STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225645	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomas Upham House	519 Main Street Medfield, MA 02052

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46862 Based on observation and interview, the facility failed to ensure residents in two of two dining rooms had a dignified dining experience. Findings include: Review of the facility's Mission Statement, undated, indicated but was not limited to: -It is the mission of the [Facility Name] to provide resident focused quality care in a safe home-like environment. -Individuality will be encouraged Review of the facility's Resident Rights, dated 5/15/19, indicated but was not limited to: -Residents have the right to: -Dignity, considerate and respectful care -Informed participation -Freedom of choice to make their own, independent decisions Review of the facility's policy titled Assistance with Meals, dated as revised 7/2017, indicated but was not limited to: -All residents will be encouraged to eat in the dining room. -Avoiding the use of labels when referring to residents (e.g., feeders). -Avoiding the use of clothing protectors instead of napkins, unless requested by the resident. Review of the facility's General Tips for Improving Face-to-Face Communication with Older Adults, undated, indicated but was not limited to: (continued on next page)

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 - Some	-Avoid speech that might be seen as patronizing to the older person (elderspeak). -Do not use language such as Bib, it is a Clothing Protector. On 10/16/24 at 7:45 A.M., the surveyor observed three residents seated at separate tables in the dining room on the second-floor unit. All residents had a clothing protector on and eating their meals directly off trays. There were no staff present in the dining room. On 10/16/24 from 12:10 P.M. to 12:49 P.M., the surveyor made the following observations in the second-floor unit dining room: -The lunch truck was delivered and the dining services started at 12:10 P.M., and the last tray was passed at 12:49 P.M. Table 1: -Two residents were seated at the table. -12:17 P.M., one resident received a meal, and a staff member assisted with set up, while the second resident watched. -12:34 P.M.,17 minutes later, the second resident was provided with a meal and assisted by a staff member to eat. Table 2: -Two residents were seated at the table. -12:20 P.M., one resident had a meal and ate independently, while the other resident watched. -12:21 P.M., a meal was served to the second resident. The second resident did not attempt to eat independently. A staff member assisted the resident to eat at 12:36 P.M., 15 minutes after the tray had been placed. Table 3: -One resident was seated in a Broda chair (positioning wheelchair) facing Table 1. -12:32 P.M., the resident's meal was placed on the table. A staff member assisted the resident to eat at 12:49 P.M.,17 minutes after the tray had been placed. During the lunch meal service, the surveyor did not observe staff wash any resident's hands prior to meal delivery. The staff were observed placing a clothing protector on the meal tray of each resident, and then placing them on the residents prior to meal set up. Staff members did not ask residents if they would like to use a clothing protector. All residents were eating their meals directly off of trays. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 12:26 P.M., Nurse #3 entered the dining room and sat in a chair facing the door. Nurse #3 had left the day room at 12:36 P.M. when CNA #4 and CNA #5 had returned to the dining room after passing the remainder of the lunch trays to resident's rooms. During an interview on 10/16/24 at 1:08 P.M., Nurse #3 said she was told to check the residents' tray ticket. Nurse #3 said she was not told to assist any residents to eat or to socialize. Nurse #3 said she was told to monitor the dining room while the state was here. During an interview on 10/17/24 at 7:57 A.M., CNA #4 said the nurse would check the meal trays. CNA #4 said we pass out the trays to residents who can eat independently first. We will pass out the trays to residents who need assistance last and leave them to the side until someone could help them. CNA #4 said we usually take the tray away from the residents in the dining area. CNA #4 said the nurses are busy, but they had been told they need to assist during mealtimes. CNA #4 said it depends on what nurse was working. CNA #4 said not all nurses help. On 10/17/24 at 8:20 A.M., the breakfast truck was delivered to the dining room on the first-floor unit. There were three residents present in the dining room. The dining services started at 8:20 A.M., and the last tray was passed at 8:49 A.M. The surveyor did not observe staff wash any resident's hands prior to meal delivery. The staff were observed placing a clothing protector on the meal tray of each resident. Clothing protectors were placed on the resident prior to meal set up. Staff members did not ask residents if they would like to use a clothing protector. All residents were eating off of trays. On 10/17/24 at 12:29 P.M., the surveyor made the following observations in the first-floor unit dining room: -The lunch truck was delivered and the dining services started at 12:29 P.M., and the last tray was passed at 12:52 P.M. Table 2: -There were two residents seated at the table. -12:39 P.M., Nurse #6 placed a clothing protector on both residents. The surveyor heard Nurse #6 say, I need to put on your bib, to each of the two residents. Table 5: -One resident was seated at the table. -12:34 P.M., resident received a meal and a staff member assisted with set up. -Staff initially piled meal trays on the table while the resident was eating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the lunch meal service, the surveyor did not observe staff wash any resident's hands prior to meal delivery. The staff were observed placing a clothing protector on the meal tray of each resident. Clothing protectors were placed on the residents prior to meal set up. Staff members did not ask residents if they would like to use a clothing protector. All resident trays were removed during meal pass. On 10/17/24 at 1:10 P.M., the surveyor observed a resident leaving the day room with a clothing protector on. The surveyor observed Nurse #6 follow the resident to the dining room door and say, in a loud voice, Let me remove your bib. During an interview on 10/17/24 at 1:27 P.M., CNA #3 said we always put a bib on the residents for meals; we do not need to ask them. CNA #3 said we do not always take away the meal trays. CNA #3 said we should have removed the meal trays this morning at breakfast. During an interview on 10/17/24 at 4:55 P.M., the Director of Nurses (DON) and Nurse #5 were made aware of the surveyor's dining observations. Nurse #5 said meals in the dining room should be served at the same time and residents seated at a table should all be served meals at the same time for a dignified experience. The DON agreed with Nurse #5 and added that meals should be served off trays for a homelike dining experience. The DON said staff should not place a clothing protector on the residents without getting their permission and the staff should never use the term bib as it is demeaning.

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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 observation, interview, and record review, the facility failed to notify the Physician/Nurse Practitioner (NP) timely of the unavailability of a prescribed treatment, based on a specialist medical practitioner's recommendations for one Resident (#9), out of a total sample of 12 residents. Specifically, the facility failed to notify the Physician/NP (Nurse Practitioner) and/or consultant wound care provider to determine the need to alter treatment when a prescribed treatment for a stage 4 pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (tissue made of dead cells that can be yellow, tan, gray, green, brown) and/or eschar (dead tissue colored tan, black, brown) in the wound bed) was unavailable from the pharmacy. Findings include: Review of the facility's policy titled Telephone Reporting of Change in Condition, Medication Not Available and Critical Lab Results, undated, indicated but was not limited to: -Policy is to ensure timely and accurate reporting of information to physician/nurse practitioner. MD/NP will determine any new orders that would be deemed appropriate for a resident. Resident #9 was admitted to the facility in April 2021 with diagnoses including pressure ulcer of the right buttock. Review of the Minimum Data Set assessment, dated 10/7/24, indicated Resident #9 had severe cognitive impairment as evidenced by his/her inability to complete the Brief Interview for Mental Status, was dependent on staff for all activities of daily living and had one stage 4 pressure ulcer. Review of a progress note from the facility's consultant wound NP, dated 10/11/24, indicated the Resident's stage 4 buttock wound had developed slough in the wound bed. The treatment recommendation was changed to apply Santyl (a prescription medication that removes dead tissue from wounds), calcium alginate to base of the wound and secure with bordered foam daily and as needed for soiling. During an interview on 10/16/24 at 2:40 P.M., Nurse #2 said Resident #9 is supposed to have Santyl applied to the buttock wound, but the pharmacy is out of it, and it is on back order. Nurse #2 said she told NP #1 on 10/16/24 (five days after the recommendation was made by the wound care NP) that Santyl was on back order. Review of the medical record failed to indicate any evidence that Nurse #2 notified NP #1. During a telephone interview on 10/17/24 at 3:36 P.M., NP #1 said she was not notified that Santyl was unavailable and on back order at the pharmacy. She said she would have expected the facility to notify her or the consultant wound care NP. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 2:20 P.M., the Director of Nursing (DON) said she was not aware that the pharmacy was out of Santyl, and it was on back order. She reviewed Resident #9's medical record and said there was no documentation to indicate the MD/NP #1 or consultant wound NP was notified the pharmacy was out of Santyl and it was on back order. During an interview on 10/18/24 at 7:00 A.M., the consultant wound care NP said she was not notified that Santyl was on back order at the pharmacy. She said she just found out just now (10/18/24 at 7:00 A.M.) from Nurse #2 that Santyl was not available and not applied as ordered. She said the staff could have also contacted the primary MD/NP to notify them. During a subsequent telephone interview on 10/21/24 at 4:05 P.M., NP #1 said she reviewed her notes (which were not available during the previous interview) and wanted to clarify that Nurse #2 did notify her on 10/16/24 (five days after the recommendation was made by the wound care NP) that Santyl was not available and on back order at the pharmacy.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 34145 Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards of practice for two Residents (#9 and #2), out of a total sample of 12 residents. Specifically, the facility failed to ensure: 1. For Resident #9, that wound care provided was consistent with professional standards of practice to ensure interventions ordered and/or recommended for the treatment of a pressure ulcer (injury to the skin and underlying tissue resulting from prolonged pressure to the skin) were implemented; and 2. For Resident #2, to ensure: a. physician's orders were obtained for fingerstick blood sugars (FSBS) in order to implement the physician's order for sliding scale insulin (medication used in the treatment and management of diabetes mellitus), and b. physician's orders were obtained for an albuterol inhaler (used to treat or prevent bronchospasm or narrowing of the airways in the lungs) that was being self-administered by the Resident. Findings include: Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered nurse and Practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered nurse and practical nurse incorporate into the plan of care, and implement prescribed medical regimens. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. 1. Review of the facility's policies titled Unavailable Medication Policy, last revised 7/2018, and Telephone Reporting of Change of Condition, Medication Unavailable and Critical Lab Results Policy, undated, indicated but were not limited to: -In the event that a medication is unavailable, for any reason, the facility shall act promptly to notify the appropriate practitioners to obtain a new medication supply/order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Dressings, Dry/Clean, dated September 2013, indicated but was not limited to: Preparation: -Verify that there is a physician's order for this procedure. Resident #9 was admitted to the facility in April 2021 and had diagnoses including a stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) of the right buttock. Review of the Minimum Data Set (MDS) assessment, dated 10/7/24, indicated Resident #9 had severe cognitive impairment as evidenced by his/her inability to complete the Brief Interview for Mental Status (BIMS), was dependent on staff for all activities of daily living, and had one stage 4 pressure ulcer. Review of the medical record indicated a progress note from the wound consultant, dated 9/20/24, indicated Resident #9 had a stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed) that was stable. Treatment recommendations included to apply calcium alginate (used in the treatment of moderately to heavily exuding partial- and full-thickness draining wounds such as stage III-IV pressure ulcers) to the base of the wound and secure with a bordered foam dressing (antimicrobial foam dressing that effectively absorbs and retains exudate and maintains a moist environment) daily and as needed for soiling or accidental removal. Review of the medical record indicated the following Physician's Order: -Right buttock: cleanse with normal saline. Pack wound with calcium alginate. Make sure there is a tail of calcium alginate showing for easy removal. Apply a bordered foam. (9/17/24) Review of a progress note from the wound consultant, dated 9/27/24, indicated the Resident's stage 3 pressure ulcer had worsened and was found to have increased depth with exposed bone. The wound was now a stage 4 pressure ulcer. Treatment recommendations were to apply calcium alginate to the wound base and secure with a bordered foam dressing daily and as needed for soiling. Review of a progress note from the wound consultant, dated 10/11/24, indicated the Resident's buttock wound had developed slough (dead tissues that separates from living tissue, especially an ulcer) in the wound bed. A change in treatment was recommended. The recommendation was to apply Santyl (a prescription medication that removes dead tissue from wounds) along with calcium alginate to the base of the wound and secure with bordered foam daily and as needed for soiling. Review of the medical record failed to indicate that Resident #9's physician (MD) or NP had been notified, approved and gave an order to administer the new treatment recommendation. Review of October 2024 Medication/Treatment Administration Records (MAR/TAR) indicated that nursing was performing the treatment to the Resident's right buttock wound (Santyl and calcium alginate and a bordered foam dressing) daily from 10/11/24 to 10/16/24 (as indicated by nursing staff initials on the TAR for each date) without an order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 10:50 A.M., the surveyor observed Nurse #2 perform a dressing change to Resident #9's wound as follows: -Nurse #2 gathered the dressing supplies, placed them on the Resident's bedside table and prepared the supplies needed for the wound treatment. She then cleansed the wound with gauze and normal saline (NS), packed it with the calcium alginate and then covered the area with a bordered foam dressing. During an interview on 10/16/24 at 2:40 P.M., Nurse #2 said the wound consultant recommended a change to Resident #9's treatment to include Santyl with the current treatment. Nurse #2 said there was Santyl in the treatment cart that had been applied to the Resident's leg wound but the treatment had been discontinued on 9/27/24. Nurse #2 said she used the Santyl (even though it had been ordered for another wound) until it was depleted on 10/14/24. She said she called the pharmacy on 10/14/24 and was told they did not have Santyl in stock and it is on back order. Nurse #2 said she called and told NP #1 on 10/16/24 after the dressing change earlier in the day (five days after the recommendation was made by the wound consultant and two days after the Santyl was depleted) that the Santyl was unavailable and on back order. She said she was instructed to resume the previous treatment (cleanse with normal saline, pack wound with and calcium alginate daily and cover with a bordered foam dressing daily) until the consultant wound NP evaluates the Resident again (due on 10/18/24). Nurse #2 said she did not document her conversation with NP #1 in a progress note or transcribe the verbal orders. She confirmed that the recommended Santyl treatment was administered from 10/11/24 to 10/14/24 without a transcribed order in the medical record. Nurse #2 further said that although she documented on the TAR that the Santyl was applied on 10/15/24 and 10/16/24, it was not applied because it was unavailable. During an interview with the Director of Nursing (DON), the Administrator, and Nurse #5 on 10/17/24 at 2:20 P.M., the DON said she was not aware that the pharmacy was out of Santyl and it was on back order. She also said there were no current treatment orders for Santyl and calcium alginate (last one dated 9/17/24) in the medical record. She said the Nurses should not have administered the treatment to the buttock wound without an order. She further said that the nurses should not have signed off that they were applying Santyl when they were not. She said a prescription is required for Santyl and cannot be used unless it is ordered by a MD/NP. During a subsequent telephone interview on 10/21/24 at 4:05 P.M., NP #1 said she gave a verbal order to cleanse the right buttock wound with normal saline and pack the wound with calcium alginate daily until the consultant wound care NP could see the Resident on 10/18/24. She said she was not aware Nursing was using leftover Santyl from a discontinued treatment order for another wound from 10/11/24 until 10/14/24. NP #1 said she reviewed Resident #9's medical record and saw that none of the verbal orders she gave for the treatment of Resident #9's wounds were transcribed into the medical record. 2. Resident #2 was admitted to the facility in January 2023 with diagnoses including diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin or use it properly) and asthma (a chronic inflammatory disease of the airways that makes it difficult to breathe). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 7/22/24, indicated Resident #2 was cognitively intact as evidenced by a BIMS score of 15 out of 15, was diabetic and asthmatic, and received insulin injections. Review of Physician's Orders included but was not limited to: - Novolin (insulin) 100 units/milliliter (mL) flexpen, give 8 units subcutaneously (under the skin) daily at bedtime (9/18/24) - Humalog (insulin) 100 units/mL, sliding scale insulin instruction as follows: (4/2/24) Blood sugar range: - If 0-175 = 0 units. - 176-250 = 2 units. - 251-300 = 3 units. - 301-350 = 4 units. - 351-400 = 5 units. - Schedule: daily at 7:30 A.M., 4:30 P.M. a. Review of the medical record failed to indicate a physician's order to obtain blood sugars to implement the order for sliding scale insulin administration. Review of September and October 2024 Medication/Treatment Administration Records (MAR/TAR) indicated Resident #2's glucose level (a method for measuring blood sugar levels by pricking the skin with a lancet to obtain a drop of blood, which is then applied to a test strip and analyzed by a glucometer level) was obtained on 89 occasions without a Physician's order to do so. b. Review of the medical record indicated an Assessment for Self-Administration of Medications, dated 2/1/23, that indicated Resident #2 was assessed to be capable of self-administering a rescue inhaler. During an observation with interview on 10/15/24 at 9:35 A.M., the surveyor observed Resident #2 sitting upright in bed. An albuterol inhaler was on the mattress beside him/her. The Resident said he/she has asthma and likes to keep the inhaler with him/her at all times in case he/she needs it. On 10/16/24 at 8:45 A.M., the surveyor observed Resident #2 sitting upright in bed eating breakfast. An albuterol inhaler was on the mattress beside him/her. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/24 at 11:12 A.M., Nurse #2 said FSBS are done twice a day for Resident #2 at 7:30 A.M. and 4:30 P.M. She reviewed Resident #2's medical record including physician's orders and she said there were no orders in place to have his/her blood sugar checked utilizing a FSBS two times a day. She said there is supposed to be orders in place for obtaining blood sugars when someone has a sliding scale for insulin administration, and she never noticed that it was missing. She said she could not find active orders for the Resident to self-administer albuterol. She found a discontinued order for albuterol sulfate HFA 108 microgram (mcg) aerosol solution, 2 puffs every 4 hours as needed for shortness of breath or wheeze (may self-medicate inhaler in patient room) that was initiated on 9/19/24 and discontinued on 10/3/24. On 10/16/24 at 11:20 A.M., Nurse #2 and the surveyor went to Resident #2's room. Nurse #2 asked the Resident to show her the inhaler. Resident #2 retrieved the albuterol inhaler from his/her pants pocket and gave it to Nurse #2. The Resident said the inhaler is his/hers and keeps it with him/her at all times. The Resident said he/she usually uses it in the morning due to getting out of breath when he/she gets dressed every morning. Resident #2 said the last time he/she used the albuterol inhaler was the morning of 10/15/24. Nurse #2 said there must be a physician's order in place for Resident #2 to use the albuterol inhaler.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34145 Based on observation, record review, and interview, the facility failed to ensure pharmaceutical services met the needs of each resident for one Resident (#9), in a total sample of 12 residents. Specifically, the facility failed to ensure a prescription treatment for a stage 4 wound (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) was obtained from the pharmacy and available for administration. Findings include: Review of the facility's policies titled Unavailable Medication Policy, last revised 7/2018, and Telephone Reporting of Change of Condition, Medication Unavailable and Critical Lab Results Policy, undated, indicated but were not limited to: -In the event that a medication is unavailable, for any reason, the facility shall act promptly to notify the pharmacy and the appropriate practitioners to obtain a new medication supply/order. -Call the Pharmacy and order the medication per physician's order. If the pharmacy does not have the medication or it cannot be delivered timely, the pharmacy is responsible for getting the medication delivered from a backup pharmacy. Document name of Pharmacist and Pharmacy response in progress note/nursing notes. Resident #9 was admitted to the facility in April 2021 with diagnoses including pressure ulcer of the right buttock. Review of the Minimum Data Set assessment, dated 10/7/24, indicated Resident #9 had severe cognitive impairment as evidenced by his/her inability to complete the Brief Interview for Mental Status, was dependent on staff for all activities of daily living and had one stage 4 pressure ulcer. Review of the medical record indicated a progress note from the facility's consultant wound Nurse Practitioner (NP), dated 9/27/24, indicated the Resident's stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed) had worsened and was found to have increased depth and bone was now present in the wound bed. The wound was restaged from a stage 3 to a stage 4. Treatment recommendations included to apply calcium alginate to the base of the wound and secure with a bordered foam dressing daily and as needed for soiling. Review of a progress note from the facility's consultant wound NP, dated 10/4/24, indicated the Resident's buttock wound was worsening and had increased in depth and bone remained present in the wound bed. The NP made no new recommendations for treatment of the buttock wound. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note from the facility's consultant wound NP, dated 10/11/24, indicated Resident #9 had a stage 4 worsening pressure ulcer to the Resident's right buttock. The wound had developed slough (tissue made of dead cells that can be yellow, tan, gray, green, brown) in the wound bed and a change in treatment was recommended to apply Santyl (a prescription medication that removes dead tissue from wounds), calcium alginate to base of the wound on the Resident's right buttock and secure with bordered foam daily and as needed for soiling. During an interview on 10/16/24 at 2:40 P.M., Nurse #2 said the consultant wound NP recommended a change to Resident #9's treatment to have Santyl applied to the buttock wound. Nurse #2 said there was some Santyl left over in the treatment cart from a discontinued treatment to Resident #9's leg wound (discontinued on 9/27/24) and she used that until it was depleted on 10/14/24. She said she called the pharmacy on 10/14/24 and was told they did not have Santyl in stock and it is on back order. She said it still has not been delivered. During a telephone interview on 10/17/24 at 1:34 P.M., the facility's consultant pharmacy representative said they received a call from the facility on 10/14/24 to place an order for Santyl for Resident #9. He said it is out of stock and still on back order. He said if it is urgent, they can contact a back-up pharmacy to get it delivered right away. During a telephone interview on 10/17/24 at 2:14 P.M., the facility's consultant Pharmacist said Santyl is unavailable from their primary wholesaler. However, they have the option of using back-up pharmacies and the Santyl can be delivered to the facility immediately. He could not explain why the Santyl was not obtained from one of their back-up pharmacies when the order was placed on 10/14/24. During an interview with the Director of Nursing (DON), the Administrator and Nurse #5 on 10/17/24 at 2:20 P.M., the DON said she was not aware that the pharmacy was out of Santyl and it was on back order. Nurse #5 said the pharmacy is aware that if any medication is out of stock, it should and can be obtained through a backup pharmacy and that it should have been delivered.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48695 Based on record review and interview, the facility failed to monitor adverse consequences (side effects) of anticoagulant medications (used to prevent the blood from clotting; a blood thinner) for one Resident (#21), out of a total sample of 12 residents. Findings include: Review of the facility's policy titled Anticoagulation Therapy Management, undated, indicated but was not limited to: - Purpose: This facility directive outlines the policy and procedures for the proper management of patients receiving anticoagulation therapy. - Introduction: It is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent resident compliance. - Policy: It is the policy of the facility to maintain an anticoagulation management program to individualize patient care and reduce the likelihood of patient harm associated with anticoagulant use. - Procedure: A. Anticoagulation therapy management must include at a minimum: 1. Oversight and ongoing resident monitoring. Resident #21 was admitted to the facility in October 2024 with diagnoses which included polycythemia vera (rare blood disorder in which there is an increase in all blood cells. The increase in blood cells makes the blood thicker which can lead to blood clots forming in blood vessels), gastrointestinal hemorrhage (bleed), and deep vein thrombosis (blood clot). Review of Resident #21's Minimum Data Set (MDS) assessment, dated 10/10/24, indicated Resident #21 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS indicated that Resident #21 received anticoagulant medication. During an interview on 10/15/24 at 8:36 A.M., Resident #21 said he/she was just readmitted to the facility after being discharged home last week. Review of Resident #21's October Physician's Orders indicated but was not limited to: -Eliquis (anticoagulant medication) 5 milligrams (mg) two times daily, (dated 9/20/24 and discontinued 10/10/24) -Eliquis 5 mg two times daily (dated 10/14/24) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor signs/symptoms of bleeding every shift related to Eliquis, (dated 9/20/24 and discontinued 10/10/24) Review of Resident #21's October 2024 Medication Administration Record (MAR) indicated he/she received Eliquis as ordered. Review of Resident #21's admission assessment, dated 10/14/24, indicated he/she was admitted with bilateral upper extremity bruising and a bruise to the left hip. Further review of Resident #21's medical record, including the MAR and Treatment Administration Record (TAR), failed to indicate he/she was monitored for adverse consequences of anticoagulant medication since admission. Review of Resident #21's Interim Care Plan, dated 10/15/24, indicated but was not limited to: -Problem: At risk for bleeding secondary to use of Eliquis -Goal: No signs and symptoms of bleeding for 30 days -Plan/Approach: Monitor for signs and symptoms of bleeding every shift. During an interview on 10/15/24 at 4:29 P.M., the Director of Nursing (DON) said signs and symptoms of adverse consequences of anticoagulant medication should be documented on the Treatment Administration Record (TAR). During an interview on 10/17/24 at 7:47 A.M., Nurse #9 said when a resident was on an anticoagulant medication, he/she should be monitored for bleeding, bleeding gums, and black tarry stools. Then, the results should be documented on the TAR. Nurse #9 and the surveyor reviewed Resident #21's medical record. Nurse #9 said Resident #21 had an order during his/her last admission to monitor for adverse consequences of Eliquis but did not have a current order to monitor for adverse consequences. During an interview on 10/17/24 at 3:13 P.M., Nurse #7 said when a resident was on an anticoagulant medication signs and symptoms of adverse consequences must be monitored and documented on the resident's TAR. Nurse #7 and the surveyor reviewed Resident #21's medical record. Nurse #7 said Resident #7 should have an order to monitor for adverse consequences of Eliquis but did not. During an interview on 10/18/24 at 7:19 A.M., Nurse #10 said the process in the facility was for nurses to document side effects of anticoagulant medications in the resident's TAR. Nurse #10 said she was not aware of another way to document if a resident was monitored for adverse side effects of anticoagulant medication. During an interview on 10/18/24 at 7:31 A.M., Nurse #11 said the process in the facility was for nurses to document side effects of anticoagulant medications in the resident's TAR. Nurse #11 said every resident on Eliquis is required to have an order for monitoring of adverse consequences in place and must be signed off by the nurse every shift.

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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. 48695 Based on observations and interview, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to ensure the treatment carts were locked when not in direct supervision of the licensed nurse on one of two units. Findings include: Review of the facility's policy titled Storage of Medications, dated September 2018, indicated but was not limited to: - Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access. The surveyor made the following observations on: - 10/16/24 at 1:26 P.M., Second Floor Unit treatment cart was locked and unattended with the keys in the lock, the nurse returned to the treatment cart at 1:28 P.M. and removed the key. -10/17/24 at 10:01 A.M., Second Floor Unit treatment cart was unlocked and unattended with a resident sitting next to the cart. At 10:02 A.M., Nurse #6 came over to the treatment cart, gathered treatment supplies, and then left, leaving the treatment cart unattended and unlocked. - 10/17/24 at 10:05 A.M., Second Floor Unit treatment cart unlocked and unattended with a resident sitting next to the cart. During an interview on 10/17/24 at 10:12 A.M., Nurse #6 said she should not have left the treatment cart unlocked and unattended, especially with a resident sitting next to the cart. During an interview on 10/17/24 at 3:12 P.M., Nurse #9 said treatment carts should never be left unattended and unlocked regardless of if a resident was sitting next to the cart or not. During an interview on 10/17/24 at 4:07 P.M., the Director of Nursing (DON) said the expectation is for treatment carts to be locked at all times when unattended. The DON said keys should never be left in the treatment cart, they should always be on the nurse.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43935 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. Maintain a complete and accurate system of surveillance and to analyze their collected surveillance data to identify any trends of actual or potential infections within the facility to validate the effectiveness of their program; 2. For Resident #28, perform COVID-19 rapid antigen testing at the first sign and symptom of COVID-19 in accordance with the standard; 3a. Ensure staff performed rapid antigen COVID-19 testing (using the Osang Healthcare (OHC) COVID-19 antigen self test kits) in a manner that is consistent with current standards of practice and manufacturer's instructions for 2 of 3 residents tested ; b. For Resident #15, ensure proper infection control practices were followed while conducting rapid COVID-19 outbreak testing, who was symptomatic at the time of testing; 4. Ensure staff implemented appropriate use of source control, personal protective equipment (PPE) while in nursing or resident areas of the facility during a COVID-19 outbreak to help prevent the further spread of COVID-19; 5. For Resident #9, maintain standards of infection prevention practice while performing a dressing change and ensure assisting staff were wearing the appropriate PPE as required for Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes); and 6. For Resident #4, ensure staff wore PPE as required for EBP while direct care was being provided. Findings include: 1. Review of the facility's policy titled Infection Control Program, dated as revised [DATE], indicated but was not limited to the following: - the facility infection control program will perform surveillance and investigation to prevent, to the extent possible, the onset and spread of infection - prevent and control outbreaks and cross contamination using transmission based precautions (TBP) - use records of infection incidents to improve its infection control processes and outcomes by taking corrective actions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- the facility infection control program will include the maintenance of a separate record of infection that contains the following elements: - identification of each resident with an infection and date of onset, causative organism and origin or site of infection, description of cautionary measures that were taken to prevent the spread of the infection - the facility will analyze clusters, changes in prevalent organisms, or increases in the rate of infections in a timely manner with surveillance data routinely monitored; reports concerning infection rates, organisms and infection control issues will be discussed during the facility quality assurance performance improvement (QAPI) meetings The facility infection control program includes, but is not limited to the following elements: - definition of nosocomial/facility acquired (healthcare acquired) infections and communicable diseases - methods of identifying, documenting and investigating nosocomial infections and communicable diseases; one purpose is to identify new infections quickly During an interview on [DATE] at 2:17 P.M., Infection Preventionist (IP) #1 said the facility uses McGeer criteria for surveillance of illnesses to determine if an illness rises to the level of infection She said currently she is one of three people involved in the process and is relinquishing it to IP #2 and another nurse who will assist in the surveillance and monitoring of illnesses in the facility. Review of McGeer criteria, currently in use by the facility, indicated but was not limited to the following: Syndrome: Urinary Tract Infection (UTI) without indwelling catheter Criteria: Most fulfill both 1 and 2 1. At least one of the following sign or symptom: Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate Fever or leukocytosis, AND 1 of the following: Acute costovertebral angle pain or tenderness, Suprapubic pain Gross hematuria, New or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency * If no fever or leukocytosis, then 2 of the following: Suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 4:10 P.M., IP #1, IP #2 and Nurse #5 indicated they work together to get the facility surveillance complete and each do a separate part. They said it is Nurse #5 who signs all the surveillance line listings prior to sending them to the laboratory. They said the process starts by the nurses on the unit placing a resident with any symptoms in which they believe an antibiotic is necessary on the surveillance sheet. From there they said IP #2 verifies the antibiotic (Antbx) orders and completes the time out for the total number of days the infection is treated. Nurse #5 then takes the surveillance sheets at the end of the month and completes two sections: first, if the illness is healthcare acquired (HAI) or community acquired (CAI) and second if the illness will count as an infection using the McGeer criteria definition. They said this information is also available on the units for the nurses to review prior to contacting a clinician for an antibiotic treatment order. IP #1 said the unit nurses are responsible for filling in the resident name, date on onset, symptoms, culture date and results, if applicable, and if received the Antbx treatment order. Collectively they agreed there is not one person who reviews the surveillance forms for accuracy or quantifies and analyzes the data for the facility to determine potential patterns or discrepancies in the documentation. They said as far as any signs and symptoms (s/s) of an illness that does not rise to the level of an antibiotic treatment, the nurses are not instructed to document that information on the surveillance sheets and that information is just verbally communicated for the most part through shift to shift report. IP #1 said she would look to see if there were other surveillance documents like a respiratory line listing, which would document s/s of an illness that wouldn't be treated with an Antbx but she was unsure if one existed. During an interview on [DATE] at 4:33 P.M., IP #1 said she does not have any surveillance data for respiratory illnesses or any illnesses that did not rise to the level of needing treatment with an Antbx. She said there are no other surveillance sheets or documents the facility uses to track s/s of an illness that does not meet McGeer criteria for monitoring or analyzing illness within the facility. She said whether or not something is documented on the surveillance sheets is left to the opinion of the nurses working the unit on the day they call for an Antbx and there is no one who then goes back to review the information on those sheets or determine if the surveillance information is accurate and documented in the medical record. She said only those residents that end up on an Antbx are placed on surveillance and she can see how the process is supposed to be to intervene in a potential illness prior to it meeting criteria of an infection. She said the management team process is completed on a look back of the previous month and no data analysis occurs to determine the facility's monthly attack rate (a rate of risk or actual infection in the facility in the defined period of time) or most common infection or organism and that information is only recorded and provided by the laboratory consultant quarterly and placed into the facility QAPI program. She said because only the lab maintains reports of attack rates on an ongoing basis she does not know how the facility would be aware of their current attack rate or if their HAI are improving or getting worse on an ongoing daily or month to month basis. Review of the facility Surveillance listing for [DATE] through [DATE] indicated but were not limited to the following: Surveillance sheets include columns for the following information: Name, Room, Category of illness, Date of onset (doo), s/s, Culture (cx) date, site, results, treatment, infection cleared: Yes (y) or No (n), Comment, Final status: HAI/CAI, Count : Yes (y) or No (n). [DATE]: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #15, Category O (other), doo: [DATE], s/s: temp (temperature) and cough, cx date: [DATE], result positive (+), left pleural effusion, treatment: Doxycycline, status: HAI, Count: yes The surveillance failed to indicate what the O for other was referring to and what category the illness met McGeer criteria for to count as an infection. During an interview on [DATE] at 10:51 A.M., IP #2 and Nurse #5 reviewed the [DATE] surveillance data for Resident #15. Both said they are unsure what the O for category was supposed to stand for and there was no documentation to determine the category being used. They said the surveillance data was inaccurate and therefore the illness couldn't rise to the level of an infection as indicated in the count column. [DATE]: Resident #14, Category: UTI (urinary tract infection), doo: [DATE], s/s: blank, cx date: [DATE], results + Betastrep, treatment: Macrobid, status: HAI, Count: y The surveillance document failed to indicate any s/s of illness were present and therefore using McGeer criteria the potential illness could not rise to the level of infection and count in the count column. During an interview on [DATE] at 10:54 A.M., IP #2 reviewed the [DATE] surveillance data for Resident #14. She said the surveillance data for Resident #14 was incomplete and did not document any s/s of illness and therefore the illness could not count as an infection using the facility defined McGeer criteria and the surveillance was also inaccurate. [DATE]: Resident #16, Category: PNU (pneumonia), doo: [DATE], s/s cough, cx date: blank, site: upper respiratory, results: blank, treatment: Levaquin, comment: still short of breath with non-productive cough, status: blank, count: blank Resident #32, Category: Skin, doo: [DATE], s/s: warm and edema, site: right foot second toe, treatment: Doxycycline, status: HAI, count: y The surveillance document was incomplete for Resident #16 and for Resident #32 the surveillance was inaccurate and failed to indicate the McGeer defined s/s for the illness to rise to the level of infection and be counted on the document. During an interview on [DATE] at 10:58 A.M., IP #2 and Nurse #5 reviewed the [DATE] surveillance data and said Resident #16 had an infection from the hospital and they should have completed the surveillance sheet to indicate the illness met criteria and was CAI. They said for Resident #32 the surveillance is inaccurate and the Resident did not meet criteria for a skin infection in accordance with McGeer criteria and should not have been counted. Nurse #5 said she does not review the surveillance documents for completion or accuracy prior to signing them and she writes yes in the count column if the Resident is treated with an antibiotic and was not aware the information on the surveillance should be verified as accurate in accordance with the facility defined McGeer criteria prior to being sent to the lab. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:59 A.M., IP #2 said no one on the team is verifying that the s/s of illness are being documented in the individual residents' medical records to ensure they are meeting McGeer criteria and no one is reviewing the surveillance sheets for accuracy or completion in accordance with the facility defined McGeer criteria once they are initiated by the nurses on the units. She said there is no way to look and identify the facility monthly attack rate to determine if it has improved or worsened over time and the data that is provided to the lab, which has been determined to be inaccurate, is the only analysis the facility has for their infection control surveillance program. She said the process for surveillance is a look back process and there is no documentation on surveillance of any resident with s/s of an illness that needs to be monitored or tracked and treated to prevent a potential future infection and possible outbreak. She said the facility did not understand the importance of tracking potential illnesses that were not being treated with Antbx, but it is evident that in accordance with the facility Infection Prevention plan that those things are supposed to be being completed and are not. She said there is a lot of opportunity for improvement. 2. Review of the facility's policy titled Testing Guidance, undated, indicated but was not limited to the following: - we no longer have to do routine COVID-19 testing, any symptomatic staff or resident will be tested immediately and treated accordingly Review of the Centers for Disease Control and Prevention (CDC), Infection Control Guidance: SARS-CoV-2, dated as revised [DATE], indicated but was not limited to the following: - This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health. - The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency. Perform SARS-CoV-2 Viral Testing - Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible Review of the CDC Symptoms of COVID-19 guidance, dated as revised [DATE], indicated but was not limited to the following: - Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. - Possible symptoms include: cough, congestion or runny nose, headache Resident #28 was admitted to the facility in [DATE] and had diagnoses including: hemiplegia and hemiparesis (condition of partial or complete paralysis on one side) following a cerebral infarct (stroke), and adult failure to thrive. During an interview on [DATE] at 7:11 A.M., the Director of Nurses (DON) said there were two Residents who tested positive for COVID-19 as of this morning (Resident #28 and Resident #30). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the medical record for Resident #28 indicated but was not limited to the following: - an established physician order for: COVID-19 swab as needed ([DATE]) - New order as of [DATE] at 9:24 A.M., received for Guaifenesin (cough medication) 100 milligrams (mg) per 5 milliliters (ml) solution, give 30 ml by mouth every 8 hours as needed (PRN) for cough/congestion - Medication administration record indicated the PRN Guaifenesin was administered on [DATE] at 7:48 P.M. - [DATE] at 10:48 P.M., progress note indicated: Resident congested with non-productive cough and headache temperature 98.1 degrees and oxygen saturation 94% on room air The medical record for Resident #28 failed to indicate a COVID-19 test was performed immediately when signs and symptoms of COVID-19 were identified. Further review of the medical record for Resident #28 indicated the Resident tested positive for COVID-19 on [DATE] in the morning and the medical doctor was notified. During an interview on [DATE] at 11:55 A.M., Nurse #2 said she had worked the day shift on [DATE] and noticed Resident #28 had a new onset of cough and notified the clinician for an order for PRN cough medicine. She said the Resident is not someone who would normally have a cough, but she did not think to test the Resident for COVID-19 when she noticed the new cough in the morning on [DATE]. She said there were COVID-19 tests available in the facility and the protocol at the facility is to test any resident or staff at the first sign or symptom of COVID-19. She said in retrospect she should have tested Resident #28 for COVID-19 on the morning of [DATE] when the cough was first identified. During an interview on [DATE] at 1:28 P.M., Nurse #1 said the process in the facility is to test any staff or resident immediately if they develop any new cold symptoms, a cough, fatigue, temperature, or congestion and then act according to the test results. She said the facility always has COVID-19 rapid tests available in the storage closet. During an interview on [DATE] at 5:13 P.M., IP #1 said the expectation is that staff are testing any resident who exhibits signs or symptoms of COVID-19 immediately in accordance with the guidance. She said this morning ([DATE]) she noticed that the staff had been documenting that Resident #28 had symptoms of COVID-19 as of [DATE] and had not completed a COVID-19 test, as they should have, and she instructed them to do so and the test was positive. During an interview on [DATE] at 7:48 A.M., the DON said Resident #28 developed symptoms of COVID-19 on [DATE] and was not tested until [DATE] and that is not in line with the guidance or facility expectation of testing any resident who develops symptoms of COVID-19 immediately and the process needed to be tightened up. 3a. Review of the CDC Infection Control Guidance: SARS-CoV-2, dated as revised [DATE], indicated but was not limited to the following: Perform SARS-CoV-2 Viral Testing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible - Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. - If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts - Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to patients on the affected units as opposed to the entire facility. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every three to seven days until no new cases are identified for at least 14 days. Review of the OHC COVID-19 Antigen self-test kit insert, dated as revised [DATE], indicated but was not limited to the following: - this product has been authorized only for the detection of proteins from SARS-CoV-2 (COVID 19), not for any other viruses or pathogens - set a timer and read test results at 15 minutes after the four drops from the sample are applied to the sample well of the testing slide - do not read the results after 20 minutes - inadequate or improper specimen collection and handling may yield false negative results, collect specimen and immediately perform test according to instructions - WARNING: inaccurate test interpretations may occur if results are read before 15 minutes or after 20 minutes During an interview on [DATE] at 7:11 A.M., the DON said there were two Residents who tested positive for COVID-19 on the same unit and the facility was testing all the Residents on the first floor and one Resident who could have been potentially exposed on the second floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation with interview on [DATE] at 8:16 A.M., the DON informed the survey team that another resident had tested positive for COVID-19 this morning on the first floor and they are continuing to test all residents who reside on the first floor for COVID-19 daily and one potentially exposed resident on the second floor. She was observed to instruct Nurse #4 to perform OHC COVID-19 tests on all residents on the first floor this shift. They reviewed the testing process together including that full PPE must be worn when testing a resident with suspected COVID-19, including an N-95 mask, gown, eye protection and gloves. They reviewed the process of completing the test by swabbing the resident's bilateral nares (nostrils) five times each, inserting the swab into the development solution and stirring at least 10 times, placing the nozzle cap on the solution vial and placing four drops of solution on the sample well of the test slide and then waiting 15 minutes prior to reading the test for accurate results. Nurse #4 said she understood the process and set up a cart with PPE, COVID-19 tests, a resident roster to document test results, and alcohol based hand sanitizer to complete the tests on the first floor as directed by the DON. On [DATE] at 8:46 A.M., the surveyor observed the following: - Nurse #4 put on all necessary PPE, notified Resident #15 she was going to perform a COVID-19 test and swabbed the Resident's nares and readied the solution to read the test - at 8:55 A.M., Nurse #4 placed four drops of the development solution into the sample well of Resident #15's COVID-19 slide test and told the Resident the test would take 15 minutes - 9:05 A.M., Nurse #4 read and interpreted Resident #15's COVID-19 test results as negative and disposed of the test and all used PPE The surveyor observed that Nurse #4 read and interpreted the COVID-19 test results for Resident #15 as negative and documented that on the resident roster 10 minutes after the development solution was placed in the sample well, not the required 15 minutes as indicated in the testing instructions. During an interview on [DATE] at 9:32 A.M., Nurse #4 said it takes 15 minutes for a COVID-19 test to be read. She said it was approximately 8:45 A.M., when she entered Resident #15's room to start his/her COVID-19 test. She said she did not realize she did not place the development solution into the sample well until 8:55 A.M., and that she misjudged the read time on the COVID-19 test, only waiting 10 minutes, not the required 15 minutes, when reading and interpreting the test results for Resident #15. She said in order for the test to be accurate, she should have waited the full 15 minutes and did not. During an interview on [DATE] at 10:48 A.M., the DON said she personally reviewed the testing process with Nurse #4 prior to her starting to test all the first floor residents. She said Resident #15's COVID-19 test was invalid since it was not read and interpreted at the 15 minute mark in accordance with the testing instructions and Nurse #4 should have waited the full 15 minutes for the test to develop prior to interpreting the results and marking them on the log as negative. On [DATE] at 7:40 A.M., the surveyor observed the following: - Nurse #2 performed a OHC COVID-19 test on Resident #15. She said all residents on the first floor were being tested for COVID-19 today, but Resident #15 was symptomatic and had some nasal congestion. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation with interview on [DATE] at 9:10 A.M., the surveyor observed the Social Worker in the first floor day room speaking with a resident. She was observed to pull her surgical mask down while speaking with the resident exposing her mouth and nose and then replacing it when she was done speaking. The Social Worker said she should not have done that; she should have raised her voice not lowered her mask. She said the mask is supposed to be covering her nose and mouth at all times while in a resident care area. During an interview on [DATE] at 10:58 A.M., Nurse #5 said the facility is using surgical masks as source control and signs have been posted all over the facility to remind staff that surgical masks are to be worn at all times in all resident and nursing areas. She said staff are required to ensure their masks are covering both their nose and mouth at all times. During an interview on [DATE] at 10:59 A.M., the DON said she has informed all staff that they are to wear surgical masks as source control at all times when they are in resident care areas. She said the staff are required to keep both their mouth and nose covered with the masks at all times while they are in a resident area and there are no exceptions. She said the facility is following state, federal and CDC guidelines during their outbreak and Epidemiology informed her that the staff can wear surgical masks as source control and N95 masks are only required when interacting with suspected or confirmed COVID-19 positive residents. During an observation with interview on [DATE] at 3:15 P.M., the surveyor observed Nurse #6 sitting at the first floor nurses' station on the telephone with her surgical mask pulled down and tucked under her chin exposing both her nose and mouth. She said she knows she is supposed to wear the mask, but pulled it down to make it easier to speak on the phone, she adjusted the mask and remained behind the nurses' station. During an observation with interview on [DATE] at 3:26 P.M., the surveyor observed Nurse #6[TRUNCATED]