STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225667	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Cod Post Acute Care	383 South Orleans Road Brewster, MA 02631

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on interview and record review, the facility failed to ensure professional standards of practice were followed for two Residents (#39 and #24), out of a total sample of 23 residents. Specifically, the facility failed to ensure: 1. For Resident #39, a. The diagnosis of schizophrenia added after admission had supporting documentation in the medical record; and b. Eye ointment was administered per physician's orders and the physician was notified timely of the medication being unavailable for administration; and 2. For Resident #24, to follow Pharmacy/MD recommendation to do an Abnormal Involuntary Movement Scale (AIMS) test assessing for tardive dyskinesia (an involuntary neurological movement disorder that is usually a side effect of certain dopamine receptor blocking drugs). Findings include: Review of [NAME], Manual of Nursing Practice 11ed, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. 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. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of the facility's policy titled Schizophrenia Documentation Review, dated July 23, 2024, indicated but was not limited to the following: - Completed signed forms and associated supporting documentation are to be uploaded into PCC (the electronic medical record). -To ensure appropriate assessment and coding of a diagnosis of schizophrenia for residents, the following worksheet must be completed in its entirety and signed by the attending physician. Review of the facility's policy titled Unavailable Medications, dated June 2021, indicated but was not limited to the following: -In conjunction with the contracted pharmacy, the facility will make every effort to ensure that a medication ordered for the resident is available to meet their needs. -Upon receipt of information from pharmacy regarding a medication that is unavailable, nursing staff shall notify the physician of the unavailable medication, explain the circumstance, obtain a new order and discontinue prior order, or obtain a hold order for the unavailable medication. Resident #39 was admitted to the facility in June 2020 with diagnoses which include atrial fibrillation, low back pain, and a chronic foot ulcer. Review of the Minimum Data Set (MDS) assessment, dated 3/1/25, indicated Resident #39 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact, and he/she had a diagnosis of schizophrenia. a. Review of the Diagnosis List in the electronic medical record indicated the diagnosis of Schizophrenia was added to Resident #39's profile on 12/7/22 with an effective date of 6/17/20 and ranked history of diagnosis. Review of the medical record failed to indicate why the diagnosis was added to his/her profile two and a half years after admission. Review of the medical record failed to indicate Resident #39 had this diagnosis on admission and failed to indicate supporting documentation of the diagnosis had been provided to the facility to facilitate adding the diagnosis to his/her profile. Review of the comprehensive care plan failed to indicate a care plan for Schizophrenia had been developed. Further review of the medical record failed to indicate any supporting documentation of the diagnosis from any historical medical provider. During an interview on 5/6/25 at 10:35 A.M., Social Worker #2 said she did not know where the diagnosis came from. During an interview on 5/6/25 at 11:00 A.M., the Administrator said she thought all historical documents had been scanned into the electronic medical record. (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 5/6/25 at 11:20 A.M., Medical Records Staff #1 said there were no documents waiting to be scanned in, everything should be uploaded, and she was unable to locate any supporting documentation related to the diagnosis. During an interview on 5/6/25 at 4:45 P.M., Consulting Staff/Regional MDS Nurse #3 said she was unable to validate the diagnosis, and they were working on it. She said she did not know where it came from and could not find any documentation of where it came from in the medical record. She said the MDS Nurse that added it to the profile is no longer employed at the facility and she was going to remove the diagnosis from the MDS pending confirmation/supporting documentation. During an interview on 5/6/25 at 4:45 P.M., Consulting Staff #1 said they had a care plan meeting today and they asked his/her sister about the diagnosis, and she told them Resident #39 was behavioral as a child but was unsure if the diagnosis was a true diagnosis because lots of things were tossed around. She said they had the sister sign a medical records release to attempt to get prior records from out of state. She said she was unable to obtain historical psych notes from the previous provider to see if they had acknowledged where the diagnosis came from. During an interview on 5/8/25 at 8:37 A.M., the Director of Nurses (DON) said she did not know where the diagnosis came from, and the corporate team was still looking into it. b. Review of the Physician's Orders indicated but were not limited to the following: -Sodium Chloride 5% Ophthalmic Ointment, instill 0.25 inch in right eye at bedtime for eye health (start 10/19/24 end 4/16/25) - Sodium Chloride 5% Ophthalmic Ointment, instill 0.25 inch in right eye at bedtime for eye health (4/16/25) Review of the Medication Administration Record (MAR) indicated but was not limited to the following: -January 2025 the medication was not administered 4 times out of 31 opportunities. -February 2025 the medication was not administered 3 times out of 28 opportunities. -March 2025 the medication was not administered 6 times out of 31 opportunities. -April 2025 the medication was not administered 12 times out of 30 opportunities. Further review of the MAR indicated the code (22) was documented on the MAR indicating Drug/Treatment not administered. Review of the nursing progress notes failed to indicate why the medication was not administered and failed to indicate the physician was notified the medication was not administered. Further review of the physician orders indicated but were not limited to the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sodium Chloride 5% Ophthalmic Ointment, instill 0.25 inch in right eye at bedtime for eye health; Pharmacy Alert dated 11/30/24 indicated the order will not be filled because it has been rejected. Over the Counter (OTC). The alert was cleared by staff on 2/20/25. - Sodium Chloride 5% Ophthalmic Ointment, instill 0.25 inch in right eye at bedtime for eye health; Pharmacy Alert, dated 4/16/25, indicated the order will not be filled because it has been rejected. This item is ordered through Central Supply NOT FROM THE PHARMACY. The alert was cleared by staff on 4/16/25 and the order was rewritten. During an interview on 5/6/25 at 9:52 A.M., Unit Manager #2 said they have some difficulty getting this medication from the new pharmacy. She said they were arguing that it was OTC/house stock, but the old pharmacy used to supply it. She said they don't usually have trouble getting meds delivered and sometimes they just need to rewrite the order and then they send it. She said if it was not available and not administered the nurses should have checked the emergency supply, notified the physician to put it on hold or get a new order, and it should have been documented in a nurse's note. She said it should not continue for days being unavailable/not administered without notifying the physician to see what they want to do. During an interview on 5/6/25 at 10:00 A.M, Nurse #6 said she noticed it was not available when working the evening shift. She said the pharmacy was arguing with her that it was OTC, but the previous pharmacy used to deliver it, so she didn't know what the issue was. She said there were a lot of agency and travel nurses working that shift, and she was not sure how long it had been unavailable before they got it discontinued last week. During an interview on 5/8/25 at 8:05 A.M., Central Supply Staff #1 said she did not stock that item as routine house stock and did not recall ever being asked to order it for a specific resident. She said anything that is not on the routine stock list she needs to get approval for, or it comes from the pharmacy. During an interview on 5/8/25 at 8:37 A.M., the DON said if a medication is unavailable the nurse should be notifying the physician to put it on hold until it is available, obtain a new order for something else, or discontinue the medication. She said if something is OTC and it is not in the medication room; the nurse should be checking with Central Supply to order it. Additionally, she said if the pharmacy sends an alert, they will not fill it because it is OTC, the nurses should not be clearing the alert without reaching out to Central Supply to obtain the medication. 46862 2. Review of the facility's policy titled Abnormal Involuntary Movement Scale (AIMS), undated, indicated, but was not limited to: 1. The Abnormal Involuntary Movement Scale (AIMS) is a standardized evaluation. 2. Conduct the AIMS examination procedure as ordered by the physician or as per state guidance. 3. The AIMS should be conducted by a licensed nurse, physician or other licensed practitioner. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The results of the AIMS should be used in conjunction with clinical data ant the primary physician to guide treatment decisions. Review of Cureus. 2023 May 25;15(5):e39486. doi: 10.7759/cureus.39486 titled Increasing Abnormal Involuntary Movement Scale (AIMS) Screening for Tardive Dyskinesia in an Outpatient Psychiatry Clinic: A Resident-Led Outpatient Lean Six Sigma Initiative indicated the AIMS is used not only to detect tardive dyskinesia (TD) but also to follow the severity of a patient's TD over time [3]. It is a valuable tool for clinicians who are monitoring the effects of long-term treatment with neuroleptic medications and for researchers studying the effects of these drugs. The AIMS is administered every three to six months to monitor the patient for the development of TD. For most patients, TD develops three months after the initiation of neuroleptic therapy. In elderly patients, however, TD can develop after as little as one month. https://pmc.ncbi.nlm.nih.gov/articles/PMC1029217 Resident #24 was admitted to the facility in September 2024 with diagnoses which included atrial fibrillation, depression, and dementia with behavioral disturbance. Review of the MDS assessment, dated 3/26/25, indicated Resident #24 had moderate cognitive impairment as evidenced by a BIMS score of 13 out of 15. The MDS also indicated Resident #24 was receiving antipsychotic medication. Review of the Physician's Orders indicated the following: -Seroquel oral tablet 25 milligram (mg) (Quetiapine Fumarate), give 2 tablets by mouth at bedtime, dated 1/2/2025 -Seroquel oral tablet 12.5 mg (Quetiapine Fumarate), give 2 times by mouth a day, dated 9/25/2024 and discontinued 11/8/24 Review of the MAR for September 2024 through May 2025 indicated Resident #24 received Seroquel as ordered by the Physician. Review of the Consultant Pharmacist Recommendations to Prescriber dated 11/8/2024 indicated: -Resident is receiving the following antipsychotic medication: Seroquel -AIMS assessment is required every 6 months. -Physician response agree assess AIMS. Further review of the medical record did not indicate the AIMS had been completed. During an interview on 05/06/25 at 9:00 A.M., Nurse #1 said the DON receives the pharmacy recommendations. Nurse #1 said the DON will give them to the Unit Managers (UM) or Nurse on the unit when we don't have a UM. Nurse #1 said she could not see that an AIMS had been completed per the pharmacy recommendation. (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 05/08/25 at 12:46 P.M., the DON said she receives the pharmacy recommendations. The DON said she and/or the UM would give the recommendations to the physician to review and sign. The DON said if recommendations are agreed by the physician, she or the UM would make the order changes. The pharmacy recommendation would be signed by the DON or UM and dated to signify the change was completed. The recommendation would then be given to the medical records staff to scan into the computer. The DON and surveyor reviewed the pharmacy consultant recommendation dated 11/8/24. The DON said the recommendation was not carried out as agreed upon by the physician. The AIMS was not done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49425 Based on observation, interview, and record review, the facility failed to ensure quality of care based on professional standards of practice for one Resident (#20), out of a sample of 23 residents. Specifically, the facility failed to ensure staff fully assessed Resident #20 who was observed to be in respiratory distress, resulting in a delay in treatment. Findings include: Review of the facility's policy titled Change in a Resident's Condition or Status, dated as last revised February 2021, indicated but was not limited to the following: -Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. -The nurse will notify the resident's attending physician when there has been: a significant change in the resident's physical/emotional/mental condition. -The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility's policy titled Resident Examination and Assessment, dated as last revised February 2014, indicated but was not limited to the following: -The purpose of this procedure is to examine and assess the resident for any abnormalities in health status. -Respiratory: Lung sounds (upper and lower lobes) for wheezing, rales, rhonchi, or crackles, irregular or labored respirations -Documentation: All assessment data obtained during the procedure; How the resident tolerated the procedure; and If the resident refused, the reason(s) why and the intervention taken. - Reporting: Notify the physician of any abnormalities such as labored breathing, change in cognitive status. Review of the facility's policy titled Hospice Program, dated as revised July 2017, indicated, but was not limited to the following: -The responsibility of the facility to meet the resident's nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include notifying the hospice about the following: -A significant change in the resident's physical, mental, social, or emotional status; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Clinical complications that suggest a need to alter the plan of care; and -Communicating with the hospice provider and documenting such communication to ensure the needs of the residents are addressed and met. Resident #20 was admitted to the facility in December 2024 with diagnoses including Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) (a progressive lung disease that causes persistent airflow obstruction characterized by respiratory symptoms), and respiratory failure. Review of the Minimum Data Set (MDS) assessment, dated 3/21/25, indicated Resident #20 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Review of the medical record indicated Resident #20 was placed on hospice services in May 2025 for a diagnosis of COPD, after a recent re-hospitalization for shortness of breath. Review of the comprehensive care plans for Resident #20 included: Focus: I have altered respiratory status related to CHF Goal: I will be free from signs or symptoms of respiratory infection by the review date Interventions: -Administer medications as ordered, monitor effectiveness and for side effects, report abnormal findings to practitioner, document findings and interventions. -Administer oxygen as ordered -Administer respiratory treatments and inhalants as ordered, monitor effectiveness and for side effects, report abnormal findings to practitioner, document findings and interventions. -Apply continuous positive airway pressure (CPAP) (non-invasive ventilation that uses a steady stream of pressurized air into the airways, through a mask that fits over the nose or nose and mouth). Focus: I am oxygen dependent related to COPD, chronic respiratory failure and CHF. CPAP at bedside. Goal: I will remain free of symptoms and complications of low oxygen levels, such as shortness of breath, dizziness, tachycardia (increased heart rate), headache through review date. Interventions: -Duo nebs (combination of medications that relax muscles in airways and increase air flow to the lungs) as ordered -Dependent on oxygen at 1-2 liters per minute continuously via nasal cannula (NC) -Monitor and document breath sounds, breathing patterns, and dyspnea (shortness of breath). Report abnormal findings to physician or designee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor vital signs, including pulse oximeter, as ordered and clinically indicated. On 5/7/25 at 9:18 A.M., the surveyor observed Certified Nursing Assistant (CNA) #3 approach Nurse #3 and tell him Resident #20 wanted his/her CPAP mask put on. At this time, another resident approached Nurse #3 and said Resident #20 does not feel well, and requested Nurse #3 check on him/her. Nurse #3 and the surveyor entered Resident #20's room. The surveyor observed Resident #20 sitting on the edge of the bed holding a CPAP mask in his/her hands. The CPAP machine was on, and the surveyor could hear the pressurized air coming out of the mask. Resident #20 was wearing a NC delivering oxygen at 3 liters per minute. The Resident's skin color appeared bluish/gray and breathing appeared labored, he/she was taking very quick short breaths and making grunting sounds. Nurse #3 approached the Resident and asked what they needed. Resident #20 was unable to speak and responded with a mumble. Nurse #3 exited the room and told the surveyor he was going to notify the Director of Nursing (DON) about the Resident's distress. The surveyor observed Nurse #3 return to the medication cart and start preparing medications. On 5/7/25 at 9:20 A.M., the surveyor observed Nurse #3 enter a different resident's room with medications. Nurse #3 did not return to Resident #20's room. On 5/7/25 at 9:24 A.M., the surveyor was approaching the nursing station to alert Unit Manager #3 to check on Resident #20 when the surveyor observed Hospice Nurse #1 enter Resident #20's room. On 5/7/25 at 9:28 A.M., the surveyor observed Nurse #3 speaking with a co-worker, next to his medication cart, having a casual conversation. The surveyor walked past Nurse #3 and entered Resident #20's room. Hospice Nurse #1 said Resident #20 is struggling to breathe and asked the surveyor if the nurse checked the oxygen saturation and the last time the Resident had been medicated to make him/her comfortable. At this time, Nurse #3 entered the room, holding a pair of surgical gloves in his hand. Nurse #3 said he was just about to put on Resident #20's CPAP mask. Nurse #3 then applied Resident #20's CPAP mask without difficulty. The surveyor exited the room and remained in the hallway outside of the room to allow nursing staff to provide care. On 5/7/25 at 9:38 A.M., the surveyor overheard from the doorway to Resident #20's room, Hospice Nurse #1 request Nurse #3 to increase the liter flow of oxygen because the Resident's oxygen saturation was 85%. She also asked Nurse #3 when the Resident had his/her Morphine (a medication used to manage pain and shortness of breath in terminally ill patients) administered to improve his/her shortness of breath. Nurse #3 responded that the Resident was medicated with Morphine at 6:00 A.M, prior to his shift. Hospice Nurse #1 said she was going to recommend a medication for anxiety, and a medication to reduce secretions to help improve the Resident's comfort level. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 9:47 A.M., Nurse #3 said when a resident appears to be in distress, he completes a nursing assessment. He said he takes their oxygen saturation, respiratory rates and blood pressure. He said when he entered Resident #20's room this morning and asked him/her what he/she needed, he was unable to understand him/her, so he notified the DON. He said he counted his/her respirations in his head, and they were 16 which is normal. He said the DON was going to come assist Resident #20, so he continued to complete his medication pass. Nurse #3 said he could have done more to help the Resident and not taking a complete set of vital signs with the oxygen level is not his normal practice. He said having a surveyor with him made him nervous. Nurse #3 said he just offered the Resident Morphine to assist his breathing, however the Resident refused. He said he just increased the Resident's oxygen flow to five liters, put on the CPAP mask, and his/her breathing has improved. He said hospice is aware of the change of condition because they are here now. Review of a Hospice Nurse #1's progress note, dated 5/7/25, time blank, indicated Resident #20 had significant dyspnea (shortness of breath), lung sounds severely diminished with crackles throughout. Vital signs 93% on 3 liters of oxygen, respirations 18, Blood pressure 131/84, heart rate 75. New recommendations for Hyoscine 0.125 milligrams (mg) (used to reduce saliva) every four hours as needed for secretions, and Lorazepam 0.5-1mg (used to treat anxiety) every four hours as needed for anxiety. Physician was made aware of recommendations and is in agreement. Review of the nursing progress note, dated 5/7/25 at 10:11 A.M., written by Nurse #3, indicated Resident #20 was asked if he/she wanted Morphine for shortness of breath, and declined. The progress note failed to include any respiratory assessment. Review of the nursing progress note, dated 5/7/25 at 1:05 P.M., indicated at approximately 9:15 A.M., Resident #20 wanted to apply his/her own CPAP, and respirations were noted to be 16, and Resident #20 was agitated, and not in distress. The progress note failed to include documentation if the CPAP was in place, any further respiratory assessment or intervention taken for the documented agitation. During an interview on 5/7/25 at 11:35 A.M. with the DON, Consulting Staff #1 and Consulting Staff #2, the DON said she expects nurses to complete a full head to toe assessment of a resident when there is a suspected change of condition. She said the assessment must include a complete set of vital signs, including oxygen saturation, lung sounds, pain level and review of the resident's medication list. The surveyor reviewed her observations with the DON and Consulting staff #1 and #2, and the DON said the nurse must ensure the resident is stable, prior to resuming their medication pass. The DON said she feels the Resident becomes overwhelmed when there are too many people in the room. Consulting staff #2 said Nurse #3 did not follow the proper procedure.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 48084 Based on record review and interview, the facility failed for one Resident (#89), with a history of trauma, out of a total sample of 23 residents, to assess the history of trauma and failed to develop a plan of care accounting for the Resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization. Findings include: Review of the facility's policy titled Trauma Informed Care and Culturally Competent Care, dated as last revised August 2022, indicated but was not limited to the following: -To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. -Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. -Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care and delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporated knowledge about the trauma into care plans, policies, procedures, and practices to avoid re-traumatization. -Trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. -Triggers are highly individualized. Common triggers may include lack of privacy, confinement in a crowd or small space, loud noises, bright/flashing lights, certain sights, objects, sounds, smells, or physical touch. -Evaluate the need for trauma-informed care as part of the facility assessment. -Perform universal screening of residents. -Screening may include trauma history, including type, severity, and duration. -Utilize initial screening to help identify the need for further assessment and care. -Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identified triggers. -Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Identify and decrease exposure to triggers that may re-traumatize the resident. Resident #89 was admitted to the facility in September 2024 with diagnoses which include Post-Traumatic Stress Disorder (PTSD), insomnia, REM Sleep behavior disorder, depression, Psychotic disorder, and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 3/20/25, indicated Resident #89 scored 7 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment, and he/she had PTSD. Review of the medical record including Assessments and Evaluations failed to indicate a Trauma Assessment to identify potential triggers had been completed on admission. Review of the comprehensive care plan indicated but was not limited to the following: FOCUS: I have a history of PTSD related to surviving a traumatic event (1/9/25) GOAL: I will be able to identify the triggers that cause me to experience anxiety, trauma, and flashbacks, and learn coping mechanisms to mitigate their impact on my well-being. INTERVENTIONS: -Accept my current level of function. Be consistent, positive, honest, and non-judgmental while working with me. -Assist me with identifying coping/calming mechanisms to manage anxiety or correct misunderstandings conditioned at the time of trauma/stress, such as relaxation techniques, deep breathing, visualization, and removing myself from the situation. -Avoid situations that may cause flashbacks. Ask me about my triggers and incorporate them into my plan of care. -Consult psychiatry/psychology as needed. -Monitor and document resident feelings, such as insecurities, anxiety, anger mistrust emotional detachment, unwanted/intrusive thoughts, insomnia, etc. Report observations to physician or designee as clinically indicated. -Provide spiritual/religious support as needed. The comprehensive care plan failed to identify potential triggers related to the diagnosis of PTSD. During an interview on 5/6/25 at 9:52 A.M., Unit Manager #2 said the Social Workers do the trauma assessment and update the care plans. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 8:20 A.M., Social Worker #2 said every resident should have a trauma evaluation regardless of the diagnosis of PTSD and a resident with the diagnosis should not only have one done on admission, but it should also be re-addressed quarterly. She said Resident #89 did not have one done on admission and he/she should have. Additionally, she said there is a separate Trauma Evaluation, and one built into the Social Worker Evaluation, but neither were done in this case. She said he/she was on a different unit at the time of admission, but it still should have been done and was unsure why it was not. She said the subsequent quarterly evaluations she did also did not address the PTSD/trauma. She said Resident #89 has dementia and is unreliable. She said in this situation the questions should have been deferred to the Health Care Proxy (HCP), but she did not address it with the HCP and should have. During an interview on 5/8/25 at 8:37 A.M., the Director of Nurses said every resident should have a trauma evaluation and those with PTSD should have potential triggers on the care plan. She said the Social Worker does them and was unsure why this one had not been completed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49425 Based on observation, interview, and document review, the facility failed to ensure staff stored drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. Ensure open drinks were not stored in the medication freezer, in one of two medication rooms observed; and 2. Ensure medications are not left unsecured and unattended in the Resident room and on top of the medication cart, during a medication pass. Findings include: Review of the facility's policy titled Administering Medications, dated as revised April 2019, indicated but was not limited to the following: -Medications are administered in a safe and timely manner, and as prescribed. -The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. -During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. -No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications. Review of the facility's policy titled Medication Labeling and Storage, dated as last revised February 2023, indicated but was not limited to the following: -Compartments containing medications are locked when not in use, and carts used to transport such items are not left unattended if open or otherwise potentially available to others. -Medications are stored separately from food. -Multi-dose vials that have been opened are dated and discarded within 28 days unless manufacturer specifies a shorter or longer date for the open vial. -If the facility has discontinued, outdated medications the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 1. On 5/5/25 at 1:48 P.M., the surveyor observed the medication storage room on the North 1 Unit with Nurse #3, and made the following observations: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Inside the medication freezer was an extra-large plastic cup with blue slush drink labeled Coolata, opened, with a straw placed inside. During an interview on 5/5/25 at 1:49 P.M., Nurse #3 said food and drinks are not supposed to be stored in the medication refrigerator or freezer. He said someone must have placed it inside the freezer for him. Nurse #3 said the drink belongs to him and it should have been stored in the employee break room. 2. On 5/6/25 at 9:33 A.M., the surveyor observed Nurse #4 prepare Resident #24's 8:00 A.M. medications which included the following: -Aspirin 81 milligrams (mg) -Breyna Inhaler (used to treat asthma) -Diltiazem 60 mg (used for high blood pressure) -Fluoxetine 20 mg (used for depression) -Metoprolol 25 mg (used for high blood pressure) -Spironolactone 25 mg (used to treat heart failure) -Toresimide 20 mg (used to treat fluid overload) -Plavix 75 mg (used to prevent blood clots) -Praxdia 150 mg (used to prevent blood clots) -Voltaren ointment (used to treat pain) Nurse #4 popped six pills into one plastic medication cup and the two blood pressure medications into another plastic medication cup. She took the tube of Voltaren ointment and Breyna inhaler and placed them on top of the medication cart. Nurse #4 took the two plastic medication cups and entered Resident #24's room, leaving the ointment and inhaler on top of the medication cart, within her view. She placed the two medication cups down on the Resident's overbed table and attempted to take the Resident's blood pressure. Nurse #4 said she needed to get a larger blood pressure cuff and exited the room. The two medication cups remained on the Resident's overbed table, unsecured and unattended. At 9:42 A.M., Nurse #4 locked the medication cart and proceeded down the hallway to obtain a larger blood pressure cuff. The two medications remained on top of the medication cart, unsecured and unattended. At 9:47 A.M., Nurse #4 returned to the medication cart, took the inhaler from the top of the cart, leaving the Voltaren ointment on top of the cart and entered the Resident's room. Nurse #4 took Resident #24's blood pressure, administered both plastic cups of medications and the inhaler to Resident #24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/25 at 9:54 A.M., Nurse #5 said she should not have left the medications at the bedside or on top of the cart, it is not safe. She said she was focused on getting a larger blood pressure cuff, and did not remember to secure the medications. During an interview on 5/7/25 at 12:10 P.M., the Director of Nursing (DON) said no food or drink should ever be stored in the medication refrigerator or freezer for risk of cross contamination of the medications. The DON said medication should never be left unsecured at the resident's bedside, or on top of a medication cart. The DON said all medications must be secured when unattended.

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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. 48695 Based on observation 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 ensure food was properly stored in the walk-in refrigerator in the main kitchen. Findings include: Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised January 2023, indicated but was not limited to: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. Review of the facility's policy titled Food Receiving and Storage, undated, indicated but was not limited to: - Critical Control Point means a specific point, procedure, or step in food preparation and serving process at which control can be exercised to reduce, eliminate, or prevent the possibility of a food safety hazard. Some operational steps that are critical to prevent or eliminate food safety hazards are thawing, cooking, cooling, holding, reheating of foods, and employee hygienic practices. - Foods shall be received and stored in a manner that complies with safe food handling practices. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). - Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. On 5/4/25 at 7:49 A.M., the surveyor observed in the main kitchen walk-in refrigerator: - One pouch of whipped cream, undated, tip uncovered and exposed and resting on refrigerator shelf; - One plastic food storage container containing coleslaw covered with plastic wrap, dated 5/2/25 use by manufacturers date, not stored in manufacturer's container and no manufacturer's date listed; - One metal container of chopped spinach covered with plastic wrap, prepped on 4/29/25 use by 5/2/25, large amount of condensation on the plastic wrap and spinach with brown discoloration; - One plastic container labeled turkey sandwich, prepped on 5/1/25 use by 5/3/25; - Two containers of soup, prepped on 5/1/25 use by 5/3/25; - One plastic food storage container containing a roasted red pepper, dated 5/2/25 use by manufacturer's date, not stored in manufacturer's container and no manufacturer's date listed; - One container of chopped lettuce, prepped on 4/29/25 use by 5/1/25, with reddish brown discoloration; - One container of sliced tomatoes, prepped on 4/29/25 use by 5/1/25, soggy and limp; - One open bag of cilantro, with brown and white discoloration, dried out; - Three bags of shredded carrots, best by 4/27/25, soggy with brown discoloration; - One box of frozen meat, undated, opened and meat exposed; - One metal bowl of shredded lettuce, undated; - One bag of defrosted cinnamon rolls, dated pulled on 4/26/25 use by 4/27/25; - One box of bacon, undated, opened and bacon exposed; - One box of frozen sausage, undated, sausage open and exposed; On 5/4/25 at 12:39 P.M., the surveyor observed in the main kitchen walk-in refrigerator: - One plastic container labeled turkey sandwich, prepped on 5/1/25 use by 5/3/25; - One metal container of chopped spinach covered with plastic wrap, prepped on 4/29/25 use by 5/2/25, large amount of condensation on the plastic wrap and spinach with brown discoloration; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One open bag of cilantro, with brown and white discoloration, dried out; - One container of sliced tomatoes, prepped on 4/29/25 use by 5/1/25, soggy and limp; - One pouch of whipped cream, undated, uncovered and exposed resting on another pouch of whipped cream in a box; - Two containers soup, prepped on 5/1/25 use by 5/3/25; - Three bags of shredded carrots, best by 4/27/25, soggy with brown discoloration; On 5/5/25 at 12:40 P.M., the Food Service Manager (FSM) and the surveyor observed in the main kitchen walk-in refrigerator: - Three bags of shredded carrots, best by 4/27/25, soggy with brown discoloration; - One open bag of cilantro, with brown and white discoloration, dried out; - One box of frozen sausage, undated, sausage open and exposed; - One pouch of whipped cream, undated, tip exposed and resting on another pouch of whipped cream in a box; During an interview on 5/5/25 at 12:45 P.M. the FSM said prepared foods should be stored in the manufacturers' containers and labeled with an open date. The FSM said the nozzle on the pouch of whipped cream should not have been exposed and should have been covered to prevent contamination and dated with an open date. The FSM said all foods in the walk-in refrigerator must be rotated and either used by or discarded by the expiration date or use by date. The FSM said frozen foods should be defrosted and used by the use by date and meats should not be exposed to the elements but kept covered to prevent cross contamination.

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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. 48084 Based on observations, record review, and interviews, 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 ensure contact tracing and outbreak testing were completed on two occurrences in February 2025. Findings include: Review of the facility's policy titled Infection Prevention and Control Program, dated December 2023, indicated but was not limited to the following: -Outbreak Management is a process that consists of determining the presence of an outbreak, managing affected residents, preventing the spread, and documenting information about the outbreak. Review of the facility's policy titled Contact Tracing-Residents, dated July 2023, indicated but was not limited to the following: -Contact tracing is a method of identifying those who may have been exposed to COVID-19, to help track and prevent the transmission of COVID-19. -Close contact (exposure) is defined by the Centers for Disease Control (CDC) as being within 6 feet of an infected person for a cumulative total of 15 minutes over a 24-hour period. -Identify the infectious period (2 days prior to the onset of symptoms, if symptomatic). -For each day of the infectious period, identify all locations the resident visited. -For each location, make notes about each person that could have been in contact with the resident. -Identify contacts at each location for each day. -A person in close contact with the case-patient during the symptomatic period would be considered exposed. -Notify all exposed persons and the required monitoring and quarantine restrictions. Review of the facility's policy titled COVID-19 Testing Requirements-MA, dated as last revised May 11, 2023, indicated but was not limited to the following: Outbreak testing: -If a new case of COVID-19 is identified the facility will test exposed residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case unless a Department of Public Health epidemiologist directs otherwise. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Testing should take place as soon as possible. If the facility identifies that the resident or staff members first exposure occurred less than 24 hours ago, then they should wait to test until 24 hours after exposure. Review of the Infection Surveillance Monthly Report for February 2025 indicated Resident #307 tested positive for COVID-19 on 2/15/25 and Resident #1 tested positive for COVID-19 on 2/17/25. a. Resident #307 was admitted to the facility in January 2024 with diagnoses which include chronic obstructive pulmonary disease (COPD), Parkinson's disease, respiratory failure, heart failure, and dementia. Review of the Minimum Data Set (MDS) assessment, dated 3/5/25, indicated Resident #307 scored 1 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had severe cognitive impairment. Review of the medical record including progress notes indicated he/she was symptomatic and had tested positive for COVID-19. b. Resident #1 was admitted to the facility in January 2023 with diagnoses which include cognitive impairment, malnutrition, and history of COVID-19. Review of the MDS assessment, dated 3/25/25, indicated Resident #1 scored 6 out of 15 on the BIMS, indicating he/she had severe cognitive impairment. Review of the medical record including progress notes indicated he/she was symptomatic and had tested positive for COVID-19. The surveyor requested contact tracing and outbreak testing for the two cases. The facility failed to provide the surveyor with a list of who had been exposed to Resident #307 or Resident #1 and when they were tested . Review of the COVID Testing Log in the Testing Room indicated six staff COVID-19 tests had been logged for the month of February. The six tests that were logged were done between 2/20/25 and 2/28/25. The surveyor reviewed the COVID Testing Log with the Director of Nurses (DON)/Infection Preventionist (IP), Consulting Staff #2, and Consulting Staff #1. They were unable to identify if the staff members that tested had been exposed to either of the residents or if they were testing as a precaution. During an interview on 5/8/25 at 11:25 A.M., the DON/IP and Consulting Staff #2 said they use contact tracing for positive COVID-19 cases. They said outbreak testing for everyone exposed would be done every 48 hours until they go seven days without a new case. They were unable to provide the surveyor with contact tracing and outbreak testing information for these two cases. They said the previous IP should have ensured everyone exposed was tested every 48 hours, but the log was incomplete, and they were unable to provide the surveyor with any other testing log or documentation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/25 at 2:06 P.M., Consulting Staff #1 said they use contact tracing and those exposed would test every 48 hours. She said unless they did not work, she would expect to see a test logged every day they worked or at least every 48 hours starting when the positive case was identified. She said she was unable to locate any contact tracing or outbreak testing information for either case.

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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** 48084 Based on record review and interview, the facility failed to provide education, assess for eligibility, offer and administer Pneumococcal vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations for four Residents (#19, #60, #61, #78), out of a total sample of five residents reviewed for immunizations. Findings include: Review of the facility's policy titled Vaccination of Residents, dated as last revised October 2019, indicated but was not limited to the following: -All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated. -Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. (See current vaccine information statements at Centers for Disease Control and Prevention (CDC) website for educational materials.) Review of the facility's policy titled Pneumococcal Vaccine, dated as last revised October 2023, indicated but was not limited to the following: -All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. -Administration of pneumococcal vaccines are made in accordance with current CDC recommendations. Review of the CDC guidance Pneumococcal Vaccine Timing for Adults, dated 10/2024, indicated but was not limited to the following: For Adults [AGE] years old or older, vaccine recommendations are as follows: -Unvaccinated adults should receive: a) PCV20 (Prevnar 20, a pneumococcal conjugate vaccine) or PCV21 vaccine (Capvaxive, a pneumococcal conjugate vaccine) or b) PCV15 followed by PPSV23 at least one year later -Adults who have received PPSV23 vaccine only (at any age): a) PCV20 or PCV21 vaccine administered at least one year after PPSV23 was received -Adults who have received PCV13 vaccine at any age: a) PCV20 or PCV21 vaccine administered at least one year after PCV13 was received (continued on next page)

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	225667	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Cod Post Acute Care	383 South Orleans Road Brewster, MA 02631

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Adults who have received PCV13 at any age and PPSV23 when younger than age 65: a) PCV20 or PCV21 at least 5 years after PCV13 or PPSV20 vaccine was received a. Resident #19 was admitted to the facility in December 2023 with diagnoses which included respiratory failure, diabetes, hypertension, and cerebral infarct (stroke). Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #19 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate cognitive impairment. Review of the medical record indicated he/she had consented to receive the Pneumococcal vaccine on 1/8/24. Review of the electronic Immunization Record indicated he/she had consented on admission and refused the Pneumococcal (PCV13) vaccine on 4/22/24. Based on CDC guidance he/she would be eligible to receive the current pneumococcal vaccine (PCV20 or PCV21). Further review of the medical record failed to indicate the facility had reapproached the Resident and offered the current Pneumococcal vaccine (PCV20 or PCV21). b. Resident #60 was admitted to the facility in March 2023 with diagnoses which included hypertension, COVID-19, and Atrial Fibrillation. Review of the MDS assessment, dated 4/22/25, indicated Resident #60 scored 15 out of 15 on the BIMS, indicating he/she was cognitively intact. Review of the electronic Immunization Record failed to indicate he/she had been offered, accepted, or refused the pneumococcal vaccine. c. Resident #61 was admitted to the facility in May 2021 with diagnoses which included diabetes, pneumonia, and respiratory failure. Review of the MDS assessment, dated 3/15/25, indicated Resident #61 scored 5 out of 15 on the BIMS, indicating he/she had severe cognitive impairment. Review of the electronic Immunization Record indicated that he/she had refused the Pneumococcal (PPSV23) vaccine. Based on CDC guidance he/she would be eligible to receive the current pneumococcal vaccine (PCV20 or PCV21). Further review of the medical record failed to indicate the facility had reapproached the Resident/Resident Representative and offered the current Pneumococcal vaccine (PCV20 or PCV21). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Resident #78 was admitted to the facility in June 2022 with diagnoses which included hypertension, emphysema, and malnutrition. Review of the MDS assessment, dated 4/19/25, indicated Resident #78 scored 3 out of 15 on the BIMS, indicating he/she had severe cognitive impairment. Review of the Consent for Immunizations, dated 6/22/22, indicated he/she had already received a pneumococcal vaccine. The form failed to indicate which vaccine he/she had previously received and when. Based on CDC guidance he/she would be eligible to receive the current pneumococcal vaccine (PCV20 or PCV21). Review of the electronic Immunization Record failed to indicate the Resident/Resident Representative had been offered, accepted, or refused the current pneumococcal vaccine (PCV20 or PCV21). During an interview on 5/6/25 at 9:31 A.M., Nurse #5 said everything was scanned into the electronic medical record and there were no paper charts. She said she did not know who coordinated the consents and administration of vaccines. During an interview on 5/6/25 at 9:52 A.M., Unit Manager #2 said all consents and administration records should be in the electronic medical record. She said she thought everything had been administered for the year but was unsure who oversaw it now because the Infection Preventionist (IP) Nurse had left. During an interview on 5/6/25 at 4:39 P.M, Consulting Staff #2 said she was working with the Director of Nurses in assuming the IP role. She said they have been doing it together because the previous IP had left abruptly. She said she was unable to locate any additional consents or administration records but was going to continue to look. During an interview on 5/7/25 at 11:00 A.M., Consulting Staff #2 said they recently started to offer the current pneumococcal vaccine (PCV20) but was unsure if it had been offered to the other residents because she was unable to locate any additional consents or administration records.

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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** 48084 Based on record review and interview, the facility failed to provide education, assess for eligibility, offer and administer COVID-19 vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations for five Residents (#54, #19, #60, #61, #78), out of a total sample of five residents reviewed for immunizations. Findings include: Review of the facility's policy titled Vaccination of Residents, dated as last revised October 2019, indicated but was not limited to the following: -All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated. -Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. (See current vaccine information statements at Centers for Disease Control and Prevention (CDC) website for educational materials.) Review of the facility's policy titled COVID-19 Vaccinations, dated as last revised March 20,2024, indicated but was not limited to the following: -Residents who meet eligibility criteria will be offered the COVID-19 vaccine. -Each resident who has not already been immunized and does not have medical contraindication will be offered the vaccine dose(s) for which they are eligible as recommended by the CDC. -When COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member will be provided with current information regarding those additional doses, including any change in the benefits to risks and potential side effects associated with the COVID-19 vaccine. -The facility will document in the medical record education provided, including the date the education took place, that the resident (or representative) either accepted and received or did not receive the vaccine. Review of CDC guidance titled Stay Up to Date with COVID-19 Vaccines, revised 1/7/25, indicated but was not limited to the following: -Everyone ages 6 months and older should get the 2024-2025 COVID-19 vaccine. This includes people who have received a COVID-19 vaccine, people who have had COVID-19, and people with long COVID. -People ages [AGE] years and older: (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	You are up to date when you have received: 2 doses of any 2024-2025 COVID-19 vaccine 6 months apart. a. Resident #54 was admitted to the facility in April 2025 with diagnoses which include malnutrition, heart failure, kidney disease, diabetes, and respiratory failure. Review of the Minimum Data Set (MDS) assessment, dated 4/4/25, indicated Resident #54 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Review of the COVID-19 Consent form indicated refused-already had. The form was signed and undated. The form failed to indicate what COVID-19 vaccine he/she previously had, when it was administered, if he/she was to up to date, or if he/she should be offered the current vaccine. Review of the electronic Immunization Record failed to indicate any vaccination records had been documented (the record was blank). b. Resident #19 was admitted to the facility in December 2023 with diagnoses which include respiratory failure, diabetes, hypertension, and cerebral infarct (stroke). Review of the MDS assessment, dated 3/26/25, indicated Resident #19 scored 11 out of 15 on the BIMS, indicating he/she had moderate cognitive impairment. Review of the medical record failed to indicate the facility offered the current (2024-2025) COVID-19 vaccine to the Resident. Review of the electronic Immunization Record indicated he/she had received the 2023-2024 COVID-19 vaccination but failed to indicate he/was offered and accepted or declined the current vaccine. c. Resident #60 was admitted to the facility in March 2023 with diagnoses which include hypertension, COVID-19, and atrial fibrillation. Review of the MDS assessment, dated 4/22/25, indicated Resident #60 scored 15 out of 15 on the BIMS, indicating he/she was cognitively intact. Review of the medical record indicated the facility offered the current (2024-2025) COVID-19 vaccine to the Resident and he/she wished to accept the vaccination. The form was signed and dated 12/19/24. The Internal Use only section for documentation of the administration was left blank. Review of the electronic Immunization Record indicated he/she had received the 2023-2024 COVID-19 vaccination but failed to indicate he/she had received the current vaccination as requested. d. Resident #61 was admitted to the facility in May 2021 with diagnoses which include diabetes, pneumonia, and respiratory failure. Review of the MDS assessment, dated 3/15/25, indicated Resident #61 scored 5 out of 15 on the BIMS, indicating he/she had severe cognitive impairment. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated the facility offered the current (2024-2025) COVID-19 vaccine to the resident/resident representative and they wished to accept the vaccination. The form was signed and dated 12/10/24. The Internal Use only section for documentation of the administration was left blank. Review of the electronic Immunization Record indicated he/she had received the 2023-2024 COVID-19 vaccination but failed to indicate he/she had received the current vaccination as requested. e. Resident #78 was admitted to the facility in June 2022 with diagnoses which include hypertension, emphysema, and malnutrition. Review of the MDS assessment, dated 4/19/25, indicated Resident #78 scored 3 out of 15 on the BIMS, indicating he/she had severe cognitive impairment. Review of the medical record indicated the facility failed to offer the current (2024-2025) COVID-19 vaccine to the resident/resident representative. Review of the electronic Immunization Record indicated he/she had received an unspecified COVID-19 vaccination on 1/4/24 but failed to indicate he/she was offered, received, or declined the current vaccination. During an interview on 5/6/25 at 9:31 A.M., Nurse #5 said everything was scanned into the electronic medical record and there were no paper charts. She said she did not know who coordinated the consents and administration of vaccines. During an interview on 5/6/25 at 9:52 A.M., Unit Manager #2 said all consents and administration records should be in the electronic medical record. She said she thought everything had been administered for the year but was unsure who oversaw it now because the Infection Preventionist (IP) Nurse had left. During an interview on 5/6/25 at 4:39 P.M, Consulting Staff #2 said she was working with the Director of Nurses in assuming the IP role. She said they have been doing it together because the previous IP had left abruptly. She said the newer consent form offers the current (2024-2025) vaccine but could not locate any administration records for those that had signed it and was unsure if it had been offered to the others.