STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225683	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Rehabilitation and Senior Living	277 Elliot Street Newton Upper Falls, MA 02464

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 36431 Based on observation, record review and interview the facility failed for one Resident (#12), to complete the Minimum Data Set (MDS) assessment that accurately reflects the Resident's status, out of a total sample of 20 residents. Specifically, the MDS assessment indicated Resident #12 was receiving hospice care services, when he/she was not. Findings include: Resident #12 was admitted to the facility in August 2017 and has diagnoses that include but not limited to chronic obstructive pulmonary disease, dementia, and adult failure to thrive. Review of the most recent MDS assessment, dated 3/24/24 indicated Resident #12 scored a 3 out of 15 on the Brief Interview for Mental Status exam, indicating he/she has a severe cognitive impairment and is dependent on staff for daily care including toileting, hygiene, bathing, and dressing. Further, the MDS assessment indicated Resident #12 was receiving hospice care while a resident. On 4/30/24 at 8:01 A.M. Resident #12 was observed in his/her bed. Resident #12 had his/her eyes closed and was observed to be small stature and frail. Review of Resident #12's medical record indicated the following: -There was no physician's order for hospice services. -There was no comprehensive person-centered care plan for hospice care services. During an interview on 5/1/24 at 7:08 A.M., Unit Manager #2 said there was discussion about having Resident #12 placed on hospice care services, but that the Health Proxy Agent was not in agreement. During an interview on 5/1/24 at 9:29 A.M. and on 5/1/24 at 11:30 A.M., the MDS nurse said there had been a discussion about Resident #12 signing on to hospice care. Further, the MDS nurse said she reviewed Resident #12's medical record and that Resident #12 was not on hospice and the MDS assessment was a coding error.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43846 Based on observations, record review and interviews, the facility failed to ensure comprehensive resident centered care plans were developed for two Residents (#10, and #221) out of a total sample of 20 Residents. Specifically the facility failed to; 1.) develop an individualized comprehensive resident centered care plan related to the monitoring and care of a pacemaker for Resident #10 and Resident #221. Findings include: Review of the facility policy titled Pacemaker Policy, undated, indicated: - Residents will be assessed upon admission for pacemaker insertion. - On going monitoring of pacemaker is based on pacemaker and cardiologist. - Need for follow up appointments are decided by cardiology team. 1a.) Resident #10 was admitted to the facility in August 2023 with diagnoses that included Parkinson's disease, dysphagia, presence of cardiac pacemaker, and contractures of the right and left hand. Review of Resident #10's most recent Minimum Data Set (MDS) assessment, dated 4/13/24, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15 which indicated the Resident had moderate cognitive impairment. Review of Resident #10's physician orders and care plans, failed to indicate a paced rate, serial number, frequency of pacemaker checks and cardiologist information. During an interview on 5/1/24 at 11:49 A.M., Resident #10 said he/she has a pacemaker in his/her chest. During an interview on 5/1/24 at 11:50 A.M., Nurse #2 said she is Resident #10's regular nurse and she was not aware that the Resident has a pacemaker. Nurse #2 said there is not a transmission box in the Resident's room and is not sure how the pacemaker is checked by cardiology or how often. During an interview on 5/1/24 at 11:53 A.M., Unit Manager #1 said Resident #10 has a pacemaker and said the pacemaker care plan should have the cardiologist information, paced rate and serial number. Unit Manager #1 said she is not sure how Resident #10's pacemaker is monitored. During an interview on 5/1/24 at 12:05 P.M., the MDS Nurse said if a resident has a pacemaker they need to have physician orders that say who the cardiologist is and how often the paced checks are. The MDS Nurse said the pacemaker care plan should have the paced rate, cardiologist information, frequency of checks and the serial number so the nurses are aware. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45343 1b.) Resident #221 was admitted to the facility in April 2024 with diagnoses including pneumonitis, atrial fibrillation, chronic diastolic congestive heart failure, sick sinus syndrome, and presence of a cardiac pacemaker. Review of Resident #221 most recent Minimum Data Set (MDS) assessment, dated 4/13/24, indicated he/she was assessed by nursing staff to have severe cognitive impairments. Further review of the MDS indicated Resident #221 has a pacemaker. Review of Resident #221's care plan, initiated 4/12/24, failed to indicate a pacemaker care plan with the type and serial number of the pacemaker. During an interview on 5/1/24 at 11:53 A.M., Unit Manager #1 said the pacemaker care plan should have the cardiologist information, paced rate and serial number. During an interview on 5/1/24 at 12:05 P.M., the MDS Nurse said if a resident has a pacemaker they need to have physician orders that say who the cardiologist is and how often the pacer checks are. The MDS Nurse said the pacemaker care plan should have the paced rate, cardiologist information, frequency of checks and the serial number so the nurses are aware. During an interview on 5/1/24 at 1:28 P.M., Nurse #1 said he was aware Resident #221 had a pacemaker but there was no transmission box in the Resident's room, so he monitors Resident #221's pacemaker by taking his/her vital signs. During an interview on 5/1/24 at 2:35 P.M., the Corporate Nurse said Resident #221 was a new admission, and the facility was in the process of getting the pacemaker information.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49880 Based on record review, policy review and interviews, the facility failed to meet professional standards of quality for one Resident (#24) out of a total sample of 20 residents. Specifically, for Resident #24, the facility failed to implement physician's orders to notify the Physician or Nurse Practitioner of a weight change. Findings include: Review of the facility policy titled Physician/ Family Notification, undated, indicated The Nurse Supervisor or Charge Nurse will notify a resident's Attending Physician or On-Call Physician when there has been: i. Instructions to notify the physician of changes in the resident's condition. Resident #24 was admitted to the facility in September 2023 with diagnoses that included congestive heart failure, adult failure to thrive, dysphagia and muscle weakness. Review of Resident #24's Minimum Data Set (MDS) assessment, dated 2/24/24, indicated a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 indicating that the Resident has moderate cognitive impairment. Review of Resident #24's Physician's orders indicated the following: - Weigh daily before breakfast. Notify MD/NP (Physician/ Nurse Practitioner) for +/-2 lbs (pounds) in one day or +/-5 lbs in 1 week, dated 9/8/23. Review of Resident #24's weights indicated the following: - 3/9/24 128.2 lbs - 3/10/24 132.0 lbs - 3/11/24 127.6 lbs - 3/22/24 126.6 lbs - 3/23/24 130.0 lbs - 3/30/24 126.8 lbs - 4/12/24 128.6 lbs - 4/13/24 123.2 lbs - 4/14/24 123.6 lbs (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/15/24 125.6 lbs Review of Resident #24's March and April 2024 nursing progress notes failed to indicate that an MD or NP were notified of a 3.8 lb weight gain from 3/9/24 to 3/10/24. Review of the nursing progress notes failed to indicate that an MD or NP were notified of a 4.4 lb weight loss from 3/10/24 to 3/11/24. Review of nursing progress notes failed to indicate that an MD or NP were notified a 3.4 lb weight gain from 3/22/24 to 3/23/24 or a 2.3 lb weight loss from 3/29/24 to 3/30/24. Review of nursing progress notes further failed to indicate that an MD or an NP were notified of a 5.4 lb weight loss from 4/12/24 to 4/13/24 or a 2 lb weight gain from 4/14/24 to 4/15/24. During an interview on 5/1/24 at 10:53 A.M., Unit Manager #1 said that daily weights are used to monitor residents who have Congestive Heart Failure. During an interview on 5/1/24 at 11:49 A.M., Nurse #2 said that if a resident has an order to notify MD or NP about a daily weight gain or loss then it should be documented in a nursing note that we notified the MD or NP. During an interview on 5/2/24 at 8:14 A.M., the Director of Nurses (DON) said that if a nurse is calling an MD or an NP then the nurses should document that in a nurses note.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review, and interview the facility failed for one Resident (#14), to provide activities of daily living, out of a total sample of 20 residents. Specifically, for Resident #14, who is assessed to be dependent on staff for daily care, the staff failed to provide fingernail care. Findings include: Review of the facility's policy titled 'Activities of Daily Living' not dated indicated the following: In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility provides assistance with activities of daily living (ADL) as needed. Review of the facility's policy entitled 'Care of Fingernails/Toenails, not dated indicated the following: The purposes of this procedure are to clean the nail bed, to keep fingernails trimmed, and to prevent infections. General Guidelines, included 1. Nail care includes daily cleaning and regular trimming. Resident #14 was admitted to the facility in May 2019 and has diagnoses that include but not limited to legal blindness and dementia. Review of Resident #14's Minimum Data Set assessment dated [DATE] indicated a score of 2 out of 15 on the Brief Interview for Mental Status exam, indicating Resident #14 has a severe cognitive impairment and is dependent on staff for activities of daily living including shower/bathing, dressing and hygiene. Further review of the MDS indicated that Resident #14 was not documented as having behaviors including rejection of care. Review of Resident #14's medical record indicated the following: -A care plan with the focus ADL Dependent: Resident is dependent on staff with all ADLs due to deconditioning cognitive deficit and, decrease functional status, dated as revised 8/23/2023. Goal: Resident will accept care as AEB (as evidenced by) being out of bed, well groomed, daily times 90 days. Interventions: Staff will provide bathing, dressing, and grooming, dated 8/24/23. Review of the Resident ADL Guide/Kardex (a document that guides staff on a resident care needs), not dated, indicated: -Resident #14 is checked off as dependent for showering/bathing, and personal hygiene. Observations made by the surveyor included the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 8:06 A.M., Resident #14 was observed in the sitting area in a recliner chair. Resident #14 did not respond to the surveyor's greeting. Resident #14 was rubbing his/her left hand on his/her face and his/her fingernails on that hand had dark grey matter under the nail bed. Resident #14's right hand also had dark grey matter under the nail beds that were visible. On 4/30/24 at 12:20 P.M., Resident #14 was being assisted with his/her lunch meal by a staff member and his/her hands were under the clothing protector and not visible. On 4/30/24 at 1:20 P.M. Resident #14 was resting in his/her recliner in the sitting area and his/her right-hand fingernails in view had dark grey matter under the nail bed. On 4/30/24 at 4:43 P.M., Resident #14 was resting in his/her bed. Both of Resident #14's right and left fingernails were observed to be slightly long and the three middle fingers on each hand had dark grey matter under the nail beds. On 4/30/24 at 4:50 P.M. the surveyors observed Resident #14's right and left fingernails with grey matter under the nail beds on his/her middle three fingers on each hand. On 4/30/24 at approximately 5:00 P.M., Unit Manger #2 was observed assisting Resident #14 with his/her supper meal. On 5/1/24 at 7:12 A.M. Resident #14 was up and dressed, sitting in his/her recliner in the sitting area. Resident #14's middle three fingernails on his/her left hand had grey matter under his/her three middle nail beds. The right hand was not in view and was folded under his/her sleeve of his/her left arm. On 5/1/24 at 10:32 A.M., Resident #14 was in his/her recliner chair in the sitting area. Resident #14's fingernails had grey matter under the nail beds in the three middle fingers on each hand. The grey matter under the nail beds was consistent with being unclean. During an interview on 5/1/24 at 10:50 A.M., Certified Nursing Assistant (CNA) #2 said Resident #14 requires complete care and accepts care. CNA #2 said nail care is part of the CNA's task for residents. CNA #2 said he does not always have the time to get nail care done. CNA #2 observed Resident 14 with the surveyor and said his/her nails need to be cleaned and that he/she scratches him/herself. During an interview on 5/1/24 at 11:31 A.M., Unit Manager #2 said she assisted Resident #14 last evening with his/her supper and did not notice Resident #14's nails. Unit Manager #2 and the surveyor observed Resident #14's nails and Unit Manager #2 said they need to be cleaned. Unit Manager #2 said nail care is provided by the CNA's. Resident #14, who is documented as being dependent on staff for daily care was not observed to have clean nail beds existing over at least four shifts, when staff provided for his/her care needs.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43846 Based on observations, interviews, and record review for one Resident (#171), out of 20 total sampled residents, the facility failed to provide the necessary treatment and services to prevent the development and promote healing of pressure ulcers. Specifically, the facility failed to implement a physician's order to offload the heels of Resident #171, who has a stage 3 pressure ulcer on his/her left heel. Findings include: Resident #171 was admitted to the facility in April 2024 with diagnoses that included stage 3 pressure ulcer to the left heel, adult failure to thrive and spondylosis. Review of Resident #171's Nursing Assessment, dated 4/25/24, indicated the Resident was alert and oriented times two (person and time). During an interview on 4/30/24 at 7:52 A.M., Resident #171 said he/she has a wound on his/her left heel and said no one has offered to place a pillow or anything under his/her heels. On 4/30/24 at 7:52 A.M. and 1:21 P.M., the surveyor observed the Resident in bed with their heels directly on the mattress. On 5/1/24 at 8:34 A.M. and 10:44 A.M., the surveyor observed the Resident in bed with their heels directly on the mattress. Review of Resident #171's physician orders, dated 4/25/24, indicated Free float heels while in bed. Review of Resident #171's Braden Scale for predicting pressure sore risk, dated 4/25/24, indicated the Resident scored a 15 indicating he/she is at mild risk. Review of Resident #171's wound physician wound evaluation and management summary, dated 4/29/24, indicated the Resident has a pressure ulcer on his/her left heel with interventions to float heels in bed and offload wound. During an interview on 5/1/24 at 11:33 A.M., Nurse #1 said Resident #171 should have their heels elevated as ordered because the Resident has a pressure ulcer on his/her heel but has not offloaded the Residents heels. During an interview on 5/1/24 at 12:52 P.M., Certified Nurse Aide (CNA) #1 said she is assigned to Resident #171 today and provided care to the Resident last night. CNA #1 said she has not seen any pillows to float the Resident's heels. CNA #1 said the Resident's heels have been directly on the mattress today.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, interviews and record review, the facility failed to provide food in a form to meet the needs of one Resident (#47) out of a sample of 20 Residents. Specifically, the facility failed to provide a soft and bite sized diet as ordered by the physician and provide the International Dysphagia Diet Standardization Initiative (IDDSI) level 6 diet as indicated by Speech Language Pathology. Findings Include: Review of the facility policy titled Nutrition - Clinical Protocol, undated, indicted the following: - The Physician will authorize, and the staff will implement appropriate general or cause-specific interventions, as indicated, with careful consideration of the following: - Chewing and swallowing abnormalities: Modifications in food or fluid consistency in the diet will be ordered (if determined necessary by the Physician) only after careful consideration of the resident's preferences, the overall condition of the resident, and a review of the underlying problems related to the chewing and swallowing difficulties. - Diet Modifications: Decisions to downgrade or alter the consistency of diets must include the resident and be based on a review of the resident's overall condition, as well as the benefits and risks of a more liberalized diet. Review of the facility policy titled Therapeutic Diets, undated, indicated the following: - Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered therapeutic diets. - A therapeutic diet must be prescribed by the resident's Attending Physician. The physician's diet order should match the terminology used by Food Services. - The Clinical Dietitian (RD), nursing staff, and Attending Physician will review, along with other orders, the need for, and resident acceptance of, prescribed therapeutic diets. - Routine menus (without therapeutic purpose) are planned by the Food Services Manager and approved by the RD for nutritional adequacy. The regular menu will be notified by the RD for therapeutic diets, with input from the Dietary Manager for feasibility of kitchen production. - The Food Services Manager and/pr RD will establish and use a tray identification system to ensure that each residents his or her diet as ordered. Diets should also be available through PCC. - The RD is overall responsible for all residents' diets. The licensed nurses are responsible for all the changes in diets during their shifts. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47 was admitted to the facility in July 2021 with diagnoses including Multiple Sclerosis, Neuralgia, abnormal posture, and unspecified dementia. Review of Resident #47's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 11 out of a possible 15 indicating that he/she has moderate cognitive impairment. Further review of Resident #47's MDS indicated that he/she requires supervision or touching assistance with eating. Review of Resident #47's physician's orders indicated the following orders: - Dated 4/10/24: dysphagia evaluation (x), dysphagia treatment (x) 4x per week for 30 days - Dated 4/9/24: House Consistent Carbohydrates diet, soft & bite sized texture, regular/thin consistency Review of Resident #47's meal ticket indicated the Resident was on a soft & bite sized diet. The surveyor made the following observations of Resident #47's meal service: - On 4/30/24 at 8:20 A.M., a whole, unpeeled banana was observed on the Resident's meal tray, the banana was not cut up. His/her meal ticket said he/she should have been provided banana bread. No staff were present in the room while Resident #47 was eating his/her meal. - On 4/30/24 at 12:08 P.M., a peanut butter and jelly sandwich that was cut in half was observed on the meal tray. The sandwich was not cut up into bite sized pieces. No staff were present in the room while Resident #47 was eating his/her meal. - On 5/1/24 at 8:35 A.M., three pieces of dry toast were observed on the meal tray. The toast was not cut up into bite sized pieces. No staff were present in the room while Resident #47 was eating his/her meal. - On 5/1/24 at 12:15 P.M., a peanut butter and jelly sandwich that was cut in half was observed on the meal tray. The sandwich was not cut up into bite sized pieces. No staff were present in the room while Resident #47 was eating his/her meal. - On 5/2/24 at 8:13 A.M., four pieces of dry toast were observed on the meal tray. The toast was not cut up into bite sized pieces. A slice of orange with the skin still on was also on the meal tray, the sliced orange was not bite sized. Review of Resident #47's care plan dated 8/29/23 indicated the following: Focus: Risk for Aspiration: Resident #47 is at risk for entry of GI (gastrointestinal) contents into the tracheobronchial (throat) passage d/t impaired swallowing Evidenced by s/p MBS (modified barium swallow) Interventions: - Aspiration precaution as tolerated by resident. (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Remind him/her to eat slow small pieces -SLP (speech language pathologist): dietary other consults as needed - Resident will be followed by dietary and ST (Speech Therapy) as needed Review of Resident #47's Dietary Quarterly Assessment, dated 2/20/24, indicated the following: - Diet Consistency: Soft Bite Sized - Summary and Plan of Care: Current diet is soft and bite size and remains appropriate. Review of Resident #47's dietary progress notes indicated the following: - 2/20/24: Current diet is soft and bite size and remains appropriate. -12/7/23: Current diet is soft and bite size and remains appropriate. Review of Resident #47's Speech Therapy Evaluation and Plan of Treatment dated from 4/9/24 - 5/8/24 indicated the following: - Reason for Referral: Pt (patient) is referred from nursing due to pt reports of choking with hard boiled eggs. Pt. has known hx (history) of dysphagia 2* (secondary) to MS (multiple sclerosis). Pt. was DC (discharged) on IDDSI 6/0 (level 6) diet. - Objective tests - Results and Interpretation: Pt. is current on IDDSI 6/0 diet. Given pt's known history of dysphagia and recent choking episodes, skilled SLP services for dysphagia to assess and evaluate for safest level of oral intake. - Recommended: what modified diet is recommended for the patient to swallow solids safely: soft & bite sized Review of the facility binder titled Diet and Diet [NAME] for Extended Care in a Culture Change Environment indicated the following: - Under the Modified Consistencies tab: - Soft/Bite Size Texture: Foods are cut-up to bite-size measuring no bigger than 1.5 cm (centimeters) for adults. This is ordered for individuals with some difficulty chewing larger pieces or hard, sticky foods, have pain or fatigue when chewing, or has mild swallowing difficulty. No hard, sticky, or crunchy foods allowed. Foods should still be moist and in bite-size pieces at the oral phase of the swallow, more chewing ability is required. Transitioning to Level-6 Blue on the IDDSI (International Dysphagia Diet Standardization Initiative) Chart. -Review of the IDDSI section, dated March 4, 2017, indicated the following under the Level 6 - Soft & Bite-Sized section: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225683	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Rehabilitation and Senior Living	277 Elliot Street Newton Upper Falls, MA 02464

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Bite-sized pieces as appropriate for size and oral processing skills - Adults, 1.5 cm (centimeter) pieces. - Food Specific or Other examples: - Fruit: Serve mashed, adults = 1.5 cm pieces, fibrous parts of fruit are not suitable - Bread: No regular dry bread unless assessed as suitable by dysphagia specialist, on an individual basis The IDDSI guidelines were developed for global standardization to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and all cultures. Review of the IDDSI website guidelines, dated July 2019, a more recent edition than the facility has in their diet manual indicated the following updated recommendations: -Food Specific or Other examples: - Fruit: Serve minced or mashed if cannot be cut to soft & bite-sized pieces, adults = 1.5 cm pieces, fibrous parts of fruit are not suitable - Bread: No regular dry bread, sandwiches, or toast of any kind During an interview on 5/1/24 at 2:11 P.M., the Registered Dietitian (RD) said Resident #47 is on a soft and bite sized diet and his/her food should be cut up into bite sized pieces. The RD continued to say she would expect the IDDSI level 6 diet to be followed if that is what the SLP recommended. The surveyor and the RD reviewed the IDDSI level 6 guidelines together and the RD said Resident #47 receiving bread or toast does not follow the guidelines. During an interview on 5/1/24 at 2:33 P.M., the Food Service Director (FSD) said he works with SLP for diet textures. He continued to say if a resident receives bread or a sandwich while on a soft and bite sized diet it would be cut up into at least six pieces. He continued to say the nursing aides would cut up the banana for the resident. During an interview on 5/2/24 at 7:16 A.M., Unit Manager #2 said Resident #47 receives soft and bite sized food and his/her food needs to be cut up into small pieces. Unit Manager #2 said nurses and nursing aides cut up his/her food when it is delivered as needed. During an interview on 5/2/24 at 8:48 A.M., the Director of Rehab (DOR) reviewed the photographs the surveyor took of Resident #47's meals, she said they are not following the IDDSI level 6 diet as the Resident received bread products and they were not bite sized. She continued to say if he/she receives fruit it should be cut up as well. The facility's Speech Language Pathologist was unavailable for an interview, a call back request was made on 5/2/24 at 9:33 A.M.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36431 Based on observation, record review and interview the facility failed to implement procedures to ensure the prevention of infection for one Resident (#65), out of three applicable residents who have an indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag), out of a total sample of 20 residents. Findings include: Review of the facilities policy, titled 'Catheter Care, Urinary,' Level III, not dated, indicated the following: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Infection Control 2. b. Be sure the catheter tubing and drainage bag are kept off the floor. Resident #65 was admitted to the facility in October 2023 and has diagnoses that include but not limited to vascular dementia and neuromuscular dysfunction of bladder. Review of the Minimum Data Set (MDS) assessment, dated 4/6/24, indicated Resident #65 scored a 13 out of 15 on the Brief Interview for Metal Status exam, indicating he/she is cognitively intact. The MDS also indicated that Resident #65 is dependent on staff for toileting, bathing, and upper and lower body dressing. Further, the MDS indicated Resident #65 has an indwelling urinary catheter. Review of Resident #65's care plans indicated the following: -A care plan with the focus Indwelling Foley Catheter Placement: Resident at risk for complications r/t (related to) insertion of indwelling foley catheter, urinary retention, neurogenic bladder, dated as revised 2/29/24. -An ADL (activities of daily living) Dependent: Resident is currently dependent on staff with ADLs due to: L (left) hip FX (fracture): DX (diagnoses) Dementia dated as revised 2/21/24. -A Behavior: Resident exhibits behavioral problems daily or almost daily AEB (as evidenced by) resistance to care, refusing to get out of bed, refuses lab (laboratory work), weights, dated as revised 3/28/24. Review of the care plans did not indicate Resident #65 had behaviors of placing his/her urinary drainage bag on the floor. During an observation on 4/30/24 at 7:52 A.M., Resident #65 was observed in his/her bed with the urinary catheter drainage bag directly on the carpeted floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 8:02 A.M., a staff member was observed entering Resident #65's room with medications, interacted with Resident #65 then exited the room. The urinary catheter drainage bag was observed to be resting on the carpeted floor. During an observation on 4/30/24 at 9:28 A.M., Resident #65 was observed in his/her bed, with the urinary drainage bag observed on the carpeted floor. During an observation on 4/30/24 at 12:17 P.M., Resident #65 was observed in bed. The bottom of urinary drainage bag was grazing on the carpeted floor. During an observation and interview on 5/1/24 at 10:47 A.M., Resident #65 was observed in his/her bed. The urinary drainage bag was on the carpeted floor. Resident #65 said he/she just got washed up. During an interview and observation on 5/01/24 at 11:23 A.M. Nurse #3 said that infection control for a Foley catheter includes making sure the urinary collection bag is not in contact with the floor. Nurse #3 and the surveyor observed Resident #65's urinary drainage bag was resting on the carpeted floor. Nurse #3 said the catheter bag should not be on the floor and should be hanging on the side of the bed.