression wraps. During an observation and interview on 4/9/24 at 7:37 A.M., the surveyor observed the Resident seated in a chair at his/her bedside, feet resting on the floor, legs reddened and with edema present. The Resident said he/she has been in the shower one time since he/she had been admitted and did not think that anybody had ever performed a full body skin check on him/her. He/she further said that staff do not offer or assist him/her in elevating his/her legs. During an interview on 4/9/24 at 9:40 A.M., with Nurse #2 and the Medical Records Coordinator, Nurse #2 said all skin assessments should be documented under the assessment section in the EHR and that that Nursing staff were required to complete full skin assessments weekly. The Medical Records Coordinator said that skin assessments were supposed to be completed weekly on shower days. Nurse #2 said if a resident refused a shower, the Certified Nurses Aide (CNA) is supposed to notify the Nurse and the Medical Records Coordinator said if the Nurse was aware the Resident refused a shower, they were supposed to document that in a Nursing Progress Note. Nurse #2 said that even if the Resident refused a shower, it was still the facility Nurse's responsibility to perform a skin assessment and document their findings in the EHR. Review of the Resident's Medical Record indicated no evidence that the Resident ever refused showers or skin assessments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/24 at 10:20 A.M., UM #1 said weekly skin assessments should be documented under the assessment section in the EHR. UM #1 said it did not appear that weekly skin assessments were completed as ordered after 2/29/24. UM #1 further said when a provider writes a recommendation, the Nursing staff should review the recommendation and ensure the recommendation becomes integrated in the Resident's plan of care. UM #1 said the providers communicate their orders and recommendations in different ways to the Nursing staff. The NP writes her recommendations on a Progress Note sheet and UM #1 said the Nursing staff need to review the NP Progress Notes to ensure recommendations and orders were implemented. UM #1 reviewed Resident #12's record and said the NP recommendation dated 3/29/24 to elevate the Resident's extremities was never reflected in the Resident's Care Plan, as required.

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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** 37400 Based on observation, interview, record and policy review, the facility failed to ensure that care and services to prevent and/or treat pressure ulcers were provided for two Residents (#57 and #15), out of three applicable residents reviewed, out of a total sample of 17 residents. Specifically, the facility failed to: 1. For Resident #57, ensure timely assistance with bedpan use to prevent the development of a pressure ulcer to his/her sacrum (triangular bone in the lower back) for the Resident who was at increased risk for pressure ulcers. 2. For Resident #15, ensure weekly skin assessments were completed as ordered by the Physician so that a resulting Stage 2 Pressure Ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) could have been identified earlier and prevented from progressing. Findings include: Review of the facility policy titled Wound and Skin Care-Pressure Injury Prevention and Management, dated 6/27/23, indicated the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable. The policy also included the following: -Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. -Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with the resident's needs; resident goals; and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. -Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. -Assessments of pressure injuries will be performed by a licensed nurse and documented in the medical record. -Training in the completion of the pressure injury risk assessment, full body skin assessment, and pressure injury analysis will be provided as needed. -The attending physician will be notified of the presence of a new pressure injury upon identification . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-A Performance Improvement Project (PIP) will immediately be initiated to identify root cause(s) for the resident in question and then all other residents who are identified with similar characteristics. 1. Resident #57 was admitted to the facility in December 2023 with a diagnosis of displaced intertrochanteric left femur fracture (left hip fracture). Review of the Nursing Assessment, dated 12/13/23, included the following: -Resident was at risk for pressure ulcers -Recent major surgery -Skin was normal, warm, dry and turgor was normal -Healed incision to the left hip -Superficial wounds to the right and left heels -No edema was present -Occasionally incontinent of bladder and bowel, used briefs/pads -Dependent on toileting, bathing, upper and lower body dressing, personal hygiene, rolling side to side, sitting to standing Review of the Bladder and Bowel Program Screening, dated 12/16/23 indicated the Resident: -Voids appropriately without incontinence not always, but at least daily -Incontinent of stool 1-3 times weekly -Needs assistance of one person with toileting -Alert and oriented -Usually aware of need to toilet -No redness to the genital, perineal and buttocks -No predisposing factors Review of the Minimum Data Set (MDS) Assessment, 12/19/23, indicated the Resident: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of 15. -required assistance of staff with toileting. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-was at risk for pressure injuries. -had two Stage 2 (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure injuries present on admission. Review of the Resident's Risk for Alteration in Comfort Care Plan, initiated 12/13/23 and revised 1/10/24, indicated the Resident's Stage 2 pressure ulcers to the right and left heels had resolved on 12/19/23. Review of the Activity of Daily Living (ADL- functions including eating, bathing toileting) Care Plan, initiated on 12/13/23 and revised 12/27/23 indicated the Resident had an ADL self care performance deficit related to impaired mobility. The care plan included the following interventions: -Assistance of one staff with rolling walker to the bathroom -Extensive assist of one staff for toileting Review of the Potential for Pressure Injury Development Care Plan, initiated 12/13/23, indicated the Resident was at increased risk related to impaired mobility and included the following intervention: -follow facility policies/protocols for the prevention/treatment of skin breakdown. Review of Nurse's Notes, dated 1/14/24, 1/15/24, 1/16/24, and 1/23/24 indicated the Resident used a bedpan with assistance from staff. Review of a Nurse's Skilled Note, dated 1/18/24, indicated: -a new superficial open area was identified on the Resident's right sacrum, measuring 2.0 centimeters (cm) by (x) 1.0 cm. -The wound bed was moist and beefy red, and had no drainage. -The Physician was notified and an order was in place to apply Z-guard (skin protectant paste). -The Resident was educated on frequent position changes due to the new open area identified. Review of the Nurse's Skilled Notes, dated 1/19/24 through 1/22/24 indicated the Resident's skin integrity was within normal limits (warm, dry, intact, normal color for patient) with no physical assessment findings (despite the open area being identified on 1/18/24). Review of the Weekly Skin Assessment, dated 1/22/24, indicated the Resident: -had no alterations to his/her skin. -Listed under Other a notation indicated a wound was present, Stage 2 on the right sacrum. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Nursing Note, dated 1/22/24, indicated a Stage 2 wound was present on the Resident's right coccyx (tail bone) measuring 2.0 cm x 0.2 cm x 0.1 cm. A cream was applied and note was left for the Wound Consultant to evaluate the next day. Review of the clinical record indicated no changes to the Resident's plan of care when the new sacral area was identified on 1/18/24 and 1/22/24. Review of the Wound Consultant Note, dated 1/23/24, indicated that the Resident reported that he/she had been left on the bedpan for longer than normal and the injury began. The evaluation included the following assessment: -Injury is tender -Suspect pressure injury from bedpan as the ulcer is linear (horizontal) -Measurement of sacral wound area measured 0.5 cm (length) x 2.5 cm (width) x 0.1 cm (depth), and had small amount of serous drainage. -The periwound (area surrounding the wound) exhibited brawny (swollen and hardened) induration (abnormal firmness of tissues with margins and results from an inability to pinch the tissues) and swelling consistent with inflammation from pressure -Suspect from bedpan -Ulcer Staging is unspecified as depth is undetermined due to inflammation and swelling -At this time, injury is partial thickness Review of the Subsequent Wound Consultant Notes from 1/30/24 through 2/20/24 indicated the sacral wound improved and was determined to be healed as of 2/20/24. Review of the MDS Assessment, dated 3/20/24, indicated Resident #57: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 13 out of 15. -had no behaviors or rejections of care. -required assistance of staff with toileting. -was at risk for pressure ulcers but did not have any pressure ulcers at the time of the assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/7/24 at 11:28 A.M., the surveyor observed Resident #57 dressed and seated in a wheelchair in his/her room watching television. During an interview at the time, the Resident said he/she required assistance from staff with personal care, had to wait for staff assistance with toileting, and sometimes had episodes of incontinence during the night because the facility was short staffed, especially at night and on the weekends. The Resident said there was a time months ago that he/she was waiting an hour for someone to answer the call light after it was pressed. During an interview on 4/9/24 at 4:45 P.M., with Unit Manager (UM) #1, when the surveyor inquired about the Resident's wound that was acquired in January 2024, Unit Manager (UM) #1 said there was no investigation or incident report completed when the pressure ulcer was identified. UM #1 said they provided the Resident with a larger bedpan and facility staff were verbally in-serviced on ensuring the call lights were accessible and responded to timely. UM #1 further said Resident #57 was unable to use the bedpan by him/herself and relied on staff to place and remove the bedpan for him/her. On 4/10/24 at 9:17 A.M., the surveyor observed the Resident dressed and seated in a wheelchair. During an interview at the time, the Resident said he/she prefers to use the bedpan at night because of fear of falling. When the surveyor asked about the use of the bedpan, the Resident said he/she would ring the call light for assistance with the bedpan and staff would assist him/her. The Resident said after placing the bedpan, sometimes the staff stay and sometimes they leave. If the staff leaves, the Resident said he/she would need to use the call light to ask for assistance off the bedpan and sometimes it takes less than an hour, but there are times when it takes an hour or over for them to respond. The Resident further said that he/she thought that there was not enough help in the facility because sometimes there is only 1 or 2 Certified Nurses Aides (CNAs) on the overnight shift (11:00 P.M. to 7:00 A.M.). During an interview on 4/10/24 at 9:57 A.M., CNA #2 said Resident #57 required assistance of 1 to 2 staff with care. CNA #2 said the Resident was alert and oriented and able to make his/her needs known. CNA #2 said the Resident uses the call light to request assistance with toileting, was usually continent but sometimes has episodes of incontinence when the staff were unable to get to him/her in time to provide assistance. CNA #2 said that the bedpan is used for the Resident if he/she was in bed and takes 1-2 staff to assist with this depending on the day. CNA #2 further said the Resident was unable to place/remove the bedpan and relies on staff to do this. CNA #2 said when the bedpan is positioned under the Resident, staff will make sure the call light is accessible and than leave, because the Resident will ring for assistance when finished. CNA #2 said the Resident is very easy to care for, has no behaviors or rejections of care and is able to alert staff when he/she requires assistance. During an interview on 4/10/24 at 1:20 P.M., the Wound Consultant said that she rounded with the Unit Manager for the Resident's initial sacral wound observation on 1/23/24. She said pressure relieving interventions were put into place and education was provided to the facility staff to respond to call lights timely. The Wound Consultant said that most injuries from medical devices (like bedpans) are preventable, and that prolonged time on the device for one time can cause pressure. During an interview on 4/10/24 at 4:01 P.M., the Director of Nurses (DON) said once the area to the Resident's sacrum was identified, a skin incident report should have been completed and an investigation started. The DON said because the Resident indicated that he/she was left on the bedpan longer than usual, an investigation should have been completed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Refer to F725 44129 2. Resident #15 was admitted to the facility in October 2020 with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), Diabetes (disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood), Hypertension (high blood pressure), and obesity. Review of the MDS assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a BIMS score of 13 out of 15 points. Further review of the MDS Assessment indicated the Resident was at risk for developing pressure ulcers/injuries and currently had a Stage 2 pressure injury. Review of the April 2024 Physician's orders indicated: -Complete Weekly Skin Assessment weekly on Mondays 3:00 P.M.-11:00 P.M. shift, initiated 11/28/22 Review of the Wound Care Nurse Progress Notes indicated: -11/28/23 - Initial evaluation, coccyx tender on exam, new open wound, wheelchair bound and total care. -Stage two pressure injury not healed, measuring 0.5 centimeters (cm) long x 0.5 cm wide x 0 cm deep. Small amount of fresh blood, no odor, peri wound (skin surrounding wound) texture, moisture, and color normal. -100% nongranular (smooth in appearance) injury over coccyx consistent with stage two pressure injury in the setting of immobility and incontinence. -1/23/24 - Coccyx wound resolved. -3/13/24 - On 3/12/24, facility requested this Nurse Practitioner (NP) re-evaluate Resident for open wound near buttock measuring 0.5 cm x 0.5 cm x 0.1 cm. Peri wound texture, moisture, and color normal. - 4/9/24 - Coccyx wound worsening. Size 0.8 cm x 0.5 cm x 0.3 cm. During an observation and interview on 4/7/24 at 10:32 A.M., the surveyor observed Resident #15 lying on his/her back in his/her bed. The Resident said that he/she has a sore on his/her backside that came back from before and now it would not heal. During an interview on 4/10/24 at 9:42 A.M., Unit Manager (UM) #1 said weekly skin assessments completed by Nursing staff are in the Assessment section of the Electronic Health Record (EHR) and should be completed weekly per facility policy. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/10/24 at 12:08 P.M., UM #1 said weekly skin assessments were necessary and important because skin issues could be caught at an early stage so interventions could be put in place before the issue worsened. UM #1 said no weekly skin assessments were completed for Resident #15, as required on the following dates: -10/16/23 -10/30/23 -11/20/23 (Stage two pressure injury was noted on the following weekly skin assessment dated , d+[DATE]//23) -12/18/23 -12/25/23 -2/12/24 -2/19/24 -4/1/24 The surveyor reviewed the above missing weekly skin assessments with UM #1, specifically pointing out that no weekly skin assessment was completed on 11/20/23 and a Stage 2 pressure injury was subsequently found on the next weekly assessment on 11/28/23. The surveyor asked UM #1 if she thought the pressure injury might have been caught at an earlier stage (Stage 1 - an area of non-blanchable (does not turn white and return to normal skin color when pressed, or a blanchable reddened area (not yet considered a pressure injury), if a skin assessment had been completed on 11/20/23. UM #1 said she was confident that if there were a skin issue, the Certified Nurses Aides (CNAs) would have reported it to the primary Nurse. UM #1 further said that only Licensed Nurses can perform skin assessments, not CNAs. During a telephone interview on 4/10/24 at 1:25 P.M., the Wound Care Specialist NP said it was best practice for the Licensed Nurses to perform weekly skin assessment to identify problem areas as soon as possible.

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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. 37400 Based on observation, interview, record and policy review, the facility failed to investigate accident/hazards incidents and implement interventions to the plan of care for two Residents (#60 and #57), out of a total sample of 17 residents. Specifically, the facility failed to: 1. For Resident #60, thoroughly investigate and add interventions when a new skin area was identified on his/her left index finger. 2. For Resident #57, thoroughly investigate and add interventions when a new pressure injury was identified. Findings include: Review of the facility policy titled Wound and Skin Care- Skin Assessment, effective 6/25/23, indicated it was the policy of the facility to perform a full body skin assessment as part of their systemic approach to pressure injury prevention and management. The policy also included the following: -A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, and after any newly identified pressure injury is noted. -Documentation of skin assessment: >include date and time of the assessment, your name and position title >document observations (i.e. skin conditions, how the resident tolerated the procedure .) >document the type of wound >describe the wound (measurements, color, type of tissue in the wound bed, drainage, odor, pain) >document if resident refused the assessment and why >document other information as indicated and appropriate 1. Resident #60 was admitted to the facility in January 2024 with diagnoses including Alzheimer's disease (progressive disease which impairs memory and function), cognitive communication deficit, and status-post joint replacement left hip. Review of the Minimum Data Set (MDS) Assessment, dated 1/22/24, indicated the Resident: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-required assistance from staff with activities of daily living (ADLs- functional daily tasks including eating, personal hygiene, dressing, toileting). -had a recent surgery for hip replacement. Review of the Potential for Pressure Injury Development Care Plan, initiated 1/16/24, indicated the Resident had a potential risk related to impaired mobility and included the following interventions: -follow facility policies/protocols for the prevention/treatment of skin breakdown Review of a Nurse's Note dated 3/14/24, indicated the Resident was found at 6:00 A.M. with blood all over his/her hands. Upon inspection, the blood was observed coming from the Resident's left index finger. The area was cleansed with normal saline (mixture of sodium chloride and water), bacitracin (antibiotic ointment) and a bandage were applied. There was no indication that the Physician or Resident Representative were notified of the area on the Resident's left index finger or that treatment orders were obtained. Review of a Skilled Nurse's Note, dated 4/1/24, indicated the Resident had an abrasion on his/her left pointer finger .cleansed and a bandage was put on. The surveyor observed Resident #60 with an undated bandage on his/her left index finger on the following dates/times: -4/07/24 at 9:39 A.M. -4/08/24 at 11:41 A.M. -4/09/24 at 8:38 A.M., On 4/9/24 at 1:10 P.M. and 1:24 P.M., the surveyor observed the Resident with Nurse #6. When the surveyor inquired about the bandage on the Resident's left index finger, Nurse #6 said that she assessed the Resident's finger today by pulling the bandage off the finger, that it was not open, but thought it was because he/she scratched or pulled at something. The Nurse attempted to pull the bandage off of the Resident's finger for the surveyor to observe and was unable. Nurse #6 said there was no date on the bandage and there were no Physician's orders in place for a treatment to the area. On 4/9/24 at 2:06 P.M., Unit Manager (UM) #1 and the surveyor reviewed Resident #60's clinical record. UM #1 said that an incident report should have been completed when the Resident's finger was found to be bleeding, but one was not completed. On 4/9/24 at 2:22 P.M., the Director of Nurses (DON) said she was not aware of the area on Resident #60's left index finger until the surveyor brought it to her attention. The DON said any time there was a skin incident, an incident report should be initiated, the Physician and Resident Representative would be notified, and a treatment order would be put in place, but this did not occur for Resident #60 because no incident report was completed. (continued on next page)

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Mount Carmel Care Center	320 Pittsfield Road Lenox, MA 01240

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #57 was admitted to the facility in December 2023 with a diagnosis including displaced intertrochanteric left femur fracture (left hip fracture). Review of the MDS Assessment, 12/19/23, indicated the Resident was cognitively intact as evidenced by a BIMS score of 14 out of 15, required assistance of staff with toileting, and was at risk for pressure injuries. Review of a Nurse's Skilled Note, dated 1/18/24, indicated a new superficial open area was identified on the Resident's right sacrum (triangular bone located at the base of the spine), measuring 2.0 centimeters (cm) by 1.0 cm. The wound bed was moist and beefy red, and had no drainage. The Physician was notified and an order was in place to apply Z-guard.The Resident was educated on frequent position changes due to the new open area identified. Review of a Nursing Note, dated 1/22/24, indicated a Stage 2 wound was present on the Resident's right coccyx, a cream was applied, and note was left for the Wound Consultant to evaluate the next day. Review of the clincal record indicated no changes to the Resident's plan of care when the new sacral area was identified on 1/18/24 through 1/22/24. Review of the Wound Consultant Note, dated 1/23/24, indicated the Resident reported that he/she had been on the bedpan for longer than normal and the injury began. The evaluation included the following assessment: -Injury is tender -Suspect pressure injury from bedpan as the ulcer is linear (horizontal) During an interview on 4/9/24 at 4:45 P.M., when the surveyor inquired about the Resident's wound that was acquired in January 2024, UM #1 said there was no investigation or incident report completed when the pressure ulcer was identified. UM #1 said they provided the Resident with a larger bedpan and facility staff were verbally in-serviced on ensuring the call lights were accessible and responded to timely. During an interview on 4/10/24 at 4:01 P.M the DON said once the area to the Resident's sacrum was identified, a skin incident report should have been completed and an investigation started. The DON said because the Resident indicated that he/she was on the bedpan longer than usual, a facility investigation into this concern should have been completed.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on interview, record and policy review, the facility failed to perform a trauma assessment on admission to the facility and develop a trauma care plan for one Resident (#10) out of a total sample of 17 residents. Specifically, the facility failed to assess whether Resident #10, who was admitted with a diagnosis of Post Traumatic Stress Disorder (PTSD-a disorder in which a person has difficulty recovering after a traumatic experience), had a history of trauma and failed to identify any triggers which may cause re-traumatization. Findings include: Review of the facility policy titled; Trauma Informed Care dated 10/24/23 indicated but was not limited to: -It is the policy of this facility to address trauma in the lives of the residents served by this company. -The interdisciplinary care team will be responsible for developing a care plan that addresses assessed emotional and psychosocial needs of the resident, monitoring effectiveness of approaches and updating the care plan as needed. The care plan should address: >The resident's expression, manifestations, or indications of distress >Potential triggers >Individual person-centered care approaches that reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Resident #10 was admitted to the facility in February 2023 with a diagnosis of PTSD. Review of the Resident's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15 points. Review of Resident #10's Medical Record did not indicate a Trauma Assessment was ever completed, nor was there a Care Plan developed relative to the Resident's PTSD diagnosis. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/24 at 12:20 P.M., Social Worker (SW) #1 said the facility did not utilize a Trauma Assessment, and if a resident had a trauma history, that information usually came up during his/her initial Social Service assessment or during a visit with the Psychiatric Nurse Practitioner. SW #1 further said if a resident was identified as having a trauma history, a care plan should be developed that identified what, if any, the resident's triggers for re-traumatization were. The surveyor and SW #1 reviewed the Resident's Medical Record and Care Plan. SW #1 said there was no Trauma Assessment completed despite the Resident's diagnosis and there was not a PTSD Care Plan in place that identified what the Resident's triggers for re-traumatization were, as required.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interview, record and policy review, the facility failed to ensure that there was sufficient nursing staff to assist residents in attaining and maintaining the highest practicable physical, mental, and psycho-social well-being on two out of two units observed (St. Louise and St. [NAME] Units) and six Residents (#16, #57, #62, #28, #2, and #32). Specifically, the facility staff failed to: -For Resident #16, answer the call light timely for assistance with toileting. -For Resident #57, respond to the call light timely to assist with bedpan use by the Resident, who was unable to independently use the bedpan due to a fractured hip. -For Resident #62, provide bathroom assistance to the Resident during meal times. -For Resident #28, provide liquids and assistance in the early morning hours. -For Resident #2, respond timely when the call light was activated. -For Resident #32, answer call lights and provide assistance timely on evening and night shifts. Findings include: Review of the facility policy titled Call Lights: Accessibility and Timely Response, dated 4/23/23, indicated the purpose of the policy was to ensure that the facility was equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The policy also included the following: -All staff who see or hear an activated call light are responsible for responding . Review of the Facility Assessment, undated but with data pulled from 4/1/22 through 3/31/23, and provided to the survey team during the recertification survey, included the following information under Staffing Plan: -Based on the facility resident population and their needs for care and support, the approach to staffing was to ensure that each of the residents has the minimum direct care staff to meet their needs at any given time. -Certified Nurse Aides (CNAs): >1:10 (staff: resident ratio) on the day shift (7:00 A.M. to 3:00 P.M. shift) >1:10 on the evening shift (3:00 P.M. to 11:00 P.M. shift) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	>1:15-20 on the night shift (11:00 P.M. to 7:00 A.M. shift) -Other nursing personnel (e.g. those with administrative duties) included: >Staff Development/Infection Control Preventionist (SDC/IP) >2 Unit Managers 1. During the initial pool process on 4/7/24 from 7:50 A.M. through 9:15 A.M., on the St. Louise Unit, the surveyor observed the following: -At 7:52 A.M., the call light in Resident #16's room was observed to be on and was not responded to until 7:59 A.M. (7 minutes later) -At 8:22 A.M., Resident #16's call light was observed to be on. No staff were observed in the hallway. At 8:25 A.M., Staff observed to walk past the nursing station, where the call light was sounding, and proceed to the St. [NAME]'s Unit. The Resident's call light remained on. At 8:29 A.M., the surveyor knocked and entered Resident #16's room. The Resident was observed lying in bed. During an interview at the time, Resident #16 said he/she has been ringing the call light for staff assistance but no one had responded yet. The Resident said he/she needed to use the bathroom and needed staff assistance. At 8:31 A.M., a CNA was observed to enter the room to assist the Resident (9 minutes after the 8:22 A.M. alert). -At 8:45 A.M., the meal cart arrived to the St. Louise Unit. The Administrator was observed to bring a pile of towels, place them on the nursing station and then leave the unit. Nurse #9 was observed to check the resident meal trays at this time. At 8:46 A.M., meal tray pass began and included CNA #2, Nurse #8, and the Director of Social Services and the Director of Nurses (DON). During an interview at 8:50 A.M., the Director of Social Services said she was usually not in the facility on the weekends. During an interview at 8:56 A.M., the DON said she was not scheduled to work today. The DON said there was a Manager on Duty position that rotates on the weekends and either work 4 hours on each weekend day or an 8 hour day on one weekend day. She said in addition to the Manager on Duty position, there was also a Nurse Manager that is scheduled to be on call if needed. The DON said the Manager on Duty for this weekend was the Food Service Director. -At 9:02 A.M., the call light in room [ROOM NUMBER] was observed to be on and at 9:12 A.M., a CNA was observed to enter the room, and the call light was turned off (10 minutes later). 2. During an interview on 4/7/24 at 10:30 A.M. during the initial pool process, a Resident who resided on the St. Louise Unit, said he/she had concerns about the facility staffing. The Resident said that when the call light was put on, no one responded to answer or address his/her needs for at least a half an hour. The Resident further said this occurred at least daily and occurred on all shifts. The Resident said he/she required assistance from staff to get up and use the bathroom, had reported his/her concerns about the staffing and has been told by the CNAs that they will relay these concerns to the Nurse. The Resident said that he/she has recently had an issue with his/her buttocks, that it was raw and uncomfortable, and the facility staff have recently started putting a cream on the area. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an interview on 4/8/24 at 10:39 A.M. with CNA #2, who worked on 4/7/24, said he worked on both the 7:00 A.M. to 3:00 P.M. and the 3:00 P.M. to 11:00 P.M. shifts, worked full time and also worked on the weekends. CNA #2 said they had 3 CNAs yesterday (on Sunday 4/7/24) and that he was responsible for 10 residents. CNA #2 said when there are 3 CNAs scheduled, it makes the day difficult and takes longer to get the work done because of the staffing level. CNA #2 said that 8 of the 10 residents he was assigned to were dependent with care and required more than one staff. CNA #2 said when there are 3 CNAs scheduled, there are times when the call lights are on and he was unable to assist and respond to the call lights/requests because he was in a room with another resident. CNA #2 also said there are times when the resident he is assisting requires another person in addition to himself, and there is no one available. CNA #2 said that during the week, the administrative staff are helpful with assisting the staff with resident needs, but could he not recall if the administrative staff are regularly in the facility on the weekends. CNA #2 said during the weekdays, they usually have 4-5 CNAs and also at times have a Hospitality Aide (HA), which makes the day go great and resident care can be provided timely. CNA #2 further said when there are less than 4-5 CNAs for staff, it makes it difficult to do the job. 4. On 4/8/24 from approximately 11:00 A.M. to 11:30 A.M., a Resident Council Meeting was held with the surveyor. Ten residents were present for the meeting, had regularly attended the Resident Council Meetings previously, and the following concerns were identified: -9 of the 10 residents present said they are told they have to wait for staff and the response time for answering the call lights was long and this mostly occurred on the night shift (11:00 P.M. to 7:00 A.M. shift) and on the weekends. -Sometimes on the 3:00 P.M. to 11:00 P.M. shift, there was only one CNA. 5. During an interview on 4/8/24 at 2:00 P.M., CNA #1 said she worked on the St. Louise Unit and worked full time on the 7:00 A.M. to 3:00 P.M. shift as well as on every other weekend. CNA #1 said that she normally cares for 10 residents but sometimes has 2-3 extra residents to care for if there are staffing issues/call outs. CNA #1 said there are supposed to be 4 CNAs scheduled but there are times when they have 3 CNAs. CNA #1 said administrative staff help during the week, and they all work together, but administrative staff are not usually present on the weekends. CNA #1 further said it is more difficult to do her job when there are 3 CNAs working. CNA #1 said when it comes to responding to resident call lights, they should be answered immediately but at most within 2-3 minutes. 6. Resident #57 was admitted to the facility in December 2023 with a diagnosis including displaced intertrochanteric left femur fracture (left hip fracture). Review of the Minimum Data Set (MDS) Assessment, 12/19/23, indicated the Resident was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of 15, and required assistance of staff with toileting. Review of the Activity of Daily Living (ADL- functions including eating, bathing toileting) Care Plan, initiated on 12/13/23 and revised 12/27/23 indicated the Resident had an ADL self care performance deficit related to impaired mobility. The care plan included the following interventions: -Assistance of one staff with rolling walker to the bathroom (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Extensive assist of one staff for toileting On 4/7/24 at 11:28 A.M., the surveyor observed Resident #57 dressed and seated in a wheelchair in his/her room watching television. During an interview, the Resident said he/she required assistance from staff with personal care, had to wait for staff assistance when toileting, and sometimes had episodes of incontinence during the night because the facility was short staffed, especially on the weekends and at night. The Resident said there was a time months ago that he/she was waiting an hour for someone to answer the call light after it was pressed. During an interview on 4/9/24 at 4:45 P.M., when the surveyor inquired about the Resident's wound that was acquired in January 2024, Unit Manager (UM) #1 said facility staff were verbally in-serviced on ensuring the call lights were accessible and responded to timely. UM #1 further said Resident #57 was unable to use the bedpan by him/herself and relied on staff to place and remove it for him/her. On 4/10/24 at 9:17 A.M., the surveyor observed the Resident dressed and seated in a wheelchair. During an interview, the Resident said he/she prefers to use the bedpan at night because of fear of falling. When asked about the use of the bedpan, the resident said he/she would ring the call light for assistance with the bedpan and staff would assist him/her. The Resident said after placing the bedpan, sometimes the staff stay and sometimes they leave. If the staff leaves, the Resident said he/she would need to use the call light to ask for assistance off the bedpan and sometimes it takes less than an hour, but there are times when it takes an hour or over for them to respond. The Resident further said that he/she thought that there is not enough help in the facility because sometimes there is only 1 or 2 Certified Nurses Aides (CNAs) on the overnight shift (11:00 P.M. to 7:00 A.M.). During an interview on 4/10/24 at 9:57 A.M., CNA #2 said Resident #57 required assistance of 1 to 2 staff with care. CNA #2 said the Resident is alert and oriented and able to make his/her needs known. CNA #2 said the Resident uses the call light to request assistance with toileting, is usually continent but sometimes has episodes of incontinence when the staff are unable to get to him/her in time to provide assistance. CNA #2 said that the bedpan is used for the Resident if he/she is in bed and takes 1-2 staff to assist with this depending on the day. CNA #2 further said the Resident was unable to place/remove the bedpan and relies on staff to do this. CNA #2 said that the bedpan is positioned under the Resident, staff will make sure the call light is accessible and then leave, because the Resident will ring for assistance when finished. CNA #2 said the Resident is very easy to care for, has no behaviors or rejections of care and is able to alert staff when he/she requires assistance. 42690 7. Resident #62 was admitted to the facility in March 2024 and was cognitively intact as evidenced by a BIMS score of 13 indicated on the MDS assessment dated [DATE], and resided on the St. Louise Unit. During an interview on 4/7/24 at 2:22 P.M., Resident #62 said that there were not enough staff. He/she said that at lunch time and supper time the facility does not have enough people to help. Resident #62 said if you have to go to the bathroom at the same time as dinner, you would not go. Resident #62 said that he/she does require assistance to the bathroom and has had to wait up to an hour before getting assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Resident #32 was admitted to the facility in January 2024 and was cognitively intact as evidenced by a BIMS score of 15 indicated on the MDS assessment dated [DATE], and resided on the St. Louise Unit. During an interview on 4/07/24 at 12:05 P.M., Resident #16 said that the staff are very kind but the call light times can be very long, especially early in the morning and into the day time shift. The Resident said that he/she had a history of falls and that is why he/she was now at the facility. Resident #32 further said that sometimes he/she will call for help to either go to the bathroom or use the bed pan and will have to wait so long that he/she has an accident and then has to wait to be cleaned up. The Resident said he/she knows when he/she has to go to the bathroom and will call for help. 9. Resident #28 was admitted to the facility in March 2024 and was cognitively intact as evidenced by a BIMS score of 15 out of 15 indicated on the MDS assessment dated [DATE], and resided on the St. Louise Unit. During an interview on 4/7/24 at 11:16 A.M., Resident #28 said that the staff were very kind, there is just not enough of them. Resident #28 said that he/she has put his/her call light to ask for water and said that it has taken up to an hour to have someone answer it. Resident #28 said early morning seems to be the time of day where there are less staff and wait times can be longer. 44129 10. During an observation of the St. [NAME]'s Unit on 4/7/24 from 8:05 A.M., until 8:30 A.M., the surveyor observed the following: -8:05 A.M.: Three call lights activated (light and sound) in rooms [ROOM NUMBER]. CNAs were busy in a resident room down the hallway and no other staff were present that the surveyor could visualize. -8:19 A.M.: Nurse answered the call light in room [ROOM NUMBER] (14 minutes from initial observation of the call light being activated). The resident in room [ROOM NUMBER] was heard responding, I need to go to the bathroom, all I have to do is pee. The surveyor did not observe any staff in the vicinity or hearing distance of the room. -8:22 A.M.: Staff member answers call light in room [ROOM NUMBER] (17 minutes from initial observation of call bell being activated) to assist the resident into the bathroom. - 8:23 A.M.: Two CNAs exited room [ROOM NUMBER] and answered the call light in room [ROOM NUMBER] (18 minutes from initial observation of the call bell being activated). -8:28 A.M.: room [ROOM NUMBER]'s call light remained unanswered (23 minutes later). -8:30 A.M.: room [ROOM NUMBER]'s call light answered by Director of Maintenance (25 minutes from the initial observation of the call bell being activated). -8:40 A.M.: Resident #2's call light was activated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/7/24 at 9:55 A.M., the surveyor observed that Resident #2 call light remained activated until an Activity staff member responded (1 hour and 15 minutes later). The Resident told the Activity staff member he/she would like to get dressed. The Activity staff member told Resident #2 that the staff were just finishing cleaning up after breakfast. During an interview at the time, Resident #2 told the surveyor, here it is, almost 10:00 in the morning and I am not dressed yet. Resident #2 said they need more people to help and more people to take residents to the bathroom. Resident #2 said there are so many people that just walk around here, they come and see what you want, then turn off the call light. Resident #2 said he/she has waited two hours at times to go to the bathroom as well as sat on a bedpan for that amount of time. 11. During an interview on 4/7/24 at 10:49 A.M., Resident #32 said sometimes they have to wait a very long time for somebody to answer the call lights. Resident #32 further said the long waits often occur during both the 3:00 P.M.- 11:00 P.M. shift (evening) and the 11:00 P.M.- 7:00 A.M. shift (night) and it was terrible. 12. During an interview on 4/8/24 at 2:33 P.M., Nurse #2 said her shift is the 7:00 A.M. until 3:00 P.M., however she will often work late, until 7:00 P.M., to fill in. Nurse #2 said yesterday morning (4/7/24) they only had two CNAs for 30 residents, and they were supposed to be staffed with 3 CNAs. Nurse #2 further said there are usually two CNAs on the weekend days because of call-outs. During a follow-up interview on 4/9/24 at 9:10 A.M., Nurse #2 said weekend staffing was a challenge due to call outs and no shows. 13. During a follow-up interview on 4/9/24 at 9:21 A.M., Resident #2 said the long call light response time mostly happens on the 11:00 P.M. - 7:00 A.M. shift (night). Resident #2 said if the staff don't show up to help, he/she is incontinent and will stay wet because he/she had to wait a long time for the staff to provide care. Resident #2 said he/she remembered one time he/she sat on a bedpan for an hour and it was painful and often the call light was not accessible. Resident #2 further said if it was not for his/her roommate putting on his/her call light, he/she would not get help at all. Resident #2 also said no CNA or Nurse should leave the room unless they know the resident has their call light within reach. 14. During an interview on 4/9/24 at 11:55 A.M., CNA #4 said when they are short staffed on the weekends, the nursing supervisor will do their best to get help to come in, shift staff from unit to unit, or try to get staff to stay late or come in early. CNA #4 said weekends are the worst for call outs and no-shows.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Care Center	320 Pittsfield Road Lenox, MA 01240

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37400 Based on observation, interview, record and policy review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one Resident (#60) who was receiving intravenous (IV) antibiotics, out of a total sample of 17 residents. Specifically, the facility failed to ensure that six Nurses (#3, #8, #10, #11, #13 and #14) had the specific competencies and certification necessary to provide appropriate Central Venous Access Device (CVAD: long flexible tube that is inserted through one of the central veins found in the neck, chest or groin to allow access to the bloodstream to deliver medication) care and services for Resident #60, who was receiving IV antibiotics for a left hip infection. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Review of the facility policy titled Central Venous Access Device (CVAD) Catheter Dressing Change, effective January 2022, indicated the purpose of the policy was to provide specific intervals and technique for CVAD dressing changes. The policy also included the following: -The licensed nurse will have documented education and competency in the management of vascular access devices (VADs) and will practice according to state law. -The IV therapy order for care and maintenance is required -VAD assessment should occur: at least every 2 hours during a continuous infusion; before, during and after medication administration; during dressing changes; at a minimum of once each shift, when not in use; at prescribed intervals if complications are observed -With each site assessment of the VAD, presence of the following, at a minimum, should be included: erythema (redness); drainage; induration (thickening and hardening of the soft tissues of the body); tenderness; warmth; swelling, of the extremity (if applicable) and at the site, sutures, if present; external catheter length. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility Assessment, undated but with data pulled from 4/1/22 through 3/31/23, under Services and Care We Offer Based on our Residents' Needs, indicated the types of care that their resident population required, and that the facility staff and other resources apply to provide care for the resident population and included the following for competencies the facility staff have completed and will have annually evaluated: -Administration of medications that residents need by route: intravenous (peripheral or central lines). Resident #60 was admitted to the facility in January 2024 with diagnoses including Alzheimer's disease (progressive disease that destroys memory and other important mental functions), status post joint replacement left hip, bacterial infection, and vascular access site. Review of the Minimum Data Set (MDS) Assessment, dated 1/22/24, indicated the Resident had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15 and had a recent surgery for hip replacement. Review of the April 2024 Physician's orders included the following: -Peripherally Inserted Central Catheter (PICC) /Midline for IV Antibiotic, initiated 3/9/24 -PICC/Midline: have clamp at bedside at all times every shift, initiated 3/9/24 -Change dressing unless biopatch on gauze every 48 hours and as needed, initiated 3/9/24 -Change needless access device every 7 days and as needed, initiated 3/9/24 -Change transparent dressing every 7 days and as needed, initiated 3/9/24 -22 G PICC in right jugular, single lumen, insertion date 3/22/23, initiated 3/22/24 -Flush PICC line (right jugular PICC line) with 5 milliliters (mls) of normal saline (NS: mixture of sodium chloride and water) before and after each medication and every 24 hours, initiated 3/22/24 -Ampicillin Sodium IV Solution Reconstituted 2 grams (gms), use 2 gms IV every 6 hours for infection of left hip until 4/12/24, initiated 3/22/24 Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for March 2024 and April 2024 indicated that Nurses #3, #8, #10, #11, #13 and #14, had all provided care and/or administered medication through Resident #60's IV line. On 4/7/24 at 11:35 A.M., the surveyor observed Resident #60 seated in a wheelchair within his/her room. An IV pole with a clear bag containing a clear fluid was hanging. The bag was labeled Ampicillin 2 gm/100 milliliter (ml) 0.9% Normal Saline, was dated 4/7/24 and was observed to be infusing via an IV pump set at 100 ml/hour. The IV tubing was dated 4/7/24. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/10/24 at 3:00 P.M., the Administrator provided evidence of the IV education that was conducted on 11/14/23. The Administrator said that all Nurses that provide IV care need to have education and a competency completed prior to providing any care to the IV, and would include antibiotic administration. The Administrator said if the Nurse assigned to a resident with an IV did not have the required certification and competency, then another Nurse who did have the requirements would provide the IV care and services for the resident. The surveyor provided the Administrator with the list of Nurses including Nurse's #3, #8, #10, #11, #13 and #14, who had provided care and services to Resident #60's IV and required evidence of their IV certification and competency. During an interview on 4/10/24 at 3:15 P.M the Director of Nurses (DON) said a competency checklist is completed for Nurses during their general orientation, and that Staff Development Coordinator (SDC) will ensure that the Nurses have the required competencies. The DON further said that the SDC would also ensure that the agency Nurses have the required competencies and certification. The DON said that the facility has been without a SDC since 2/23/24, and that there was currently no system in place to determine if all of the Nurses who have provided IV care and services to Resident #60 had the required training and competencies. During an interview on 4/10/24 at 4:32 P.M., the Administrator said the facility should have ensured that the Nurses who provided IV care and services for Resident #60 had the required competencies and certification but was unable to locate evidence that this was completed for all of the Nurses on the requested list.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observation, interview and policy review, the facility failed to ensure an accurate accounting of a controlled medication. Specifically the facility failed to account for the controlled medication (Ativan, generic name Lorazepam) in the controlled substance accountability record book, as required. Findings include: Review of the facility policy titled, Disposal of Medications and Medication-Related Supplies, dated 2017 indicated but was not limited to: -Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations. -Disposition is documented on the individual controlled substance accountability record/book. -Unused, unwanted, and non-returnable medications should be removed from the storage area and secured until destroyed. -Accountability records for controlled substances that are disposed of or destroyed are maintained with the unused supply until it is destroyed or disposed of and then stored for five years or per applicable law or regulation. On [DATE] at 9:15 A.M., the surveyor observed Unit Manager (UM) #1 count the controlled medications in a medication cart on the St. Luke's Unit with Nurse #5. During an observation and interview on [DATE] at 10:15 A.M., the surveyor observed the medication storage room on the St. Luke's unit with Nurse #5. The surveyor observed two controlled substances lock boxes in the refrigerator, one box was locked and the other box was unlocked. Nurse #5 said neither of the lock boxes were her responsibility, looked at her keys, found a master key and was able to unlock the locked controlled substance box. The surveyor and Nurse #5 observed in the controlled substance box, one opened 20 cubic centimeters (cc) Lorazepam (Ativan) syringe with 15cc remaining, labeled for a resident who had expired in February 2024. Nurse #5 said this medication was not part of her controlled substance count and she would have to find out who was responsible for accounting for the Ativan by examining both controlled substance accountability record books from both the St. Luke's Unit front medication and back medication carts. During an interview on [DATE] at 10:24 A.M., Nurse #5 said the Lorazepam should have been counted with the St. Luke's Unit front medication cart and recorded in the corresponding controlled substance accountability record book, and it was not counted, as required. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:30 P.M., the Director of Nurses (DON) said all controlled substances, including those that are locked in the medication room refrigerator should be counted, recorded, and reconciled within the controlled substance accountability log book by two Nurses at the beginning and end of each shift.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 42690 Based on record review and interview, the facility failed to monitor for side effects and adverse reactions to medications for one Resident (#45) out of a total sample of 17 residents. Specifically, for Resident #45, the facility staff failed to monitor for side effects and adverse reactions related to the use of an anticoagulant (medication used to thin the blood) medication. Findings include: Resident #45 was admitted to the facility in March 2024, with the following diagnoses: Pulmonary Embolism (a blockage of an artery in the lungs by a substance that has moved from elsewhere in the body through the bloodstream) and Atrial Fibrillation (Afib - irregular, rapid heartbeat that can lead to blood clots and other heart related complications). Review of the current Order Summary Report, printed on 4/9/24, indicated the following order: -Anticoagulant medication: monitor for discolored urine, black tarry stools, sudden severe headache, numbness and tingling, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, nose bleeds. *Document 'Y' if monitored and none of the above (symptoms) was observed. *Document 'N' if monitored and any of the above (symptoms) was observed. *select chart code 'Other/see Nurses notes' and progress note findings, order date of 3/1/24. -Apixaban (an anticoagulant medication used to treat and prevent blood clots) Oral Tablet 5 milligrams (mg) by mouth two times a day for anticoagulant, start date 3/2/24 (discontinued on 4/2/24). -Apixaban Oral Tablet 5 mg by mouth two times a day for anticoagulant, start date 4/2/24. Review of the March 2024 and April 2024 Medication Administration Records (MARs) indicated the Resident was administered the Abixiban as ordered two times a day with the exception of 3/25/24 through 4/2/24 due to being hospitalized . Further review of the March 2024 and April 2024 MARs indicated no documented evidence that any monitoring for side effects and/or adverse reactions from anticoagulant therapy were bring done as required. Review of the Resident's clinical record did not show any evidence of regular monitoring for side effects and/or adverse reactions related to the use of Apixaban or anticoagulant therapy. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/24 at 8:02 A.M., Nurse #1 said that when a resident was prescribed an anticoagulant medication, they would be monitored for things like, nose bleeds, bruising, and tarry stools. Nurse #1 reviewed the Resident's medical record and said there was an order to monitor for signs and symptoms for use of anticoagulant medication and that the monitoring should be documented on the MAR. Nurse #1 further reviewed the MARs and Treatment Administration Records (TARs) and said that it had not been documented if the Resident was being monitored for signs and symptoms for anticoagulant use. Nurse #1 said that residents who received anticoagulants should be monitored per shift and it should be documented with a 'Y' that they were monitored with no symptoms or 'N' that they were monitored and had symptoms. Nurse #1 said it did not appear that Resident #45 was being monitored for signs and symptoms of anticoagulant medication use as required.

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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. 37400 Based on interview, record and policy review, the facility failed to ensure that an as needed (PRN) psychotropic medication (medication that affect the mind, emotions and behavior) was limited to 14 days for one Resident (#60), of five applicable residents reviewed, out of a total sample of 17 residents. Specifically, the facility failed to ensure that PRN Valium (an anti-anxiety medication) was limited to 14 days and was reviewed by the Physician for continued use. Findings include: Review of the facility policy titled Use of Psychotropic Medications, dated 1/11/24, indicated the following: -Psychotropic drugs are any medication that affects brain activities associated with mental processes and behavior. -Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressantss, anti-anxiety and hypnotics -PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days) -If the attending physician or prescribing practitioner believes that is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. Resident #60 was admitted to the facility in January 2024 with diagnosis including Alzheimer's disease (progressive disease that destroys memories and other important mental functions). Review of the March 2024 and April 2024 Physician's orders included the following: -Valium 5 milligrams (mg), give 1 tablet every 8 hours as needed for spasms, initiated 3/9/24 Review of the March 2024 and April 2024 Medication Administration Records (MARs), indicated that Valium was administered 9 times during the month of March, and was administered 5 times from 4/1/24 through 4/9/24. Review of the clinical record indicated no documented evidence that the PRN Valium had been assessed by the Physician and a duration given for the use of the psychotropic medication beyond 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/24 at 2:06 P.M., Unit Manager (UM) #1 said PRN Valium should be ordered for 14 days and then reassessed by the Physician or Practitioner. UM #1 said upon assessment, the Physician can continue the medication for PRN use and indicate a duration for re-evaluation, schedule the PRN medication or discontinue the medication.

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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. 37400 Based on observation, interview, record and policy review, the facility failed to ensure that Transmission Based Precautions (TBP: for patients who are known or suspected to be infected or colonized with infectious agents which require additional control measures to effectively prevent transmission) were in place and adhered to by staff in order to minimize the potential spread of infection for two Residents (#118 and #60), of three applicable residents reviewed, out of a total sample of 17 residents. Specifically, the facility failed to ensure that Enhanced Barrier Precautions (EBP: infection control intervention designed to reduce the transmission of multi-drug resistant organisms or MDROs) were implemented for Residents #118 and #60. Findings include: Review of the facility policy titled Enhanced Barrier Precautions Policy, dated 3/27/24, indicated the following: -It is the policy of the facility to implement EBP for the prevention of transmission of MDROs -Residents will be reviewed upon admission and/or change of condition for the need for EBP by the Director of Nursing (DON)/designee -The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by the Centers for Disease Control and Prevention (CDC). -Make gown and gloves available immediately near or outside of the resident's room. Face protection may also be needed if performing activity with risk of splash or spray (i.e. wound irrigation, tracheostomy care) -Personal protective equipment (PPE) for EBP is only necessary when performing high-contact care activities and may not need to be donned (put on) prior to entering the resident's room -High contact care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing 1. Resident #118 was admitted to the facility in April 2024 with diagnoses including fall with left hip fracture with surgical revision. Review of the April 2024 Physician's orders included the following: -Monitor left hip incision, apply clean ABD (type of gauze pad that is thick and absorbent) pad every shift, initiated 4/8/24 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/24 at 8:17 A.M., the surveyor observed the following: -Signage posted outside of Resident #118's room that indicated: > 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 gowns for the following high contact resident care activities: *dressing, bathing/showering, transferring, changing linens, providing hygiene, 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 The surveyor also observed an over the door holder containing surgical masks, gloves of different sizes and disposable gowns and Resident #118 lying in bed in his/her room. On 4/8/24 at 12:44 P.M., the surveyor observed Resident #118 utilizing a walker and being assisted by Certified Nurses Aide (CNA) #1 into the bathroom within the room. CNA #1 was observed to be wearing gloves only, and was not wearing a gown. CNA #1 was further observed to enter the bathroom with Resident #118 and close the door. During an interview on 4/8/24 at 2:00 P.M., CNA #1 said Resident #118 required assistance from staff with ambulation, and personal care. CNA #1 said the Resident has an open wound and has precautions in place. CNA #1 further said that when she assists the Resident with morning care, like washing and dressing, she makes sure to wear a gown and gloves. CNA #1 said that when she assists the Resident with toileting needs, she only wears gloves. 2. Resident #60 was admitted to the facility in January 2024 with diagnoses including bacterial infection and vascular access site (process of gaining entry into the bloodstream, typically through a vein, for the purpose of administering fluid, medications, blood products). Review of the Minimum Data Set (MDS) Assessment, dated 1/22/24, indicated Resident #60 was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15, required assistance from staff with toileting, showering, dressing, personal hygiene, and had a recent hip replacement. Review of the Enhanced Barrier Precaution Care Plan, initiated 2/22/24 and revised 3/18/24, indicated the Resident was on EBP due to a left hip surgical incision. The plan of care included the following interventions: -Ensure proper personal protective equipment is in place, initiated 2/22/24 Review of the April 2024 Physician's orders included the following: (continued on next page)

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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	-Peripherally Inserted Central Catheter (PICC: thin flexible tube that is inserted into a vein in the upper arm and guided into a large vein above the heart) /Midline for Intravenous (IV) Antibiotic, initiated 3/9/24 -22 G PICC in right jugular (neck or throat), single lumen, insertion date 3/22/23, initiated 3/22/24 -Ampicillin Sodium IV Solution Reconstituted 2 grams, use 2 grams IV every 6 hours for infection of left hip until 4/12/24, initiated 3/22/24 On 4/8/24 at 8:06 A.M., the surveyor observed the following: -Signage posted outside of Resident #60's room that indicated Enhanced Barrier Precautions. -An over the door holder containing surgical masks, gloves of different sizes and disposable gowns. -Resident #60 was dressed and lying in bed. -CNA #2 entered the Resident's room with a hoyer lift. CNA #2 was wearing a surgical mask only. CNA #1 entered the room wearing gloves only, and closed the door to the room. Shortly after, the door re-opened and the Resident was observed to be seated in his/her wheelchair. The hoyer lift remained in the room and CNA #2 was observed wearing a surgical mask and gloves and CNA #1 was observed wearing gloves only. Both CNA's were observed to remove their gloves, conduct hand hygiene, and leave the Resident's room. On 4/8/24 at 1:10 P.M., the surveyor observed Nurse #3 administering the IV antibiotic to Resident #60. Nurse #3 conducted hand hygiene and donned gloves. Nurse #3 then proceeded to administer the antibiotic as ordered, without donning a gown as indicated on the EBP signage. During an interview on 4/8/24 at 1:18 P.M., the surveyor asked Nurse #3 about the EBP signage posted outside of the Resident's room. Nurse #3 said that she should have worn gown and gloves when administering the IV medication to Resident #60 and did not wear the gown as required. During an interview on 4/8/24 at 2:24 P.M., CNA #2 said he was not aware that Resident #60 was on any type of precautions. The surveyor and CNA #2 reviewed the signage posted on the door to enter the Resident's room. CNA #2 said that he was not sure what the EBP precautions were for, but after reviewing the signage said that gown and gloves should be worn during personal care. When the surveyor asked about the observation from that morning when CNA #2 and CNA #1 were transferring the Resident using the hoyer lift, CNA #2 said that he should have worn a gown during that interaction but did not. During an interview on 4/9/24 at 1:47 P.M., Unit Manager (UM) #1 said when providing any direct care for residents with EBP precautions, including personal care or IV medication administration, the staff should be donning a gown and gloves. UM #1 further said that Resident #60 had a surgical incision and was receiving IV antibiotics so Enhanced Barrier Precautions needed to be in place.