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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225589	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarah S Brayton Center	4901 North Main Street Fall River, MA 02720

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. 49425 Based on observation, interview, and record review, the facility failed to ensure for one sampled Resident (#7) with an indwelling nephrostomy tube (a catheter inserted through the skin into the kidney draining urine into a collection bag outside of the body), out of a total sample of 33 residents, that the Resident's dignity was maintained. Specifically, the facility failed to consistently place the Resident's nephrostomy tube drainage bag in a privacy bag. Findings include: Review of the facility's policy titled Resident Rights, dated as revised February 2021, indicated but was not limited to the following: - Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. - Helping the resident to keep urinary catheter bags covered. Resident #7 was readmitted to the facility in October 2024 with a diagnosis of obstructive nephropathy (a blockage in the urinary tract), hydronephrosis (back up of urine in one or more kidneys), and had a right nephrostomy tube. Review of the Minimum Data Set (MDS) assessment, dated 11/23/24, indicated Resident #7 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Further review of the MDS indicated Resident #7 required maximum assistance with transfers and ambulation and had an indwelling catheter. On 12/16/24 at 3:29 P.M., the surveyor observed Resident #7 sitting up in his/her wheelchair in the threshold of the doorway to their room, with a urinary drainage bag placed on their lap with visible urine in the bag. The drainage bag was fully exposed and not placed in a privacy bag to conceal it from public view. On 12/18/24 at 9:41 A.M., the surveyor observed Resident #7 sitting in his/her chair with an overbed table placed in front of him/her. Directly on the table was a urinary drainage bag with visible urine in the bag. The drainage bag was fully exposed and not placed in a privacy bag to conceal it from public view. (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	During an interview on 12/18/24 at 9:48 A.M., Certified Nurse Aide (CNA) #1 said urinary drainage bags should always be in a privacy bag so the urine is not visible to others. On 12/18/24 at 10:58 A.M., the surveyor observed Resident #7 sitting in a chair next to the doorway with a urinary drainage bag hanging down on his/her right side with visible urine in the bag. The drainage bag was fully exposed and not placed in a privacy bag to conceal it from public view. During an interview on 12/18/24 at 11:02 A.M., Nurse #4 said all drainage bags should be placed in a privacy bag. During an interview with observation on 12/18/24 at 11:04 A.M., Unit Manager (UM) #2 said drainage bags must be placed in a privacy bag. The surveyor and UM #2 observed Resident #7 sitting in his/her chair next to the doorway with a urinary drainage bag hanging down on his/her right side, with visible urine in the bag. UM #2 approached the bed, lifted the blankets, and showed the surveyor a privacy bag attached to the bed frame. UM #2 said the staff should have taken the privacy bag off the bed and attached it to the Resident's chair, when they transferred him/her to the chair, and placed the drainage bag inside. During an interview on 12/18/24 at 4:18 P.M., the Director of Nursing (DON) said the urinary drainage bag should have been placed inside of a privacy bag to maintain the Resident's dignity.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 34145 Based on interview and observations, the facility failed to post a notice of availability of survey results and prominently post the Department of Public Health (DPH) Survey inspection results binder. Findings include: On 12/18/24 at 9:57 A.M., the surveyor held a Resident Group meeting with 12 residents in attendance. Twelve of 12 residents said they were not aware of the location of the DPH Survey inspection results and said they were not aware the survey results were available for review. On 12/18/24 and 12/19/24, the surveyor toured the four resident care units and front lobby of the facility and failed to observe any postings which indicated survey results were readily available and accessible for examination without having to ask to view them. On four of four units, the surveyor observed wall mounted document holders (positioned approximately five feet from the floor) across from the nursing stations. The document holders held a paper folder labeled grievance forms and behind that was a thin, three-ringed binder which had survey results printed on the spine (facing upward). The holder was not easily identified as survey results due to the label facing toward the ceiling and was not accessible as beverage carts and furniture were positioned in front of the holders. During an interview on 12/19/24 at 11:10 A.M., the Administrator said the survey results were kept in a binder which was located in the main lobby on the ground floor (only accessible to residents that go into the lobby) and should also be somewhere on each unit. The Administrator was made aware the residents were unaware that survey results were available for review, that the surveyor was unable to locate any postings which indicated survey results were readily available and accessible without having to ask to view them, and that the results on the units were inaccessible due to positioning of the binders and obstacles in the way. The Administrator said she would have to work on that.

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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. 34145 Based on record review and interview, the facility failed to notify the Physician/Nurse Practitioner when one Resident (#30), out of a total sample of 33 residents, did not keep medical appointments with his/her consultant cardiologist and urologist as scheduled. Findings include: Review of the facility's policy, Change in a Resident's Condition or Status, dated February 2022, indicated but was not limited to: -Our facility notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Resident #30 was admitted to the facility in December 2021 and had diagnoses including sick sinus syndrome (a condition where the heart's natural pacemaker, known as the sinus node, does not function properly), hypertensive heart disease with heart failure, presence of a cardiac pacemaker (a small, battery-powered implanted device used to correct a slower-than-normal heart rate), retention of urine, and a Foley catheter (a thin, flexible tube inserted into the bladder to drain urine). Review of the Minimum Data Set (MDS) assessment, dated 10/31/24, indicated Resident #30 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, and had an indwelling urinary catheter. During an interview on 12/18/24 at 2:03 P.M., Unit Manager #1 said Resident #30's health insurance had lapsed and he/she had missed a few appointments. She said the Resident was due to see his/her cardiologist on 10/24/24 and the urologist on 11/25/24, but the appointments were cancelled because he/she does not currently have health insurance. Review of the medical record indicated Resident #30 had appointments scheduled with his/her cardiologist on 10/24/24 and his/her urologist on 11/25/24. Review of the entire medical record failed to indicate Resident #30 went to his/her 10/24/24 cardiology appointment. During a telephone interview on 12/19/24 at 10:06 A.M., the Resident's cardiology office staff said Resident #30 was a no show for the 10/24/24 appointment with the cardiologist for a pacemaker check and evaluation. Review of a Clinical Nurse's Note, dated 11/25/24, indicated the nurse called the Resident's Urologist's office and cancelled the 11/25/24 appointment and did not reschedule it. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the entire medical record, including Physician/Nurse Practitioner visit notes, failed to indicate the Physician/Nurse Practitioner was notified that Resident #30 did not go to a cardiology appointment scheduled for 10/24/24 and a urology appointment on 11/25/24. During a telephone interview on 12/19/24 at 11:15 A.M., Nurse Practitioner #1 said she was not notified that the Resident did not go to the 10/24/24 cardiology appointment and the 11/25/24 urology appointment as scheduled but would have expected staff to inform her. Attempts to reach Resident #30's attending Physician on 12/19/24 were unsuccessful.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 48695 Based on interview and record review, the facility failed to protect one Resident (#413) from misappropriation of resident property, out of a total sample of 33 residents, when fifty dollars and a store credit card were taken from his/her personal bag. Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, last revised April 2021, indicated but was not limited to: - Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. - Policy Interpretation and Implementation: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone. 2. Develop and implement policies and protocols to prevent and identify: c. theft, exploitation, or misappropriation of resident property. 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation- Reporting and Investigating, last revised September 2022, indicated but was not limited to: -Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. - Reporting Allegations to the Administrator and Authorities 1. If the abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegations immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Law enforcement officials 3. Immediately is defined as: b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. - Investigating Allegations 1. All investigations are thoroughly investigated. The administrator initiates investigations. - Follow-up Report 1. Within five (5) business days of the incident the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation is verified. 3. The follow-up investigation report will provide as much information as possible at the time of submission of the report. 4. The resident and/or representative are notified of the outcome immediately upon the conclusion of the investigation. Resident #413 was admitted to the facility in December 2024. Review of Resident #413's Admission Assessment, dated 12/12/24, indicated he/she was alert and oriented to person, place, and time. During an interview on 12/16/24 at 8:59 A.M., Resident #413 said he/she was admitted to the facility on the previous Thursday. Resident #413 said upon admission he/she completed an inventory sheet with Certified Nursing Assistant (CNA) #4 and showed CNA #4 that he/she had fifty dollars in cash in his/her personal bag. Resident #413 said when he/she looked in his/her personal bag the next day, he/she realized the fifty dollars and a store credit card were gone. Resident #413 said he/she reported the missing money and store credit card to CNA #4 and the Social Worker. Review of Resident #413's Personal Inventory List, undated, indicated he/she had one personal bag and fifty dollars in cash. Further review of the Personal Inventory List failed to indicate Resident #413 had a store credit card. Review of the Health Care Facility Reporting System (HCFRS- State agency reporting system), on 12/16/24, failed to show the facility had reported an allegation of misappropriation to the Department of Public Health (DPH). (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephonic interview on 12/18/24 at 2:14 P.M., CNA #4 said she completed the Personal Inventory List for Resident #413 on 12/12/24. CNA #4 said Resident #413 had fifty dollars folded in a piece of paper in his/her personal bag. CNA #4 said she was not aware Resident #413 had a store credit card on admission but found out about it the next day. CNA #4 said when she came into work on 12/13/24, Resident #413 told her that someone had taken his/her store credit card and the fifty dollars. CNA #4 said she searched Resident #413's room and notified Social Worker (SW) #1. During an interview on 12/17/24 at 3:50 P.M., SW #1 said she was notified on 12/13/24 about Resident #413's missing fifty dollars and store credit card. SW #1 said she notified the Administrator and started an investigation. SW #1 said the fifty dollars and store credit card had gone missing some time during the 11:00 P.M. to 7:00 A.M. shift of Thursday into Friday. SW #1 said Resident #413 had the personal bag tucked under his/her hip while he/she slept and was only able to describe the person who took the money and store credit card as wearing all black. SW #1 said she wasn't sure how Resident #413 couldn't feel someone taking his/her money and store credit card but was able to see their clothes. SW #1 said she offered to call the police, but Resident #413 declined. SW #1 said missing money and missing credit card should be reported to state agencies and the police within two hours. SW #1 said she was going to finish the investigation on Monday, 12/16/24, but lost track of time. During an interview on 12/17/24 at 4:02 P.M., the Director of Nursing (DON) said she had not been aware Resident #413 was missing fifty dollars and a store credit card. During an interview on 12/18/24 at 7:38 A.M., the Administrator said the investigation into the missing fifty dollars and store credit card had not been completed yet.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48695 Based on interview and record review, the facility failed to implement policies and procedures for alleged misappropriation of resident property for one Resident (#413), out of a total sample of 33 residents. Specifically, the facility failed to investigate and report an allegation of misappropriation of Resident #413's fifty dollars and a store credit card. Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, last revised April 2021, indicated but was not limited to: - Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. - Policy Interpretation and Implementation: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone. 2. Develop and implement policies and protocols to prevent and identify: c. theft, exploitation, or misappropriation of resident property. 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation- Reporting and Investigating, last revised September 2022, indicated but was not limited to: -Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. -Reporting Allegations to the Administrator and Authorities 1. If the abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegations immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Law enforcement officials 3. Immediately is defined as: b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. - Investigating Allegations 1. All investigations are thoroughly investigated. The administrator initiates investigations. - Follow-up Report 1. Within five (5) business days of the incident the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation is verified. 3. The follow-up investigation report will provide as much information as possible at the time of submission of the report. 4. The residents and/or representative are notified of the outcome immediately upon the conclusion of the investigation. Resident #413 was admitted to the facility in December 2024. Review of Resident #413's Admission Assessment, dated 12/12/24, indicated he/she was alert and oriented to person, place, and time. During an interview on 12/16/24 at 8:59 A.M., Resident #413 said he/she was admitted to the facility on the previous Thursday. Resident #413 said upon admission he/she completed an inventory sheet with Certified Nursing Assistant (CNA) #4 and showed CNA #4 that he/she had fifty dollars in cash in his/her personal bag. Resident #413 said when he/she looked in his/her personal bag the next day, he/she realized the fifty dollars and a store credit card were gone. Resident #413 said he/she had reported the missing money and store credit card to CNA #4 and the Social Worker (SW). Review of Resident #413's Personal Inventory List, undated, indicated the Resident had one personal bag and fifty dollars in cash. Further review of the Personal Inventory List failed to indicate Resident #413 had a store credit card. Review of the Health Care Facility Reporting System (HCFRS- State agency reporting system), on 12/16/24, failed to indicate that the facility reported an allegation of misappropriation to the Department of Public Health (DPH). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/24 at 3:50 P.M., SW #1 said she was notified on 12/13/24 about Resident #413's missing fifty dollars and store credit card. SW #1 said she notified the Administrator and started an investigation. SW #1 said the fifty dollars and store credit card had gone missing some time during the 11:00 P.M. to 7:00 A.M. shift of Thursday into Friday. SW #1 said Resident #413 had the personal bag tucked under his/her hip while he/she slept and was only able to describe the person who took the money and store credit card as wearing all black. SW #1 said she wasn't sure how Resident #413 couldn't feel someone taking his/her money and store credit card but was able to see their clothes. SW #1 said she offered to call the police, but Resident #413 declined. SW #1 said missing money and missing credit card should be reported to state agencies and the police within two hours. SW #1 said she was going to finish the investigation on Monday, 12/16/24, but lost track of time. During an interview on 12/17/24 at 4:02 P.M., the Director of Nursing (DON) said she had not been aware Resident #413 was missing fifty dollars in cash and a store credit card. During an interview on 12/18/24 at 7:38 A.M., the Administrator said the investigation into the missing fifty dollars cash and store credit card had not been completed yet or reported in HCFRS. The Administrator said the facility had two hours to report the allegation of abuse and five days to complete the investigation. The Administrator said the facility had not implemented their policy.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48695 Based on record review and interviews, the facility failed to ensure an allegation of misappropriation of resident property was reported timely to the state agency and to the police as required, for one Resident (#413), of 33 sampled residents. Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, last revised April 2021, indicated but was not limited to: 9. Investigate and report any allegations within timeframes required by federal requirements. Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation- Reporting and Investigating, last revised September 2022, indicated but was not limited to: -Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. -Reporting Allegations to the Administrator and Authorities 1. If the abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegations immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; e. Law enforcement officials 3. Immediately is defined as: b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Resident #413 was admitted to the facility in December 2024. Review of Resident #413's Admission Assessment, dated 12/12/24, indicated he/she was alert and oriented to person, place, and time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/24 at 8:59 A.M., Resident #413 said he/she was admitted to the facility on the previous Thursday. Resident #413 said that upon admission to the facility he/she completed an inventory sheet with Certified Nursing Assistant (CNA) #4. Resident #413 said he/she showed CNA #4 that he/she had fifty dollars in cash in his/her personal bag. Resident #413 said when he/she looked in his/her personal bag the next day, he/she realized the fifty dollars in cash and a store credit card had been taken. Resident #413 said she had reported the missing money and store credit card to CNA #4 and the Social Worker. Review of the Health Care Facility Reporting System (HCFRS- State agency reporting system), on 12/16/24, failed to indicate that the facility reported an allegation of misappropriation to the Department of Public Health (DPH). During an interview on 12/17/24 at 3:50 P.M., SW #1 said she was notified on 12/13/24 about Resident #413's missing fifty dollars in cash and missing credit card. SW #1 said she notified the Administrator and started an investigation. SW #1 said she offered to call the police and report the missing money and credit card but Resident #413 declined. During an interview on 12/17/24 at 4:02 P.M., the Director of Nursing (DON) said she had not been aware Resident #413 was missing fifty dollars in cash and a credit card. During an interview on 12/18/24 at 7:38 A.M., the Administrator said the investigation into the missing fifty dollars in cash and store credit card had not been reported timely in HCFRS as it should have and the incident was not reported to the police because Resident #413 declined to have them notified.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 43935 Based on record review and interview, the facility failed to complete a discharge assessment to ensure timely coding and transmitting of a Minimum Data Set (MDS) assessment for one Resident (#60), out of one resident assessment reviewed, resulting in a 129-day delay in the encoding and transmission of a MDS post-discharge from the facility. Findings include: Review of Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, Version 3.0, indicated assessments must be completed no later than 14 calendar days after the assessment reference date (ARD) and transmitted and encoded within 7 days of assessment completion. Resident #60 was admitted to the facility in March 2024 following a hospitalization for generalized weakness and frequent falls. Review of the medical record for Resident #60 indicated the Resident had been transferred to the hospital on 8/10/24 for possible sepsis and was later admitted to the hospital with a diagnosis of urinary tract infection. Review of the census for the facility indicated the facility had stopped billing for the Resident on 8/11/24, indicating the Resident had been discharged 129 days prior to the record review. During an interview on 12/17/24 at 1:19 P.M., the MDS Nurse said the discharge assessment was not started or coded and had somehow been missed. She said the facility should have completed and transmitted an MDS for Resident #60's discharge back in August of 2024 but did not.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 48084 Based on record review and interview, the facility failed to ensure three Residents (#74, #117, and #155) were offered or provided a summary of their baseline care plans, out of a total sample of 33 residents. Findings include: Review of the facility's policy titled Care Plans - Baseline, dated as last revised March 2022, indicated but was not limited to the following: -A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. -A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment. -The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: the stated goals and objectives of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and any updated information based on the details of the comprehensive care plan, as necessary. -Provision of the summary to resident and/or the resident representative is documented in the medical record. a. Resident #74 was admitted to the facility in March 2024 with diagnoses including encounter for surgical aftercare following surgery and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 9/19/24, indicated Resident #74 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Review of the Comprehensive Care Plan indicated it had been developed upon admission. Review of the medical record including assessments, nursing and social service progress notes, and scanned documents failed to indicate the baseline care plan had been provided to the Resident. During an interview on 12/19/24 at 12:30 P.M., Resident #74 said he/she never had a care plan meeting after admission, and he/she was never provided a copy of the baseline care plan. b. Resident #117 was admitted to the facility in November 2023 with diagnoses including Chronic Obstructive Pulmonary Disease, diabetes with foot ulcer, and dementia. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 10/17/24, indicated Resident #117 scored 11 out of 15 on the BIMS indicating he/she had mild cognitive impairment. Review of the Comprehensive Care Plan indicated it had been developed upon admission. Review of the medical record including assessments, nursing and social service progress notes, and scanned documents failed to indicate the baseline care plan had been provided to the Resident. During an interview on 12/19/24 at 12:39 P.M., Resident #117 said he/she did not recall if there was a meeting or if the care plan was provided. c. Resident #155 was admitted to the facility in September 2024 with diagnoses including encounter osteoporosis, scoliosis, and encounter for surgical aftercare following surgery on the nervous system. Review of the MDS assessment, dated 9/11/24, indicated Resident #155 scored 13 out of 15 on the BIMS indicating he/she was cognitively intact. Review of the Comprehensive Care Plan indicated it has been developed upon admission. Review of the medical record including assessments, nursing and social service progress notes, and scanned documents failed to indicate the baseline care plan had been provided to the Resident. During an interview on 12/19/24 at 12:02 P.M., Resident #155 said he/she never had a care plan meeting after admission and never got or was offered a copy of their care plan. The Resident said he/she only had one meeting and it was a couple weeks ago for discharge planning. During an interview on 12/19/24 at 10:20 A.M., Unit Manager #4 said they usually have care plan meetings and provide the care plan to the resident and then the social worker writes a note indicating the meeting had occurred. During an interview on 12/19/24 at 10:30 A.M., Social Worker #3 said she has only been here a few months and could not speak if these care plan meetings took place or if the resident was provided with a copy of the baseline care plan. She said they usually have the meeting on Mondays, Wednesdays, and Fridays and then would put a note in the medical record. During an interview on 12/19/24 at 10:35 A.M., the Director of Social Service said she was coordinating the meetings during the time frame these meetings should have occurred. She said the meetings are documented in the electronic medical record in a progress note. She said there is no assessment or paper document in the charts, the proof of the meeting would be the progress note. She said for Resident #74 she was unable to locate a note indicating the meeting had occurred and a copy of the baseline care plan had been provided. She said for Resident #155 the progress note dated 9/12/24 was a late entry for 9/6/24, but it was not a care plan meeting note, it was the initial social service interview note. She said there was not a progress note indicating the meeting had taken place or that the baseline care plan was provided to the resident. Additionally, she said for Resident #117 there was not a progress note indicating the meeting had occurred and a copy of the care plan was provided, but Social Worker #2 manages the meetings for that unit. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/24 at 11:17 A.M., Social Worker #2 said she uses a version of a care plan meeting form to log attendance and would locate the meeting document. During an interview on 12/19/14 at 1:18 P.M., Social Worker #2 provided the surveyor with a quarterly care plan meeting form from October 2024 (not the baseline care plan meeting) and said she did not do the initial care plan meeting for Resident #117 and was unable to locate any documentation of that meeting or if the baseline care plan was provided to the resident and/or family. During an interview on 12/19/24 at 12:52 P.M., the Director of Nurses said the baseline care plan is generated on admission and the team usually has the meeting 48-72 hours after admission on Mondays, Wednesdays, and Fridays. She said the meeting includes the resident and the health care proxy (HCP), if applicable, and after they review the plan of care, they are given a copy of the care plan if they want it. She said the meeting should be documented in the electronic medical record under progress notes. During an interview on 12/19/24 at 1:56 P.M., the Director of Social Service said the Social Worker that was doing the meetings at the time of Resident #117's admission is no longer employed and there was not a note indicating the meeting took place or that the HCP was provided a copy on the baseline care plan. She said at the time of admission Resident #117's HCP was invoked and the baseline care plan should have been provided to the HCP. Additionally, she said she did not have an audit system in place to ensure the meetings occurred, the baseline care plan was provided, and it was documented in the medical record and was unable to provide any documentation for Residents #74, #117, or #155 indicating the meetings had occurred and a copy of the baseline care plan was provided to the Resident and/or HCP.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on record review and interview, the facility failed to ensure that individualized, comprehensive care plans were developed and consistently implemented for two Residents (#30 and #72), out of 33 sampled residents. Specifically, the facility failed to: 1. For Resident #30, develop and implement an individualized plan of care for a pacemaker; and 2. For Resident #72, develop a person-centered, individualized care plan that was implemented for wandering and elopement risk. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised [DATE], indicated but was not limited to: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -Assessments of residents are ongoing and care plans are revised as information about the residents and residents' conditions change -Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -Reflects currently recognized standards of practice for problem areas and conditions. 1. Resident #30 was admitted to the facility in [DATE] with diagnoses including sick sinus syndrome (a condition where the heart's natural pacemaker, known as the sinus node, does not function properly) and presence of a cardiac pacemaker (a small, battery-powered implanted device used to correct a slower-than-normal heart rate). Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #30 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15, and had sick sinus syndrome. Review of comprehensive care plans included but was not limited to: -Focus: Resident exhibits or is at risk for cardiovascular symptoms or complications related to diagnosis of congestive heart failure (CHF), coronary artery disease (CAD), hypertension (HTN) (last revised [DATE]); (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Administer medications as ordered and assess for effectiveness ([DATE]); assess and monitor for chest pain including intensity, location and duration and report to the physician ([DATE]) -Goal: Resident will not experience any chest pain through the next review date (last revised [DATE]) Further review of comprehensive care plans failed to indicate Resident #30 had a cardiac pacemaker. During an interview on [DATE] at 2:03 P.M., Unit Manager #1 said Resident has a cardiac pacemaker and has a monitoring device at the bedside. She reviewed Resident #30's medical record and was unable to find a care plan for the Resident's cardiac pacemaker. She said a pacemaker care plan should have been developed for Resident #30 that included information about the pacemaker device, and symptoms for staff to monitor for pacemaker failure. During an interview on [DATE] at 4:02 P.M., the Director of Nursing (DON) said a care plan had not been developed for Resident #30's cardiac pacemaker, and they created one today subsequent to the surveyor's inquiry. 43935 2. Review of the facility's policy titled Wandering and Elopements, dated as revised [DATE], indicated but was not limited to the following: - If a resident is identified as a risk for wandering, elopement or other safety issue, the resident's care plan will include strategies and interventions to maintain the resident's safety. Resident #72 was admitted to the facility in [DATE] and had diagnoses including schizophrenia, bipolar disorder, and adjustment disorder with mixed anxiety and depression. Review of the MDS assessment, dated [DATE], indicated Resident #72 was moderately cognitively impaired as evidenced by a BIMS score of 12 out of 15 and used a wander/elopement alarm daily. Throughout the survey, the surveyor observed a wanderguard band on Resident #72's right lower extremity (RLE) on the following days and times: [DATE] at 8:34 A.M. [DATE] at 1:42 P.M. [DATE] at 8:19 A.M. [DATE] at 8:36 A.M. [DATE] at 11:27 A.M. Review of the current care plans for Resident #72 indicated, but were not limited to the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FOCUS: Check function and placement of wanderguard every shift ([DATE]) - The goals and intervention section of this care plan focus were blank FOCUS: Resident is an elopement risk and has a history of attempts to leave the facility unattended, impaired safety awareness related to (r/t) psych history. Wanderguard to RLE INTERVENTIONS: Wander alert expires: [DATE] - left lower extremity; assess for fall risk; Identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something, does it indicate the need for more exercise?; Monitor for weight loss and fatigue; Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: ([DATE]) The Resident's preference for diversional activities remained blank and was not Resident-centered; and the location of the wanderguard under interventions indicated left lower extremity which was inaccurate. During an interview on [DATE] at 8:24 A.M., Nurse #6 said the Resident does well in his/her room, in the dining room on the unit watching television, or in the small group activities offered on the Sagamore unit, but does not do well in large group activities. She said these things are not documented anywhere that she is aware of she only knows these things by working with the Resident so often. Review of the current Physician's Orders indicated but were not limited to the following: - Wanderguard/Wander elopement device due to poor safety awareness, Expiration date: ,d+[DATE], right lower extremity, every shift check placement ([DATE]) - Wanderguard/Wander elopement device due to poor safety awareness, Expiration date: ,d+[DATE], right lower extremity, every night check function ([DATE]) Review of the December Treatment Administration Record (TAR) for Resident #72 indicated but was not limited to the following: -The wanderguard was documented as being in place to the RLE 47 of 51 opportunities. -The wanderguard function check was documented as being completed 16 out of 17 nights. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:29 A.M., Nurse #5 said she works the overnight shift and knows the Resident well. She said the Resident has a wanderguard bracelet on his/her RLE and she signs off that the device is in place each night and that it is not expired. She said she has never seen the Resident attempt to get on the elevator or set off the alarm on the elevator and isn't sure how she is supposed to know if the bracelet is functioning, if it is not by simply checking the expiration date on the bracelet to ensure it is not expired. She said when she signs off on the function each night she is signing off that the wanderguard bracelet is not expired and therefore must be functioning, she said she is not aware of any other way to verify the function of the bracelet. Nurse #5 was not verifying the function of the wanderguard device, by testing it, regardless of the signed order on the TAR, therefore the care plan for verifying function was not implemented. During an interview on [DATE] at 8:36 A.M., Resident #72 said he/she has not tried to leave the facility in a long time but did once. The Resident showed the surveyor the wanderguard bracelet on his/her right ankle. The Resident said the staff come in and look at it every day and check the expiration date but he/she doesn't know if there is a way for them to test it because he/she has never seen them bring a small box or machine to test it and he/she doesn't remember it making any noise when they come to check it. During an interview on [DATE] at 8:44 A.M., Certified Nurse Aide (CNA) #3 said Resident #72 wears a wanderguard band, but she hasn't really ever seen the Resident wander. She said she doesn't know what types of diversional activities the Resident enjoys and she isn't sure how she would know that. She said the Resident can be very demanding and yell and at those times it is best to just give the Resident whatever he/she wants so he/she calms down. During an interview on [DATE] at 12:13 P.M., Nurse #6 said she has two residents on her assignment with wanderguard bands in place. She said on her shift she checks the placement of the bands and signs off that the band is in place. She said she doesn't know how functioning is tested and there is not any way that she is aware of to get that done unless the residents are ambulated to the elevator to set off the alert. She said there is probably an official way with a testing box but she has never seen that and doesn't know where it is. During an interview on [DATE] at 12:58 P.M., Nurse #7 said there are residents on her unit who wear wanderguard bands, but she does not have any testing box in her cart and does not know how testing the function of the wanderguards would be completed. During an interview on [DATE] at 1:58 P.M., CNA #2 said Resident #72 wears a wanderguard bracelet, but doesn't really wander but did have a history of attempting to leave the facility once. She said the best way to keep the Resident calm during a behavior is to either have him/her take a moment to his/herself in their bedroom or bring him/her to the small dayroom on the unit for some small group socialization and television. She said she doesn't know anything specific the Resident would enjoy otherwise or what the Resident's favorite activities or shows are and isn't sure where she would find that information. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:46 P.M., the Maintenance Director said he is not sure if there is a box for the Nurses to verify function of the wanderguard bands for the Residents and he has never seen one and the system in place is old. He said when the staff requests a new wanderguard band from him he verifies the band works by walking it around the facility to each alert box to ensure the band is functioning. During an interview on [DATE] at 4:18 P.M., Nurse #8 said she works both the evening and night shift, occasionally. She said the Resident wears a wanderguard band on his/her RLE related to a previous attempt to leave the facility. She said every shift she verifies placement of the bracelet on the Resident and then the night shift also signs off on the functioning of the device. She said this can be done by walking the Resident to the elevator, if he/she is awake, or checking that the device is not expired. She said there is supposed to be a testing box that you hold next to the bracelet that then lights up if the bracelet is functioning, but she has been asking where that is and has not yet received any follow up on the missing testing box. She said that is the normal process for testing the bracelets but the testing box has been missing for a while. She said when she signs off on its functioning it is either because the Resident has set off the alert system by the elevator or that the device is not expired. She said when the Resident's behavior is occurring, she does not know any Resident specific or preferred activities to distract him/her and typically brings the Resident to his/her room. Nurse #8 was not verifying the function of the wanderguard device, by testing it, regardless of the signed order on the TAR, therefore the care plan for verifying function was not implemented, as it should have been. During an interview on [DATE] at 4:29 P.M., Unit Manager #3 said the normal process for testing the functioning of the wanderguard bracelets is to use a testing box. She said the testing box was missing and she does not know where it is. She said she would expect that the staff would bring the residents to the elevator each night to ensure the wanderguard bracelets were functioning prior to signing them off and simply checking the expiration date was not an appropriate method to verify that it's functioning. During an interview on [DATE] at 10:48 A.M., Unit Manager #3 reviewed the care plans for wandering/elopement and said the care plan that simply is a focus that says check placement and function should have been placed as an intervention under the original elopement care plan. She said on review of the care plan that the care plan was incomplete and not individualized to Resident #72 since it did not indicate what diversional or distraction activities that the Resident prefers and the care plans needed work to ensure all pieces were implemented and specific to Resident #72's individual needs. During an interview on [DATE] at 11:03 A.M., Social Worker #2 reviewed Resident #72's care plans with the surveyor and said they were not individualized for the Resident and needed work since the Resident prefers section was left blank. During an interview on [DATE] at 12:16 P.M., the DON said her expectation is that resident care plans are specific and individualized to the residents they are developed for and all sections are complete and the care plan is implemented to ensure it is effective. She said it appears that did not occur in this instance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:37 P.M., the DON said the night shift nurses are responsible for verifying the function of the wanderguard bands by using the testing box each night. She said if they were not aware of testing the function with the testing box and the box was missing then the process was not followed and the care plan was not fully implemented and the process required improvement. During an interview on [DATE] at 1:38 P.M., the Administrator said the facility found the wanderguard testing box on a different unit and that is why the Nurses on this unit did not know where it was or how to test the wanderguards and the process needed improvement.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34145 Based on observation, interview, and record review, the facility failed to review and revise the care plan for one Resident (#115), out of a total sample of 33 residents. Specifically, the facility failed to ensure the care plan for communication was updated to reflect the Resident's non-functioning bilateral hearing aids. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised March 2022, indicated but was not limited to: -The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Resident #115 was admitted to the facility in July 2022 and had diagnoses including diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 10/10/24, indicated Resident #115 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15, and had highly impaired ability to hear. Review of the medical record indicated Resident #115 received new bilateral hearing aids on 4/15/24. On 12/17/24 at 8:30 A.M., the surveyor observed Resident #115 seated in a chair at the bedside. The Resident's spouse was sitting on the bed writing on a whiteboard with a pen. The spouse said that Resident #115's hearing aids stopped working a few months ago when the hospital mistakenly placed them in a denture cup with water, and now needs to write on the whiteboard to communicate with him/her. The Resident's spouse said he/she has not worn the hearing aids since being in the hospital and wears wireless headphones while watching television to be able to hear the shows. The surveyor attempted to engage Resident #115 in conversation, and he/she kept pointing to his/her ears and shaking his/her head back and forth. Review of Nursing Notes indicated but was not limited to: -10/4/24: Resident returned from the hospital with his/her hearing aids in a green denture cup with water. The hearing aids were removed from the water and attempts were made to dry them. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/5/24: Resident's hearing aids are not turning on. -10/10/24: Unable to find hearing aids. -11/18/24: Hearing aids are waiting for repair; on the charger in the med room. -11/19/24: Hearing aids not working at this time; appropriate people made aware. Review of Resident #115's comprehensive care plans indicated but was not limited to: Focus: Resident can experience communication problems related to hearing deficit (1/9/23) Interventions: -Communication board as needed related to hearing deficit (9/1/23) -Ensure Resident has headphones for television within reach (1/9/23) -Hearing aids to be given to Resident by nurse in A.M. and return to med room for charging at bedtime (6/28/24) -Resident offered hearing services through (contracted provider) as needed (4/20/23) Goal: Resident will be able to make basic needs known by verbal communication on a daily basis through the review date (1/9/23) Review of interdisciplinary care plan meeting documentation indicated a care plan meeting was held on 11/15/24 without a revision to the care plan to reflect the Resident was no longer able to use his/her hearing aids as they were non-functioning as of 10/4/24. During an interview on 12/19/24 at 10:13 A.M., Social Worker #1 said a care plan meeting for Resident #115 was held on 11/15/24 and only she and Unit Manager #1 were present. She reviewed the Care Plan Conference Summary document and said although it is documented by nursing in the medical record, she was not aware that Resident #115's hearing aids were not functioning and therefore did not update the care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34145 Based on observation, interview and record review, the facility failed to follow professional standards of practice for one Resident (#30), out of a total sample of 33 residents. Specifically, the facility failed to monitor for signs/symptoms for pacemaker complications and monitor the function of the pacemaker. Findings include: Review of the facility's policy titled Pacemaker, Care of a Resident With, last revised 12/2015, indicated but was not limited to: -The purpose of this procedure is to provide information about and guidance for the care of a resident with a pacemaker. -Pacemakers are electronic devices that artificially stimulate the heart muscle with electrical impulses when the heart rhythm is too slow. -Pacemakers are programmed to sense the heart and respiratory rate and to administer electrical pulses when the heart rate falls below a set threshold. -Permanent pacemakers are surgically implanted when the cause of the arrhythmia is chronic, and it has been determined that the cause is not transient. Complications -If the pulse generator or battery fails, or if the leads become displaced the pacemaker may not work properly, leading to bradyarrhythmias (abnormal heart rhythms characterized by a slow heart rate, typically below 60 beats per minute). -The following devices or procedures may interfere with pacemaker functioning: cell phones and MP3 players (for example iPods); magnetic resonance imaging (MRI) machines Monitoring -Monitor the resident for pacemaker failure by monitoring for signs and symptoms of bradyarrhythmias. -Symptoms associated with bradyarrhythmia may include: a. Syncope (fainting). b. Shortness of breath. c. Dizziness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Fatigue; and/or e. Confusion -The pacemaker battery should be monitored remotely through the telephone or an internet connection. The resident's cardiologist will provide instructions on how and when to do this. -Make sure the resident has a medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well. According to the National Institute of Health, Treatment/Management of permanent pacemakers: -Postoperatively, monitor rhythm and device function, obtain interrogation of the device, and restore settings as appropriate. (September 12/2022) Resident #30 was admitted to the facility in December 2021 and has diagnoses including sick sinus syndrome (a condition where the heart's natural pacemaker, known as the sinus node, does not function properly), hypertensive heart disease with heart failure, and presence of a cardiac pacemaker. Review of the Minimum Data Set assessment, dated 10/31/24, indicated Resident #30 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, and had an indwelling urinary catheter. On 12/17/24 at 8:25 A.M., the surveyor observed Resident #30 sitting upright in bed watching television. A white box was noted on the bedside table. The Resident did not respond the surveyor's question if he/she knew what the white box was for. Review of Physician and Nurse Practitioner (NP) notes, dated 6/3/24, 6/10/24, 6/17/24, 7/8/24, 7/22/24, 8/21/24, 9/20/24, 11/15/24, and 12/6/24 indicated Resident #30 had a cardiac pacemaker and was followed by outpatient cardiology. Review of the entire medical record failed to indicate any documentation from the Resident's cardiologist, failed to indicate that the facility staff monitored the Resident for signs/symptoms of pacemaker complications and bradyarrhythmia: syncope (fainting), shortness of breath, dizziness, fatigue and/or confusion, and failed to indicate the functioning of the pacemaker was monitored according to facility policy. During an interview on 12/18/24 at 2:03 P.M., Unit Manager #1 said Resident #30 has a cardiac pacemaker and the monitoring device manufacturer conducts pacemaker checks remotely. She said she does not know anything about the device and how frequently pacemaker checks are conducted. She said nursing should check that the monitoring box is functioning by checking that the light is illuminated green. Unit Manager #1 reviewed the entire medical record and was unable to find any information about the pacemaker device, or any evidence that staff was checking the device to ensure it was functioning. She said the Resident was due to see the cardiologist on 10/24/24 but missed the appointment due to not having health insurance coverage. During interviews with the Director of Nursing on 12/18/24 at 3:30 P.M. and 4:02 P.M., she said there was no documentation in the medical record about Resident #30's pacemaker device monitoring. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 11:15 A.M., Nurse Practitioner #1 said she was aware Resident #30 had a cardiac pacemaker but did not know anything about the device or how frequently pacemaker checks were done. She said the Resident is followed by a cardiologist in the community. Attempts to reach Resident #30's attending Physician on 12/19/24 were unsuccessful.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observation, record review, and interviews, the facility failed to provide services to ensure that proper treatment to maintain hearing ability was provided for one Resident (#115), out of a total sample of 33 residents. Specifically, the facility failed to notify the consultant provider to address Resident #115's non-functioning hearing aids for more than two months, resulting in a delay in the process of repairing them. Findings include: Review of the facility's policy titled Hearing Aid, Care of, last revised February 2018, indicated but was not limited to: -The purpose of this procedure is to maintain the resident's hearing at the highest attainable level. Care of the hearing aid: -Never clean or immerse any part of a hearing aid (other than the ear mold) in water. The device must be returned to the dealer or to an audiologist to be cleaned properly. Documentation: The following information should be recorded in the resident's medical record: -The date and time the hearing aid was checked and/or battery was replaced. -The name and title of the individual(s) who checked the hearing aid and changed the battery. -If the resident refused the procedure, the reason(s) why and the intervention taken. -The signature and title of the person recording the task. Reporting: -Notify the supervisor if hearing aid is damaged or needs to be sent to the dealer for cleaning. -Report other information in accordance with facility policy and professional standards of practice. Resident #115 was admitted to the facility in July 2022 and had diagnoses including diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 10/10/24, indicated Resident #115 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15, and had highly impaired ability to hear. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated a referral was made for the consultant Audiologist on 1/10/24 due to complaints of newly decreased hearing. Review of the medical record indicated the following documentation from the consultant Audiologist: -A hearing evaluation was performed for Resident #115 on 4/1/24. The progress note indicated clinical findings that Resident #115 had mild to severe hearing loss in both ears and the Audiologist recommended bilateral hearing aids. -An Audiology progress note, dated 4/15/24, indicated Resident #115 was provided bilateral hearing aids and a charger unit. The hearing aids fit well, and the Resident was noted to hear well with the hearing aids. On 12/17/24 at 8:30 A.M., the surveyor observed Resident #115 seated in a chair at the bedside. The Resident's spouse was sitting on the bed writing on a whiteboard with a pen. The spouse said that Resident #115's hearing aids stopped working a few months ago when the hospital mistakenly placed them in a denture cup with water, and now needs to write on the white board to communicate with him/her. The Resident's spouse said he/she has not worn the hearing aids since being in the hospital and wears wireless headphones while watching television to be able to hear the shows. The surveyor attempted to engage Resident #115 in conversation, and he/she kept pointing to his/her ears and shaking his/her head back and forth. Review of the medical record indicated Resident #115 was admitted to the hospital in September 2024 and was readmitted to the facility in October 2024. Review of Nursing Notes indicated but was not limited to: -10/4/24: Resident returned from the hospital with his/her hearing aids in a green denture cup with water. The hearing aids were removed from the water and attempts were made to dry them. -10/5/24: Resident's hearing aids are not turning on. -10/10/24: Unable to find hearing aids. -11/18/24: Hearing aids are waiting for repair; on the charger in the med room. -11/19/24: Hearing aids not working at this time; appropriate people made aware. Review of the medical record indicated the following Physician's order, initiated more than six weeks after staff identified Resident #115's hearing aids were not functioning: -Bilateral hearing aids stored in medication room-ON HOLD PENDING REPAIR (11/20/24) Further review of the medical record failed to indicate the supervisor or Audiologist/dealer was notified the hearing aids were not functioning to determine if the damaged devices needed to be sent to the dealer for cleaning or repair. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/17/24 at 8:37 A.M., Unit Manager #1 said Resident #115 returned from the hospital in October with his/her hearing aids in a denture cup submerged in water. She said they tried to dry out the hearing aids, but they still didn't work. She said the hearing aids are now kept in the medication room. She said she thinks the hearing aids are under warranty and said the Audiologist was in the process of replacing them. During a subsequent interview on 12/18/24 at 1:09 P.M., Unit Manager #1 reviewed Resident #115's medical record and said she could not find any evidence that she notified the Audiologist or dealer that Resident #115's hearing aids were not functioning. She said she called the Audiologist's office today and found out that the hearing aids may not be covered under the warranty. She said she was told the hearing aids need to be sent out to [NAME] for testing to determine if they can be repaired. She confirmed that the non-functioning hearing aids were not addressed until 12/18/24, more than six weeks after nursing documented the hearing aids were not functioning and following surveyor intervention. During an interview on 12/19/24 at 10:13 A.M., Social Worker #1 and Social Worker #2 said they were not aware that Resident #115's hearing aids were not functioning until recently. They said they have not been involved in any efforts to get them repaired. During an interview on 12/19/24 at 11:10 A.M., the Administrator said she thinks the Admissions Director called the hospital to see if they would pay to replace the broken hearing aids since they are responsible for what happened. She said she did not know anything else about the non-functioning hearing aids, but the Admissions Director would know. During an interview with the Admissions Director and Chief Operations Officer (COO) on 12/19/24 at 11:49 A. M., the Admissions Director said she did not make any calls to the hospital regarding Resident #115's hearing aids. She said the Regional Admissions Director called them, but she is away and unavailable for an interview. The COO said he did not know where to find any information about efforts made to have Resident #115's hearing aids repaired but would find out and inform the survey team. During an interview on 12/19/24 at 12:55 P.M., Resident Representative #1 (RR #1) said Resident #115 received new hearing aids in April of this year, and they worked really well. He said he was told that when Resident #115 returned from the hospital in October, the hearing aids were in a denture cup with water and did not work anymore. He said he last spoke with Unit Manager #1 about a month ago but hasn't heard any more about it. RR #1 said prior to getting the hearing aids, they had to write on a dry erase board to communicate with him/her and ever since the hearing aids have broken, he needs to use the whiteboard to communicate with him/her again. No further information regarding efforts to repair Resident #115's non-functioning hearing aids was provided to the survey team by the time of exit on 12/19/24.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48695 Based on observation, interview, and record review, the facility failed to ensure the proper care and treatment of a peripherally inserted central catheter (PICC) line device (inserted into a vein in the upper arm and is advanced until the internal tip of the catheter is in the superior vena cava to deliver medications and other treatments directly to the large central veins near your heart) was provided in accordance with professional standards of practice for one Resident (#66), out of a total sample of 33 residents. Specifically, the facility failed to ensure Resident #66's PICC line dressing was secured to prevent infection. Findings include: Review of the facility's policy titled Central Venous Catheter Care and Dressing Changes, last revised March 2022, indicated but was not limited to: - Purpose: The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter- related infections that are associated with contaminated, soiled, or wet dressings. - General Guidelines: 1. Perform site care and dressing change at established intervals or immediately if skin integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled). 3. Change the dressing if it becomes damp, loosened, or visibly soiled. Resident #66 was admitted to the facility in November 2024 with diagnoses including pneumonia and pulmonary fibrosis. Review of the Minimum Data Set (MDS) assessment, dated 11/28/24, indicated Resident #66 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review of the MDS assessment indicated Resident #66 had a central line and received intravenous (IV) antibiotic medication. Review of Resident #66's current Physician's Order indicated but was not limited to: - Change IV Catheter Securement Device upon admission and weekly every day shift every Thursday and as needed (if not integral to the dressing) and with dressing change, dated 11/21/24 - Change Catheter Site Transparent Dressing. Indicate external catheter length and upper arm circumference (10 centimeters (cm) above antecubital). Notify practitioner if the external length has changed since last measurement one time only for 1 day post PICC insertion or upon admission and every day shift every Thursday and as needed, dated 11/21/24 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Observe IV site routinely for signs and symptoms of infiltration/extravasation at a frequency based on therapy and resident condition. Document in PN (progress note) at least every shift. Every shift before and after administration of intermittent medications or when not in use, dated 11/21/24 - PICC Non-Valved: Gauge 4 French Total Length: 42 centimeters, Lumens: Double lumen, dated 11/21/24 - Normal Saline Flush Solution Use 10 milliliters (ml) intravenously every 6 hours for PICC line management Flush each IV catheter lumen with 10 ml normal saline after each intermittent IV administration, dated 11/21/24 - Normal Saline Flush Solution Use 10 ml intravenously every 6 hours for PICC line management Flush each IV catheter lumen with 10 ml normal saline before intermittent IV administration, dated 11/21/24 - Heparin Sodium Lock Flush Intravenous Solution 10 Unit/ml. Use 5 ml intravenously every 12 hours for patency flush each IV catheter lumen, dated 11/21/24 - Zosyn (antibiotic) 4.5 grams intravenously every 6 hours, dated 11/21/24 On 12/16/24 at 10:12 A.M., the surveyor observed Resident #66 in bed with a PICC line in his/her right upper arm. The dressing to the PICC line was lifting/loose on the bottom left corner and was not secured. On 12/16/24 at 12:03 P.M., the surveyor observed Resident #66 in bed and the dressing to Resident #66's PICC line was lifting/loose on the bottom left corner and was not secured. On 12/16/24 at 1:02 P.M., the surveyor observed Resident #66 ambulating in the hallway with physical therapy. Resident #66's PICC line dressing was lifting on the bottom and loose. The PICC line was observed to be hanging slightly away from the Resident's body and moving side to side. The dressing was not secured. On 12/16/24 at 1:30 P.M., the surveyor observed Nurse #1 administer Resident #66's IV antibiotics via his/her PICC line, the lower part of the dressing was loose and visibly lifting. On 12/16/24 at 4:27 P.M., the surveyor observed Resident #66 in bed and the dressing to his/her PICC was line lifting/loose on the bottom. The PICC line was able to move side to side and it was not secured. On 12/18/24 at 1:23 P.M., the surveyor observed Resident #66 in bed and the dressing to Resident #66's PICC line was lifting/loose on the bottom and was not secured. Review of Resident #66's Medication Administration Record (MAR) indicated Resident #66's PICC line dressing was changed on 12/16/24 at 4:48 P.M. by Nurse #1. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 1:26 P.M., Nurse #1 said a PICC line dressing should be clean and secure. Nurse #1 said on 12/16/24 while administering the 12:00 P.M. dose of antibiotics to Resident #66 she noticed his/her PICC line dressing was loose and not secured. Nurse #1 said she changed Resident #66's dressing but not until about 4:45 P.M. Nurse #1 said she should have changed Resident #66's dressing when she observed it was loose and not secured. Nurse #1 said she realized Resident #66's transparent PICC line dressing was loose and peeling at the bottom prior to administering his/her 12/18/24 12:00 P.M. antibiotic. Nurse #6 said prior to administering the medication she had pushed the dressing back down to secure the transparent dressing to the skin. During an interview on 12/18/24 at 1:35 P.M., Unit Manager (UM) #4 said PICC line dressings should be clean, dry, and intact. UM #4 said the expectation was for nurses to check PICC line dressings prior to administering medications. UM #4 said if the dressing was loose and not secured it should be changed prior to medication administration to prevent infection and/or pulling the PICC line out. During an interview on 12/18/24 at 4:28 P.M., the Director of Nursing (DON) said PICC line dressings should be changed if visibly loose and nurses should follow the facility policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observation, interview, and record review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles on four of four units. Specifically, the facility failed: 1. On the [NAME] Unit to date insulin pens with an open and discard date; 2. On the Sagamore Unit to date ophthalmic ointment with a discard date; 3. On the Pocasset Unit to maintain a medication cart free from loose pills; and 4. On the [NAME] Unit to date eye drops with an open and discard date. Findings include: Review of the facility's policy titled Storage of Medications, last revised November 2020, indicated but was not limited to: - Policy heading: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. - Policy Interpretation and Implementation: 3. The nursing staff is responsible for maintaining medication storage and preparation area clean, safe, and sanitary manner. 4. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of the facility's policy titled Miscellaneous Medications with shortened Expiration Dates Requiring Refrigeration, undated, indicated but was not limited to: - All medications will include an open/discard (expire) sticker affixed to the unit. - The date opened and date to discard (expire) will be documented on the sticker as referenced below per manufacturer specifications once the medication is opened and/or removed from the refrigerator. - It is the responsibility of the nurse opening and/or removing the medication from the refrigerator to document the date opened/date discard (expire) on the sticker affixed to the medication unit. - Latanoprost eye drops (Xalatan)- Expiration date (once opened): 42 days (6 weeks) once opened (refrigerator storage unopened, room temperature once opened) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sarah S Brayton Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4901 North Main Street Fall River, MA 02720	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 12/17/24 at 11:18 A.M., the surveyor completed a review of the medication storage room on the [NAME] Unit with Nurse #6 and observed the following in the refrigerator: - Two Admelog (fast-acting insulin) pens, opened not marked with the opened/discard date. During an interview on 12/17/24 at 11:24 A.M., Nurse #6 said insulin pens should have been labeled with the date opened and the discard date. Nurse #6 said the two open insulin pens should not have been in the refrigerator but discarded because they belonged to a resident that had passed away. 2. On 12/17/24 at 1:00 P.M., the surveyor completed a review of the medication cart (Side 1) on the Sagamore Unit with Nurse #2 and made the following observations: - One Erythromycin (antibiotic) Ophthalmic Ointment tube, date opened 10/17/24 - One Erythromycin Ophthalmic Ointment tube, date opened 10/29/24 During an interview on 12/17/24 at 1:04 P.M., Nurse #2 said the two tubes of the Erythromycin were both prescribed for a limited time and should have been discarded after the antibiotics had been completed. 3. On 12/17/24 at 1:09 P.M., the surveyor completed a review of the medication cart (South Side) on the Pocasset Unit with Nurse #9 and made the following observations: - Second drawer of the medication cart with multiple loose pills During an interview on 12/17/24 at 1:16 P.M., Nurse #9 said medication carts should not contain loose pills and medication carts should be kept clean. During an interview on 12/17/24 at 1:39 P.M., Unit Manager (UM) #4 said medication carts should be kept clean and free of loose medications. UM #4 said the expectation was if a pill fell into the drawer, it would be discarded immediately. 4. On 12/17/24 at 1:39 P.M., the surveyor completed a review of the medication cart (Side 1) on the [NAME] Unit with Nurse #10 and made the following observations: - One bottle of Dorzolamide Hydrochloride and Timolol Maleate Ophthalmic Solution (eye drops used to treat glaucoma), opened not marked with the opened/discard date - One bottle of Latanoprost Ophthalmic Solution (eye drops used to treat glaucoma), opened not marked with the opened/discard date - One bottle of Ofloxacin Ophthalmic Solution (eye drops used to treat eye infections), date dispensed 9/14/24 - One bottle of Lubricating Eye Drops, opened not marked with the opened/discard date or a resident's name (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One bottle of Ketorolac Ophthalmic Solution (eye drops used to treat itching caused by seasonal conjunctivitis) During an interview on 12/17/24 at 1:53 P.M., Nurse #10 said she was unaware that she was supposed to label eye drops with an open/discard date and she did not date them when she would open them. Nurse #10 said she was unaware to which resident the lubricating eye drops belonged to. During an interview on 12/17/24 at 1:57 P.M., UM #2 and the surveyor reviewed the contents of the medication cart. UM #2 said eye drops should always be labeled with a Resident's name and open/discard date because once they are opened, they have a shortened expiration date. UM #2 said the Ofloxacin Ophthalmic Solution and Ketorolac Ophthalmic Solution should have been discarded after the course of the medication was completed. During an interview on 12/17/24 at 4:05 P.M., the Director of Nursing (DON) said the expectation was for medication rooms and carts to be kept clean. The DON said eye drops and insulin pens should have been labeled with a name and the opened/discard date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49425 Based on resident and staff interviews, observation, and meal test tray results, on one of four units, the facility failed to prepare and serve meals in a manner conserving flavor, were palatable, and served at safe and appetizing temperatures for one out of one test tray conducted. Findings include: During initial resident screening on 12/16/24 and 12/17/24, the residents expressed the following concerns about the food served at the facility: - Food has been cold lately, especially breakfast. - No variety, and it is always cold. - Food sucks, no flavor it is too bland. Review of Resident Council Meeting Minutes, dated 8/14/24, indicated a resident was concerned about food temperatures and receiving cold food. On 12/18/24 at 9:57 A.M., the surveyor held a Resident Group meeting with 12 residents in attendance. The residents expressed concern with the temperature of the food served at the facility that included but was not limited to: - Food is cold for all meals. - Food is cold all days of the week and even worse on the weekends. - Staff are slow to distribute trays and leave the door open to the food truck. - Residents do not bother to ask staff to reheat the food anymore, because the staff always say they are too busy. On 12/18/24 at 11:27 A.M., the surveyor requested a lunch test tray to the Pocasset Unit. The test tray, a regular texture meal, was plated and placed on the food truck at 12:59 P.M. The food truck left the kitchen at 1:00 P.M. and arrived on the unit at 1:01 P.M. The first tray was passed at 1:01 P.M., and the last tray was passed at 1:08 P.M. The surveyor and Nurse #3 conducted the test tray at 1:09 P.M., the surveyor obtained temperatures in degrees Fahrenheit (F) with the following results: - Chicken with lemon pepper: 114.9 F flavorful; cold to taste - Rice: 112.8 F: flavorful; cold to taste. - Mixed Vegetables: 105.0 F: cold to taste. - Soup: 113.2 F: flavorful; cold to taste. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Milk: 46.2 F -Cranberry juice: 45.9 F -Coffee: 147.2 F During an interview on 12/18/24 at P.M., Nurse #3 said the food had flavor but was cold. Nurse #3 said she was going to go around and ask the residents if they wanted their food reheated. During an interview on 12/18/24 at 1:53 P.M., the Food Service Director (FSD), Dietitian, and Kitchen Assistant Manager, reviewed results of the test tray with the surveyor. The FSD said the tray was passed timely and should not have affected the temperature of the food; the temperatures on the test tray were very low. The Dietitian said she does not know why the food temperatures are so low. The FSD said he needs to make changes to how the food is stored on the steam table while serving the line, so it is not on the steam table for an extended period of time. The FSD said his expectation is for hot food to be over 135 F and cold food to be below 41 F. During an interview on 12/19/24 at 2:00 P.M., the Dietitian said she completed two test trays in November 2024, one being satisfactory and one being unsatisfactory. Review of the test tray results from 11/21/24 indicated the American chop suey was cold (112 F) and the green beans were cold (113 F), stringy, and mushy. The Dietitian said she did not know why the food was cold.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on observation, record review, and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to maintain safe and clean equipment, in two of four kitchenettes. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised January 2023, indicated but was not limited to the following: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. 4-602.13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 6-501.12 (A) Physical facilities shall be cleaned as often as necessary to keep them clean. Review of the facility provided Kitchenette Cleaning Schedule for the month of December 2024, indicated a kitchen staff member was assigned to cleaning the kitchenettes daily Monday through Friday. On 12/16/24 at 2:42 P.M., the surveyor observed the following in the [NAME] Unit kitchenette: -Inside the microwave, the right-side wall steel plate appeared to have melted away, leaving a large hole with blackish/brown staining along the edges of the hole with crusted black debris inside the opening -Inside the microwave, on the back top left and right corners, areas of rust On 12/16/24 at 2:49 P.M., the surveyor observed the following in the Pocasset Unit kitchenette: -Inside the microwave on the right-side steel plate, brownish/blackish areas of rust, flaking off -Inside the microwave, in the back lower right corner, crusted brownish/orange debris -Inside the microwave, under the glass turntable, brownish dried food spatter During an interview on 12/17/24 at 11:09 A.M., Unit Manager (UM) #2 said the dietary staff is responsible for cleaning the equipment in the kitchenettes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/24 at 9:08 A.M., the Food Service Director (FSD) said they have a dietary aide assigned to the kitchenettes daily to clean the equipment. He said they wipe down the microwave daily. The FSD said if the dietary aide finds equipment that needs repair, they notify him, and he notifies maintenance through the TELS system (computer software used to manage maintenance tasks) or verbally. During an interview on 12/18/24 at 10:01 A.M., the Maintenance Director said he has not been notified of any microwaves needing repair or replacement in the TELS System or verbally. During an interview with observation of the Pocasset Unit kitchenette on 12/18/24 at 2:11 P.M., the FSD said the inside of the microwave wall is beginning to rust and needs to be replaced. The surveyor and FSD then entered the [NAME] Unit kitchenette and observed the inside of the microwave. He said the inner wall had rusted away, creating the hole inside and it needed to be replaced. The FSD said he was made aware of the condition of the microwave earlier and was going to notify maintenance. During an interview on 12/18/24 at 4:23 P.M., the Director of Nursing (DON) said any microwave that has rust or an open area inside of it should not be in use. She said they are supposed to be maintained daily and she was unaware of the condition of the microwaves until the surveyor brought it to her attention.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34145 Based on record review and staff interview, the facility failed to ensure that medical records were complete and accurately documented in accordance with professional standards of practice for one Resident (#30), out of a total sample of 33 residents. Specifically, the facility failed to ensure Resident #30's medical record included information about his/her cardiac pacemaker. Findings include: Review of the facility's policy titled Pacemaker, Care of a Resident With, last revised 12/2015, indicated but was not limited to: Documentation -For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a. The name, address, and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and g. Paced rate -When the resident's pacemaker is monitored by the Physician, document the date and results of the pacemaker surveillance, including: a. How the resident's pacemaker was monitored (phone, office, internet); b. Type of heart rhythm; c. Functioning of the leads; d. Frequency of utilization; and e. Battery life. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #30 was admitted to the facility in December 2021 and had diagnoses including sick sinus syndrome (a condition where the heart's natural pacemaker, known as the sinus node, does not function properly), hypertensive heart disease with heart failure, and presence of a cardiac pacemaker. Review of the entire medical record failed to indicate any specific information related to the cardiac pacemaker device such as: -Type of pacemaker; -Type of leads; -Manufacturer and model; -Serial number; -Date of implant; -Paced rate; -Battery life; -special precautions identified and placed in residents record, and no subsequent physician orders. -orders for pacemaker management and telephonic/office monitoring. -orders that may include, but are not limited to contact number, frequency of telephonic checks, schedule of planned phone checks. During an interview on 12/18/24 at 2:03 P.M., Unit Manager #1 said Resident #30 has a cardiac pacemaker and the monitoring device manufacturer conducts pacemaker checks remotely. She said she does not know anything about the device and how frequently pacemaker checks are conducted. Unit Manager #1 reviewed the entire medical record and was unable to find any information about the pacemaker device or any documentation from the Resident's cardiologist. During interviews on 12/18/24 at 3:30 P.M. and 4:02 P.M., the Director of Nursing said there was no documentation in the medical record about Resident #30's pacemaker device.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42742 Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to: 1. Ensure environmental cleaning was maintained in the laundry room including flooring and surfaces and properly store linens; 2. For Resident #154, who has chronic wounds, putting him/her at increased risk for infection, to ensure that staff implemented Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. Findings include: 1. Review of the Centers for Disease Control and Prevention Core Infection Prevention and Control Practices for Safe Health Care Delivery in All Settings, last reviewed 11/29/22, indicated but was not limited to: Environmental Cleaning and Disinfection require routine targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling. Review of a facility document titled 5-Step Daily Routine Cleaning, revised October 2016, indicated but was not limited to the following: Purpose: To teach Environmental Services employees the proper cleaning method to sanitize a patient room or any area in a healthcare facility. Review of a facility document titled Quality Control Inspection-Laundry, undated, indicated but was not limited to the following: Other: -Machines clean -Floors clean -Behind machines On 12/18/24 at 8:07 A.M., the surveyor toured the laundry room with the Housekeeping Manager and observed the following: -One tower fan along the back wall and one tabletop fan on top of a washer in the off position, both significantly laden with dust. Clean linens stored nearby and potentially exposed to any environmental pathogens if fans in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Top surface of three washing machines laden with dust. One pillow and a pillowcase stored on top exposed. -Floor drain in front of the washers with a buildup of debris, lint, and other unidentified accumulated particles partially obstructing the drain. -Area behind washing machines with numerous unidentified deteriorating paper and cloth like objects on the floor and against wall, one with numerous blackened areas on the surface, various debris, lint, plastic wrappers, and hoses. A large rectangular floor cage was observed with a buildup of debris, lint and other unidentified accumulated particles partially obstructing the cage. During an interview on 12/18/24 at 8:07 A.M., the Housekeeping Manager said she was responsible for housekeeping in the facility and said staff clean the laundry room around 11:30 A.M. every morning and wash the floor and all the machines but said there was no checklist or log to show the surveyor. The Housekeeping Manager removed the fans and said laundry staff use the fans because it gets hot in there. She said the top surfaces of the washers needed to be cleaned and the pillow and pillowcase should not have been stored there. She said she was not responsible for cleaning behind the washing machines, maintenance was. During an interview on 12/18/24 at 9:59 A.M, the Infection Preventionist (IP) said her expectation is that laundry is stored properly and in a sanitary way and laundry room staff were responsible for the cleanliness of the fans and environmental cleaning. During an interview on 12/18/24 at 10:14 A.M., the Maintenance Director said he usually pulls stuff out of the drain on the floor and sweeps behind the washers. He said he's also responsible for cleaning the cage on the floor behind the washers, so lint doesn't build up and sometimes he'll see diapers back there. The Maintenance Director said he does this monthly, but it should be cleaned as needed as well if staff complain or if he goes back there and sees it. He said he saw it today after surveyor intervention and it was a mess back there, but he's seen worse. He said he found broken hoses and gloves and crumbling sheetrock that had fallen off the wall from all the chemicals. He said the expectation is that the floor drain and cage be clean and free of debris and lint so water can drain but wasn't sure when they were last cleaned and had no record of it. He said lint and gloves may have been swept towards there. 34145 2. Review of the Centers for Medicare and Medicaid Services (CMS) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated but was not limited to: -Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. -EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing -EBP are indicated for residents with any of the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO -EBP should be used for any residents who meet the above criteria, wherever they reside in the Facility Review of the facility's policy titled Enhanced Barrier Precautions, last revised March 2024, indicated but was not limited to: -EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply a. gloves and gown are applied prior to performing the high contact resident care activity -Examples of high contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care -EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization -Signs are posted in the door or wall outside the resident room indicating the type of precaution and PPE required -PPE is available outside of the residents' rooms Resident #154 was admitted to the facility in November 2024 and had two stage 2 pressure ulcers. Review of the Minimum Data Set assessment, dated 11/28/24, indicated Resident #154 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 7 out of 15, had functional limitation in range of motion on one side of his/her upper extremity, required partial to moderate assistance for bed mobility, and had two stage 2 pressure ulcers. Review of Physician's Orders indicated but was not limited to: -Maintain enhanced barrier precautions with high contact care-wounds, every shift for prevention (11/25/24) Review of comprehensive care plans indicated but were not limited to: -Focus: The resident is on enhanced barrier precautions due to increased risk to acquire infection related to wounds (11/25/24) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: Maintain enhanced barrier precautions: clean hands before entering and leaving the room. [NAME] (put on) gloves and gown prior to providing high contact care and discard prior to exiting room (11/25/24) -Goal: The resident will remain free of healthcare acquired infection through the review date (last revised 12/13/24) On 12/17/24 at 8:20 A.M., the surveyor observed an EBP sign posted on the wall outside Resident #154's room. A three-tiered PPE cart was outside the door to the Resident's room and contained gowns and gloves. Resident #154 was sitting upright in bed but slouched down and leaning to his/her right side. On 12/17/24 at 8:25 A.M., the surveyor observed Nurse #2 and Speech Therapist (ST) #1 enter Resident #154's room. Nurse #2 and ST #1 repositioned the Resident in bed. Neither Nurse #2 nor ST #1 wore PPE during high contact care. During an interview on 12/17/24 at 8:27 A.M., ST #1 said she should have worn PPE when she assisted Nurse #2 to boost the Resident and did not. During an interview on 12/17/24 at 8:28 A.M., Nurse #2 said Resident #154 is on EBP and she should have worn a gown and gloves when repositioning the Resident. During an interview on 12/19/24 at 9:31 A.M., Unit Manager #1 said for residents on EBP, staff are to follow what is printed on the sign posted at the resident's door. She said Nurse #2 and ST #1 should have worn a gown and gloves when repositioning Resident #154.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER: Sarah S Brayton Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 4901 North Main Street, Fall River, MA 02720	

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on record review, document review, and interview, the facility failed to ensure residents were screened for eligibility to receive the recommended influenza and/or pneumococcal vaccinations, residents/residents' representatives were educated on the benefits and potential side effects of the vaccine, and were offered and administered (if applicable) the vaccine in a timely manner for one Resident (#117), out of a total sample size of five residents reviewed for immunizations. Findings include: Review of the Centers for Disease Control and Prevention (CDC) document titled Pneumococcal Vaccine Timing for Adults, dated October 2024, indicated the following: -Make sure your patients are up to date with pneumococcal vaccination. Adults >= [AGE] years Old, Complete Pneumococcal Vaccine Schedules: -PPSV23 only at any age - give PCV20 or PCV21 >= 1 year later Review of the facility's policy titled Pneumococcal Vaccine, revised March 2023, indicated but was not limited to the following: -All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. -Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated/available, are offered the vaccine series within the facility unless medically contraindicated, awaiting shipments of vaccines, or the resident has already been vaccinated. -Assessments of pneumococcal vaccination status are conducted within thirty (30) days of the resident's admission if not conducted prior to admission. -Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of education is documented in the resident's medical record. -Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. -Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Review of the facility's policy titled Influenza Vaccine, revised September 2024, indicated but was not limited to the following: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. -Between as early as August 1st through March 31st of the following year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. -Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of education shall be documented in the resident's/employee's medical record. Resident #117 was admitted to the facility in November 2023 and was [AGE] years old. Review of the Resident's Immunization record indicated the following: -Resident #117/Resident's representative refused the Influenza vaccine on 9/9/24. The record indicated vaccination education was not provided. -Prevnar-23 vaccine administered 7/31/17, outside of the facility Further review of the medical record failed to indicate documentation of follow up screening, an assessment for eligibility to receive the recommended Pneumococcal vaccine dose (PCV20 or PCV21), the provision of education related to the Influenza and Pneumococcal vaccines, signed consent to either receive or refuse the vaccines, and offering and/or administration of the vaccines. During an interview on 12/18/24 at 9:29 A.M., the Infection Preventionist (IP) said the facility had infection control policies and procedures that were current and based on national standards. She said they follow CDC, Massachusetts Department of Public Health (DPH), or Centers for Medicare and Medicaid Services (CMS) guidance for vaccines, whichever is most stringent. During an interview on 12/18/24 at 9:46 A.M., the IP said she finally got a hold of the Resident's son yesterday, after surveyor intervention, who consented to receive the recommended Influenza and Pneumococcal vaccinations. During an interview on 12/18/24 at 9:48 A.M., the IP said the expectation is to ensure all residents are provided education, offered the vaccines, and either consent to receive the vaccines or decline them.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on record review and interview, the facility failed to provide education and/or offer the COVID-19 vaccination as required or appropriate per the Centers for Disease Control and Prevention (CDC) recommendations for two Residents (#153 and #117), out of a total sample size of five residents reviewed for immunizations. Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance titled Use of COVID-19 Vaccines in the U.S. revised October 2024, indicated but was not limited to the following: -People ages 5-[AGE] years should receive 1 dose of an age appropriate 2024-2025 COVID-19 vaccine. Ages 12-[AGE] years (Previous COVID-19 vaccination before 2024-2025 vaccine): -Receive 1 dose of 2024-2025 vaccine -People ages [AGE] years and older, vaccinated under the routine schedule, are recommended to receive 2 doses of an 2024-2025 COVID-19 vaccine (i.e., Moderna, Novavax, or Pfizer-BioNTech) separated by 6 months (minimum interval 2 months) regardless of vaccination history, with one exception: Unvaccinated people who initiate vaccination with 2024-2025 Novavax COVID-19 Vaccine are recommended to receive 2 doses of Novavax followed by a third dose of any COVID-19 vaccine 6 months (minimum interval 2 months) later. Review of the facility's policy titled Coronavirus Disease (COVID-19) - Vaccination of Residents, revised April 2023, indicated but was not limited to the following: -Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident has already been immunized. -Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so. -The resident (or resident representative) has the opportunity to accept or refuse a COVID-19 vaccine, and to change his/her decision. -COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist. -Vaccines are administered in accordance with CDC, ACIP, FDA and manufacturer guidelines. -Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents or HCP/guardian must sign a consent to vaccinate form prior to receiving the vaccine. -The resident's medical record includes documentation that indicates, at a minimum, the following: a. That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; b. Signed consent; and c. Each dose of COVID-19 vaccine that was administered to the resident. -If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination or refusal, appropriate documentation is made in the resident's record. 1. Resident #153 was admitted to the facility in August 2024 and was [AGE] years old. Review of the Resident's Immunization record indicated the following: -Resident #153 refused the 2023-2024 formula COVID-19 vaccine. The record indicated vaccination education was not provided. -COVID-19 Dose 1 received 2/5/21, Dose 2 received 5/24/21 Review of Resident #153's Immunization Consent Form, dated 8/27/24, indicated he/she had declined the vaccine with the reason documented as received. No date was provided. Education on the form indicated the following: -COVID-19 Vaccine/Booster: Soreness, swelling, redness of the arm, fever, muscle aches and pains; rarely allergic reaction. The form did not indicate education regarding the type of COVID-19 vaccine being offered or benefits and risks associated with the vaccine. During an interview on 12/18/24 at 9:41 P.M., the Infection Preventionist (IP) said she did the COVID-19 education with the Resident yesterday, after surveyor intervention, and the Resident refused. She said the only documented COVID-19 vaccinations the Resident received were from 2021 and the Resident did not have anything recent that she knew of. She said there had been no follow up on if the Resident had received a more recent dose as indicated on the consent form. 2. Resident #117 was admitted to the facility in November 2023 and was [AGE] years old. Review of the Resident's Immunization record indicated the following: -Resident #117/Resident's representative refused the COVID-19 Pfizer Booster on 12/15/23. The record failed to indicate that vaccination education was provided. -COVID-19 Dose 1 received 5/10/22, Dose 2 received 6/7/22 (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the medical record failed to indicate documentation of follow up screening, an assessment for eligibility to receive the recommended 2024-2025 COVID-19 vaccine dose, the provision of education related to the COVID-19 vaccine, completed consent to either receive or refuse the vaccine in the medical record, and offering or administration of the vaccine. During an interview on 12/18/24 at 9:29 A.M., the IP said the facility had infection control policies and procedures that were current and based on national standards. She said they follow CDC, Massachusetts Department of Public Health (DPH), or Centers for Medicare and Medicaid Services (CMS) guidance for vaccines, whichever is most stringent. During an interview on 12/18/24 at 9:46 A.M., the IP said she finally got a hold of the Resident's son yesterday, after surveyor intervention, who consented for Resident #117 to receive the recommended COVID-19 vaccination. During an interview on 12/18/24 at 9:48 A.M., the IP said the expectation is to ensure all residents are provided education, offered the vaccine, and either consent to receive the COVID-19 vaccination or decline it.