STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225697	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elaine Center at Hadley	20 North Maple Street Hadley, MA 01035

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51466 Based on observation, interview, and record review, the facility failed to ensure two Residents (#59 and #85), out of a total sample of 19 residents, were provided with a dignified dining experience. Specifically, the facility failed to: 1. Provide Resident #85 timely assistance with feeding, after leaving a tray of food in front of the Resident and out of reach of the Resident, which resulted in an undignified dining experience. 2. Provide Resident #59 with an uninterrupted meal, when staff removed the Resident from the meal to provide wound care and treatment, which resulted in the Resident missing a meal. Findings include: Review of facility Resident Rights dated 11/26/16 indicated: -The resident has the right to be treated with respect and dignity, including: >the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents. -The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safety. Review of the facility policy titled Resident Rights, revised 2/1/23, indicated the following: -Patients/Residents (herein after resident) have the fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social and spiritual values. -Purpose: >to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her self-esteem and self-worth. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	>to incorporate the resident's goals, preferences, and choices into care. 1. Resident # 85 was admitted to the facility in October 2024, with diagnoses including Alzheimer's Disease, Major Depressive Disorder, and Urinary Tract Infection. Review of the Minimum Data Set (MDS) Assessment, dated 10/30/24, indicated Resident #85: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15. -required setup assistance from staff for eating and required moderate assistance from staff for Activities of Daily Living (ADL) areas (dressing, bathing, positioning, transfers, ambulation). -had a weight of 150 lbs and height of 60 inches. -had no therapeutic weight approaches. -had no known weight loss or gain in the past 6 months. -was at risk for developing pressure ulcers. On 1/16/25 at 8:18 A.M., the surveyor observed Resident #85 seated at the dining table with two residents, one of whom was being assisted to eat by a staff member, and one was eating independently. Resident #85 had not been provided with food or drinks. On 1/16/25 at 8:20 A.M., the surveyor observed staff placing Resident #85's breakfast tray on the table in front of him/her, and the food remained covered with a lid over the plate, and not within reach of the Resident. On 1/16/25 at 8:27 A.M., the surveyor observed Resident #85 seated at the table watching his/her tablemates eat their breakfast while his/her tray remained covered and out of reach on the table in front of him/her. On 1/16/25 at 8:42 A.M., the surveyor observed CNA #1 sit beside Resident #85, uncover the food and began assisting Resident #85 to eat. During an interview on 1/16/25 at 9:20 A.M., CNA #1 said that Resident #85 ate 75% of his/her meal with assistance. CNA #1 said Resident #85 sat for an extended amount of time at the table, watching tablemates eat, with food in front of him/her but out of reach. CNA #1 said the food tray should not have been put in front of Resident #85 until staff were ready to assist in feeding. CNA #1 said that the Resident could not reach the food and did not have the ability to feed him/herself. CNA #1 said Resident #85 should not have to sit and watch other people eat, while he/she could not feed him/herself. CNA #1 said the staff have been struggling with meal trays coming from the kitchen on different food carts and is not always consistent causing residents sitting at the same table to eat at different times. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 12:15 P.M., the Certified Dementia Practitioner (CDP) and Unit Manager (UM) #2 said Resident #85 should not have waited twenty-two minutes with the tray in front of him/her, without being assisted to eat. The CDP and UM #2 said that Residents sitting at the same table should receive meal trays at the same time, to promote a dignified meal experience. Both staff members further said that Resident #85's food should have been reheated, or a new tray obtained and that staff have been struggling with meal pass and tray service in relation to where people are sitting, and which meal truck the tray arrives on. 2. Resident #59 was admitted to the facility in February 2024 with diagnoses including Unspecified Dementia, Type 2 Diabetes, Dysphagia, and history of Cerebral Infarction. Review of Resident #59's MDS assessment dated [DATE], indicated the Resident: -Scored one out of 15 possible points on the Brief Interview of Mental Status (BIMS), indicating severe cognitive impairment. -Required supervision for eating. -Was dependent on staff for personal hygiene. -Required Maximum assistance from staff for dressing, bed mobility and standing. -Had an unstageable pressure injury (type of pressure injury that has full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured). Review of Resident #59's Activities of Daily Living (ADL) Care plan, initiated 2/27/24, indicated: -Resident was dependent on staff for eating, transfers, and locomotion related to impaired cognition and weakness. -Eat in a supervised area. -Provide set-up and supervision for eating. -Encourage Resident to attend meals in the dining room. On 1/15/25 at 8:21 A.M., the surveyor observed Resident #59 seated in the dining area with his/her breakfast tray set up in front of him/her. Unit Manager (UM) #2 was observed prompting Resident #59 to eat by placing a utensil in his/her hand, followed by the Resident taking one bite then putting his/her utensil down. On 1/15/25 at 8:27 A.M., the surveyor observed the Wound Nurse remove Resident #59 from the dining room, leaving his/her breakfast uncovered on the table. Resident #59 was observed to be brought to his/her room to be seen by the facility Wound Nurse and the contracted Wound Specialist. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:57 A.M., the surveyor observed CNA #4 remove Resident #59's partially eaten breakfast tray from the dining table and place it in the food cart. During an interview at the time, CNA #4 said the Resident ate 25% of his/her meal. On 1/15/25 at 9:06 A.M., the surveyor observed Resident #59 remain in his/her room after the Wound Nurse left the room. CNA #1 returned the Resident to the dining area and no food items or drinks were offered to Resident #59 upon return to the dining room. During an interview on 1/15/25 at 9:40 A.M., CNA #4 said the Resident was not sitting at the table when she removed the breakfast tray, because he/she was being seen by the Wound Nurse. CNA #4 said she did not offer Resident #59 additional food items and did not offer to reheat his/her food when he/she returned to the dining room but should have. CNA #4 said the Resident should not have been removed while eating a meal but said this consistently happens every week with wound rounds interrupting mealtime. During an interview on 1/15/25 at 9:41 A.M., CNA #1 said that resident mealtimes are consistently interrupted every week from wound rounds and staff have informed the Nurses that this has been a problem. During an interview on 1/15/25 at 9:45 A.M., Unit Manager (UM) #2 said that it is an ongoing issue that wound rounds happen at 8:00 A.M. and meals are interrupted. UM #2 said that staff did not recognize Resident #59's breakfast had not been eaten, until the surveyor brought it to their attention. UM #2 said the Resident's mealtime should not have been interrupted, staff should have offered him/her a new tray or reheated his/her food. UM #2 then gave Resident #59 a supplement shake (nutritional shake to help supplement caloric needs) and said that meal consumption can impact wound healing and was very important. During an interview on 1/15/25 at 10:38 A.M., the Wound Nurse said she did remove the Resident during breakfast by telling him/her it was time to be seen by the Wound Consultant and the Resident was returned to the dining room, but after his/her food was removed.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 42761 Based on interview, and record review, the facility failed to uphold resident rights for one Resident (#65), out of a total sample of 19 residents, relative to rights exercised by the Resident's Representative. Specifically, the facility failed to provide Resident #65's Representative with the right to make an informed decision relative to the administration of a new medication (Remeron [Mirtazapine]- antidepressant medication requiring informed consent for administration) when: -The Resident had been deemed incapacitated by the Court. -The Resident had a court appointed Legal Guardian. -The facility initiated administration of Mirtazapine to the Resident without consent from the Resident's Legal Guardian. Findings include: Review of the facility's policy titled Resident Rights Under Federal Law, dated 6/1/96 and revised 2/1/23, indicated the following: -The purpose included to protect and promote the rights of residents. -Practice standards included helping the resident/representative understand and exercise their rights. Resident #65 was admitted to the facility in July 2022 with diagnoses including Dementia. Review of Resident #65's Minimum Data Set (MDS) Assessment, dated 10/19/24, indicated: -The Resident was severely cognitively impaired as evidenced by a BIMS score of one out of 15 total possible points. -The Resident had no episodes of rejection of care. -The Resident exhibited behavioral symptoms not directed toward others on one to three days during the observation period for the Assessment. -The mood interview was completed with the Resident and the Resident reported no mood issues. -The Resident required substantial/maximal assistance (helper does more than half the effort) for eating. -The Resident weighed 120 lbs. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident had experienced significant weight loss and was not on a Physician prescribed weight loss regimen. -The Resident was not taking any antidepressant medication. Review of Resident #65's November 2024 Physician orders indicated: -Mirtazapine 7.5 milligram (mg) Tablet, give one tablet by mouth at bedtime for Dementia, initiated 11/15/24 Review of Resident #65's November 2024 Medication Administration Record (MAR) indicated: -Mirtazapine was administered to the Resident, as ordered by the Physician, on 11/15/24 through 11/18/24 (four consecutive days). -Mirtazapine was held on 11/19/24 and 11/20/24. -Mirtazapine was administered to the Resident, as ordered by the Physician on 11/21/24 through 11/30/24. Review of Resident #65's Nursing Notes, dated 11/19/24 and 11/20/24, indicated Mirtazapine was held due to no consent to administer the medication. Review of an email communication sent from the Certified Dementia Practitioner (CDP) to Resident #65's Legal Guardian, dated 11/18/24 (three days after Mirtazapine medication was ordered and administered to the Resident), indicated: -A consent for Mirtazapine was attached to the email. -The Resident was not eating well and had experienced a 10% weight loss over the last 180 days. -The Resident was often refusing to eat and often refusing to drink health shakes. -The Resident reports he/she is not hungry. -Consent to administer Mirtazapine was requested in attempt to stimulate the Resident's appetite so that he/she would begin to eat more. Review of Resident #65's December 2024 MAR indicated: -Mirtazapine was administered to the Resident on 12/1/24 and 12/2/24. -Mirtazapine was discontinued on 12/3/24. Review of Resident #65's clinical record did not include any evidence the Resident's Legal Guardian consented to the administration of Mirtazapine for the Resident. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/24 at 4:04 P.M., with Unit Manager (UM) #2 and the CDP, UM #2 said that the Resident had experienced weight loss and the facility had discussed initiating Mirtazapine as an appetite stimulant for the Resident. The CDP said that she sent an email communication to the Resident's Legal Guardian and that the Legal Guardian did not consent to the administration of Mirtazapine for the Resident, so the Mirtazapine/Remeron could not be administered. During an interview on 1/17/25 at 8:05 A.M., Resident #65's Legal Guardian said she had been contacted by the facility via email, which she read on 11/20/24, relative to the Resident losing weight and the facility's request to obtain consent for the administration of Mirtazapine to the Resident. The Legal Guardian said she did not provide consent for the administration of Mirtazapine and she did not understand why the Mirtazapine needed to be implemented when other non-pharmacological interventions had not been discussed with her first. Please Refer to F580, F657, F692, and F712.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interview, and record review, the facility failed to notify the Physician/Nurse Practitioner (NP) of changes in condition for two Residents (#65 and #85) out of a total sample of 19 residents. Specifically: 1. For Resident #65, facility staff failed to: -notify the Physician/NP timely of significant weight loss which resulted in delayed treatment and monitoring of the Resident, and continued significant weight loss. -notify the Resident's Legal Guardian of a change in treatment relative to significant weight loss prior to initiating medication treatment which required the Guardian's consent. 2. For Resident #85, facility staff failed to: -notify the Physician/NP of significant weight loss identified with weekly weights, resulting in inadequate treatment and monitoring of the Resident's nutritional status. Findings include: Review of the facility's policy titled Weights and Heights, dated 6/1/01 and revised 6/15/22, indicated the following: -Patients are weighed upon admission and re-admission, then weekly for four weeks, and monthly thereafter. -Additional weights may be obtained at the discretion of the interdisciplinary team (IDT). -The purpose was to obtain baseline weight, identify significant weight change, and to determine possible causes of significant weight change. -Refer to Weights and Heights procedure. Review of the facility's procedure titled Weights and Heights, dated 6/1/01 and revised 2/1/23, indicated but was not limited to the following: -A licensed nurse or designee will weigh the patient. -Admission and re-admission weights will be obtained within 24 hours of admission. -If the body weight is not as expected, re-weigh the patient. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	-Significant weight change is defined as >5% in one month >10% in six months -The licensed nurse will: >Notify the physician/APP and Dietician of significant changes. >Document notification of physician/APP and Dietician in the PCC Weight Change Progress Note. Review of the facility's Notification of Change in Condition policy, dated 11/28/16 and revised 7/1/24, indicated the following: -The purpose is to provide appropriate and timely information about changes relevant to the patient's condition. -A center must immediately inform the patient, consult with the patient's physician, and notify, consistent with their authority, the patient's representative, where there is: >a significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). >a need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment). 1. Resident #65 was admitted to the facility in July 2022 with diagnoses including Dementia, Hypothyroidism, and Non-toxic Single Thyroid Nodule. Review of Resident #65's Advance Directive Care Plan, initiated 7/19/22 and revised 11/10/23, indicated: -The goal was for the Resident and Guardian to participate in decisions related to medical care and treatment. -The Resident was a full code and had a Legal Guardian. -Staff were to inform the Resident's Guardian of any changes in status or care needs. Review of Resident #65's Nutrition Care Plan, initiated 3/18/24 and revised 10/24/24, indicated: -The Resident was at nutritional risk related to gradual weight loss trend (3/18/24). -Weigh as ordered and alert Dietician and Physician to any significant loss or gain (3/18/24) (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	-Monitor for changes in nutritional status and report to food and nutrition/Physician as indicated (3/18/24). -Monitor intake at all meals, offer alternate choices as needed, alert Dietician and Physician to any decline in intake (3/18/24). -The Resident's goal was to maintain stabilized weight of current body weight (CBW- 120 lbs) +/- three lbs x 90 days (10/24/24 with a target goal date of 1/21/25). Review of Resident #65's Physician orders, dated 6/15/23 with a start date of 7/1/23 indicated: -weigh monthly. Review of Resident #65's Weights and Vitals Summary indicated the following weights: -7/1/24 -141.7 pounds (lbs) -8/1/24 - 136.4 lbs -9/3/24 -132.2 lbs -10/1/24 - 130.6 lbs (weight change of 7.8% over three months) -10/14/24 - 120 lbs -No weight was documented for November 2024 and December 2024 in the Weights and Vitals Summary -1/1/25 - 90.6 lbs Review of Resident #65's Nurse Practitioner (NP) Note, dated 8/9/24, indicated: -The Resident had experienced a 15 lb weight loss over the last year. -The Resident had unintended weight loss. -The Resident's body mass index (BMI) was still healthy at 23.4. -Consider caloric supplementation if needed. Review of Resident #65's Quarterly Nutrition Assessment, dated 9/16/24, indicated the following: -The Resident's usual body weight (UBW) was 145 lbs. and BMI was within normal limits (WNL) though low for age. -The Resident's diet was appropriate. -The Resident had a gradual weight loss over 180 days. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	-Continue to follow. Review of Resident #65's Minimum Data Set (MDS) Assessment, dated 9/16/24, indicated: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points. -The Resident was independent for eating. -The Resident weighed 132 lbs -Weight loss of greater than five percent in one month or greater than 10% in six months had not been identified. Review of Resident #65's clinical record indicated: -The Resident was discharged to the hospital on 10/10/24 related to fall with injury and readmitted to the facility on [DATE] with diagnosis of left hip fracture. -The Resident's re-admission weight obtained 10/14/24, was 120 lbs (15% weight loss over a 90-day period). Review of Resident #65's Physician orders dated 10/24/24, indicated: -House supplements with meals. Review of Resident #65's General Progress Note, dated 10/24/24, and written by the Certified Dementia Practitioner (CDP) indicated: -The Resident's Guardian had been contacted via email that same day with consent forms for medications . -An update was provided on the Resident's medical status. Further review of the General Progress Note did not include information relative to what medications required consent and what update was provided pertinent to the Resident's medical status. Review of Resident #65's November 2024 Medication Administration Record (MAR) indicated: -The Resident's weight was 120 lbs on 11/1/24. -Mirtazapine (Remeron: antidepressant medication that can be used to stimulate one's appetite and requires consent for administration) Tablet 7.5 milligrams (mg), one tablet at bedtime for Dementia was ordered for the Resident on 11/15/24. -Mirtazapine Tablet 7.5 milligrams (mg) was administered to the Resident: >11/15/24 through 11/18/24 (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	>11/21/24 through 11/30/24 -Mirtazapine Tablet 7.5 mg was held on 11/19/24 and 11/20/24, due to no consent to administer the medication. Review of an email communication, dated 11/18/24 (three days after Mirtazapine medication was ordered and administered), from the CDP to Resident #65's Guardian indicated: -A consent for Mirtazapine was attached to the email. -The Resident was not eating well and had experienced a 10% weight loss over the last 180 days. -The Resident was often refusing to eat and often refusing to drink health shakes. -The Resident reports he/she is not hungry. -Consent to administer Mirtazapine was requested in attempt to stimulate the Resident's appetite so that he/she would begin to eat more. Review of Resident #65's clinical record included no evidence the Resident's Guardian was notified of the change in medication to administer Mirtazapine on 11/15/24 and the medication was discontinued on 12/3/24. Review of a Physician order, dated 11/20/24, indicated: -liquid protein daily, 30 cc (unit of measure) one time a day. Review of Resident #65's clinical record included no evidence the Resident was weighed in December 2024. Review of Resident #65's Weights and Vitals Summary indicated the Resident weighed 90.6 lbs on 1/1/25 (24.5% loss in three months: significant weight loss). Review of Resident #65's Quarterly Nutrition Consult, dated 1/13/25, indicated: -The Resident weighed 90.6 lbs and the Resident's BMI was 15.5 (underweight), low. -Current weight shows significant loss, 24.5% x 90 days. -Add nourishment BID (two times daily[the type of nourishment or the amount of nourishment to be provided was not indicated]). -Order weekly weights for four weeks to monitor. -No further assessment needed. Review of Resident #65's clinical record did not include any evidence that the Physician/NP was notified of: (continued on next page)

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Elaine Center at Hadley	20 North Maple Street Hadley, MA 01035

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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 0580 Level of Harm - Actual harm Residents Affected - Few	-The Resident's significant weight loss on 10/1/24 (130.6 lbs). -The Resident's continued significant weight loss on 10/14/24 (120 lbs) and 1/1/25 (90.6 lbs). -The Dietician's recommendations to add nourishment BID and order weekly weights for four weeks on 1/13/25. On 1/15/25 at 1:10 P.M., the surveyor observed Resident #65 sitting in a wheelchair in the Unit Dining Room wearing a hospital gown that was tied loosely around his/her neck, and forearms and lower legs were exposed. The surveyor observed that the Resident was very thin, both sides of the Resident's neck were sunken in behind his/her collar bone, and the Resident's exposed lower legs and forearms were thin and bony. During an interview on 1/15/25 at 1:23 P.M., CNA #1 said that staff weighed residents monthly, weekly, or daily, and that the Nurse alerted the CNAs relative to when to obtain weights. CNA #1 also said that the Nurses entered the residents' weights into the computer. During an interview on 1/15/25 at 2:04 P.M., the NP said she started providing routine coverage at the facility in October 2024 and saw Resident #65 for the first time on 10/16/24, after the Resident returned from the hospital on 10/13/24. The NP said she did not have access to any of the residents' electronic health records for about one month after she began providing routine coverage at the facility and was dependent on staff reports and a written communication log for any changes in residents' conditions during that time. The NP said she had not been alerted that Resident #65 had experienced weight loss and the facility staff did not notify her of Resident #65 having had severe weight loss. The NP said if the facility identified significant weight changes for a resident, the staff would notify her so that she could evaluate the weight loss and implement appropriate treatment interventions. The NP said if the facility had notified her of the Resident's severe weight loss, she would have ordered a chest x-ray and blood work to evaluate for malignancy. The NP said she was not notified that Resident #65's weight was 90.6 lbs on 1/1/25. The NP also said she had not yet been notified of the Dietician's recommendations from 1/13/25 to implement nourishment BID and to order weekly weights. The NP said she wished the facility had notified her of the Resident's weight loss a couple of months ago. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/15/25 at 3:37 P.M., the Dietician said she worked part time at the facility and she did have opportunities where she observed residents eating, but that she was only in the facility approximately one to two times per week, so she depended on staff reports and documentation for monitoring residents for nutrition. The Dietician said the facility held a Risk Meeting weekly and that Resident #65 was discussed weekly at that meeting. The Dietician also said Resident #65 was on her radar for weight loss. The Dietician said that the facility identified Resident #65 as having had a significant weight loss on 10/1/24 and the Resident's weight loss was discussed at the Risk Meeting on 10/3/24. The Dietician said that she assessed Resident #65 on 10/18/24, following the Resident's return to the facility from the hospital on 10/13/24. The Dietician said that the re-assessment she completed on 10/18/24 was due to the Resident having had a change in condition relative to a hip fracture. The Dietician said when she re-assessed the Resident on 10/18/24, she recommended house supplements. The Dietician said when she recommends house supplements for residents, either a Nurse or she will enter the order into the computer for the Physician to review within one day of the recommendation. The Dietician further said that she did not enter the order into the computer until 10/24/24 for Resident #65 to be provided with house supplements and that she was unsure why obtaining the order for the house supplements was delayed. During an interview on 1/15/25 at 4:04 P.M., with Unit Manager (UM) #1 and UM #2, UM #1 said that Resident #65 was not eating well and was losing weight when he/she returned from the hospital. UM #2 said that the Resident's Guardian had been contacted regarding initiating Remeron as an appetite stimulant, and the Guardian did not consent to Remeron being administered. UM #1 said that the facility held weekly Risk Meetings where residents with weight loss were discussed. UM #1 said that the Dietician was not always present at the meetings and would send the Risk Team an email with her recommendations for residents with weight loss if she could not be at the meeting. UM #1 said that the Dietician sent an update to the Risk Team for the meeting that was scheduled for 1/9/25 and the Dietician's recommendations included adding nourishment BID and weekly weight monitoring for Resident #65. UM #1 further said that the meeting scheduled for 1/9/25 did not occur and the recommendations made by the Dietician for Resident #65 had not yet been implemented. UM #1 said that the Risk Meeting did not have to occur in order for recommendations to be implemented. During an interview on 1/15/25 5:00 P.M., the Physician said that he had no recall of having been notified of Resident #65's significant weight loss. During an interview on 1/17/25 at 8:05 A.M., Resident #65's Guardian said the facility contacted her via email regarding the Resident's weight loss and requested consent to administer Remeron to the Resident to stimulate his/her appetite. The Guardian said that she read the email on 11/20/24 and spoke with facility staff on 11/20/24 and that staff reported wanting to initiate the use of Remeron in order to try and stimulate the Resident's appetite. The Guardian said that no other interventions had been discussed with her other than use of Remeron on 11/20/24. The Guardian said that she did not provide consent for the Remeron to be administered and she did not understand why the facility staff were recommending Remeron when other non-pharmacological interventions had not been implemented. During a follow-up interview on 1/17/25 at 10:15 A.M., the NP said she ordered 30 cc of liquid protein for Resident #65 on 11/20/24. The NP said she ordered the liquid protein specifically for bone healing due to the Resident having had a hip fracture. The NP said that the liquid protein could have some nutrition supplementation benefit, but she did not order it specific for the Resident's nutrition because she did not know the Resident had significant weight loss. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	51466 2. Resident # 85 was admitted to the facility in October 2024, with diagnoses including Alzheimer's Disease, Malignant Neoplasm of Unspecified site of right breast, Major Depressive Disorder, Urinary Tract Infection, Abnormalities of gait and mobility, Generalized muscle weakness. Review of the Minimum Data Set (MDS) Assessment, dated 10/30/24, indicated Resident #85: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15. -required setup assistance from staff for eating and required moderate assistance from staff for Activities of daily living (ADL) areas (dressing, bathing, positioning, transfers, ambulation). -had a weight of 150 lbs and height of 60 inches. -had no therapeutic weight approaches. -had no known weight loss or gain in the past 6 months. Review of the Medication Administration Record (MAR) for November 2024, indicated a Physician order initiated on 10/28/24, for weights to be obtained every Monday for 4 weeks. Review of Physician orders from October 2024 through January 2025, did not include any orders for ongoing weights, after the initial 4 weeks of weights were completed. Review of the Electronic Record Weights & Vital Signs Module, and MARs for October 2024 and November 2024 indicated: -No record of a weight for the 4th week after admission (11/24/24 through 11/30/24). Review of the Electronic Record Weights & Vitals indicated the following weights: -10/28/24: 150.4 lbs. -11/4/24: 139.4 lbs. (7.3% loss) -11/11/24: 139.5 lbs. -11/18/24: 144.4 lbs. -12/11/24: 140.8 lbs. -1/16/25: 130.4 lbs. (13% loss) Review of Resident #85's Nutrition Care Plan, initiated 11/14/24, indicated: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	-Resident was at nutritional risk related to hypercholesterolemia, Hypertension, Alzheimer's Disease, Breast Cancer, UTI, Depression, and poor intake. -Interventions included: >Weigh, as ordered. >alert Dietician and Physician of any significant weight loss or gain. During an interview on 1/15/25 at 9:11 A.M., Certified Nurses Aide (CNA) #5 said that if a resident needs to be weighed, the Nurses let the CNAs know. During an interview on 1/15/25 at 4:05 P.M., Nurse #5 said that residents are weighed upon admission, weekly for 4 weeks, then monthly or per order and the weights are documented on the MAR. Nurse #5 said if a weight loss occurs, the MD[Physician]/NP/Dietician and family are updated right away. Nurse #5 said if staff notice there is a change from the previous weight, then the Resident should be re-weighed to verify the weight is accurate. The surveyor and Nurse #5 reviewed Resident #85's medical record and Nurse #5 said there was no active Physician orders for weights and weights have not been completed since 12/12/24. During an interview on 1/16/25 at 8:14 A.M., UM #2 said Resident #85 had no active weight order and the Physician, NP, Dietician, and family had not been notified of the weight change that occurred between 10/28/24 and 11/4/24, or any other weight loss since admission, but those individuals should have been notified. UM #2 said Nurses ask the CNAs to obtain a weight, when the MAR indicates a weight is due. UM #2 said if there is a discrepancy from the previous weight, then the resident is reweighed. If the resident has a weight loss or gain, the Nurse needs to notify the MD/Family/ Dietician right away. During an interview on 1/16/25 at 12:55 PM, Dietician #1 said that every resident is weighed upon admission, weekly for four weeks then monthly. Dietician #1 said a Physician order should be in the medical record indicating how often a weight is needed. Dietician #1 said that a Nurse should have notified her and the Physician/NP of Resident #85's significant weight loss (-7.3%) on 11/4/24, but they were not notified until 1/16/25. Dietician #1 said the last time she had seen Resident #85 was for his/her admission review on 10/30/24. On 1/16/25 at 1:45 P.M., the surveyor observed staff weighing Resident #85 for a weight of 130.4 lbs. via Hoyer lift scale (lifting device used to assist caregivers). During an interview at the time, UM #1 said that this weight further indicates significant weight loss which would be reported to the Dietician and MD/NP. During an interview on 1/17/25 at 10:49 A.M., the NP said that she was not updated about Resident #85's weight loss prior to 1/16/25, and had she been updated on 11/4/24 that a weight loss had occurred, she would have put interventions into place right away to prevent further weight loss. The NP said she expected that the facility follows their weight policy, and that weights are standard orders upon admission. During an interview on 1/17/25 at 11:37 A.M., Dietician #1 said that the facility should be following their weight policy and said that had she been notified of the weight loss on 11/4/24, she would have completed another Nutrition Consult and potentially initiated nutritional interventions at that time. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/17/25 at 2:16 P.M., CNA #1 said that Nurses alert the CNA's when a weight needs to be obtained, either verbally or write the weight request on the assignment sheets. CNA #1 said some residents receive daily, weekly, or monthly weights depending on what the need is. CNA #1 said that if a weight discrepancy is noticed, the CNA should reweigh the resident right away or the Nurse will tell them to reweigh. CNA #1 said if the resident loses or gains over 5 lbs, they should reweigh and then the Nurse will call the Physician. CNA #1 said staff has a sitting scale, a wheelchair scale, and a Hoyer scale, and all the scales are in good working condition. Please Refer to F657, F692, and F712.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, and interview, the facility failed to provide a clean and homelike environment for two Residents (#3, and #32) out of a total sample of 19 residents. Specifically, the facility failed to: 1. for Resident #3, ensure that personal clothing was kept safe from loss when clothing items was consistently lost and/or not delivered from laundry services back to the Resident. 2. for Resident #32, ensure that personal clothing was returned to the Resident after being laundered by a facility contractor to mitigate the Resident's family needing to frequently purchase and replace his/her clothing. Findings include: Review of the facility policy, titled Personal Property, revised 8/15/23, indicated: -Personnel will identify and record the patient's/resident's belongings upon admission to the Center. -The facility staff will protect the patient's right to retain their personal belongings and preserve the patient's individuality and dignity. Review of the facility policy, titled Resident Rights, revised 2/1/23, indicated that the facility will exercise reasonable care for the protection of the resident's property from loss or theft. 1. Resident #3 was admitted to the facility in August 2023 with diagnoses of Dementia and Depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #3 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of seven out of 15 total possible points. During an interview and observation on 1/10/24 at 10:29 A.M., Resident #3 was observed watching TV seated in a wheelchair next to his/her bed. Resident #3 said his/her only concern was many of his/her clothes were missing. Resident #3 said sometimes facility staff are able to locate the missing items, but most of the time the facility staff borrow other residents' clothes to dress him/her. The Resident further said he/she would always find other residents' clothing in his/her closet. 2. Resident #32 was admitted to the facility in July 2021 with diagnoses of Anxiety Disorder, Dementia, and Depression. Review of the MDS assessment dated [DATE], indicated Resident #32 was severely cognitively impaired as evidenced by a BIMS score of three out of 15 total possible points. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/10/25 at 10:41 A.M., Family Member #1 said Resident #32's clothing had persistently gone missing. Family Member #1 said each time he/she would bring this concern up, the facility staff would inform him/her that it was because the Resident's clothing was laundered outside the facility by a contracted company, and it was difficult for the facility to trace the Resident's clothing. Family Member #1 said he/she was tired of buying new clothing every week for Resident #32. During the Resident Council Group Meeting held on 1/14/25 from 2:00 P.M., through 2:45 P.M., 14 out of the 14 residents in attendance said their major concern was having their personal clothing returned to them after it was sent out to be laundered. One resident said his/her family member had to repeatedly purchase socks for him/her. All of the 14 residents said they had discussed these concerns with staff, but the missing clothing concern had not been resolved. During an interview on 1/15/25 at 10:12 A.M., the Activity Director (AD) said the facility had an outside company which laundered residents clothing, and the missing personal belongings had been an on-going concern for the residents and their families. During an interview on 1/15/24 at 2:46 P.M., the facility Administrator said the facility had an outside company that laundered the residents clothing. The Administrator said the laundry company would pick up the soiled residents clothing three times a week and would return the laundered residents clothing three times a week. The Administrator said the residents missing clothing had been a concern for a period of time. The Administrator further said she had no system for tracking which clothing items were sent to be laundered and which items were returned. During an interview on 1/17/25 at 1:01 P.M., Certified Nurses Aide (CNA) #1 said he would return the residents clothing to their closet when the laundry was brought back, but most of the time it would take about six months before some of the residents missing clothing would be returned from the laundry company. CNA #1 said the residents personal clothing items are picked up and returned by an outside company three times a week. Please Refer to F585

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on record review and interview, the facility failed to resolve a grievance timely for one Resident (#32) out of a total sample of 19 residents. Specifically, for Resident #32, the facility failed to ensure that reported grievances by the Resident's family regarding missing clothing was documented and the grievance process intiatied to resolve the grievance within a reasonable time period. Findings include: Review of the facility policy, titled Resident Rights, revised 2/1/23, indicated: -The facility will exercise reasonable care for the protection of the resident's property from loss or theft. -The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issue of resident care and life in the facility. -The facility must be able to demonstrate their response and rationale for such response. Resident #32 was admitted to the facility in July 2021 with diagnoses of Anxiety Disorder, Dementia, and Depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #32 was severely cognitively impaired as evidenced by a BIMS score of three out of 15 total possible points. During an interview on 1/10/25 at 10:41 A.M., Family Member #1 said Resident #32's clothing had persistently gone missing, each time he/she would bring this concern up, the facility staff would inform him/her that it was because the Resident's clothing was laundered outside the facility by a contracted company, and it was difficult for the facility to trace the Resident's clothing. Family Member #1 said he/she was tired of buying new clothing every week for Resident #32. Review of the Grievance Binder did not indicate a record of Family Member #1's grievance regarding Resident #32's missing clothing items. During an interview on 1/15/25 at 1:51 PM., Social Worker (SW) #1 said he was aware of Family Member #1's concerns but had not documented a formal grievance and had not been able to resolve the grievance. SW #1 said Family Member #1 had reported to him on numerous occasions about Resident #32's missing clothing but he had not formally written these as grievances. SW #1 further said he should have documented the missing clothing as formal grievances, investigated the concerns, and followed-up for resolution, but he had not. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 2:46 P.M., the Administrator said she would review the grievance log with her team every morning and discuss if any grievances had been reported. The Administrator said if Family Member #1's grievances was documented on a grievance log, it would have been reviewed, but Family Member #1's concerns had not been documented.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51466 Based on interview, and record review, the facility failed to ensure that Significant Change in Minimum Data Set (MDS) Assessments (SCSA) were completed for one Resident (#59), out of a total sample of 19 residents. Specifically, the facility failed to ensure a SCSA was completed when the Resident #59 experienced a decline in activities of daily living (ADLs) and skin condition. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, dated October 2023, indicated the following: -The SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either a major improvement or decline. -A significant change is a major decline or improvement in a resident's status that: >Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting. >Impacts more than one area of the resident's health status. >Requires interdisciplinary review and/or revision of the care plan. -An SCSA is appropriate when: >There is determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent quarterly assessments. Resident #59 was admitted to the facility in February 2024, with diagnoses including Unspecified Dementia, Type 2 Diabetes, Difficulty in walking, Lack of Coordination, Dysphagia, History of Cerebral Infarction. Review of Resident #59's quarterly MDS assessment dated [DATE], indicated the Resident: -Required maximum assistance from staff for upper body dressing. -Was dependent on staff for personal hygiene. -Required maximum assistance from staff for bed mobility. -Required maximum assistance from staff for sit to stand ability. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Did not ambulate -Had an unstageable pressure injury (type of pressure injury that has Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured). Review of the Resident #59's prior quarterly MDS assessment dated [DATE], indicated the Resident: -Required moderate assistance from staff for upper body dressing. -Required maximum assistance from staff for personal hygiene. -Required supervision from staff for bed mobility. -Required supervision from staff to ambulate up to 50 feet. -Required moderate assistance from staff to ambulate up to 150 ft. -Did not have any pressure injury. During an interview on 1/17/25 at 11:19 A.M., MDS Nurse #1 said she refers to the Long-Term Care Facility Resident Assessment Instrument (RAI) Manual to decide whether a SCSA is needed. The surveyor and the MDS Nurse reviewed Resident #59's most recent quarterly MDS assessment dated [DATE], and Resident #59's prior quarterly MDS assessment dated [DATE]. The MDS Nurse said Resident #59 had multiple declines in his/her status and his/her last quarterly MDS Assessment should have been completed as a SCSA, and but had not been. The MDS Nurse said Resident #59's decline did not appear to be self-limiting or that the decline would resolve without staff intervention.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 42761 Based on interview and record review, the facility failed to complete a Level I Preadmission Screening and Resident Review (PASRR) for one Resident (#58) out of a total sample of 19 residents. Specifically, the facility failed to completed a Level I PASRR Screening for Resident #58 in a timely manner which resulted in the Resident's admission to the facility without determination whether the Resident screened positive for intellectual disability (ID)/developmental disability (DD) or serious mental illness (SMI) requiring further evaluation. Findings include: Review of the facility's policy titled Preadmission Screening for Mental Disorder and/or Intellectual Disability Patients, dated 6/1/01 and revised 2/16/24, indicated the following: -All individuals are screened for mental disorders (MD) and/or ID prior to admission. -The PASRR will be placed in the patient's medical record. Resident #58 was admitted to the facility in December 2024, with diagnoses including Bipolar Disorder, Depression, Anxiety Disorder, and Dementia. Review of the Resident's clinical record did not include any evidence that a Level I PASRR had been completed. During an interview on 1/16/25 at 10:57 A.M., Social Worker (SW) #2 said that she, SW #1, and the Certified Dementia Practitioner (CDP) all had the ability to complete Level I PASRR screenings for residents prior to their admission to the facility. SW #2 said she usually completed the Level I PASRRs and that when she was not available, either SW #1, or the CDP would complete the screenings. SW #2 said that she would have to review the Resident's clinical record and the electronic PASRR portal to locate the Level I PASRR screening for Resident #58. During a follow-up interview on 1/16/25 at 11:30 A.M., SW #2 provided a copy of Resident #58's Level I PASRR screening dated 12/26/24 (completed after the Resident was admitted to the facility). SW #2 said that she did not work from when the facility received notification the Resident would be admitted until 12/26/24. SW #2 said when she came into work on 12/26/24, she noticed that Resident #58's Level I PASRR screening had not been completed, and she completed it at that time. SW #2 further said that this was not the first time a resident was admitted to the facility when she has been unavailable and a Level I PASRR Screening has not been completed timely. SW #2 said that she has reminded other staff of the requirement for Preadmission Screening.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interview, and record review, the facility failed to review and revise the care plan for one Resident (#65), with the participation of the Resident's Representative, following the completion of one comprehensive assessment. Specifically, facility staff failed to review and revise the care plan when Resident #65 sustained a fall with fracture, experienced a significant change in condition, and a comprehensive assessment for significant change in status (SCSA) was completed. Findings include: Review of the facility's policy titled Person-Centered Care Plan, dated 11/28/16 and revised 10/24/22, indicated the following: -Care plans will be reviewed and revised by the interdisciplinary team (IDT) after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals. -A comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual, or SCSA) and review and revise the care plan after each assessment. -Care plan meetings will be documented on the Care Plan Evaluation Note. Resident #65 was admitted to the facility in July 2022, with diagnoses including Dementia, Hypothyroidism, and Non-toxic Single Thyroid Nodule. Review of Resident #65's Advance Directive Care Plan, initiated 7/19/22 and revised 11/10/23, indicated: -The goal was for the Resident and Guardian to participate in decisions related to medical care and treatment. -The Resident was a full code and had a Legal Guardian. Review of Resident #65's Minimum Data Set (MDS) Assessment, dated 9/16/24, indicated: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points. -The Resident was independent for eating, transfers, walking, and bed mobility. -The Resident had no pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident weighed 132 pounds (lbs) and weight loss of greater than five percent in one month or 10 percent in six months had not occurred or was unknown. Review of Resident #65's Care Plan Meeting Note, dated 10/10/24, indicated the following: -An IDT Care Plan Meeting was held on 10/10/24. -The Resident ambulated (walked) independently. -The Resident ate with set-up. -The Resident's Guardian did not attend the Care Plan Meeting. Review of Resident #65's clinical record indicated: -The Resident was discharged to the hospital on 10/10/24, related to a fall with injury. -The Resident was readmitted to the facility on [DATE], with a diagnosis of left hip fracture. Review of Resident #65's SCSA MDS, dated [DATE], indicated: -The Resident was severely cognitively impaired as evidenced by a BIMS score of one out of 15 total possible points. -The Resident required substantial/maximal assistance to eat. -The Resident was dependent on staff to roll left to right. -Transfers and walking were not attempted due to medical condition or safety concern. -The Resident expressed vocal complaints of pain. -Indications of pain or possible pain were observed daily. -The Resident experienced weight loss of greater than five percent on one month or 10 percent in six months. -The Resident was not on a Physician prescribed weight loss regimen. -The Resident weighed 120 lbs. Review of Resident #65's clinical record did not include any evidence that an IDT Care Plan Meeting was held following completion of the Resident's SCSA. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 1:10 P.M., the surveyor observed Resident #65 sitting in a wheelchair in the Dining Room, was wearing a hospital gown that was tied loosely around his/her neck, and his/her lower legs were exposed from the calf down to his/her ankles and his/her forearms were also exposed. The surveyor observed that the Resident was very thin and both sides of his/her neck were sunken in behind his/her collar bone, and the Resident's exposed forearms and lower legs were thin and bony. On 1/15/25 at 5:15 P.M., the surveyor observed Resident #65 seated in a wheelchair in the Dining Room. The surveyor observed Certified Nurses Aide (CNA) #6 approach the Resident and ask if he could assist the Resident back to his/her room. The Resident was observed to agree and CNA #6 transported the Resident back to his/her room by means of pushing the wheelchair. On 1/16/25 at 9:10 A.M., the surveyor observed Resident #65 positioned upright in bed. CNA #2 was seated next to the Resident's bed assisting the Resident to eat by loading the Resident's fork with pieces of french toast and bringing the french toast to the Resident's mouth. The Resident was observed eating slowly and accepting small bites of food. During an interview on 1/17/25 at 8:05 A.M., Resident #65's Legal Guardian said the facility always invited her to IDT Care Plan Meetings for Resident #65 and that if she was unable to attend in person, she would try to attend by phone. Resident #65's Legal Guardian said she could not recall the date of the last IDT Care Plan Meeting she was invited to. During an interview on 1/17/25 at 10:48 A.M., Social Worker (SW) #2 said the IDT did not hold a Care Plan Meeting for Resident #65 to review and revise his/her care plan after the SCSA was completed because the IDT had just held a meeting on 10/10/24. SW #2 said that since the IDT had met just prior to the SCSA, the Team did not need to meet. When the surveyor asked whether the Resident's status had changed between the time the IDT met on 10/10/24 and when the SCSA was completed, SW #2 said she did not know. Please Refer to F692 and F712.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51466 Based on observation, interview, and record review, the facility failed to ensure two Residents (#59 and #33) out of a total sample of 19 residents, were provided assistance with personal hygiene. Specifically, the facility failed to ensure Resident #59 and Resident #33 were offered and/or provided with grooming assistance when the Resident required the assistance of staff for grooming activities. Finding includes: Resident #59 was admitted to the facility in February 2024, with diagnoses including Unspecified Dementia, Type 2 Diabetes, Difficulty in walking, Lack of Coordination, Dysphagia, and History of Cerebral Infarction. Review of the Care Plan for Activities of Daily Living (ADL: refers to an individual's daily self-care activities and includes bathing, dressing and grooming), initiated 2/27/24, indicated: -Resident #59 required assistance/ dependent on staff for ADL care related to impaired cognition and weakness. -Intervention to provide Resident with extensive to total assist of 1 for bed mobility, personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving), initiated 2/27/24. Review of Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident: -Scored one out of 15 on the Brief Interview for Mental Status (BIMS) and had severe cognitive impairment. -Required maximum assistance from staff for upper body dressing. -Was dependent on staff for personal hygiene including grooming needs. -Required maximum assistance from staff for bed mobility. -Required maximum assistance from staff for sit to stand ability. -Did not ambulate. -Did not exhibiti any behaviors or rejection of care. On 1/14/25 at 8:36 A.M., the surveyor observed Resident #59 seated in the dining area for the breakfast meal. He/she was fully dressed and was unshaven with facial hair on his/her chin, upper lip, and bilateral cheeks. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/14/25 at 1:09 P.M., the surveyor observed Resident #59 seated in his/her bedroom with visitors. Resident #59 remained unshaven with facial hair on his/her chin, upper lip, and bilateral cheeks. During an interview on 1/14/25 at 1:34 P.M., Family Member #3 said Resident #59 has always preferred not to have facial hair. Family Member #3 said it appeared that the Resident had not had facial hair removed for several days because of the long whiskers on his/her chin, and cheeks. Family Member #3 said Resident #59 is unable to shave himself/herself and requires staff to perform this task and shaving has not been getting done as often as it should be. On 1/15/25 at 8:21 A.M., the surveyor observed Resident #59 seated in dining room. Resident #59 was fully dressed and remained with facial hair on his/her chin, upper lip, and bilateral cheeks. During an interview on 1/15/25 at 9:33 A.M., CNA #1 said Resident #59 is dependent for grooming needs and he/she cannot shave himself/herself without assistance. On 1/15/25 at 1:58 P.M., the surveyor observed that Resident #59 remained with facial hair on his/her chin, upper lip, and bilateral cheeks. On 1/16/25 at 8:04 A.M., the surveyor observed Resident #59 seated in the dining room. The Resident was fully dressed, and hair on his/her chin, upper lip, and bilateral cheeks were no longer present. During an interview on 1/16/25 at 9:30 A.M., CNA #2 said that she provides grooming/shaving for residents about once a week. CNA #2 said that staff should know when a Resident needs to be shaved by looking to see if facial hair or whiskers have started to grow. CNA #2 said she shaved Resident #59 on 1/15/25 evening shift, because he/she had some agitation on the day shift. CNA #2 said Resident #59 does not normally have behaviors and was agreeable when re-approached later in the day. CNA #2 said Resident #59 should have been shaved days prior because he/she had significant hair growth on the face, and it appeared he/she had not been shaved for several days. 42761 2. Resident #33 was admitted to the facility in April 2023 with diagnoses including Dementia. Review of Resident #33's Activities of Daily Living (ADL) Care Plan, initiated 4/26/23 and revised 1/3/24, indicated the following: -The Resident was at risk for decreased ability to perform ADLs . grooming . -The Resident had a history of refusing care at times, i.e. showers or ADL assist. -Provide Resident with stand by assist/contact guard assist with cues for . grooming .cue thoroughness. Review of Resident #33's Advance Directive Care Plan, initiated 4/27/23 and revised 11/10/23, indicated the Resident's healthcare proxy (HCP: individual designated to make healthcare decisions for another person) was invoked on 4/28/23 by the Physician. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #33's Physician order, dated 4/28/23 indicated: HCP invoked. Review of Resident #33's Minimum Data Set (MDS) Assessment, dated 11/7/24, indicated: -The Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of eight out of 15 total possible points. -The mood interview was conducted with the Resident and the Resident reported no mood issues. -The interview for resident preferences was conducted with the Resident and the Resident reported it was very important for him/her to have family or a close friend involved in discussions about his/her care. -The Resident exhibited impaired range of motion in one upper extremity. -The Resident required set up/clean up assistance for personal hygiene (grooming). -The Resident did not exhibit any refusal of care during the observation period for the MDS Assessment. Review of Resident #33's January 2025 Certified Nurses Aide Documentation Survey Report for Personal Hygiene indicated: -The Resident required varied levels of assistance, from dependence on staff to supervision, for personal hygiene, including grooming. -The Resident did not exhibit any refusal of care relative to personal hygiene. During an interview on 1/10/25 at 1:14 P.M., Resident #33's HCP said that Resident #33 did not always receive assistance for shaving and that the Resident preferred not to have facial hair. Resident #33's HCP said that he/she had contacted the facility the week of Christmas in December 2024 to request that the Resident be shaved for the day after Christmas (12/26/24) because the Resident would be having visitors that day. Resident #33's HCP said he/she was upset because the Resident had not been shaved prior to visitors arriving on 12/26/24. Resident #33's HCP said that the Resident took photos with his/her visitors on 12/26/24, and that the Resident had facial hair in the photos. During an observation and interview on 1/14/25 at 1:15 P.M., the surveyor observed Resident #33 in his/her room sitting on the edge of the bed and facing the hallway. The surveyor observed Resident #33 to have visible facial hair, approximately one quarter inch long along his/her upper lip, chin, and both sides of the face. During an interview at the time, the Resident said that he/she never kept facial hair, then took his/her hand and ran it over his/her chin and cheeks and said he/she had more facial hair lately. Resident #33 said it was not his/her preference to have facial hair and that he/she liked to have no facial hair. Resident #33 said that he/she used to use an electric razor and that he/she did not know where it was. Resident #33 also said staff would sometimes assist him/her to remove the facial hair, but only when staff noticed it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 8:48 A.M., the surveyor observed Resident #33 sitting at a table in the Dining Room. The surveyor observed that the Resident was dressed and remained with facial hair over his/her chin, upper lip, and on the sides of his/her face. On 1/16/25 at 8:20 A.M., the surveyor observed Resident #33 sitting at a table in the Dining Room, eating breakfast. The Resident remained with facial hair which now appeared thicker and slightly longer than when initially observed on 1/14/25. During an interview at the time, Resident #33 said that he/she wanted the facial hair removed. During an interview on 1/16/25 at 9:09 A.M., Certified Nurses Aide (CNA) #1 said that all residents should be groomed daily and that residents with facial hair should be shaved daily, especially if they had a preference to be shaved. CNA #1 said it was a regular occurrence that residents with facial hair remained unshaven for several days. CNA #1 said that Resident #33's HCP had brought in an electric razor for the staff to use with the Resident and that Resident #33 preferred to have no facial hair. CNA #1 also said that staff needed to offer removal of facial hair for Resident #33 because the Resident did not always ask to be shaved. CNA #1 further said when staff offered to shave the Resident, the Resident agreed and wanted to be shaved. During an interview on 1/16/25 at 11:21 A.M., Unit Manager (UM) #2 said Resident #59 and all other residents should be shaved daily and the staff are provided with electric razors and hand razors to shave them properly. UM #2 said that Resident #59 does not have behaviors or enough agitation to prohibit CNA's from properly grooming him/her. UM #2 also said that she recalled Resident #33's HCP requesting that Resident #33 be shaved to see visitors on 12/26/24 and that the Resident was not shaved. UM #2 said grooming and shaving had been an ongoing issue with not only Resident #59 and #33, but many other residents who also requiring assistance with shaving.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interview, and record review, the facility failed to maintain acceptable parameters of nutritional status for two Residents (#65 and #85) out of a total sample of 19 total residents. Specifically, the facility failed to: 1. For Resident #65, A.-address significant weight loss and implement effective interventions when the Resident was identified to have greater than 7.5 percent (%) weight loss prior to a hospitalization . -adhere to Physician orders for monthly weight monitoring. B.-implement and monitor weekly weights as required after the Resident was hospitalized and readmitted to the facility. -implement and monitor dietary interventions timely when dietary supplements, additional nourishment, and weekly weights were recommended. -adequately monitor meal and dietary supplement intakes after significant weight loss was identified by facility staff. 2. For Resident #85, -adequately monitor the Resident's weights after admission to the facility, resulting in failure to assess the Resident's significant weight loss in a timely manner. Findings include: Review of the facility's policy titled Weights and Heights, dated 6/1/01 and revised 6/15/22, indicated the following: -Patients are weighed upon admission and re-admission, then weekly for four weeks, and monthly thereafter. -Additional weights may be obtained at the discretion of the interdisciplinary team (IDT). -Hospital weight will not serve as admission or re-admission weight. -The purpose was to obtain baseline weight, identify significant weight change, and to determine possible causes of significant weight change. -Refer to Weights and Heights Procedure. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Weights and Heights Procedure, dated 6/1/01 and revised 2/1/23, indicated the following: -A licensed nurse or designee will weigh the patient. -Admission and re-admission weights will be obtained within 24 hours of admission. -If the body weight is not as expected, re-weigh the patient. -The weight will be entered into the Point Click Care (PCC: electronic health record) Weights/Vitals Signs module on that shift. -The Weights Exception Report will be reviewed by a licensed nurse with follow-up as indicated. -Significant weight change is defined as >5% in one month >10% in six months -The licensed nurse will: >Notify the Physician/APP and Dietician of significant changes. >Document notification of Physician/APP and Dietician in the PCC Weight Change Progress Note. Review of the facility's policy titled Food and Nutrition Goals and Objectives, dated 5/1/23, indicated: -The purpose was to provide food and nutrition services to meet the physiological and psychosocial needs of patients/residents. -Resident's nutritional status is assessed, and individualized plan of care is implemented, and outcomes are monitored and evaluated to promote optimal nutritional status. Review of the Centers for Disease Control and Prevention (CDC) guidelines titled Adult BMI (Body Mass Index: calculation used as a potential health indicator) Categories dated 3/19/24, indicated the following relative to BMI for adults [AGE] years of age and older: -BMI of less than 18.5 = underweight -BMI of 18.5 to less than 25 = healthy weight -BMI of 25 to less than 30 = overweight -BMI of 30 or greater = obesity (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	1A. Resident #65 was admitted to the facility in July 2022 with diagnoses including Dementia, Hypothyroidism, and Non-toxic Single Thyroid Nodule. Review of Resident #65's Dietary Activity Log indicated the Resident had been receiving large portions of food for meals and fortified oatmeal for breakfast since 3/18/24. Review of Resident #65's Physician orders, dated 6/15/23 with a start date of 7/1/23, indicated: -weigh monthly. Review of Resident #65's Weights and Vitals Summary indicated the Resident weights as follows: -7/1/24: 141.7 pounds (lbs) -8/1/24: 136.4 lbs -9/3/24: 132.2 lbs -10/1/24: 130.6 lbs (weight change of 7.8% over three months) -10/14/24: 120 lbs -No weight was documented for November 2024 and December 2024 in the Weights and Vitals Summary -1/1/25: 90.6 lbs Review of Resident #65's Nurse Practitioner (NP) Note, dated 8/9/24, indicated the Resident: -was seen for an annual exam. -experienced a 15 lb weight loss over the last year. -had unintended weight loss. -body mass index (BMI) was still healthy at 23.4. -appeared well-nourished. -had no edema. -should be considered for caloric supplementation if needed. -Nursing reported good PO (per os: by mouth) intake. Review of Resident #65's Quarterly Nutrition Assessment, dated 9/16/24, indicated: -The Resident's usual body weight (UBW) was 145 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The Resident's BMI was within normal limits (WNL) though low for age. -The Resident's diet was appropriate. -The Resident had a gradual weight loss over 180 days. -Continue to follow. Further Review of the Quarterly Nutrition assessment dated [DATE], did not indicate that the Resident's weight loss from the 7/1/24 weight was addressed. Review of Resident #65's Minimum Data Set (MDS) Assessment, dated 9/16/24, indicated: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points. -The Resident was independent for eating. -The Resident weighed 132 lbs. -Weight loss of greater than five percent in one month or greater than 10% in six months had not been identified. Review of Resident #65's Weights and Vitals Summary indicated: -the Resident weighed 130.6 lbs on 10/1/24 -decreased weight from 141.7 lbs on 7/1/24 -with significant loss of 7.8% over three months (7/1/24 - 10/1/24). Further Review of the medical record did not indicate that Resident #65 has been assessed for the 7.8% weight loss identified on 10/1/24. 1B. Review of Resident #65's clinical record indicated: -The Resident was discharged to the hospital on 10/10/24, related to a fall with injury. -The Resident was readmitted to the facility on [DATE], with a diagnosis of left hip fracture. -no evidence the Resident was re-assessed by the Dietician between 10/1/24 (when the significant weight loss was identified) and 10/10/24 (when the Resident was discharged to the hospital). -no evidence the facility had implemented any new interventions to address the Resident's significant weight loss between 10/1/24 and 10/10/24, prior to the Resident being hospitalized . -The Resident's re-admission weight obtained 10/14/24, was 120 lbs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elaine Center at Hadley	20 North Maple Street Hadley, MA 01035

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Further Review of the clinical record did not indicate that weekly weight monitoring had been implemented as required after Resident #65 was readmitted to the facility. Review of Resident #65's Nutrition Care Plan, initiated 3/18/24 and revised 10/24/24, indicated: -The Resident was at nutritional risk related to gradual weight loss trend (3/18/24). -Weigh as ordered and alert Dietician and Physician to any significant loss or gain (3/18/24). -Monitor for changes in nutritional status and report to food and nutrition/Physician as indicated (3/18/24). -Monitor intake at all meals, offer alternate choices as needed, alert Dietician and Physician to any decline in intake (3/18/24). -Offer alternate food choices if less than 50% consumed at mealtime (3/18/24). -Provide large entree portions and fortified oatmeal with breakfast (3/18/24). -The Resident's goal was to maintain stabilized weight of current body weight (CBW: 120 lbs) +/- three lbs x 90 days (10/24/24 with a target goal date of 1/21/25). Review of Resident #65's October 2024 Physician orders indicated: -An order, initiated on 7/21/22 and discontinued on 10/31/24, for regular diet texture. -An active order, initiated 10/31/24 with no stop date, for regular liberalized diet, regular texture, standard thin liquids consistency. -An active order, initiated 10/24/24 with no stop date, for House Supplement with meals. Review of Resident #65's Nurse Practitioner (NP) Note, dated 10/16/24, indicated: -The Resident was seen for a routine visit following hospitalization . -The Resident had Dementia and decline was expected. -Continue supportive care. Further review of the NP Note did not include any evidence the Resident had been evaluated for significant weight loss. Review of Resident #65's Activities of Daily Living Care Plan, initiated 7/19/22 and last revised 10/14/24, indicated: -May require assistance for eating due to Dementia and new hip fracture 10/10/24, which is not being surgically repaired. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Provide assist of one for eating. Review of Resident #65's clinical record indicated the Dietician did not assess the Resident after re-admission to the facility on [DATE] until 10/18/24. Review of the Resident's Nutrition Consult, dated 10/18/24, indicated: -The Consult was being completed due to the Resident having had a significant change in status due to a fall and subsequent injury. -The Resident's current weight was 120 lbs, and was significant for weight loss of 13% over 180 days. -The Resident's BMI was 20.6, within normal limits, low for age. -Will add House Supplement BID (twice daily) with lunch and dinner. -Will continue to follow with changes. Review of Resident #65's Nutrition Progress Note, dated 10/18/24, indicated: -A Nutrition Assessment was completed that same day. -The Resident's Nutrition Concern(s) Category: No concern(s) identified. Review of Resident #65's Significant Change in Status MDS, dated [DATE], indicated: -The Resident was severely cognitively impaired as evidenced by a BIMS score of one out of 15 total possible points. -The Resident had no episodes of rejection of care. -The Resident required substantial/maximal assistance (helper does more than half the effort) for eating. -The Resident weighed 120 lbs. -The Resident had experienced significant weight loss and was not on a Physician prescribed weight loss regimen. Review of Resident #65's NP Notes, dated 10/19/24 and 10/21/24, indicated the Resident was seen for acute rounding visits. Neither NP Note indicated that the Resident was evaluated for significant weight loss. Review of Resident #65's Physician orders dated 10/24/24, indicated that House Supplements were not ordered for the Resident until 10/24/24 (six days after the Dietician's recommendation on 10/18/24). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Further review of the Physician's orders failed to indicate: -ordered amounts for the supplement that was to be provided. -instructions for monitoring the amount of the supplements consumed by the Resident. Review of Resident #65's NP Note, dated 10/25/24, indicated: -The Resident was seen for acute rounding relative to persistent pain. -The Resident had been progressively declining since his/her hip fracture and was expected to decline. -The Resident's Guardian was in agreement to expand guardianship to change code status. -Continue supportive care. Further review of the NP Note did not include any evidence the Resident was evaluated for significant weight loss. Review of Resident #65's NP Notes, dated 10/31/24, 11/5/24, 11/8/24, and 11/13/24 indicated: -The Resident was progressively declining since his/her hip fracture and was expected to decline. Review of the 11/13/24 NP Note indicated that the Resident's current Advanced Directive was for full code (all medical measures will be taken to maintain life) status. Further review of each NP Note included no evidence that the Resident's significant weight loss had been evaluated by the NP. Further Review of the medical record did not indicate that weekly weights for Resident #65 had been obtained since re-admission to the facility. Review of Resident #65's October 2024 Medication Administration Record (MAR) indicated the following: -No house supplements were administered to the Resident on 10/24/24 and 10/25/24 (ordered by the Physician on 10/24/24). -House supplements were administered to the Resident with meals from 10/26/24 through 10/31/24. Further Review of the October 2024 MAR did not indicate the quantity of the House Supplements consumed by the Resident. Review of Resident #65's Certified Nurses Aide Documentation Survey Report (flow sheet) for eating indicated: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Meal percentages consumed for 30 of 56 meals provided on the day (7:00 A.M. through 3:00 P.M.) shift to the Resident were not recorded in October 2024. -Meal percentages consumed for 17 of 27 meals provided on the evening (3:00 P.M. through 11:00 P.M.) shift to the Resident were not recorded in October 2024. Review of Resident #65's November 2024 Medication Administration Record (MAR) indicated: -The Resident's weight was 120 lbs on 11/1/24. -The house supplement was administered to the Resident with meals between 11/1/24 and 11/30/24. -The Resident refused the house supplement five times. Further review of the November 2024 MARs did not include any information relative to the amounts of the house supplements the Resident consumed. Review of Resident #65's Certified Nurses Aide Documentation Survey Report (flow sheet) for November 2024 for eating indicated: -Meal percentages consumed for 16 of 58 meals provided on the day shift to the Resident were not recorded in November 2024. -Meal percentages consumed for four of 26 meals provided on the evening shift to the Resident were not recorded in November 2024. Review of a Physician order dated 11/20/24, indicated: -liquid protein daily, 30 cc (unit of measure) one time a day. Review of Resident #65's clinical record included no evidence that the Resident was weighed in December 2024. Review of Resident #65's NP Note, dated 12/16/24, indicated: -The Resident had trace (minimal) edema in both lower extremities. -The Resident remained a full code status. Further review of the NP Note included no evidence the Resident's significant weight loss had been evaluated by the NP. Review of Resident #65's Weights and Vitals Summary indicated the Resident weighed 90.6 lbs on 1/1/25 (24.5% loss in three months: significant weight loss). Further review of the Resident's Weights and Vitals Summary included no evidence that the Resident was re-weighed when the weight of 90.6 lbs was obtained (which indicated a loss of 29.4 lbs since the previously obtained weight in November 2024). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #65's December 2024 Medication Administration Record (MAR) indicated: -The house supplement was administered to the Resident with meals between 12/1/24 and 12/31/24. Review of Resident #65's Certified Nurses Aide Documentation Survey Report (flow sheet) for December 2024 for eating indicated: -Meal percentages consumed for 16 of 56 meals provided on the day shift to the Resident were not recorded in December 2024. -Meal percentages consumed for 10 of 29 meals provided on the evening shift to the Resident were not recorded in December 2024. Review of Resident #65's January 2025 Medication Administration Record (MAR) indicated: -The house supplement was administered to the Resident with meals between 1/1/25 and 1/15/25. Further review of Resident #65's January 2025 MAR included no information to indicate the percentage of the house supplements the Resident consumed. Review of Resident #65's Certified Nurses Aide Documentation Survey Report (flow sheet) for January 2025 for eating indicated: -Meal percentages consumed for eight of 32 meals provided on the day shift to the Resident were not recorded between 1/1/25 and 1/15/25. -Meal percentages consumed for six of 14 meals provided on the evening shift to the Resident were not recorded between 1/1/25 and 1/15/25. On 1/10/25 at 9:21 A.M., the surveyor observed Resident #65 lying in his/her bed, wearing a hospital gown. The Resident was observed to have a small amount of oatmeal on the front of his/her hospital gown and was pulling the front of the hospital gown away from his/her body. Review of Resident #65's Quarterly Nutrition Consult, dated 1/13/25, indicated: -The Resident weighed 90.6 lbs and the Resident's BMI was 15.5 (underweight), low. -The Resident ate independently, supervision as needed. -Regular liberalized diet remained appropriate for promoting adequate intake to meet the Resident's estimated needs. -Meal intakes are 75-100% most meals. -Intake observation for meals was obtained via meal intake records. -Excellent appetite. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Current weight shows significant loss: 24.5% x 90 days. -Add nourishment BID (the type of nourishment or the amount of nourishment to be provided was not indicated). -Order weekly weights for four weeks to monitor. -No further assessment needed. On 1/15/25 at 1:10 P.M., the surveyor observed Resident #65 sitting in a wheelchair in the Unit Dining Room. The Resident was wearing a hospital gown that was tied loosely around his/her neck and his/her forearms and lower legs from the calf down to his/her ankles were exposed. The surveyor observed that the Resident was very thin and both sides of the Resident's neck were sunken in behind his/her collar bone, and the Resident's exposed lower legs and forearms were thin and boney. During an interview on 1/15/25 at 1:23 P.M., CNA #1 said that house supplements were delivered to the Unit by the kitchen staff and that House supplements were not stocked on the Unit. CNA #1 said that the kitchen staff sent one House supplement for each meal on Resident #65's meal trays. CNA #1 said that Resident #65 often consumed the house shakes and that the Resident enjoyed food items that were sweet tasting. CNA #1 also said that meal percentages consumed for every meal provided were to be recorded in the computer for all residents. CNA #1 said that not all meals got recorded at times when there was too much going on the Unit and if there were staff call-outs. CNA #1 said that residents are weighed monthly, weekly, or daily, depending on what the residents need and that the Nurse alerts the CNAs to weights needing to be obtained. CNA #1 said that the Nurse was responsible to enter the residents' weights into the computer as the CNAs were not allowed to enter the weights. During an interview on 1/15/25 at 2:04 P.M., the NP said she had started providing routine coverage at the facility in October 2024 and that she had seen Resident #65 for the first time on 10/16/24, after the Resident returned from the hospital on 10/13/24. The NP said she did not have access to any of the residents' electronic health records for about one month after she began providing routine coverage at the facility and that she was dependent upon staff reports and a written communication log for any changes residents may have experienced during that time. The NP said she had not been alerted that Resident #65 had experienced weight loss. The NP said if the facility identified a significant weight change, she should have been notified in order to implement effective dietary interventions, and if necessary, testing to rule out any medical causes for the significant weight change. The NP said if she had been alerted to Resident #65 having a significant weight change, she would have ordered dietary supplementation, such as health shakes, and if weight loss continued, she would have ordered a chest x-ray and additional blood work to evaluate for malignancy. The NP said that she was not notified that the Resident experienced significant weight loss in October 2024 and that the Resident's weight was down to 90.6 lbs as of 1/1/25. The NP also said she had not yet been informed of the Dietician's recommendations to implement weekly weights and nourishment BID following the Dietician's assessment on 1/13/25. The NP said she wished the facility had notified her a couple of months ago that the Resident's weight was trending down and that the Resident had significant weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/15/25 at 3:37 P.M., the Dietician said she worked part time at the facility. The Dietician said that she did have opportunities where she observed residents eating, but that she was only in the facility approximately one time per week, so she depended on staff reports and documentation for monitoring residents for nutrition. The Dietician said the facility held a Risk Meeting weekly and that Resident #65 was discussed weekly at that meeting. The Dietician also said Resident #65 was on her radar for weight loss. The Dietician said the facility identified Resident #65 as having had a significant weight loss on 10/1/24 and that the Resident's weight loss was discussed at the Risk Meeting on 10/3/24. The Dietician said although the Resident had a gradual weight loss over the previous year that was identified in August 2024, and a significant weight loss identified on 10/1/24, no new interventions were implemented for the Resident following the Risk Meeting held on 10/3/24. The Dietician said that she was continuing to monitor the Resident for dietary supplementation need. The Dietician said that Resident #65's meal intake percentages were not bad and that she monitored meal intake percentages based off of the meal percentage intakes that were entered into the computer. The Dietician also said the facility was good about entering meal percentage intakes. When the surveyor asked about the meal percentage monitoring when several meals were not entered into Resident #65's record, the Dietician said she did not think meal intake percentage recording had been a problem and she would have to look into it. The Dietician said that she did not see Resident #65 between 10/1/24 and 10/10/24, when the Resident was discharged to the hospital, and that she did not re-assess the Resident until 10/18/24, following the Resident's return to the facility on [DATE]. The Dietician said that the re-assessment she completed on 10/18/24 was due to the Resident having had a change in condition relative to a hip fracture and that the change in condition assessment was not triggered due to weight loss. The Dietician said that when she re-assessed the Resident on 10/18/24, she recommended house supplements. The Dietician further said she did not enter the order into the computer until 10/24/24 for the Resident to be provided with house supplements and that she was unsure why obtaining the order for the house supplements was delayed. During an interview on 1/15/25 at 4:04 P.M., with Unit Manager (UM) #1 and UM #2, UM #1 said that Resident #65 was not eating well and was losing weight when he/she returned from the hospital. UM #2 said no interventions were implemented relative to the Resident's weight loss. UM #1 said that Resident #65's weight was down to 90.6 lbs on 1/1/25, the weight was discussed at the facility's weekly Risk Meeting and no re-weight was requested by the Dietician. UM #2 said she did not think the Resident's weight of 90.6 lbs was accurate and that she had requested CNAs re-weigh the Resident. UM #2 asked the surveyor if the re-weight was in the Resident's clinical record. UM #1 was observed to review the Resident's clinical record and said that the record included no information relative to a re-weigh after the weight that was obtained on 1/1/25. UM #1 also said the Dietician did not always attend the weekly Risk Meeting and that the Dietician would provide an email to the facility with recommendations for residents. UM #1 said that the Dietician sent an update to the Risk Team for the meeting that was scheduled for 1/9/25 and the Dietician's recommendations included adding nourishment BID and weekly weight monitoring for Resident #65. UM #1 further said that the meeting scheduled for 1/9/25 did not occur and the recommendations made by the Dietician for Resident #65 had not yet been implemented. UM #1 said that the Risk Meeting did not have to occur in order for recommendations to be implemented. UM #1 also said that Resident #65 received house supplements and the amount consumed by the Resident should be monitored in the Resident's clinical record. UM #2 said she did not know why Resident #65's re-weight from 1/1/25 was not in the Resident's record and that she was going to re-weigh the Resident. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 1/15/25 at 5:15 P.M., the surveyor observed UM #2 request that CNA #6 assist her to weigh Resident #65. CNA #6 assisted the Resident to his/her room and UM #2 transported the chair scale to the Resident's room for weighing. UM #2 said the Resident's weight was 101.2 lbs. UM #2 said that the Resident's current weight still indicated a significant weight loss over the last three months. UM #2 further said, the process is broken. Let's just say that. On 1/16/25 at 8:40 A.M., during an observation and interview, the surveyor observed Resident #65 lying in bed. There were two meal carts observed on the Unit at the time and the surveyor observed CNA #2 passing meal trays from the meal carts to residents in their rooms. CNA #2 said that she was passing meal trays to residents who ate in their rooms and that she would be assisting Resident #65 to eat. The surveyor observed UM #2 in the hallway and asked UM #2 if the surveyor could observe Resident #65's breakfast meal tray. UM #2 removed the tray from the meal cart and picked up the meal ticket which indicated special request for House supplement. The surveyor observed the Resident's breakfast tray contained a covered plate and a covered bowl that UM #2 said was fortified oatmeal. The breakfast tray did not contain a house supplement. UM #2 said that the house supplement was a health shake that was to be sent to the Unit on the Resident's meal tray from the kitchen. UM #2 said that House supplements were not stocked on the Units and it was the kitchen staffs' responsibility to send the house supplements on the meal trays. UM #2 said she needed to go to the kitchen to obtain a house supplement to give to Resident #65. On 1/16/25 at 8:47 A.M., the surveyor observed Resident #65 holding a house supplement while sitting up in bed. The Resident took two sips of the house supplement through a straw, then held the supplement in front of him/herself. During an interview on 1/16/25 at 8:50 A.M., CNA #2 said that she normally assisted Resident #65 to eat breakfast. CNA #2 said that it was hit or miss relative to the Resident accepting the house supplement. CNA #2 said that she found that the Resident more frequently did not accept the house supplement than accept the house supplement at breakfast. CNA #2 also said that Resident #65 required physical assistance from staff to eat. On 1/16/25 at 9:10 A.M., the surveyor observed Resident #65 positioned upright in bed. CNA #2 was seated next to the Resident's bed assisting the Resident to eat. The Resident was eating slowly and accepting small bites of french toast. The surveyor observed the bowl of fortified oatmeal was uncovered, and the bowl was still full. During an interview on 1/17/25 at 7:55 A.M., the Regional Nurse said Nurses are triggered to obtain residents' weights when they view the administration records in the electronic health records. The Regional Nurse said that when the Nurse records the weights into the administration record, that record of weight does not automatically transfer into the Weights and Vitals module in PCC and the Nurse would then have to also enter the weight into the Weights and Vitals module. The Regional Nurse said that he would not expect the Nurses to have to record the weight twice because the weight was already recorded in the clinical record. The Regional Nurse also said that the Weights Exception Report was generated by the weights entered into the Weights and Vitals module in PCC, so if only the Weights Exception Report was being reviewed, staff would miss identifying significant weight changes if not reviewing all of the weight information in the clinical record. The Regional Nurse said that the Nurses were responsible to determine whether a weight obtained was accurate, whether a re-weigh was required, and obtain a re-weight. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a follow-up interview on 1/17/25 at 10:15 A.M., the NP said she ordered 30 cc of liquid protein for Resident #65 on 11/20/24. The NP said she ordered the liquid protein specifically for bone healing due to the Resident having had a hip fracture. The NP said that the liquid protein could have some nutrition supplementation benefit, but that she did not order it specific for the Resident's nutrition because she did not know the Resident had significant weight loss. 51466 2. Resident #85 was admitted to the facility in October 2024, with diagnoses including Alzheimer's Disease, Malignant Neoplasm of Unspecified site of right breast, Major Depressive Disorder, and Urinary Tract Infection. Review of the Minimum Data Set (MDS) Assessment, dated 10/30/24, indicated Resident #85: -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15. -required setup assistance from staff for eating and required moderate assistance from staff for Activities of Daily Living (ADL) areas (dressing, bathing, positioning, transfers, ambulation). -had a weight of 150 lbs and height of 60 inches. -had no therapeutic weight approaches. -had no known weight loss or gain in the past 6 months. -was at risk for developing pressure ulcers. Review of the Electronic Record Weights & Vital Signs Module, and Medication Administration Records for October 2024, November 2024, and December 2024, indicated the following weights were obtained: -10/28/24: 150.4 lbs (three individual weight entries of 150.4 lbs were documented on this date) -11/4/24: 139.4 lbs (decrease of 7.3 % in less than 30 days) -11/11/24: 139.5 lbs. -11/18/24: 144.4 lbs. -No evidence of weight obtained on the fourth week after admission. (11/24/24 through 11/30/24) -12/11/24: 140.8 lbs. -No evidence of the Resident having been weighed between 1/1/25 and 1/15/25 (prior to the surveyor's inquiry on 1/16/25). -1/16/25: 130.4 lbs (20 lbs. weight decline since admission and 13% weight decline over three months/ 90 days). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Further review of the Weights & Vitals Record indicated the Resident experienced a 7.3 % weight loss (significant) from 10/28/24 to 11/4/24. There was no evidence that a re-weigh was obtained after the weight obtained on 11/4/24, that validated the accuracy of the Resident's weight. Review of Resident #85's clinical record did not include evidence that the facility assessed the Resident to determine if interventions should be implemented to address the weight loss. Review of the Nutrition Care Plan initiated 11/18/24, for Nutritional Risk, indicated Resident #85: -was at nutritional risk related to Alzheimer's disease, breast cancer, Depression and poor intake. -Weigh as ordered, and alert Dietician and Physician of any significant weight loss or gain. -Honor food preferences within meal plan. -Monitor for changes in Nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated. -Monitor intake at all meals, offer alternative choices as needed, alert Dietician and Physician to any decline in intake. During an interview on 1/15/25 at 9:11 A.M., CNA #5 said that if a resident needed to be weighed, the Nurses let the CNAs know. During an interview on 1/15/25 at 4:05 P.M., Nurse #5 said that residents are weighed upon admission, weekly for 4 weeks, then monthly or per order and the weights are documented on the MAR. Nurse #5 said if a weight loss occurs, the MD[Physician]/NP/Dietician and family are updated right away. Nurse #5 said if staff notice there is a change from the prev [TRUNCATED]

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47901 Based on record review, and interview, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#49) for one applicable resident, out of a total sample of 19 residents, who required renal dialysis (a procedure to remove waste products and excess fluid from the body when the kidneys stop functioning properly). Specifically, the facility failed to communicate and maintain ongoing documentation with the dialysis center to ensure that the dialysis center and facility received the most current information pertaining to Resident #49. Findings include: Review of the facility policy titled, Dialysis, revised 6/1/21, indicated: -Patients who required HD (hemodialysis) services receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the patient's goals and preferences. Professional standards of practice include: >Ongoing assessment of the patient's condition and monitoring for complications before and after HD treatments received at a certified dialysis facility. >Ongoing assessment and oversight of the patient before and after HD treatments, including monitoring for complications, implementing appropriate interventions, and using appropriate infection control practices. >Ongoing communication and collaboration with the certified dialysis facility regarding HD care and services. Resident #49 was admitted to the facility in January 2022 with diagnoses including Repeated Falls, Vascular Dementia, and Chronic Kidney Disease (CKD) Stage 4. Review of Resident #49's January 2025 Physician's orders indicated: -Resident goes to Dialysis Mondays, Wednesdays and Fridays at 4:55 A.M., dated 12/3/24 -Please include most recent labs in dialysis binder and also Physician Consult sheet for dialysis visits to enhance communication every Monday, Wednesdays and Friday, dated 7/8/24. -Please request that Dialysis Center send a copy of any lab draws they perform back with Resident in his/her communication binder, dated 7/8/24. Review of Resident #49's communication binder indicated that the facility did not communicate any information from the facility to the dialysis center on the following dates: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/3/24, 10/11/24 -11/4/24, 11/22/24,11/29/24 -12/2/24, 12/6/24,12/11/24,12/16/24,12/22/24,12/27/24,12/29/24 -1/3/25, 1/8/25 During an interview on 1/16/25 at 9:11 A.M., the surveyor and Nurse #3 reviewed the dialysis communication sheet. Nurse #3 said there was no communication from the facility to the dialysis center on the dates listed here. During an interview on 1/16/25 at 11:00 A.M., Unit Manager (UM) #1 said the facility was responsible for sending updated information to the dialysis center on Mondays, Wednesdays, and Fridays, but the facility had not completed the dialysis communication sheet as required, and they should have.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interview, and record review, the facility failed to provide Physician visits at the required frequency for two Residents (#65 and #79) for an applicable sample of four residents, out of a total sample of 19 residents. Specifically, the facility failed to provide alternating routine 60-day visits between the Physician and the Nurse Practitioner (NP) for Resident's #65 and #79, resulting in both Residents not being seen by the Physician since July 2024. Findings include: 1. Resident #65 was admitted to the facility in July 2022 with diagnoses including Dementia. Review of Resident #65's clinical record indicated: -The Resident was seen by the Physician for a routine visit on 7/17/24. -The Resident was seen by the NP for routine rounding visits on: >8/9/24 (Annual exam) >8/15/24 (routine rounding) >9/1/24 (routine rounding) -The Resident was transferred to the hospital on 10/10/24 and readmitted to the facility on [DATE]. -The Resident was seen by the NP on: >10/16/24 (routine rounding) >12/16/24 (routine rounding) Further review of the clinical record included no evidence Resident #65 had been seen by the Physician for an alternating 60-day visit since 7/17/24. 2. Resident #79 was admitted to the facility in February 2024 with diagnoses including Alzheimer's disease. Review of Resident #79's clinical record indicated the following: -The Resident was seen by the Physician for a routine visit on 7/17/24. -The Resident had remained in the facility since 7/17/24. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Resident has been seen by the NP for subsequent routine visits since the Resident was last seen by the Physician on 7/17/24. Further review of the clinical record included no evidence Resident #79 had been seen by the Physician for an alternating 60-day visit since 7/17/24. During an interview on 1/17/25 at 10:30 A.M., the NP said that all of her routine visits for residents were scheduled through the Physician's office. The NP said that she had received a notification in October 2024 through her office's Human Resource Department that NPs could now complete all of the routine rounding visits for residents. The NP said that each resident she provided care for was coded in the computer system to indicate all routine visits could be completed by the NP and that the visit were set up by the Physician's office. The NP further said that since this change, she had completed routine rounding on all residents she is responsible for. During an interview on 1/17/24 at 12:37 P.M. the Corporate Nurse said that the Physician was at the facility two to three days per week and the NP was at the facility four to five days per week. The Corporate Nurse said that the facility followed the regulation relative to Physician visits. The Corporate Nurse said that Physician visits were required every 60 days and that those visits could alternate between the Physician and the NP.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 42761 Based on observation, interview, and record review, the facility failed to provide evidence of a written transfer agreement in effect with a hospital approved for participation under the Medicare and Medicaid Programs. Specifically, the facility failed to provide a written transfer agreement between the facility and the identified area hospital that would ensure timely and appropriate hospital admissions and appropriate care and services for the facility residents. Findings include: During an interview on 1/17/24 at 12:37 P.M., the Administrator said the facility had a written transfer agreement with one area hospital and that she was trying to locate a copy of the agreement. The Administrator said she would provide a copy of the written transfer agreement when she located it. On 1/17/24 at 4:00 P.M., the Corporate Nurse provided a copy of a written transfer agreement with the area hospital previously indicated by the Administrator. The surveyor observed that the effective date of the written transfer agreement was 1/1/25. At this time, the Corporate Nurse said that the facility had been unable to locate a written transfer agreement between them and the hospital, and that the hospital was also unable to locate a written transfer agreement between them and the facility. The Corporate Nurse said that because neither facility had evidence of a written transfer agreement, one was completed on 1/17/25, after the surveyor's inquiry, and was effective from 1/1/25.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47901 Based on interview, and record review, the facility failed to evaluate and revise performance activities for a Quality Improvement Project (QAPI) and Performance Improvement Plan (PIP) when it was identified that residents were consistently missing clothing items after clothing was sent to an outside contracted company to be laundered. Specifically, the facility failed to ensure that an effective QAPI system was maintained to analyze the cause for the identified concern, demonstrate changes implemented as part of the PIP, monitor performance, and obtain feedback from residents and representatives relative to the residents concerns of frequently missing clothing items from the contracted laundry company. Findings include: Review of the facility policy titled, Center Quality Assurance Performance Improvement Process, revised 10/24/22, indicated: -QAPI process will drive the decision-making within each Center. -QAPI process and improvements are based on evidence, drawing data from multiple sources, prioritizing improvement opportunities and benchmarking results against developed targets. -Improvement activities and Performance Improvement Projects are the structure and means through which identified problems areas are addressed with data analysis, process improvements and ongoing monitoring whenever necessary using an interdisciplinary team (IDT). -The facility staff has responsibility for reviewing data, suggestions and input from patients, staff, family members and other stakeholders. -Potential grievance/concern issues such as, but limited to; family comments, patient requests, staff suggestions, grievances. Review of Performance Improvement Project (PIP), undated, received from the Administrator, indicated the following problem had been identified: Grievances - Missing clothing - laundry. The facility QAPI PIP indicated: >Quarter 1: January to March -13 Missing clothing/items - laundry -Families primary concerns lately have been missing clothing which generally just need to be returned from laundry. >Quarter 2: April to June (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-17 Missing clothing/items -Family/resident primary concerns continue to be missing. -Only four items have been located of the 17 missing despite searches of rooms, units and laundry. -Family/residents are understanding, but frustrated. >Quarter 3: July to September -13 Missing clothing/items -Missing items are rarely able to be located. -Social Service department routinely searches laundry -Families were invited to come and claim unlabeled items, but very few did. >Quarter 4: October to December -17 Missing clothing/items -While grievances were resolved, much of that was based on discussion with residents and family members about the reimbursement process of missing items. Further review of the PIP failed to contain evidence of the following: -An analysis of the cause for the missing clothing items or lack of return from the contracted laundry services company. -Any actions taken by the facility to prevent re-occurrence of missing laundry items. -Mechanism for feedback from staff or residents regarding missing laundry items. -Education or learning provided to facility staff or residents regarding missing laundry items. During an interview on 1/10/25 at 10:41 A.M., Family Member #1 said Resident #32's clothing was consistently missing. Family Member #1 said each time he/she would bring this concern up, the facility staff would inform him/her that it was because the Resident's clothing was laundered outside the facility by a contracted company, and it was difficult for the facility to trace the Resident's clothing. Family Member #1 said he/she was tired of buying new clothing every week for Resident #32. During the Resident Council Group Meeting held on 1/14/25 from 2:00 P.M., through 2:45 P.M., 14 out of 14 total residents in attendance said their major concern was having their personal clothing returned to them after it was sent out to be laundered. One Resident said his/her family member had to repeatedly purchase socks for him/her. All 14 Residents said they had discussed these concerns with staff, but the missing clothing concern had not been resolved. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/25 at 10:12 A.M., the Activity Director (AD) said the facility has an outside company which laundered residents' clothing, and the missing personal belongings had been an on-going concern for the residents and their families. During an interview on 1/15/25 at 1:51 PM., Social Worker (SW) #1 said he was aware of Family Member #1's concerns but had not documented a formal grievance and had not been able to resolve Family Member #1's grievance. SW #1 said Family Member #1 had reported to him on numerous occasions about Resident #32's missing clothing but had not formally written these as grievances. SW #1 further said he should have documented the missing clothing as formal grievances, investigated the concerns, and followed-up for resolution but had not. During an interview on 1/15/25 at 2:46 P.M., the facility Administrator she had initiated a QAPI on missing residents personal clothing due to growing concern of the laundry company not returning the residents personal items in a timely fashion. The Administrator said when residents and/or their families would report a missing item, staff would document the concern on a grievance form, and she would use the grievance form to create a QAPI project. The Administrator said she was unaware SW #1 had not documented resident/family concerns about missing personal items on a grievance form. During a follow-up interview on 1/16/25 at 10:55 A.M., the Administrator said she was unable to evaluate the PIP about missing resident personal items to see if the missing personal items issue had improved. The Administrator said the current feedback was obtained only from the facility's number of documented grievances on the grievance documentation form, documented by staff. The Administrator said there have not been any formal education or system to track the personal laundry items that was removed from the facility to be laundered and what was received by facility after the laundered personal items were returned.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, and interview, the facility failed to adhere to infection control practices and standards increasing the risk of contamination and spread of infection for residents in the facility. Specifically, the facility failed to: 1. conduct testing of residents for COVID-19 infection, every forty-eight hours as required, when the [NAME] Nursing Unit was experiencing an outbreak of COVID-19 infections. 2. maintain the facility code carts (mobile carts containing life saving equipment used during an emergency) in a clean and sanitary manner. Findings include: Review of the Massachusetts Department of Public Health Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents dated 5/10/23, indicated the following: -Long-term care facilities are required to perform outbreak testing of residents and staff as soon as possible when a case is identified. -Once a new case is identified in a facility, following outbreak testing, long-term care facilities should 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 DPH Epidemiologist directs otherwise. 1. During an interview on 1/13/25 at 7:33 A.M., the Administrator said that one staff member who worked on the [NAME] Nursing Unit had tested positive for COVID-19 infection on 1/10/24. The Administrator said all residents on the [NAME] Nursing Unit had been tested for COVID-19 on 1/11/24 and no additional cases of COVID-19 infection had been identified. During an interview on 1/16/25 at 8:16 A.M., the Infection Preventionist (IP) said that all residents on the [NAME] Nursing Unit had been tested again on 1/13/24 and no additional resident COVID-19 infections had been identified. The IP said that no resident COVID-19 testing had taken place on 1/15/25 because the Corporate Nurse had said that testing on 1/15/25 was not necessary. The IP further said that an additional staff member had tested positive for COVID-19 infection on 1/15/25. During an interview on 1/16/25 at 11:57 A.M., the Corporate Nurse and the IP said that the residents on the [NAME] Nursing unit had been tested for COVID-19 infections on 1/11/25 and 1/13/25 but had not been tested on [DATE]. During a review of the Massachusetts Department of Public Health Update to Infection Prevention and Control Considerations When Caring for Long-Term Care Residents dated 5/10/23, the Corporate Nurse and the IP said that the residents on the [NAME] Nursing Unit should have been tested for COVID-19 infection on 1/15/24 as required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 1/15/24 at 10:00 A.M., the surveyor and Nurse #1 observed the AED (Automatic External Defibrillator- a portable device used to treat a person when their heart has stopped suddenly) on the [NAME] Nursing Unit to be located on top of the unit code cart along with other emergency equipment. The surveyor and Nurse #1 observed the emergency equipment and the surface of the code cart to be covered with a thick coating of gray dust. Nurse #1 said that the code cart equipment was used in emergency situations and should not be covered in gray dust. Nurse #1 said that the code cart and the emergency equipment on the cart needed to be cleaned. On 1/15/25 at 10:14 A.M., the surveyor and Nurse #2 observed the AED on the [NAME] Nursing Unit to be located on top of the unit code cart along with other emergency equipment. The surveyor and Nurse #2 observed the emergency equipment and the surface of the code cart was covered with a thick coating of gray dust. Nurse #2 said that the equipment and the surface of the code cart should not be covered in gray dust. Nurse #2 said that the code cart is checked every night shift and should have been cleaned by whoever checked it on the night shift.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47901 Based on interview, and record review, the facility failed to ensure that an Influenza (Flu) vaccine was administered to one Resident (#49), out of five applicable residents, out of a total sample of 19 residents. Specifically, the facility failed to obtain consent and/or provide education to Resident #49's Health Care Proxy (HCP), when the Resident's HCP was invoked (evaluation of capacity by a Physician that a resident is unable to make medical decisions). Findings include: Review of the facility's policy titled, Influenza Immunization, revised 9/18/24, indicated: -A licensed nurse will provide the appropriate influenza immunizations to patients with patient/health care decision maker consent. -In adherence with the current recommendations of the Advisory Committee on Immunizations Practices (ACIP) as set forth by the Centers for Disease Control and Prevention (CDC). -Facility staff will obtain immunization consent using Patient Informed Consent or Declination form. -If patient/representative refuses influenza immunization, provide information and counseling regarding the benefit of immunization. -If patient/representative refused immunization, document patient's and/or representative's refusal of immunization and education and counseling given regarding the benefit of immunization in the medical record. -Notify attending physician/provider of patient's and/or representative's refusal and document. Review of the CDC guidelines titled Who Needs a Flu Vaccine, dated 10/3/24, indicated the following: -Everyone 6 months and older should get a flu vaccine every season with rare exceptions. Vaccination is particularly important for people who are at higher risk for serious complications from influenza. -Flu vaccination has important benefits. It can reduce flu illnesses, visits to doctor's office's .as well as make symptoms less severe and reduce flu-related hospitalization s and deaths in people who get vaccinated, but still get sick. Review of the CDC guidelines titled People at Increased Risk for Flu Complications, dated 9/11/24, indicated individuals at increased risk for complications of the flu are: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Adults aged 65 and older -People with chronic lung disease -People with blood disorders -People with heart disease -People with a Body Mass Index (BMI) of 40 kg (kilograms)/M (meters) 2 or higher, -People with a weakened immune system due to .chronic conditions requiring chronic corticosteroids or other drugs that suppress the immune system. Resident #49 was admitted to the facility in January 2022 with diagnoses including Repeated Falls, Vascular Dementia, and Chronic Kidney Disease (CKD) Stage 4. Review of Resident #49's Minimum Data Set (MDS) assessment, dated 1/6/25, indicated the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of a total possible 15. Review of Resident #49's medical record indicated: -Resident #49 lacked capacity to make and/or to communicate health care decisions. -Physician Documentation of Resident Incapacity was signed by the Physician on 1/12/22, invoking the HCP as the decision maker. -The Physician determined the Resident lacked capacity due to Vascular Dementia, and the duration was unknown. Review of Resident #49's Immunization record in the Resident's electronic medical record indicated that the family declined an Influenza vaccine on 10/10/23, and that education was not provided. Review of an undated and an incomplete Vaccine Consent Form in Resident 49's medical record did not indicate whether the HCP consented to or declined the Influenza vaccination. The Vaccine Consent Form did not indicate whether education had been provided. Further review of Resident #49's medical record did not provide evidence of education to the Resident or their Representative on the risks and benefits or potential side effects associated with the Influenza vaccination. Review of Resident #49's January 2025 Physician orders did not indicate an order for the Resident to receive an Influenza vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 12:14 P.M., the surveyor and Unit Manager (UM) #1 reviewed Resident #49's clinical record. UM #1 said she was unable to provide evidence that written consent or declination for Influenza vaccination had been obtained since Resident #49's admission, nor could she provide evidence that education on the risks and benefits of the vaccination had been provided to the Resident's invoked HCP. UM #1 further said the facility should have obtained a written consent and educated the HCP, but they had not. UM #1 said the undated and incomplete Vaccine Consent Form was invalid.

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Elaine Center at Hadley	20 North Maple Street Hadley, MA 01035

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 48206 Based on observation, record review, and interview, the facility failed to complete an inspection of the bed rails, to identify areas of possible entrapment for one Resident (#292) out of a total sample of 19 residents. Specifically, for Resident #292, the facility failed to complete a new assessment of the bed, side rails and mattress in active use for potential entrapment when the bed mattress was changed from the previously assessed mattress, placing the Resident who had limited mobility and utilized bilateral side rails, at risk for possible entrapment. Findings include: Review of the facility policy titled Bed Safety, effective 11/28/26 and revised 11/15/24, indicated: -Center Maintenance Director, Administrator, and Director of Nursing will conduct an inspection of all bed frames, mattresses and bed rails, as applicable, as part of a regular maintenance program to identify areas of possible entrapment. -Inspections (audits) will occur at a minimum of annually and with any change in bed frame, mattress, or bed rail. -Audit components include: >Bed entrapment zones >Mattress inspection for integrity and viability >Specialty mattress inflation functionality, if applicable >Bed rail installation, bed rail integrity, if applicable -If at any time it is determined by Nursing that bed rails are needed for a patient: >Maintenance will ensure correct installation of bed rails, including adherence to manufacturer's recommendations and/or specifications >Nursing and Maintenance will complete the Bed Safety Action Grid [Bed System Measurement Device Test Results]. Resident #292 was admitted to the facility in January 2025 with diagnoses including Fracture of the Left Radius (forearm), Fracture of the Left Ulna (forearm), and Dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225697	A. Building B. Wing	01/17/2025

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 9:37 A.M., the surveyor observed Resident #292 lying in bed with the head of the bed elevated, the bed was in a low position to the floor, the mattress was a foam material, floor mats were on both sides of the bed, and bilateral quarter side rails were in use. Resident #292 was observed to have his/her left arm in a bandage and held in a sling. During an interview at the time, Resident #292 was unable to tell the surveyor why he/she was admitted to the facility, how long he/she had been there, or what happened to his/her arm. Review of the Physical Therapy Evaluation dated 1/9/25, indicated Resident #292: -Was hospitalized with diagnosis of fall and left wrist fracture resulting in impaired mobility. -Required a splint and sling for comfort. -Was NWB (Non-weight bearing- withholding pressure from a limb or extremity post-surgery or injury to allow healing) to the left wrist. -Was legally blind with severely impaired vision. -Was hard of hearing, and he/she was able to hear with moderate difficulty (speaker has to increase volume and speak distinctly). Review of the Occupational Therapy Evaluation dated 1/9/25, indicated Resident #292: -Had impaired safety awareness and diagnosis of Dementia. -Exhibited behaviors impacting function including unsafe mobility attempts with fall risk hx (history). -Required Partial/Moderate assist by staff to reposition self in bed. -Overall upper extremity positioning was impaired Review of Resident #292's January 2025 Physician orders indicated: -May have bil (bilateral) 1/4 rails for support dx (diagnosis) wrist fx (fracture) consent in place, initiated 1/8/25 -NWB LUE (left upper extremity - arm), every shift, initiated 1/10/25 -Pressure redistribution mattress to bed, initiated 1/8/25 Review of Resident #292 ADL (Activities of Daily living- bathing, dressing, mobility, hygiene) Care Plan, initiated 1/10/25 indicated: -Resident was at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to wrist fx and limited mobility. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included: >1/4 side rails for positioning, initiated 1/10/25 >Transfers limited assist of 1, initiated 1/10/25 >Sit to stand limited assist of 1, initiated 1/10/25 >Contact Guard for bed mobility, initiated 1/10/25 >NWB Upper extremity, sling for comfort left arm, initiated 1/10/25 Review of Resident #292 Bed Safety Evaluation dated 1/8/25, indicated: -Resident #292 was unable to enter/exit bed safely (including for toileting). Review of the Bed System Measurement Device Test Results Form dated 5/13/24, indicated: -Measurement was Room ---, Bed B -Bed was a Joerns Make and UCXT Model -Mattress was a rented Air Mattress During an interview on 1/16/25 at 10:30 A.M., the Maintenance Director (MD) said that bed entrapment assessments were documented on the Bed System Measurement Device Test Result Worksheets. The MD said that the purpose of the Bed Device Test was to evaluate the safety of bed rails and to make sure mattresses and beds align to prevent harm or injury to the residents. The MD said that reviewing bed safety is important to prevent entrapment and evaluate the risk for pinched limbs or potential injury. The surveyor and the MD reviewed the Bed Device Test Result dated 5/13/24, and the MD said the assessment evaluated an Air Mattress. The MD said that on 1/10/25, there was a foam mattress on Bed B of the Room and would confirm if that was correct. The MD said that when an air mattress is removed from a bed, and a foam mattress is installed, he would re-assess for entrapment and complete a new Bed Device Test. During a follow-up interview on 1/16/25 at 11:28 A.M., the MD said that on 1/10/25 the bed frame was a Joerns Make, B330 Model and a foam mattress was on the bed. The MD said that he did not have any documentation or evaluation of the B330 frame with a foam mattress for Room ---, Bed B after the 5/13/24 Bed Device Test. The MD said that a Bed Device Test should have been completed to evaluate the different bed frame and had not been.