| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225720 | A. Building<br>B. Wing | 04/25/2025 |

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| Care One at Millbury | 312 Millbury Avenue<br>Millbury, MA 01527 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741<br><br>Based on observation, interview, and record review, the facility failed to ensure that one Resident (#40) out of a total sample of 29 residents, had the ability to make choices about their daily preferences.<br><br>Specifically, for Resident #40, the facility failed to ensure the Resident's preference to be out of bed and dressed before breakfast was honored.<br><br>Findings include:<br><br>Review of the Residents' [NAME] of Rights provided to the survey team by the facility, undated, indicated:<br><br>-You have the right to make choices in your daily routine and the facility must ensure a reasonable accommodation of your individual needs.<br><br>Resident #40 was admitted to the facility in June 2024, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), muscle weakness, and right leg pain.<br><br>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #40:<br><br>-was moderately cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 12 out of a total 15<br><br>-has clear speech<br><br>-was able to make him/herself understood<br><br>-was able to understood others<br><br>-required substantial to maximum assistance with activities of daily living (ADLs - basic self care tasks such as getting dressed, bathing, toileting, etc)<br><br>-required substantial to maximum assistance with bed mobility and transfers.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/17/25 at 7:51 A.M., the surveyor observed Resident #40 lying in bed dressed in a hospital gown. During an interview at the time, Resident #40 said the staff never got him/her up, dressed, and out of bed for breakfast which was what he/she preferred. Resident #40 also said he/she would like to be seated in the chair in his/her room for breakfast, but he/she typically had to eat in his/her bed.<br><br>On 4/22/25 at 10:10 A.M., the surveyor observed Resident #40 lying in bed dressed in a hospital gown. During an interview at the time, Resident #40 said he/she had eaten breakfast in bed again and he/she hoped staff would get him/her up and dressed soon.<br><br>Review of Resident #40's Kardex, as of 4/23/25, indicated the following:<br><br>-Encourage to be out of bed daily.<br><br>-Offer to get out of bed before breakfast.<br><br>On 4/23/25 at 8:00 A.M., the surveyor observed Resident #40 reclining in his/her bed, wearing a hospital gown, with the head of the bed up, and eating his/her breakfast.<br><br>During an interview on 4/23/25 at 8:04 A.M., Certified Nurses Aide (CNA) #4 said he was one of Resident #40's CNAs who would be providing care for him/her today. CNA #4 said he did not know if it was Resident #40's preference to get up, get dressed, and out of bed for breakfast. CNA #4 said Resident #40 was still in bed and eating his/her meal in bed.<br><br>On 4/23/25 at 8:34 A.M., the surveyor observed Resident #40 reclining in bed and dressed in a hospital gown. During an interview at the time, Resident #40 said staff had assisted him/her to be seated upright in bed, but no one had offered to get him/her up, dressed, and out of bed for breakfast. Resident #40 further said that he/she was ready to get out of bed and dressed for the day.<br><br>During an interview on 4/23/25 at 9:40 A.M., Nurse #6 said the CNAs should offer Resident #40 the option to get up, out of bed, and dressed prior to breakfast. Nurse #6 said Resident #40's preference was to get up prior to breakfast and staff should be assisting him/her. Nurse #6 further said Resident #40 also enjoyed eating in the dining room with other residents on the unit if he/she was up, out of bed, and dressed before breakfast was served. |

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| F 0580<br><br>Level of Harm - Actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761<br><br>Based on observations, interviews, and record reviews for two Residents (#94 and #38) out of a total sample of 29 residents, the facility failed to notify the Physician/Nurse Practitioner (NP) of the need to significantly alter treatment (need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).<br><br>Specifically,<br><br>1. For Resident #94, the facility failed to notify the Physician/NP of the Resident's uncontrolled pain during indwelling urinary catheter care and 34 missed doses of Lidocaine (pain medication) Gel, out of 46 ordered doses, to be applied topically for the Resident's genital pain resulting in ineffective pain management.<br><br>2. For Resident #38, the facility failed to notify the Physician/NP when the Resident's Atovaquone Oral Suspension medication (antiviral medication), Mycophenolate Mofetil Oral Suspension medication (immunosuppressant medication) and Xylimelts Mouth/Throat Disk medication (artificial saliva medication) were not received from the pharmacy resulting in symptoms of persistent dry mouth and double vision.<br><br>Findings include:<br><br>Review of the facility's policy titled Change in a Resident's Condition or Status, dated 2001, indicated:<br><br>-The nurse will notify the resident's attending physician or physician on call when there has been a need to alter the resident's medical treatment significantly.<br><br>-Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring the resident's medical condition or status.<br><br>-The nurse will record in the resident's medical records relative to changes.<br><br>1. Resident #94 was admitted to the facility in September 2022 with diagnoses including Urinary Tract Infection (UTI), retention of urine, and Urethral Erosion (tearing of the urethra in individuals who have had indwelling urinary catheters for a prolonged period of time).<br><br>Review of Resident #94's Pain Care Plan, initiated 9/27/22, indicated:<br><br>-The Resident had generalized pain.<br><br>-Administer pain medication per Physician orders.<br><br>-Notify Physician if pain frequency/intensity is worsening or of [sic] current analgesia regimen has become ineffective.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying .<br><br>Review of Resident #94's Skin Breakdown Care Plan, initiated 2/3/25, indicated:<br><br>-The Resident had skin breakdown related to slit on his/her genitals.<br><br>-Administer treatment per Physician orders.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #94:<br><br>-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 total possible points.<br><br>-has an indwelling urinary catheter.<br><br>-was dependent on staff for bathing.<br><br>-reported pain, almost constantly, at a level of eight out of 10 (severe).<br><br>Review of the Nurse Practitioner (NP) Note dated 3/24/25, indicated Resident #94:<br><br>-was assessed for worsening genital slit from chronic indwelling urinary catheter.<br><br>-stated having occasional pain to his/her genital area when the indwelling urinary catheter was moved.<br><br>-will have Lidocaine gel (topical medication used to treat pain) ordered to be applied BID (twice daily) PRN (as needed) for pain.<br><br>Review of Resident #94's April 2025 Physician orders indicated:<br><br>-Provide catheter care every shift, start 10/2/24.<br><br>-Lidocaine external gel 0.5% (percent), apply to genital slit topically two times a day for pain, start 3/24/25.<br><br>Review of Resident #94's April 2025 Medication Administration Record (MAR) indicated:<br><br>-ordered Lidocaine Gel (to be applied to the Resident's genital slit) was coded as not administered due to absence of condition/not applicable.<br><br>-ordered Lidocaine Gel was not administered for 30 out of 46 scheduled doses between 4/1/25 and 4/23/25.<br><br>Review of Resident #94's April 2025 Treatment Administration Record (TAR) indicated:<br><br>-Catheter care was provided every shift (three times daily) between 4/1/25 and 4/23/25.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -The Resident reported pain to his/her genital area on 19 out of 23 days reviewed.<br><br>Review of Resident #94's Non-Pressure Skin Condition Record dated 4/23/25, indicated the Resident's genital slit measured 3.0 centimeters (cm) x (by) 3.0 cm x 0.1 cm.<br><br>On 4/23/25 at 10:31 A.M., surveyor #2 with Nurse #10 observed the following pertaining to Resident #94's indwelling urinary catheter:<br><br>-Nurse #10 requested permission from Resident #94 for Nurse #10 and surveyor #2 to observe the indwelling urinary catheter.<br><br>-Resident #94 furrowed his/her brow and clenched his/her teeth.<br><br>-Nurse #10 said she knew the Resident's genital area was tender and that she just needed to see the catheter.<br><br>-The Resident allowed the observation.<br><br>-The surveyor observed the Resident's genital area to have a large slit.<br><br>-Nurse #10 lifted the Resident's indwelling urinary catheter tubing and the Resident furrowed his/her brow, clenched his/her teeth, raised his/her hands in the air and clenched his/her fists.<br><br>-When the observation was complete, Nurse #10 exited the room.<br><br>During an interview on 4/23/25 at 2:15 P.M., Resident #94 said he/she had no pain in the genital area when staying still and that he/she always had pain whenever staff provided urinary catheter care and/or moved the catheter. Resident #94 said he/she was not aware of any topical medication being provided for genital pain at the catheter site. Resident #94 said staff just tell him/her they know the urinary catheter care hurts and is sore, and that they just need to keep him/her clean. Resident #94 said once staff stop manipulating the urinary catheter, the pain stops.<br><br>During an interview on 4/23/25 at 5:00 P.M., Nurse #10 said Resident #94 always has pain when his/her urinary catheter was manipulated and that the pain would stop when procedures for the catheter were complete. Nurse #10 said that Resident #94 had Lidocaine Gel ordered to be applied to the Resident's genital area at the catheter site BID and that the Lidocaine Gel had not been applied that day. Nurse #10 also said the Lidocaine Gel had been unavailable for quite some time. The surveyor and Nurse #10 reviewed Resident #94's April 2025 MAR and Nurse #10 said the Lidocaine Gel was last administered to the Resident on 4/6/25 (17 days prior). Nurse #10 said the NP was in the facility daily and that staff would notify the NP of residents' changes in condition and need to alter treatment. Nurse #10 said she did not know when the NP was notified of the Lidocaine Gel being unavailable. Nurse #10 also said she was not sure if the NP was notified of the missed Lidocaine Gel doses and the Resident's pain during indwelling catheter care procedures.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 4/24/25 at 12:27 P.M., the NP said she worked in the facility five days per week and that Resident #94 was one of the Resident's she provided services for. The NP said staff had not communicated to her that Resident #94 always had pain when staff provided procedures to the Resident's urinary catheter site. The NP also said she did not know the Resident's Lidocaine Gel was not being administered and was not available. The NP said if staff had made her aware of the Resident always having pain during urinary catheter procedures, she would have reassessed the Resident's pain and provided orders for effective pain management. The NP said if she had known the Lidocaine Gel was not available for Resident #94, she would have provided alternate instructions for pain management.<br><br>47901<br><br>2. Resident #38 was admitted to the facility in February 2025, with diagnoses including Myasthenia Gravis, Thrombophilia, Malignant Melanoma of Skin, Atherosclerotic Heart Disease, Drug-Induced Myopathy, Acute and Chronic Respiratory Failure with hypercapnia and recurrent enterocolitis due to Clostridium Difficile (C-DIFF).<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #38 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15.<br><br>During an interview on 4/17/25 at 8:37 A.M., Resident #38 said that he/she had not received a few of his/her medications and every time he/she would ask, the facility staff would inform him/her that the medications were on back order. Resident #38 said the medications were very important as one of the medications was his/her immunosuppressive medication related to receiving chemotherapy for Melanoma diagnosis, one medication was to combat extreme dry mouth related to the side effects of the chemotherapy medication, and another medication helped to decrease double vision symptoms.<br><br>Review of Resident #38's April 2025 Physician's orders indicated:<br><br>-Atovaquone Oral Suspension 750 milligrams (mg)/5 milliliter (ml), Give 10 ml by mouth one time a day for antiviral, ordered 2/14/25.<br><br>-Mycophenolate Mofetil Oral Suspension 200 mg/ml, Give 5 ml every 12 hours for supplement, ordered 2/14/25.<br><br>-XyliMelts Mouth/Throat Disk 550 mg, Give 2 wafers by mouth at bedtime for dry mouth, ordered 3/17/25.<br><br>Review of Resident #38's Medication Administration Records (MARs) indicated:<br><br>>February 2025:<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available), from 2/16/25 to 2/28/25.<br><br>-Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available), 17 times from 2/14/25 to 2/23/25.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | >March 2025:<br><br>-XyliMelts Mouth/Throat Disk 550 mg medication was documented as 9 (Not Available) and 13 (Does not Apply) from 3/17/25 to 3/30/25 daily.<br><br>-Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available) from 3/16/25 to 3/31/25.<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available) six times in the month of March.<br><br>>April 2025:<br><br>-XyliMelts Mouth/Throat Disk 550 mg medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/25/25 daily.<br><br>-Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/25/25 daily.<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/17/25.<br><br>On 4/24/25 at 11:02 A.M., the surveyor and Unit Manager(UM) #2 reviewed Resident #38's April 2025 MAR. UM #2 said Resident #38's XyliMelts, Mycophenolate Mofetil, and Atovaquone medications were documented as Not Available.<br><br>During an interview on 4/24/25 at 12:16 P.M., the Nurse Practitioner (NP) said she was made aware of Resident #38's medication not being available one time when the Resident was first admitted but had not been made aware that the medications were consistently not available.<br><br>During a follow-up interview on 4/24/25 at 1:20 P.M., the DON said UM #2 had left a message for Oncology about Resident #38's medications not being available, but UM #2 did not receive a return call from Oncology. The DON said that the facility had not made any effort to follow-up with Oncology. The DON said that UM #2 forgot to write a note in the Resident's clinical record when she had left the message for Oncology. The DON provided the survey team a late entry note that indicated UM #2 left a voicemail for Oncology on 4/8/25.<br><br>During a follow-up interview on 4/25/25 at 12:27 P.M., the NP said she was made aware of the medications not being available on 4/24/25, after the surveyor started making inquiries about the Not Administered medications. The NP said she would have hoped the facility staff would have notified her that the Resident's medications had not been administered before it went this long. The NP said since the medications were ordered by the Resident's Oncologist, she would have referred the Resident back to the Oncologist but she had not.<br><br>Please refer to F690, F697, F755, and F865. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138<br><br>Based on record review, and interview the facility failed to accurately complete a Comprehensive Minimum Data Set (MSS) Assessment reflective of the status of two Residents (#128 and #340) out of a total sample of 29 residents.<br><br>Specifically,<br><br>1. For Resident #128, the facility failed to conduct a Brief Interview for Mental Status (BIMS) Assessment in the Residents' primary language placing the Resident at risk for an inaccurate assessment, as well as inappropriate delivery of care and services.<br><br>2. For Resident #340, the facility failed to accurately code one comprehensive Minimum Data Set (MDS) Assessment to indicate the Resident had a surgical wound, when the Resident was admitted to the facility with a surgical wound, resulting in an inaccurate assessment of the Resident.<br><br>Findings include:<br><br>1. Review of the CMS Resident Assessment Instrument RAI) Manual 3.0, located at Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual \| CMS<br><br>included but was not limited to:<br><br>< The RAI process is the basis for the accurate assessment of each resident. The RAI must be conducted in the resident's language to ensure accurate information is gathered.<br><br>Review of the facility policy titled Communication with Persons with Limited English Proficiency (LEP), revised 10/21/16, included but was not limited to:<br><br>-It is the policy of this Center to provide language assistance through use of competent bilingual staff, staff interpreters, contacts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services.<br><br>-It is the policy of this Center to provide notice of this policy and procedure to all staff and train staff who may have direct contact with LEP individuals in effective communication techniques, including the effective use of an interpreter.<br><br>-This Center will conduct a regular review of language access needs of our patient population, as well as update and monitor implementation of this policy and these procedures, as necessary.<br><br>-The purpose of this policy is to provide meaningful communication and access for patients/residents who have LEP and ensure compliance with federal regulatory requirements.<br><br>-The social worker or designee is/are responsible for:<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a. maintaining accurate and current list showing name, language, phone number and hours of availability of bilingual staff.<br><br>b. contacting the appropriate bilingual staff member to interpret, in the event an interpreter is needed .and is qualified to interpret.<br><br>c. obtaining an outside interpreter if a bilingual staff interpreter is not available. The specific agency providing qualified interpreter services along with the agency's telephone number(s) and hours of availability are provided in an addendum to this policy.<br><br>-Need and Interpreter? Dial Certified Languages International (CLI) [phone number]. 24 hours a day/7 days a week.<br><br>Resident #128 was admitted to the facility in January 2025 with diagnoses including Benign Neoplasm Meninges and Diabetes.<br><br>Review of Resident #128's person-centered Communication Care Plan included:<br><br>-Focus: Difficulty understanding/communicating related to language barrier (initiated 1/3/25), with interventions including:<br><br><Utilize iPad for translation, (initiated 1/4/25).<br><br>Review of the Resident's Clinical Record included:<br><br>-Residents primary language was non-English.<br><br>Review of Resident #128's most recent completed Minimum Data Set (MDS) assessment dated [DATE], included but was not limited to:<br><br>-The Resident had adequate hearing and vision.<br><br>-The Resident was usually understood by others and usually understood others.<br><br>-The Resident should not have had a BIMS conducted as the Resident was rarely/never understood.<br><br>During an interview on 4/22/25 at 9:43 A.M., Social Worker (SW) #3 said that Resident #128 did not speak English and required translation services to communicate effectively with facility staff. SW #3 said that Resident #128 could use a facility communication iPad device, the telephone translation services or family members when translation was needed. SW #3 said that telephone translation services were available 24 hours a day/seven days a week in the facility. SW #3 said that she was unaware if any facility staff had the ability to translate for Resident #128. SW #3 said that she was the staff member that coded the Resident's MDS BIMS Assessment on 4/9/25. SW #3 said that she did not attempt to conduct Resident #128's BIMS Assessment on 4/9/25 with facility staff, the Resident's family members or the facility telephone translation services but should have. SW #3 said that all of Resident #128's assessments should have been attempted in the Resident's primary language. SW #3 further said that assessments were not accurate unless conducted in a language that the Resident could understand.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/22/25 at 9:59 A.M., Certified Nurses Aide (CNA) #7 said when she works in the facility, Resident #128 is assigned to her because she can understand and speak the Residents' primary language pretty good. CNA #7 said that she had been assigned to Resident #128 today. CNA #7 said that the Resident was able to clearly communicate needs, discomforts and wants. CNA #7 said that sometimes Resident #128 required a lot of time to respond to staff questions but was always able to communicate clearly in his/her primary language.<br><br>During an interview on 4/24/25 at 3:18 P.M., MDS Nurse #2 said that the facility follows the RAI manual for coding of MDS Assessments. MDS Nurse #2 said all facility staff have access to use the telephone translation services for the residents. MDS Nurse #2 said that all staff members received education about the facility translation services during the new-hire orientation period. MDS Nurse #2 said that telephone translation services were available in the facility 24 hours a day/seven days a week. MDS Nurse #2 said that not conducting an assessment in the Residents' primary language would affect the accuracy of the assessment. MDS Nurse #2 said that care and services by the facility for Resident #128 could also be affected by an inaccurate assessment of the Resident's mental status.<br><br>42761<br><br>2. Resident #340 was admitted to the facility in April 2025 with diagnoses including Cervical Spinal Stenosis.<br><br>Review of Resident #340's Hospital Discharge Summary, dated 4/9/25, indicated:<br><br>-The Resident had undergone a C4 (fourth cervical vertebra) - C5 (fifth cervical vertebra) ACDF (anterior cervical discectomy and fusion: surgical treatment for cervical spinal stenosis) on 4/7/25.<br><br>-Spine wound care instructions included:<br><br>>May leave incision site open to air 48 hours post-op (post-operative) or cover with sterile gauze for comfort.<br><br>Review of Resident #340's Hospital Patient Care Referral to the Facility dated 4/9/25, and included in the Resident's Hospital Discharge Summary, indicated:<br><br>-The Resident had a dressing to his/her anterior neck.<br><br>-The dressing was to remain in place until 4/10/25.<br><br>Review of Resident #340's Skilled Evaluation Note dated 4/10/25, indicated:<br><br>-No skin issues were identified.<br><br>-The box for surgical wound was not checked.<br><br>On 4/17/25 at 12:40 P.M., surveyor #3 observed Resident #340 to have a dressing in place on his/her anterior neck.<br><br>(continued on next page) |

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| Care One at Millbury | 312 Millbury Avenue<br>Millbury, MA 01527 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #340's Minimum Data Set (MDS) assessment dated [DATE], failed to indicate the Resident had a surgical wound.<br><br>During an interview on 4/23/25 at 9:55 A.M., Unit Manager (UM) #1 said Resident #340 was admitted to the facility with a surgical wound on the anterior neck.<br><br>During an interview on 4/24/25 at 8:47 A.M., MDS Nurse #3 said she reviewed Resident #340's clinical record, and that the Resident was admitted to the facility with a surgical wound. MDS Nurse #3 said the surgical incision should have been coded on the MDS dated [DATE], but it was not.<br><br>Please Refer to F684 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901<br><br>Based on observations, and interviews, the facility failed to provide adequate assistance for Activities of Daily Living (ADL - basic care task that an individual does on a day-to-day basis such as eating, bathing, dressing, grooming and mobility) for one Resident (#126) out of a total sample of 29 residents.<br><br>Specifically, for Resident #126, the facility failed to ensure that the Resident who desired to have his/her facial hair removed and required assistance, was offered facial grooming care, resulting in unwanted facial hair.<br><br>Findings include:<br><br>Review of the facility policy titled Activities of Daily Living (ADL) Supporting, effective 2001 indicated:<br><br>-Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:<br><br>-hygiene, mobility, elimination, dining, grooming, meals.<br><br>-If a resident with cognitive impairment or dementia resists care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care.<br><br>-Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.<br><br>Review of the facility's policy titled Dignity, effective 2001, indicated:<br><br>-Residents may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity.<br><br>-Groomed as they wish to be groomed.<br><br>Resident #126 was admitted to the facility in December 2024 with diagnoses including generalized anxiety disorder, Depression, and muscle weakness.<br><br>Review of a Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #126:<br><br>-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15.<br><br>-required assistance with personal hygiene.<br><br>Review of the Comprehensive Care Plan, last revised 2/13/25, indicated Resident #126:<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -had self-care deficit related to physical limitations.<br><br>-needed assistance with daily hygiene, grooming, dressing.<br><br>-will be clean, dressed and well groomed daily to promote dignity and psychosocial well-being.<br><br>On 4/17/25 at 11:32 A.M., the surveyor #1 observed Resident #126's chin and upper lip to have 1.5 inches of facial hair. During an interview at the time, Resident #126 said he/she does not like any facial hair and that staff would help remove the facial hair when he/she remembered to ask for assistance.<br><br>On 4/18/25 at 9:33 A.M., surveyor #1 observed that Resident #126 remained with 1.5 inches of thick facial hair on his/her chin and upper lip. During an interview at the time, Resident #126 said he/she would ask staff to remove the facial hair.<br><br>During an interview on 4/18/25 at 9:53 A.M., Certified Nurses Aide (CNA) #3 said she had not provided ADL care to Resident #126 for the day but the Resident was on her list to provide care.<br><br>On 4/18/25 at 10:39 A.M., surveyor #2 observed Resident #126's face with 1.5 inches of facial hair on the chin and upper lip. During an interview at the time, the Resident asked if surveyor #2 could shave him/her.<br><br>On 4/18/25 at 11:15 A.M., CNA #3 said she was familiar with the Resident and has provided care for the Resident many times. CNA #3 said that Resident #126 needed assistance with all ADLs and the CNA was aware that the Resident had facial hair.<br><br>On 4/18/25 at 11:21 A.M., surveyor #1 observed Resident #126 lying in bed, dressed, and facial hair was still present on his/her chin and upper lip. During an interview at the time, Resident #126 asked the surveyor if someone could assist him/her to shave. Resident #126 said that he/she had been asking to have the facial hair shaved but the CNA had not done so.<br><br>During an interview on 4/18/25 at 11:27 A.M., Nurse #2 said she was not aware of Resident #126 having refused shaving of his/her facial hair.<br><br>During an interview on 4/18/25 at 12:19 P.M., the Director of Nursing (DON) said that CNAs are expected to ask all residents with facial hair if they would like to have facial hair removed and the CNA should have removed Resident #126's facial hair. The DON said removal of the facial hair should have been addressed with Resident #126's daily ADL care but that it was not addressed. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>42761<br><br>Based on observations, interviews, and record reviews, the facility failed to provide treatment and care in accordance with professional standards of practice relative to post-operative care of a non-pressure skin condition for one Resident (#340) out of a total sample of 29 residents.<br><br>Specifically, the facility failed to assess Resident #340's surgical wound and implement post-operative instructions for surgical wound care, when the Resident was admitted to the facility with a surgical incision site on his/her neck, putting the Resident at risk for infection and delayed wound healing.<br><br>Findings include:<br><br>Review of the facility's Policy and Procedure titled Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated 2001 and revised March 2024, indicated the following:<br><br>-The staff will examine the skin of a new admission for ulcerations or alterations in skin.<br><br>-The Physician will authorize pertinent orders related to wound treatments, including .dressings .<br><br>Resident #340 was admitted to the facility in April 2025, with diagnoses including Cervical Spinal Stenosis.<br><br>Review of Resident #340's Hospital Discharge Summary dated 4/9/25, indicated:<br><br>-The Resident had undergone a C4 (fourth cervical vertebra) - C5 (fifth cervical vertebra) ACDF (anterior cervical discectomy and fusion - surgical treatment for cervical spinal stenosis) on 4/7/25.<br><br>-May wear soft collar as needed for comfort.<br><br>-Spine wound care instructions included:<br><br>>May leave incision site open to air 48 hours post op (operative) or cover with sterile gauze for comfort.<br><br>>Call the surgeon's office if there is any . pain, drainage from incision site .<br><br>-Check incision area every day for signs of infection.<br><br>Review of Resident #340's Hospital Patient Care Referral to the Facility dated 4/9/25, and included in the Resident's Hospital Discharge Summary, indicated the following relative to dressing/wound care/special treatment:<br><br>-The Resident had a dressing to his/her anterior neck with scant marked drainage (small amount of fluid with visible specific characteristics, like light pink or red in color, indicating presence of serous fluid and blood), and is a normal part of the healing process).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Some bruising noted.<br><br>-The dressing was to remain in place until 4/10/25.<br><br>Review of Resident #340's Skin Care Plan, initiated 4/10/25, indicated:<br><br>-The Resident had a surgical wound.<br><br>-Monitor for signs and symptoms of infection.<br><br>-Administer analgesia and treatments as ordered.<br><br>Review of Resident #340's April 2025 Physician orders failed to indicate any treatment orders specific to the Resident's surgical incision site.<br><br>Review of Resident #340's Skilled Evaluation Note, dated 4/10/25 indicated:<br><br>-The Resident's skin was warm and dry, normal color, and turgor (elasticity) was normal.<br><br>-No new skin issues were identified.<br><br>-The box for surgical wound was not marked or checked off.<br><br>Review of the Physician History and Physical, dated 4/11/25, indicated Resident #340:<br><br>-was admitted to the facility post hospitalization .<br><br>-underwent an ACDF for severe C4-C5 spinal canal stenosis while in the hospital.<br><br>-neck could not be examined due to the cervical collar the Resident was supposed to wear at all times while out of bed.<br><br>-Re-assessment will be conducted later.<br><br>Review of Resident #340's Skilled Evaluation Note, dated 4/11/25, indicated:<br><br>-No new skin issue noted.<br><br>Review of Resident #340's Nursing Clinical Note, dated 4/12/25, indicated:<br><br>-Anterior neck dressing with bloody drainage this shift.<br><br>Review of Resident #340's Nursing Clinical Note, dated 4/13/25, indicated:<br><br>-Anterior neck dressing intact.<br><br>Review of the Nurse Practitioner (NP) Progress Note, dated 4/15/25, indicated Resident #340:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -was assessed due to shoulder pain.<br><br>-was using a soft collar PRN (as needed).<br><br>Further review of the NP Progress Note failed to include any evidence that the Resident's surgical incision site was examined.<br><br>On 4/17/25 at 12:40 P.M., surveyor #3 observed the following:<br><br>-Resident #340 wore a white, weaved gauze dressing, approximately three inches in length by two inches in width, covered by a transparent dressing on his/her anterior neck.<br><br>-The white guaze dressing was observed with three small, distinct dried bloody areas.<br><br>Review of Resident #340's Clinical Nursing Progress Note, dated 4/19/25, indicated:<br><br>-Anterior neck dressing with dry bloody drainage.<br><br>-No signs/symptoms of infection.<br><br>Review of the NP Progress Note, dated 4/21/25, indicated Resident #340:<br><br>-was being discharged from the facility on 4/21/25.<br><br>-anterior neck surgical site with original dressing on, CDI (clean, dry, intact).<br><br>-surgical dressing to stay in place until follow-up on 4/23/25.<br><br>During an interview on 4/23/25 at 9:55 A.M., Unit Manager (UM) #1 said when Residents are newly admitted to the facility, the admitting Nurse was required to compete a head-to-toe skin check on the Resident. UM #1 said the skin check would include measurements of any alteration in skin identified. UM #1 said if a Resident was admitted with a surgical wound, the Nurse would be required to check the box for surgical wound on the Resident's skin assessment.<br><br>The surveyor and UM #1 reviewed Resident #340's clinical record and UM #1 said there were hospital discharge recommendations from the Resident's surgeon to leave the Resident's dressing in place until 4/10/25. UM #1 said the dressing should have then been removed on 4/10/25, and the Nurse should have assessed the Resident's surgical incision site. UM #1 said the Nurse should have also contacted the Physician to obtain orders for monitoring the Resident's surgical incision site as well as an order for leaving the incision site open to air with an as needed order for a dressing for comfort.<br><br>During an interview on 4/23/25 at 10:19 A.M., Nurse #5 said she remembered caring for Resident #340 when the Resident was in the facility. Nurse #5 said she received verbal report from another Nurse that Resident #340's surgical site dressing was not to be removed unless there was a lot of drainage coming through the dressing. Nurse #5 said she could not remember what day she got that information in report and that she had not looked at the Resident's surgical incision site. Nurse #5 said she did not review the Resident's clinical record for any other instructions relative to the Resident's surgical incision site.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/23/25 at 10:30 A.M., Nurse #4 said she completed the Skilled Evaluation Note for Resident #340 on 4/10/25. Nurse #4 said she did not observe the Resident's surgical incision site on 4/10/25 because the Resident was wearing a soft collar and Nurse #4 was not allowed to remove the soft collar. Nurse #4 said she did observe the Resident on a different day without the soft collar and observed one steri strip over the incision site, but she could not recall what day she observed this.<br><br>During an interview on 4/23/25 at 10:45 A.M., the Staff Development Coordinator (SDC) said she was also the Wound Nurse. The SDC said the facility implemented new admission assessments around 4/1/25 called the Nursing Advantage Clinical Admission Assessment and that this assessment was to be completed within 24 hours of a Resident's admission to the facility. The SDC said that the Nursing Advantage Clinical Admission Assessment included assessment of skin. The SDC said the Nursing Advantage Clinical Admission Assessment was a smartform, and when an issue was identified on the Assessment, that same issue would be carried forward to the next assessment being completed for the area of concern. The surveyor and the SDC reviewed Resident #340's clinical record and the SDC said the Nursing Advantage Clinical Admission Assessment was not completed for Resident #340. The SDC also said the admitting Nurse should have taken the instructions from the Resident's hospital discharge summary relative to surgical site care and obtained orders from the Physician at the facility to ensure adequate monitoring and applicable treatments be provided to the Resident. The SDC further said she did not observe the Resident's surgical incision site after the Resident was admitted to the facility because she was told by nursing staff that the incision was not an issue, had no drainage, and was being left open to air. The SDC said if in fact the Resident experienced drainage from the incision site, staff should have alerted her, then she would have assessed the Resident and observed whether a treatment was needed. The SDC said the Resident's surgical incision site should have been assessed for characteristics such as wound size, wound bed, drainage including amount and appearance, and pain.<br><br>During an interview on 4/23/25 at 12:28 P.M., Nurse #3 said he was the admitting Nurse on the 3:00 P.M. -11:00 P.M. (3-11) shift when Resident #340 was admitted to the facility. Nurse #3 said the facility often receives may new admissions on the 3-11 shift, so the Nurses working will all help each other out to complete the admission paperwork for the residents admitted . Nurse #3 said there was often a desk Nurse on the 3-11 shift who would review the hospital discharge paperwork and extract instructions that would then be obtained as Physician orders for the residents. Nurse #3 said he could not recall what admission paperwork he completed for Resident #340 when the Resident was admitted . Nurse #3 said he did not know what the instructions were from the Surgeon relative to Resident #340's surgical incision site.<br><br>During an interview on 4/25/25 at 11:11 A.M., the Director of Nursing (DON) said when Resident #340 was admitted to the facility, the admitting Nurse should have taken the hospital discharge instructions for the Resident's surgical incision site and submitted the instructions as orders for the Physician to review and approve/disapprove and/or revise.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/25/25 at 12:25 P.M., with the Physician and Nurse Practitioner (NP) #2, the Physician said she did not assess Resident #340's surgical incision site when she completed her initial assessment on 4/11/25 with the Resident because the Resident was wearing a soft collar and told the Physician that he/she could not remove the soft collar. NP #2 said she did not assess Resident #340's surgical incision site during the Resident's stay at the facility. NP #2 said she completed Resident #340's discharge summary and that upon completing the Resident's discharge summary, the Resident had a dressing in place over the surgical incision site. NP #2 said at that time, the Resident said the dressing needed to remain in place until his/her scheduled follow-up appointment with the Surgeon after the Resident was discharged from the facility. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>42761<br><br>Based on observation, interviews, and record reviews, the facility failed to provide care and services, consistent with professional standards of practice and the Resident's comprehensive person-centered plan of care relative to the care of an indwelling urinary catheter for one Resident (#94) out of a total sample 29 residents.<br><br>Specifically, the facility failed to adhere to a Physician order for elevating Resident #94's genital area when the Resident experienced an indwelling catheter associated complication of genital slit and swelling, increasing the Resident's risk for further urinary catheter associated complications.<br><br>Findings include:<br><br>Review of the facility's Urinary Catheter Care Policy and Procedure, dated 2001 and revised August 2022, indicated the following:<br><br>-The purpose of the procedure was to prevent urinary catheter-associated complications .<br><br>-Review the resident's care plan to assess for any special needs of the resident.<br><br>Resident #94 was admitted to the facility in September 2022 with diagnoses including Urinary Tract Infection (UTI) and retention of urine.<br><br>Review of the Activities of Daily Living (ADL) Care Plan, initiated 9/27/22 and revised 10/4/24, indicated Resident #94:<br><br>-had an ADL self care deficit related to physical limitations.<br><br>-declined repositioning at times.<br><br>-required assist of two with bed-level ADLs.<br><br>-required assist of two for positioning in bed.<br><br>Review of the Indwelling Urinary Catheter Care Plan, initiated 9/28/22 and revised 10/4/24, indicated Resident #94:<br><br>-required an indwelling urinary catheter due to obstructive uropathy.<br><br>-will have no acute complications of urinary catheter.<br><br>Review of the Skin Breakdown Care Plan, initiated 2/3/25, indicated Resident #94:<br><br>-had actual skin breakdown related to a slit on his/her genital area.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -administer treatment per Physician orders.<br><br>-Wound consult as needed.<br><br>Review of Resident #94's SBAR (Situation, Background, Appearance, Review and Notify) Note, dated 2/3/25, indicated:<br><br>-The Resident experienced a change in condition relative to a slit on his/her genital area.<br><br>-The Nurse Practitioner (NP) was notified of the Resident's change in condition.<br><br>Review of Resident #94's NP Note, dated 2/3/25, indicated:<br><br>-The Resident had an indwelling urinary catheter in place.<br><br>-The Resident presented with a wound on his/her genital area.<br><br>-The Resident was in no apparent distress.<br><br>-The plan included application of Bacitracin (antibacterial ointment) to the wound site.<br><br>-Continue pain medication regimen.<br><br>Review of Resident #94's Physician orders, dated 3/21/25, indicated the following:<br><br>-Air mattress to bed .<br><br>Review of Resident #94's Telehealth Note, dated 3/23/25, indicated:<br><br>-The Resident was being seen for edematous (swollen) genital area that was split open.<br><br>-The plan included to elevate the Resident's genital area.<br><br>Review of Resident #94's Nursing Progress Note, dated 3/23/25, indicated:<br><br>-Redness around the slits of the Resident's genital area was reported to the NP on-call.<br><br>-NP on-call gave new orders of Neomycin-Bacitracin-Polymyxin to be applied and for the genitals to be elevated.<br><br>Review of Resident #94's March 2025 Physician orders failed to indicate that an order was transcribed and implemented to elevate the Resident's genital area.<br><br>Review of Resident #94's April 2025 Physician orders indicated:<br><br>-An order to elevate the Resident's genital area as much as possible, every shift.<br><br>-The order to elevate the Resident's genital area was not implemented until 4/17/25.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #94's April 2025 Treatment Administration Record (TAR) indicated the Resident's genital area were being elevated as much as possible every shift from 4/17/25 on the evening (3:00 P.M. -11:00 P.M. ) shift through 4/23/25.<br><br>Review of Resident #94's Non-Pressure Skin Condition Record, dated 4/23/25, indicated the Resident's genital slit measured 3.0 centimeters (cm) in length x (by) 3.0 cm in width x 0.1 cm in depth.<br><br>On 4/23/25 at 10:31 A.M., surveyor #2 observed the following in Resident #94's room with Nurse #10:<br><br>-Resident #94 was positioned on an air mattress in bed, lying on his/her back with the head of the bead elevated approximately 30 degrees.<br><br>-Nurse #10 requested permission from Resident #94 for Nurse #10 and surveyor #2 to observe the indwelling urinary catheter.<br><br>-Resident #94 allowed the observation.<br><br>-Nurse #10 said she knew the Resident's genital area was tender and that she just needed to see the catheter.<br><br>-Surveyor #2 observed the Resident's genital area to have a large slit.<br><br>-Surveyor #2 observed that the Resident's genital area was not elevated.<br><br>During an interview on 4/23/25 at 1:55 P.M., Certified Nurses Aide (CNA) #8 said she had been working at the facility since November 2024 and frequently provided care for Resident #94. CNA #8 said Resident #94 required total staff assistance for ADLs and care of the indwelling urinary catheter. CNA #8 said the Resident also required staff assistance for positioning. CNA #8 said she was not aware of any interventions in place for elevating the Resident's genital area and that she did not offer elevation of the Resident's genital area to the Resident when she cared for him/her. CNA #8 further said she did not know how elevation to the genital area would be provided.<br><br>During an interview on 4/23/25 at 2:15 P.M., Resident #94 said he/she preferred to stay in bed and that staff would offer to reposition him/her in the bed and that elevating his/her genital area was not offered nor provided.<br><br>During an interview on 4/23/25 at 5:00 P.M., Nurse #10 said she signed off on Resident #94's TAR indicating elevation had been provided for the Resident's genital area. Nurse #10 said the fact that the Resident had an air mattress was enough to provide elevation, so she did not need to provide any other interventions to elevate the genital area. Nurse #10 said she was not aware of any other interventions to provide elevation to the Resident's genital area.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/23/25 at 5:30 P.M., the Director of Nursing (DON) said an air mattress would not provide elevation to a Resident's genital area and that elevation of genital area would be done the same way elevating other body parts would be done, such as using pillows or rolled towels. The DON said a small pillow could be used to elevate a Resident's genital area. The DON said Resident #94 had a history of refusing care, including repositioning and getting out of bed and that she would look into what was being done to provide elevation for the Resident's genital area.<br><br>During a follow-up interview on 4/24/25 at 7:30 A.M., the DON said she looked into what staff were providing for elevation of Resident #94's genital area. The DON said through interviewing staff on 4/23/25, she identified that staff did not know how to provide elevation to a Resident's genital area, so education needed to be provided to staff. The DON said if staff did not know how to provide positioning techniques for elevating the Resident's genital area, the staff should have alerted her, and education would have been provided. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>50138<br><br>Based on observations, record reviews, and interviews, the facility failed to provide care and maintenance of intravenous (IV) therapy consistent with professional standards of practice for two Residents (#343 and #68), out of a total sample of 29 residents.<br><br>Specifically,<br><br>1. For Resident #343, the facility failed to ensure nursing staff correctly transcribed and administered Physician orders for a Peripherally Inserted Central Catheter (PICC) relative to flushing when the Resident was admitted to the facility with a PICC line in place, placing the Resident at risk for PICC line blockage and impaired medication administration.<br><br>2. For Resident #68, the facility failed to provide care of a peripheral intravenous catheter (PIV) consistent with professional standards of practice and in accordance with Physician orders relative to flushing the IV and the duration of time the PIV was left in place.<br><br>Findings include:<br><br>1. Review of the facility policy, Central Venous Catheter Flushing and Locking, revision date March 2022, included but was not limited to:<br><br>-The purpose of this procedure is to maintain patency of central venous catheters; to prevent mixing of incompatible medications .and to ensure entire dose of solution or medication is administered into the venous system.<br><br>-Solution/Volume:<br><br><use preservative free 0.9% sodium chloride (normal saline) for flushing central venous access device.<br><br><lock central venous access devices with either preservative free 0.9% Sodium Chloride or Heparin (anticoagulant medication used to prevent blood from clotting) 10 units/ml (per milliliter) (or in accordance to manufacturers directions).<br><br>-Flushing to maintain patency of catheter:<br><br><flush with preservative free 0.9% Sodium Chloride using a push-pause technique.<br><br><attach syringe with locking solution and LOCK with Saline or Heparin as ordered.<br><br><repeat process on each lumen of multi lumen catheter.<br><br>-Flushing when giving medications:<br><br>< flush with preservative free 0.9% Sodium Chloride using a push-pause technique.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | <administer medication/solution at ordered rate.<br><br><flush with preservative free 0.9% Sodium Chloride using a push-pause technique.<br><br><attach syringe with locking solution and LOCK with Saline or Heparin as ordered.<br><br><document procedure in resident's medical record.<br><br>-Documentation: the following information should be recorded in the resident's medical record:<br><br><date and time the medication was administered.<br><br><total amount of flush administered.<br><br><signature and title of the person recording the data.<br><br>Review of the facility's Intravenous Protocols, dated 11/1/18, included but was not limited to:<br><br>>PICC:<br><br>-Flush unused lumens/minimum flush interval to maintain patency ever eight hours with 10 ml Normal Saline (Sodium Chloride), then if non-valved, Heparin 10 units/ml 5 ml.<br><br>-Flush for intermittent medication administration SASH (Saline, Antibiotic, Saline, Heparin) with 10 ml Normal Saline, followed by antibiotic/medication, followed by 10 ml Normal Saline, then if non-valved Heparin 10 units/ml 5 ml.<br><br>Resident #343 was admitted to the facility in April 2025 with diagnoses including bacteremia and osteomyelitis.<br><br>Review of the Medical Record included but was not limited to Resident #343:<br><br>-had intravenous access to the left upper extremity with a non-valved, double lumen PICC line at the time of admission.<br><br>-was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of a total possible score of 15.<br><br>Review of the Person-Centered Care Plan for PICC line, initiated 4/8/25, indicated for Resident #343:<br><br>-Potential for complications at PICC line site.<br><br>-Enhanced Barrier Precautions (EBP) for Central Venous Catheter (PICC) use.<br><br>-Flush IV line per Physician's orders<br><br>Review of Resident #343's April 2025 Physician orders included but was not limited to:<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Maintain EBP every shift.<br><br>-Ampicillin Sodium (antibiotic medication) Injection Solution Reconstituted 2 GM (Gram) intravenously (IV) every four hours for infection for 28 days (start date 4/9/25, end date 5/7/25).<br><br>-Ceftriaxone Sodium (antibiotic medication) Injection Solution Reconstituted 2 GM, use two gram IV one time a day for infection for 27 days (start date 4/10/25, end date 5/7/25).<br><br>-Heparin Lock Flush Solution 10 unit/ml, use 5 ml intravenously as needed for new adm [sic] flush after each use with 0.9% Sodium Chloride 10 ml then Heparin 10 units/ml 5 ml, effective 4/9/25.<br><br>-Sodium Chloride Solution 0.9%, use 10 ml intravenously as needed for IV therapy flush at least every 8 hours and PRN to maintain catheter patency, effective 4/9/25.<br><br>-Sodium Chloride Solution 0.9% use 10 ml intravenously as needed for IV therapy flush before each use, effective 4/9/25.<br><br>Review of Resident #343's April 2025 Medication Administration Record (MAR) indicated:<br><br>-Ampicillin Sodium Injection Solution Reconstituted 2 gm (Gram) intravenously, had been administered by the facility Nurses every 4 hours.<br><br>-Ceftriaxone Sodium Injection Solution Reconstituted 2 gm, use 2 gm intravenously, had been administered one time a day by the facility Nurses.<br><br>-EBP had been maintained every shift by the facility Nurses.<br><br>-No evidence that Heparin Lock Flushes had been administered since admission to the facility with a PICC line as ordered by the Physician or per the facility's intravenous protocols.<br><br>-No evidence that Sodium Chloride Flushes had been administered since admission to the facility with a PICC line as ordered by the Physician or per the facility's intravenous protocols.<br><br>On 4/22/25 at 2:12 P.M., the surveyor observed the following during an IV flush process by Nurse #4:<br><br>-Nurse #4 disconnected Resident #343 from the Ampicillin Sodium medication.<br><br>-Nurse #4 flushed both lumens of the Resident's PICC line with 10 ml of Normal Saline followed by 5 ml of 10 unit/ml Heparin.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview at the time, Nurse #4 said that she had flushed both lumens of the Resident's PICC line with Normal Saline followed by Heparin. When the surveyor asked how Nurse #4 knew when and with what to flush the PICC line with, Nurse #4 said because flushes are standard and on the Resident's MAR from the Physician's orders.The surveyor and Nurse #4 observed Resident #343's MAR and Nurse #4 said the orders to flush the Resident's PICC were not written correctly on the MAR. Nurse #4 said that Normal Saline and Heparin Flushes were only entered to be given as needed. Nurse #4 said that there was no evidence that the Resident's PICC line had ever been flushed before today. Nurse #4 said that the Resident's MAR needed to be corrected. Nurse #4 said that if the Resident's PICC line did not get flushed with Saline and Heparin as ordered, the PICC line could become blocked.<br><br>During an interview on 4/22/25 at 2:37 P.M., the Staff Development Coordinator (SDC) said that all intravenous flushing protocols were available in the electronic charting system for the facility Nurses to use. The SDC said that Resident #343 had a double lumen, non-valved PICC line which required flushing every eight hours for the non-used lumen with 10 ml of Normal Saline, followed by 5 ml of 10 unit/ml Heparin. The SDC said that the used lumen, like the one used for the antibiotic administration, required flushing before and after each use with the SASH method which would be -10 ml Normal Saline, followed by the antibiotic, followed by 10 ml of Normal Saline, and then 5 ml of 10 unit/ml Heparin. The surveyor and the SDC observed Resident #343's MAR and the SDC said that there was no indication for which lumen was being used for antibiotics and which lumen was unused on the Resident's MAR. The SDC also said that there was no evidence that either lumen of the Resident's PICC line had been flushed since admission. The SDC said that the orders had not been entered correctly and needed to be corrected. The SDC said that improper PICC line flushing could result in an occluded (blocked) PICC line.<br><br>During an interview on 4/23/25 at 12:32 P.M., the Director of Nursing (DON) said that admitting Nurses should obtain orders for intravenous medications and flushes by use of the electronic charting system protocol which are based on the current standards of professional practice then confirmed with the Physician. The DON said that PICC line flushing should be documented by the nurses onto the Residents MAR with every administration. At that same time the DON and surveyor observed Resident #343 MAR. The DON said the nurses would not know to flush per protocol with the current orders in place on the Residents MAR. The DON said that a second order check should have been done to correct the mistake on the same shift and/or the next shift. The DON said that not flushing a resident ' S PICC line was a concern because the PICC line could clot off and become unusable.<br><br>42761<br><br>2. Review of the facility's IV Protocols Reference Grid per [Pharmacy Name], dated 11/1/18, indicated the following relative to short PIV catheters:<br><br>-The minimum flush interval to maintain patency is 10 milliliters (ml) of Normal Saline (NS) every eight hours.<br><br>-Flushing for intermittent medication administration (patency check required) is 10 ml NS, administer medication, 10 ml NS.<br><br>-Transparent dressing changes with each site rotation every 96 hours and PRN (as needed).<br><br>-Needleless connector changes .with each site rotation and PRN.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #68 was admitted to the facility in March 2025 with diagnoses including Urinary Tract Infection (UTI) and Altered Mental Status (AMS).<br><br>Review of Resident #68's April 2025 Physician orders indicated:<br><br>-Obtain UA (urinalysis: test of urine which may be suggestive of UTI) C+S (culture and sensitivity: identifies the microorganism causing infection and which medication will be effective for treatment) for hematuria (blood in urine) and dysuria (pain or burning during urination). Once collected, place order for urinalysis and urine culture on lab site for specimen pick-up (4/7/25).<br><br>Review of Resident #68's Interim Physician Order Sheet, dated 4/9/25, indicated:<br><br>-Place PIV.<br><br>-Start on 4/10/25: IV Ertapenem (antibiotic medication) one gram (gm) via IV QD (daily) x 6 days for ESBL (type of multi drug resistant organism) UTI.<br><br>Review of Resident #68's Nursing Notes indicated the following:<br><br>-IV device: Peripheral cannula; Solution: NS (normal saline) IV, Location: Right arm PIV is patent. Flushes easily (dated 4/10/25, 4/15/25 and 4/16/25).<br><br>-IV device: Peripheral cannula; Solution: NS (normal saline) IV, Location: Right arm PIV is patent. Flushes easily. Dressing intact (dated 4/12/25).<br><br>- .Continues on Ertapenem via right peripheral line for ESBL, no adverse reactions noted. Peripheral line patent and flushed a/o (as ordered), blood return noted, no S/S (signs/symptoms) infiltration (when IV fluid leaks into the surrounding tissue instead of the vein) or phlebitis (inflammation of a vein) (dated 4/13/25).<br><br>-IV device: Peripheral cannula. Status post Ertapenem.<br><br>Review of Resident #68's Interim Physician Order Sheet, dated 4/16/25, indicated:<br><br>-DC (discontinue) PIV when antibiotic complete.<br><br>Review of the April 2025 Medication Administration Record indicated Resident #68:<br><br>-completed his/her course of IV Ertapenem on 4/15/25.<br><br>-PIV was discontinued on 4/17/25.<br><br>Review of Resident #68's clinical record failed to indicate any orders relative to:<br><br>-Flushing the Resident's PIV.<br><br>-Site rotation of the PIV.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Dressing changes for the PIV.<br><br>-Needleless connector changes for the PIV.<br><br>On 4/18/25 at 9:35 A.M., surveyor #1 observed Resident #68 seated in his/her wheelchair and dressed in a long sleeved shirt. During an interview at the time, Resident #68 said he/she had an infection and was receiving medication through an IV in his/her right arm.<br><br>On 4/18/25 at 10:32 A.M., surveyor #2 and Nurse #9 observed Resident #68's right upper extremity as follows:<br><br>-A PIV was in place on the Resident's right arm.<br><br>-The IV site was covered with a transparent dressing, dated 4/9/25 (nine days prior to the observation date).<br><br>-The transparent dressing was partially lifted away from the Resident's skin.<br><br>Review of Resident #68's Nurse Practitioner (NP) order, dated 4/18/25 at 10:45 A.M., indicated:<br><br>-D/C (discontinue) PIV.<br><br>During an interview on 4/18/25 at 12:15 P.M., Nurse #9 said when Residents have a short PIV placed while at the facility, the Nurse is responsible to obtain orders from the Physician/NP for care of the PIV. Nurse #9 said orders to care for the PIV would include orders for flushing the IV, dressing changes for the IV, and monitoring the IV site for infection and infiltration. Nurse #9 said the standard of practice for a short PIV was to remove the PIV after 72 hours and contact the Physician/NP to determine whether another IV should be placed and IV antibiotics continued, or if the Physician/NP wanted to switch to oral antibiotics at that time. Nurse #9 said if a Resident had special circumstances for a PIV not be removed after 72 hours, the special circumstances would be documented in the Resident's record. Surveyor #1 and Nurse #9 reviewed Resident #68's clinical record and Nurse #9 said no orders had been obtained for the Resident's PIV relative to flushing, site rotation, dressing changes, and monitoring the site for infection and infiltration. Nurse #9 said when she came into work that morning, she observed that Resident #68 still had the PIV in place, and she thought it was supposed have been discontinued. Nurse #9 said when she observed the Resident's PIV site with surveyor #2, the Resident's PIV access site was still covered, and the edge of the dressing was lifted and frayed. Nurse #9 said she reviewed the Resident's clinical record and did not see an order to discontinue the PIV, so she contacted NP #1. Nurse #9 said NP #1 gave an order to remove the PIV and Nurse #9 then removed the PIV. Nurse #9 also said the Resident had completed his/her course of antibiotics and if she had not observed the PIV still in the Resident's arm, she would not have been triggered to call NP #1 regarding removal of the PIV. Nurse #9 said leaving a PIV in longer than it should could increase the Resident's risk for infection.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/18/25 at 12:25 P.M., Nurse #13 said anytime a Resident had an IV placed, the Nurse was responsible to obtain orders for care of the IV. Nurse #13 said the orders were easy to obtain as the computer system had batch orders where the Nurse would select the type of IV and click the boxes in the drop-down for the items associated with that specific IV. Nurse #13 said she would obtain a copy of what the batch orders were that were required for the care of a short peripheral IV. Nurse #13 also said short PIVs should be removed after 72 hours.<br><br>During an interview on 4/18/25 at 1:04 P.M., the Director of Nursing (DON) said batch orders for IVs are to obtained by the Nurse when the IV is placed. The DON said short PIVs were to be removed after 72 hours unless specified in the Resident's medical record, that the PIV was not to be removed.<br><br>On 4/18/25 at 1:18 P.M., the DON provided a sample copy of the batch orders from the computer system relative to care of a PIV and said these batch orders should have been obtained for Resident #68 when the PIV was placed on 4/9/25. The surveyor and the DON reviewed the batch orders as follows:<br><br>-Flush before and after IV medication administration, and every eight hours.<br><br>-Dressing: Peripheral - short IV catheter<br><br>-Dressing: site assessment.<br><br>-IV tubing change (continuous and intermittent).<br><br>During an interview on 4/18/25 at 1:20 P.M., Nurse #14 said she worked at the facility on 4/17/25 and was responsible to care for Resident #68. Nurse #14 said she signed the Resident's MAR for 4/17/25 indicating the PIV was discontinued, but she did not remove the PIV.<br><br>During an interview on 4/18/25 at 2:01 P.M., NP #1 said when a Resident has an IV placed, the Nurse selects batch orders in the computer for IV care. NP #1 said the batch orders selected then go into a queue to be reviewed and approved by the NP or Physician. NP #1 said the batch orders should have been selected for Resident #68. NP #1 also said removing a short PIV after 72 hours is the standard of practice. NP #1 said she would sometimes write an order not to remove an IV after 72 hours if a Resident has poor vein access or difficulty with IV insertion. NP #1 said she was initially not sure how Resident #68 would react to having an IV placed and used for administration of antibiotics due to the Resident's cognitive status, but the Resident did not have any issues with the IV being placed and accessed. NP #1 said since the Resident did not have any issues with the placement and use of the IV, the IV should have been removed after 72 hours and a new IV placed for the continued administration of IV antibiotics. NP #1 also said nursing staff should have removed the Resident's PIV on 4/17/25, as ordered. |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>42761<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure that effective pain management that was consistent with professional standards of practice and the Resident's comprehensive person-centered care plan was provided for one Resident (#94) out of a total sample of 29 residents.<br><br>Specifically, for Resident #94, the facility failed to:<br><br>-adequately assess the Resident's pain during personal care of an indwelling urinary catheter when facility staff were aware the Resident had a genital wound and experienced pain during urinary catheter care, resulting in the Resident experiencing pain during indwelling urinary catheter related procedures.<br><br>-provide interventions for pain management during personal care of an indwelling urinary catheter which resulted in the Resident anticipating and experiencing pain relative to indwelling urinary catheter care.<br><br>-offer alternate pain interventions when prescribed pain medication specifically ordered for genital pain related to the Resident's genital wound was unavailable which resulted in the Resident experiencing pain.<br><br>Findings include:<br><br>Review of the facility's policy and procedure titled Pain Assessment and Management, dated 2001 and revised October 2022, indicated the following:<br><br>>The purpose of the procedure was to help staff<br><br>-identify pain in the resident.<br><br>-develop interventions consistent with the resident's goals and needs.<br><br>-address the underlying causes of pain.<br><br>>Pain management is defined as the process of alleviating the resident's pain based on his/her clinical condition and established treatment goals.<br><br>>Pain management includes the following:<br><br>-Assessing the potential for pain.<br><br>-Recognizing the presence of pain.<br><br>-Identifying the characteristics of pain.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Addressing the underlying cause of pain.<br><br>-Developing and implementing approaches to pain management.<br><br>-Identifying and using specific strategies for different levels and sources of pain.<br><br>-Modifying approaches as necessary.<br><br>-Observe the resident (during rest and movement) for psychologic and behavioral (non-verbal) signs of pain.<br><br>>Possible behavioral signs of pain include:<br><br>-Negative verbalizations and vocalizations such as groaning, crying, screaming.<br><br>-Facial expressions such as grimacing, frowning, clenching of the jaw, etc.<br><br>-Behavior such as resisting care.<br><br>-Assess the resident . to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment.<br><br>-If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated.<br><br>Resident #94 was admitted to the facility in September 2022 with diagnoses including Urinary Tract Infection (UTI), retention of urine, adjustment disorder with anxiety, and urethral erosion (tearing of the urethra in individuals who have had indwelling urinary catheters for a prolonged period of time).<br><br>Review of the Pain Care Plan, initiated 9/27/22, indicated Resident #94:<br><br>-had generalized pain.<br><br>-has a goal to express that pain management was within acceptable limits.<br><br>-had adjusted times of activities of daily living (ADLs) and treatment activities so that they occur after analgesia benefits have been achieved.<br><br>-pain medication administration per Physician orders.<br><br>-if pain frequency/intensity is worsening or of [sic] current analgesia regimen has become ineffective, notify Physician.<br><br>-report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, .<br><br>Review of Resident #94's SBAR (Situation, Background, Appearance, Review and Notify) Note, dated 2/3/25, indicated:<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -The Resident experienced a change in condition relative to a slit on his/her genital area.<br><br>-The Nurse Practitioner (NP) was notified of the Resident's change in condition.<br><br>Review of Resident #94's Skin Breakdown Care Plan, initiated 2/3/25, indicated:<br><br>-has skin breakdown related to slit on his/her genitals.<br><br>-Administer treatment per Physician orders.<br><br>Review of Resident #94's NP Note, dated 2/3/25, indicated:<br><br>-has an indwelling urinary catheter in place.<br><br>-presented with a wound on his/her genital area.<br><br>-was in no apparent distress.<br><br>-plan for application of Bacitracin (antibacterial ointment) to the wound site.<br><br>-continue pain medication regimen.<br><br>Review of the Minimum Data Set (MDS) Assessment, dated 2/27/25, indicated Resident #94:<br><br>-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 total possible points.<br><br>-has an indwelling urinary catheter.<br><br>-was dependent on staff for bathing.<br><br>-reported pain, almost constantly, at a level of 8 out of 10 (severe).<br><br>Review of Resident #94's Telehealth Note, dated 3/23/25, indicated:<br><br>-The Resident was being seen for edematous (swollen) genital area that was split open.<br><br>-okay to apply Bacitracin to keep skin moist and prevent bacterial transmission.<br><br>-diagnoses included laceration without foreign body of [genital site].<br><br>Review of Resident #94's NP note, dated 3/24/25, indicated:<br><br>-was assessed for worsening genital slit from chronic indwelling urinary catheter.<br><br>-Resident stated having occasional pain to his/her genital area when the indwelling urinary catheter was moved.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -will order Lidocaine Gel (topical medication used to treat pain) to be applied BID (twice daily) PRN (as needed) for pain.<br><br>Review of Resident #94's NP Note, dated 4/17/25, indicated:<br><br>-was assessed for blood noted to his/her indwelling urinary catheter site.<br><br>-At the time of the NP visit, the Resident presented with a scant amount of blood in his/her incontinence brief.<br><br>-The Resident denied pain.<br><br>-Continue Lidocaine Gel to be applied BID for pain/discomfort.<br><br>Review of Resident #94's April 2025 Physician orders indicated:<br><br>-Pain score every shift (0 = no pain, 1-4 = mild pain, 5-7 = moderate pain, 8-10 = severe pain), start date 9/27/22.<br><br>-Provide catheter care every shift, start date 10/2/24.<br><br>-Acetaminophen oral tablet 500 milligrams (mg), give 1000 mg by mouth every eight hours for pain, start date 10/9/24.<br><br>-Skin documentation - Slit/genital area. Every shift for pain and infection, dated 2/3/25.<br><br>-Tramadol HCL (opioid pain medication) oral tablet 50 mg, give 25 mg by mouth every 24 hours as needed for pain, start date 3/20/25.<br><br>-Lidocaine External Gel 0.5% (percent), apply to genital slit topically two times a day for pain, start date 3/24/25.<br><br>Review of Resident #94's April 2025 Medication Administration Record (MAR) indicated:<br><br>-Acetaminophen was administered as ordered.<br><br>-Tramadol HCL was administered for lower extremity pain on 4/11/25, 4/14/25, 4/15/25, 4/21/25, and 4/22/25.<br><br>-Tramadol HCL was administered for pain of an unspecified site on 4/19/25.<br><br>-Lidocaine Gel ordered to be applied to the Resident's genital slit was coded as not administered due to absence of condition/not applicable for: 30 out of 46 scheduled doses between 4/1/25 and 4/23/25.<br><br>Review of Resident #94's April 2025 Treatment Administration Record (TAR) indicated:<br><br>-Catheter care was provided every shift (three times daily) between 4/1/25 and 4/23/25.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -under skin documentation [genital area slit], the codes for pain = P, for no pain = NP.<br><br>-The Resident reported pain (P) to his/her genital area on 19 out of 23 days reviewed.<br><br>Review of Resident #94's Non-Pressure Skin Condition Record, dated 4/23/25, indicated the Resident's genital slit measured 3.0 centimeters (cm) x (by) 3.0 cm x 0.1 cm.<br><br>On 4/23/25 at 10:31 A.M., surveyor #2 with Nurse #10 observed the following in Resident #94's room:<br><br>-Nurse #10 requested permission from Resident #94 for Nurse #10 and surveyor #2 to observe the indwelling urinary catheter.<br><br>-Resident #94 furrowed his/her brow and clenched his/her teeth.<br><br>-Nurse #10 said to Resident #94 she knew the Resident's genital area was tender and that she just needed to see the catheter.<br><br>-The Resident allowed the observation.<br><br>-The surveyor observed the Resident's genital area to have a large slit.<br><br>-Nurse #10 lifted the Resident's indwelling urinary catheter tubing and the Resident furrowed his/her brow, clenched his/her teeth, raised his/her hands in the air and clenched his/her fists.<br><br>-When the observation was complete, Nurse #10 exited the room.<br><br>-The surveyor observed that Nurse #10 failed to assess Resident #94 for pain during the observation of the indwelling urinary catheter.<br><br>During an interview on 4/23/25 at 1:55 P.M., Certified Nurses Aide (CNA) #8 said she had been working at the facility since November 2024 and frequently provided care for Resident #94. CNA #8 said Resident #94 required total staff assistance for Activities of Daily Living (ADLs) and care of the indwelling urinary catheter. CNA #8 said she provided urinary catheter care as well as she could for Resident #94 because care of the urinary catheter hurt the Resident. CNA #8 said she would just try to talk the Resident through urinary catheter care and explain that it was important to keep the catheter area clean to prevent infection. CNA #8 also said urinary catheter care was more painful for the Resident when the Resident had a bowel movement as the Resident was incontinent and feces would need to be cleaned from the genital slit. CNA #8 said she would tell the Resident that she knew it was sore, and that the catheter care just needed to be done. CNA #8 said she would alert the Nurse if the Resident experienced pain once the catheter care was complete.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 4/23/25 at 2:15 P.M., Resident #94 said he/she had no pain in the genital area when staying still and that he/she always had pain whenever staff provided urinary catheter care and/or moved the urinary catheter. Resident #94 said staff frequently asked him/her about lower extremity pain and did not ask him/her about genital pain during urinary catheter care or when they moved the urinary catheter. Resident #94 also said staff just tell him/her they know the urinary catheter care hurts and is sore, and that they just need to keep him/her clean. Resident #94 said once staff stop manipulating the urinary catheter, the pain stops.<br><br>During an interview on 4/23/25 at 5:00 P.M., Nurse #10 said Resident #94 always has pain when his/her urinary catheter was manipulated and that the pain would stop when procedures for the urinary catheter were complete. Nurse #10 said she did not ask the Resident about pain during the observation on 4/23/25 at 10:31 A.M. with surveyor #2 because she did not think the Resident's pain was excruciating. Nurse #10 also said that the ordered Lidocaine Gel to be applied twice daily to Resident #94's genital slit had not been applied on 4/23/25 and that the Lidocaine Gel had been unavailable for quite some time. Nurse #10 said she did not know when the facility's last request was made to the pharmacy to deliver the Lidocaine Gel for the Resident. Nurse #10 said no alternate interventions for pain management had been offered to Resident #94 relative to genital pain this day.<br><br>During an interview on 4/24/25 at 12:27 P.M., the NP said she worked in the facility five days per week and provided services for Resident #94. The NP said staff had not communicated to her that Resident #94 always had pain when they provided procedures to the Resident's urinary catheter site. The NP also said she did not know the Resident's Lidocaine Gel was not being administered and was not available. The NP said if staff had made her aware that the Resident was always having pain during urinary catheter procedures, she would have reassessed the Resident's pain and provided orders for effective pain management. The NP further said if she had known the Lidocaine Gel was not available for Resident #94, she would have provided alternate instructions for pain management.<br><br>During an interview on 4/25/25 at 8:26 A.M., Nurse #11 said she had worked at the facility for five years and had provided care to Resident #94 for a long time. Nurse #11 said Resident #94 was not always comfortable due to his/her genital wound. Nurse #11 said the Resident always anticipated pain and would scream, even before initiating procedures for care of the urinary catheter.<br><br>During an interview on 4/25/25 at 11:01 A.M., the Director of Nursing (DON) said facility staff were required to monitor and assess residents for verbal and nonverbal signs of pain and to provide effective interventions for pain management. The DON said if interventions for pain were unsuccessful, residents would be reassessed, and effective interventions would be implemented. The DON said she was not aware the ordered Lidocaine Gel was not being administered to Resident #94 and was not aware the Lidocaine Gel had been unavailable to the Resident. The DON said staff should have assessed Resident #94 for pain when the Resident demonstrated verbal and nonverbal signs of pain for urinary catheter procedures, and developed and implemented effective interventions for pain management.<br><br>Please refer to F755 and F865. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138<br><br>Based on record reviews, observations, and interviews, the facility failed to provide pharmacy services for routine medications for three Residents (#341, #94, and #38) out of a total sample of 29 residents.<br><br>Specifically,<br><br>1. For Resident #341, the facility failed to procure and administer Amlodipine Besylate-Valsartan (high blood pressure medication) as ordered by the Physician when the Resident had a known history of Hypertension (high blood pressure).<br><br>2. For Resident #94, the facility failed to provide pharmaceutical services for obtaining Lidocaine Gel and Biofreeze (topical pain medications) when Lidocaine Gel and Biofreeze were ordered by the Physician to be administered to the Resident for pain management.<br><br>3. For Resident #38, the facility failed to provide pharmaceutical services for obtaining Atovaqone Oral Suspension (antiviral medication), Mycophenolate Mofetil Oral Suspension (immunosuppressant medication), and XyliMelts Mouth/Thorat Disk (artificial saliva medication) when the medications were ordered by the Physician to be administered to the Resident.<br><br>Findings include:<br><br>1. Review of the Facility's policy titled, Adverse Consequences and Medication Errors, revised February 2023, included but was not limited to:<br><br>-Policy Interpretation and Implementation<br><br><Examples of medication errors include:<br><br>*Omission- a drug is ordered but not administered.<br><br><Monitor the resident for medication-related adverse consequences when there is a:<br><br>*Medication error.<br><br><Promptly notify the provider of any significant error .consequence.<br><br><Document the following information in an incident report and in the resident's clinical record:<br><br>*The residents name, and age<br><br>*Factual description of the error<br><br>*Name of provider and time notified<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *Resident's condition for 24 to 72 hours or as directed.<br><br><Each incident report is forwarded to:<br><br>* Director of Nursing<br><br>*QAPI Committee<br><br>* Medical Director<br><br>*Consultant pharmacist<br><br>Resident #341 was admitted to the Facility in April 2025, with diagnoses including Hypertension.<br><br>Review of Resident #341's Physician's orders for April 2025 included but not limited to:<br><br>-Amlodipine Besylate-Valsartan Oral Tablet 10 mg (milligram) - 320 mg, give one tablet by mouth one time a day for HTN (Hypertension), start date 4/10/25.<br><br>Review of Resident #341's April 2025 Medication Administration Record (MAR), indicated Resident #341 did not receive Amlodipine Besylate-Valsartan Oral Tablet 10 mg (milligram) - 320 mg daily between 4/10/25 and 4/23/25 (14-day period) on the following dates:<br><br>*4/11/25 - 4/12/25 (2 consecutive days)<br><br>*4/16/25 - 4/23/25 (8 consecutive days)<br><br>Review of Resident #341's April 2025 Nurse Progress Notes included the following:<br><br>-4/11/25: Amlodipine Besylate-Valsartan 10-320 mg, med on order from pharmacy and not available in Omnicell (automated medication supply machine within the facility). MD/NP aware, refaxed request to the pharmacy.<br><br>-4/16/25: Amlodipine Besylate-Valsartan 10-320 mg, medication not available, awaiting pharmacy delivery-MD/NP aware.<br><br>During an interview on 4/24/25 at 8:45 A.M., the Director of Nursing (DON) said there was no evidence or record that Resident #341's Amlodipine Besylate-Valsartan medication had been delivered to the facility since the Resident had been admitted . The DON said that Amlodipine Besylate-Valsartan was not a routine medication that was stocked in the Omnicell in the facility. The DON said that the nurses' signatures, which indicated the Resident's Amlodipine Besylate-Valsartan had been administered on 4/10/25, 4/13/25, 4/14/25 and 4/15/25 were most likely an error because the medication had never been available in the facility to administer to the Resident. The DON provided the surveyor with invoice evidence that the facility staff had ordered the Amlodipine Besylate-Valsartan on 4/9/25 and 4/16/25. The DON further said that the facility did not have a system in place to confirm that medications ordered from the pharmacy were received and there was no facility incident report for omitted medication.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/24/25 at 11:49 A.M., Nurse #12 said that she had several pharmacy concerns related to back orders and delivery. Nurse #12 said that when she called the pharmacy to ask about a medication that is needed, the pharmacy staff would often tell her that the medication was on the way and when the delivery driver arrived from the pharmacy, the requested medication would not be with the pharmacy delivery person. Nurse #12 said that her pharmacy concerns have been reported the Unit Manager UM) several times.<br><br>During an interview on 4/24/25 at 12:12 P.M., Nurse Practitioner (NP) #1 said that pharmacy delivery concerns had been a problem since she started working in the facility in January 2025. NP #1 said that she had been made aware that the Resident's Amlodipine Besylate-Valsartan had not been available. NP #1 said that she would not have ordered an alternate medication or treatment unless the Resident's systolic blood pressure was 160 mmHg (millimeters of mercury) or greater. NP #1 said it's been tough receiving medications from the pharmacy.<br><br>During an interview on 4/24/25 at 1:58 P.M., the Administrator said that he had emailed and met with pharmacy staff on several occasions via telephone and in-person, starting in November 2024 related to concerns over pharmacy delivery service. The Administrator said that pharmacy communication faxes were sent to the pharmacy every shift for missing medications from the unit Nurses and/or the DON. The Administrator said that there had not been an improvement in pharmacy delivery services after repeated communications related to delivery concerns. The Administrator said it would be beneficial to have an alternate pharmacy service available to the facility, but alternate pharmacy services would require the Regional Team approval and approval had not been obtained.<br><br>42761<br><br>2. Resident #94 was admitted to the facility in September 2022 with diagnoses including Type 2 Diabetes Mellitus with foot ulcer, complete traumatic amputation of two or more left lesser toes, and Urethral Erosion (tearing of the urethra in individuals who have had indwelling urinary catheters for a long period of time).<br><br>Review of the Minimum Data Set (MDS) Assessment, dated 2/27/25, indicated Resident #94:<br><br>-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 total possible points.<br><br>-had an indwelling urinary catheter.<br><br>-was dependent on staff for bathing.<br><br>-has reported pain, almost constantly, at a level of eight out of 10 (severe).<br><br>Review of Resident #94's April 2025 Physician Orders indicated:<br><br>-Biofreeze Cool the Pain External Gel 4% (percent), apply to bilateral lower legs topically four times a day for pain, start date 2/3/25.<br><br>-Lidocaine (medication used to treat pain) External Gel 0.5%, apply to genital slit topically two times a day for pain, start date 3/24/25.<br><br>(continued on next page) |

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| | 225720 | A. Building<br>B. Wing | 04/25/2025 |

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| Care One at Millbury | 312 Millbury Avenue<br>Millbury, MA 01527 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #94's April 2025 Medication Administration Record (MAR) indicated:<br><br>-Biofreeze Cool the Pain External Gel 4% was not administered to the Resident for 91 out of 92 scheduled doses ordered between 4/1/25 and 4/23/25, due to absence of condition/not applicable.<br><br>-Lidocaine External Gel 0.5% was not administered to the Resident for 32 of 34 scheduled ordered doses between 4/7/25 and 4/23/25, due to absence of condition/not applicable.<br><br>On 4/23/25 at 10:31 A.M., surveyor #2 and Nurse #10 observed the following in Resident #94's room:<br><br>-Nurse #10 requested permission from Resident #94 to observe the indwelling urinary catheter with surveyor #2.<br><br>- Resident #94 furrowed his/her brow and clenched his/her teeth.<br><br>-Nurse #10 said she knew the Resident's genital area was tender and that she just needed to see the catheter.<br><br>-The Resident allowed the observation and the surveyor observed the Resident's genital area to have a large slit.<br><br>-Nurse #10 lifted the Resident's indwelling urinary catheter tubing and the Resident furrowed his/her brow, clenched his/her teeth, raised his/her hands in the air and clenched his/her fists.<br><br>During an interview on 4/23/25 at 2:15 P.M., Resident #94 said he/she had no pain in the genital area when staying still and that he/she always had pain whenever staff provided urinary catheter care and/or moved the urinary catheter. Resident #94 also said that he/she frequently experienced lower extremity pain.<br><br>During an interview on 4/23/25 at 5:00 P.M., Nurse #10 said Resident #94 experienced leg pain and always had pain when his/her urinary catheter was manipulated. Nurse #10 said Lidocaine Gel was ordered to be administered for Resident #94's genital pain and Biofreeze was ordered for the Resident's lower extremity pain. Nurse #10 said the facility obtained Lidocaine Gel and Biofreeze through the pharmacy and that Lidocaine Gel and Biofreeze had not been available from the pharmacy for quite some time. Nurse #10 said that when medication was unavailable, the Nurse was responsible to contact the pharmacy in an attempt to obtain the medication and if the medication could not be obtained, the Nurse would alert the Director of Nursing (DON). Nurse #10 said she did not know when the facility's last request was made to the pharmacy to deliver Lidocaine Gel and Biofreeze for Resident #94.<br><br>During an interview on 4/25/25 at 11:01 A.M., the DON said she did not recall being alerted that Resident #94's Lidocaine Gel and Biofreeze were not available from the pharmacy. The DON said if she had been alerted, she would have contacted the pharmacy to determine whether the medications could be obtained and the Provider on whether alternate treatment options would be necessary for the Resident.<br><br>47901<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Resident #38 was admitted to the facility in February 2025 with diagnoses including Myasthenia Gravis, Thrombophilia, Malignant Melanoma of Skin, Atherosclerotic Heart Disease, Drug-Induced Myopathy, Acute and Chronic Respiratory Failure with Hypercapnia and Recurrent Enterocolitis due to Clostridium Difficile (C-DIFF).<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #38 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15.<br><br>During an interview on 4/17/25 at 8:37 A.M., Resident #38 said that he/she had not received a few of his/her medications and every time he/she would ask, the facility staff would inform him/her that the medications were on back order. Resident #38 said the medications were very important as one of the medications was his/her immunosuppressive medications related to the receiving chemotherapy, and one of the medications was to combat the side effects of the chemotherapy medication related to extreme dry mouth.<br><br>Review of Resident #38's April 2025 Physician's orders indicated:<br><br>-Atovaquone Oral Suspension 750 milligrams (mg)/5 milliliter (ml), Give 10 ml by mouth one time a day for antiviral, ordered 2/14/25.<br><br>-Mycophenolate Mofetil Oral Suspension 200 mg/ml, Give 5 ml every 12 hours for supplement, ordered 2/14/25.<br><br>-XyliMelts Mouth/Throat Disk 550 mg, Give 2 wafers by mouth at bedtime for dry mouth, ordered 3/17/25.<br><br>Review of Resident #38's February 2025 Medication Administration Record (MAR) indicated:<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available) from 2/16/25 to 2/28/25.<br><br>- Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available) 17 times from 2/14/25 to 2/23/25.<br><br>Review of Resident #38's March 2025 MAR, indicated:<br><br>-XyliMelts Mouth/Throat Disk 550 mg medication was documented as 9 (Not Available) and 13 (Does Not Apply) from 3/17/25 to 3/30/25 each day.<br><br>-Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available) from 3/16/25 to 3/31/25.<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available) six times in March 2025.<br><br>Review of Resident #38's April 2025 MAR, indicated:<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -XyliMelts Mouth/Throat Disk 550 mg medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/25/25 each day.<br><br>-Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/25/25 each day.<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/17/25.<br><br>On 4/24/25 at 11:02 A.M., the surveyor and Unit Manager (UM) #2 reviewed Resident #38's April 2025 MAR. UM #2 said the Residents' XyliMelts, Mycophenolate Mofetil, and Atovaquone medications had been documented as Not Available.<br><br>During an interview on 4/24/25 at 11:35 A.M., the DON said she was not aware Resident #38 had not received his/her medications and she would review.<br><br>During a follow-up interview on 4/24/25 at 1:20 P.M., the DON said UM #2 had left a message for Oncology about Resident #38's medications not being available but had not received a return call. The DON said that the facility had not made any effort to follow-up with Oncology and that UM #2 forgot to write a note in the Resident's clinical record when she left the message for Oncology. The DON further said receiving medication from the pharmacy had been a concern for the facility but had the Nurses notified her of their inability to obtain medications, she would have followed through.<br><br>Please refer to F865. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741<br><br>Based on observation, interview, and record review the facility failed to serve food that was palatable, and at an appetizing temperature on one Unit ([NAME] Unit) out of three units observed.<br><br>Specifically, the facility failed to ensure that meals maintained a palatable temperature when served to the residents and that meal trays were provided timely on the [NAME] Unit especially for residents requiring meal assistance.<br><br>Findings include:<br><br>During the initial screening process on 4/17/25 the following comments were made by residents on the [NAME] Unit relative to the food served at the facility:<br><br>-By the time the meal trays are received in the resident's room, the food and hot beverages were lukewarm.<br><br>-The hot food was cold by the time it was served.<br><br>Review of the 2/26/25 Resident Council Meeting Minutes indicated the following:<br><br>-Residents stated that their breakfast items (mostly the eggs) were cold.<br><br>Review of the 3/27/25 Resident Council Meeting Minutes indicated the following:<br><br>-Residents present at the meeting stated their breakfast meals have been cold.<br><br>On 4/17/25, the surveyor observed the following during the breakfast meal service on the [NAME] Unit:<br><br>-7:55 A.M.: three meal trucks containing meals for residents arrived to the unit.<br><br>-8:54 A.M.: the last meal tray was passed on the unit (just under an hour after the meals had been brought to the unit).<br><br>-Residents who needed to be assisted had trays that came up on the first, second, and third meal trucks, but all of the trays that needed to be assisted were served at the end of the meal pass.<br><br>On 4/22/25, the surveyor observed the following during the breakfast meal service on the [NAME] Unit:<br><br>-Meal truck doors remained open during the entire meal pass.<br><br>-7:54 A.M.: the third meal truck was brought to the unit.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -8:34 A.M.: the final tray from the third meal truck was served to a resident, (40 minutes after the meal truck had been brought to the unit).<br><br>-Residents who needed to be assisted had trays that came up on the first, second, and third meal trucks, but all of the trays for residents needing assistance were served at the end of the meal pass.<br><br>During the Resident Council Meeting held 4/23/25 from 10:30 A.M. through 11:30 A.M., the following was said by eight of eight Residents in attendance:.<br><br>-Food that was delivered to the units was not always hot.<br><br>-The Residents expressed concern with how meal trays were passed on the unit and that the meal tray pass took a long time.<br><br>On 4/23/25 at 8:13 A.M., a breakfast meal test tray was completed on the [NAME] Unit with Nurse #7, and the following was observed:<br><br>-Scrambled eggs with peppers and onions was 113.1 degrees Fahrenheit (F) and luke warm to taste.<br><br>On 4/24/25 at 11:37 A.M., the Food Service Director (FSD) said she would expect hot food to hold its temperature and be 140 F or hotter, be palatable, and taste hot.<br><br>On 4/24/25 at 12:11 P.M., the FSD said she was unaware that the residents who needed assistance during meals had to wait until the end of the meal pass to get their meal trays. The FSD said if she had known this she could have re-organized how the meals were placed on the meal trucks so resident's meals did not sit for an extended period of time. The FSD said she had recently completed test trays on a different unit but had not observed how staff were passing the resident meals to see if there were changes that could be made to be more efficient, so when meals arrived to the residents, they would be hot. |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901<br><br>Based on observation, interview, and record review, the facility failed to ensure choices were honored when the Resident had specific needs for one Resident (#38) out of a total sample of 29 residents.<br><br>Specifically, for Resident #38, the facility failed to honor the Resident's preferences identified on the meal tray card and care plan.<br><br>Findings include:<br><br>Review of the facility policy titled Resident Food Preferences, edited 11/3/23, indicated:<br><br>-Upon the resident's admission (or as soon as feasible following his/her admission) the dietician, culinary designee or nursing staff designee identifies a resident's food preferences.<br><br>-When possible, staff interview the residents directly to determine current food preferences based on history and life patterns related to food and mealtimes.<br><br>-Resident food and eating preferences are documented in the resident's care plan and within the tray card system.<br><br>-The dietician and nursing staff, assisted by the physician, identify any nutritional issues and dietary recommendations that may conflict with the resident's food preferences.<br><br>-If the resident refuses or is unhappy with his or diet, the staff develops a care plan that the resident is satisfied with.<br><br>Review of the facility policy titled Resident Rights, dated 2001, indicated:<br><br>Residents have the right to:<br><br>-self-determination of needs.<br><br>-a dignified existence.<br><br>-exercise his or her rights as a resident of the facility.<br><br>Resident #38 was admitted to the facility in February 2025 with diagnoses including Acute and Chronic Respiratory Failure, Thrombophilia, Malignant Melanoma of the Skin, Drug-induced Myopathy and Weakness.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #38:<br><br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15.<br><br>-had complaints of difficulty or pain when swallowing, coughing or choking during meals or when swallowing medications.<br><br>-was on a mechanically altered diet.<br><br>Review of Resident #38's Diet Order dated 4/7/25, indicated:<br><br>-Regular diet, (RG7 -standard food texture used in dysphagia diets, with foods that are regular, but the texture should be soft and tender enough to be easily chewed and swallowed).<br><br>-Thin liquids (TNO) consistency.<br><br>-No lentils, bread, peas, rice, al [NAME] veggies, cola or caffeine.<br><br>-Super cereal at breakfast.<br><br>Review of Resident #38's Person Centered Care Plan for Nutrition revised on 2/16/25, indicated:<br><br>-Diet soft and bite sized<br><br>-thin liquids<br><br>-history of aspiration<br><br>During an interview on 4/17/25 at 8:37 A.M., Resident #38 said that he/she had to consistently request food items that had been identified as food preferences. Resident #38 said that he/she also consistently received food items that had been identified as disliked on his/her meal tickets. Resident #38 said staff would come in and obtain his/her food preferences but never followed through with the preferences.<br><br>On 4/18/25 at 9:15 A.M., the surveyor observed the breakfast meal tray set up for Resident #38 did not include the Resident's preferences identified on the meal tray card and care plan for nutrition. During an interview at the time, Resident #38 said this happened on most days, and even if he/she requested an alternative, he/she would be given a food item that he/she could not chew or swallow and he/she would not eat that meal.<br><br>On 4/23/25 at 9:11 A.M., the surveyor observed Resident #38 sitting upright at a 90-degree angle in bed with a meal tray. The surveyor observed dried toast included on the meal plate which was indicated on his/her meal ticket as disliked. The surveyor observed the Resident did not receive his/her super (fortified) cereal. Resident #38 was observed asking the staff that presented the meal tray about his/her fortified cereal. Resident #38 said he/she would be satisfied with the fortified cereal and that he/she would not eat anything else.<br><br>On 4/24/25 at 8:19 A.M., the surveyor observed Resident #38 eating breakfast, that the Resident received dried toast, and was not provided with fortified cereal as indicated on his/her diet slip.<br><br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/24/25 at 8:20 A.M., Unit Manager (UM) #2 said the Nurses are expected to compare Residents' meal tickets to their trays before delivering the meals to the Residents. UM #2 said the expectation of the Nurses was to ensure Resident preferences were honored based on their likes and dislikes before the meal tray was delivered to the Residents.<br><br>During an interview on 4/24/25 at 8:47 A.M., the Registered Dietician (RD) said Resident #38 had a history of Myasthenia Gravis and Dysphagia and the Resident had been very clear about what he/she could chew and swallow and that his/her food/fluid preferences were obtained immediately when the Resident was admitted to the facility. The surveyor and the RD reviewed Resident #38's meal tray and corresponding meal ticket and the RD said the Resident should not be receiving bread items (toast) which was present on the Residents' meal tray. The RD said the Resident had not received the fortified cereal as indicated on the Physician order and the meal ticket.<br><br>During a follow-up interview on 4/24/25 at 9:35 A.M., UM #2 said Resident #38's meal preferences had not been honored as indicated on the Resident's meal preferences and Physician orders. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>42761<br><br>Based on interviews and records reviewed, the facility failed to maintain an effective, comprehensive, data-driven QAPI (Quality Assurance and Performance Improvement - a comprehensive approach in healthcare that combines quality assurance and performance to systematically monitor and evaluate the quality and appropriateness of systems and process with a goal to enhance patient care and improve outcomes through a data-drive, proactive approach) program relative to pharmaceutical services for three Residents (#341, #94, and #38) out of a total sample of 29 total residents, which resulted in ordered medications not being administered to the Residents.<br><br>Specifically, the facility failed to develop and implement a performance improvement plan relative to pharmaceutical services when:<br><br>-The facility was unable to obtain ordered medications for Resident's #341, #94, and #38, which resulted in ordered medications not being administered to the Residents and increased each Resident's risks for medical complications.<br><br>-The facility had been unable to obtain ordered medications for all residents from the facility's contracted pharmacy services for a period of five months.<br><br>Findings include:<br><br>Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan, dated 2001 and revised April 2014, indicated the following:<br><br>-The facility shall develop, implement, and maintain an ongoing facility-wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve quality care, and resolve identified problems.<br><br>-Objective of the QAPI Plan included:<br><br>>Provide a means to identify and resolve present and potential negative outcomes related to resident care and services.<br><br>>Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability.<br><br>1. Resident #94 was admitted to the facility in September 2022 with diagnoses including Type 2 Diabetes Mellitus with foot ulcer, complete traumatic amputation of two or more left lesser toes, and urethral erosion (tearing of the urethra in individuals who have had indwelling urinary catheters for a long period of time).<br><br>Review of Resident #94's April 2025 Physician Orders indicated the following:<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Biofreeze Cool (topical localized pain cream) the Pain External Gel 4% (percent), apply to bilateral lower legs topically four times a day for pain, start date 2/3/25.<br><br>-Lidocaine (medication used to treat pain) External Gel 0.5%, apply to genital slit topically two times a day for pain, start date 3/24/25.<br><br>Review of Resident #94's April 2025 Medication Administration Record (MAR) indicated:<br><br>-Biofreeze Cool the Pain External Gel 4% was not administered to the Resident for 91 out of 92 scheduled doses ordered between 4/1/25 and 4/23/25 due to absence of condition/not applicable.<br><br>-Lidocaine external gel 0.5% was not administered to the Resident for 32 of 34 scheduled ordered doses between 4/7/25 and 4/23/25 due to absence of condition/not applicable.<br><br>During an interview on 4/23/25 at 2:15 P.M., Resident #94 said he/she always had pain whenever staff provided urinary catheter care and/or moved the catheter. Resident #94 also said he/she frequently experienced lower extremity pain.<br><br>During an interview on 4/22/25 at 3:07 P.M., the Director of Nursing (DON) said the facility has had issues obtaining medications from the contracted pharmacy since November 2024. The DON said she instituted a process where if medications were unavailable, the Nurses would fill out a form during their medication pass indicating the unavailable medications and give the completed form to their Unit Manager (UM). The DON said she would then email the information relative to unavailable medications to the pharmacy and the Physician. The DON said there was no improvement in obtaining medications from the contracted pharmacy.<br><br>During an interview on 4/23/25 at 5:00 P.M., Nurse #10 said the Lidocaine Gel was ordered to be administered for Resident #94's genital pain and Biofreeze was ordered for the Resident's lower extremity pain. Nurse #10 said the facility obtained Lidocaine Gel and Biofreeze through the contracted pharmacy and that Lidocaine Gel and Biofreeze had not been available from the pharmacy for quite some time. Nurse #10 said when medication was unavailable, the Nurse was responsible to contact the pharmacy in an attempt to obtain the medication and if the medication could not be obtained, the Nurse would alert the Director of Nursing (DON). Nurse #10 said she did not know when the facility's last request was made to the pharmacy to deliver Lidocaine Gel and Biofreeze for Resident #94.<br><br>2. Resident #38 was admitted to the facility in February 2025 with diagnoses of Myasthenia Gravis, Thrombophilia, Malignant Melanoma of Skin, Atherosclerotic Heart Disease, Drug-Induced Myopathy, Acute and Chronic Respiratory Failure with Hypercapnia and Recurrent Enterocolitis due to Clostridium Difficile (C-DIFF).<br><br>During an interview on 4/17/25 at 8:37 A.M., Resident #38 said that he/she had not received a few of his/her medications and every time he/she would ask, the facility staff would inform him/her that the medications were on back order. Resident #38 said the medications were very important as one medication was his/her immunosuppressive medication related to the receiving chemotherapy and another medication was to combat the extreme dry mouth side effects of the chemotherapy medication.<br><br>Review of Resident #38's April 2025 Physician's orders indicated:<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Atovaquone Oral Suspension medication (antiprotozoal/antimalarial agent - used in the prevention and treatment of pneumonia caused by fungus) 750 milligrams (mg)/5 milliliter (ml), Give 10 ml by mouth one time a day for antiviral, ordered 2/14/25.<br><br>-Mycophenolate Mofetil (immunosuppressant medication) Oral Suspension 200 mg/ml, Give 5 ml every 12 hours for supplement, ordered 2/14/25.<br><br>-XyliMelts Mouth/Throat Disk (medication to relieve persistent dry mouth) 550 mg, Give 2 wafers by mouth at bedtime for dry mouth, ordered 3/17/25.<br><br>Review of Resident #38's Medication Administration Record (MAR) indicated the following:<br><br>>February 2025:<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available) from 2/16/25 to 2/28/25.<br><br>-Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available) 17 times from 2/14/25 to 2/23/25.<br><br>>March 2025:<br><br>-XyliMelts Mouth/Throat Disk 550 mg medication was documented as 9 (Not Available) and 13 (Does Not Apply) from 3/17/25 to 3/30/25 each day.<br><br>-Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available) from 3/16/25 to 3/31/25.<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available) six times in the month of March.<br><br>>April 2025:<br><br>-XyliMelts Mouth/Throat Disk 550 mg medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/25/25 each day.<br><br>-Mycophenolate Mofetil Oral Suspension medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/25/25 each day.<br><br>-Atovaquone Oral Suspension medication was documented as 9 (Not Available) and 13 (Does not Apply) from 4/1/25 to 4/17/25.<br><br>On 4/24/25 at 11:02 A.M., the surveyor and Unit Manager (UM) #2 reviewed Resident #38's April 2025 MAR and UM #2 said the Residents's XyliMelts, Mycophenolate Mofetil, and Atovaquone medications were documented as Not Available.<br><br>3. Resident #341 was admitted to the facility in April 2025, with diagnoses including Hypertension.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #341's April 2025 Physician's orders included but not limited to:<br><br>-Amlodipine Besylate-Valsartan (combination medication used to treat high blood pressure) Oral Tablet 10 mg (milligram)-320 mg, give one tablet by mouth one time a day for HTN (Hypertension), start date 4/10/25.<br><br>Review of Resident #341's April 2025 MAR, indicated Resident #341 did not receive the Amlodipine Besylate-Valsartan Oral Tablet 10 mg (milligram)-320 mg daily between 4/10/25 and 4/23/25 (14-day period) on the following dates:<br><br>-4/11/25-4/12/25 (2 consecutive days)<br><br>-4/16/25-4/23/25 (8 consecutive days)<br><br>During an interview on 4/24/25 at 8:45 A.M., the Director of Nursing (DON) said there was no evidence or record that Resident #341's Amlodipine Besylate-Valsartan medication had been delivered to the facility since the Resident had been admitted . The DON said that Amlodipine Besylate-Valsartan was not a routine medication that was stocked in the Omnicell in the facility. The DON said the Resident's Amlodipine Besylate-Valsartan had never been available in the facility to administer to the Resident. The DON provided invoice evidence that the facility staff had ordered the Amlodipine Besylate-Valsartan on 4/9/25 and 4/16/25. The DON further said that the facility did not have a system in place to confirm that medications ordered from the pharmacy were received.<br><br>During an interview on 4/24/25 at 11:49 A.M., Nurse #12 said that she had several pharmacy concerns related to back orders and delivery. Nurse #12 said that when she called the pharmacy to ask about a medication that is needed, the pharmacy staff would often tell her that the medication was on the way and when the delivery driver arrived from the pharmacy the requested medication would not be with the pharmacy delivery person. Nurse #12 said that her pharmacy concerns have been reported the UM several times.<br><br>During an interview on 4/24/25 at 12:12 P.M., Nurse Practitioner (NP) #1 said that pharmacy delivery concerns had been a problem since she started working at the facility in January 2025. NP #1 said that she had been made aware that the Resident's Amlodipine Besylate-Valsartan had not been available. NP #1 said it's been tough receiving medications from the pharmacy.<br><br>During an interview on 4/24/25 at 1:58 P.M., the Administrator said that he had emailed and met with the pharmacy staff on several occasions via telephone and in-person, starting in November 2024 relative to concerns over pharmacy delivery service. The Administrator said that pharmacy communication faxes were sent to the pharmacy every shift for missing medications from the Unit Nurses and/or the DON. The Administrator said that there had not been an improvement in pharmacy delivery services after repeated communications related to delivery concerns. The Administrator said that a performance improvement project had not been initiated relative to pharmaceutical service concerns identified at the facility. The Administrator also said it would be beneficial to have an alternate pharmacy service available to the facility, but alternate pharmacy services would require the Regional Team approval and approval had not been obtained. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>47901<br><br>Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice to prevent contamination and the spread of infections for three Residents (#100, #101, #343) out of a total sample of 29 residents.<br><br>Specifically,<br><br>1. For Resident #100, the facility failed to ensure that staff wore the indicated Personal Protective Equipment (PPE: items such as gown and gloves worn by the staff member to decrease the chance of spread of infection) while in the Resident's room when he/she was on Contact Precautions (interventions including use of PPE to prevent the spread of a communicable disease).<br><br>2. For Resident #101, the facility failed to ensure that the appropriate PPE was utilized when the Resident was identified as being on Contact and Droplet (infection control measures used to prevent the spread of infections transmitted via respiratory droplets) Precautions, and increasing the risk of spreading respiratory illnesses.<br><br>3. For Resident #343, the facility staff failed to follow Physician orders for Enhanced Barrier Precautions (EBP-the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), while providing high contact care for the Resident's Peripherally Inserted Central Catheter (PICC line).<br><br>Findings include:<br><br>Review of the facility's policy titled Initiating Transmission-Based Precautions, dated 2001, indicated:<br><br>-Transmission-based precautions are utilized when a resident meets the criteria for a transmissible infection and the resident has risk factors that increase the likelihood of transmission.<br><br>These may include:<br><br>a) uncontained excretions/secretions.<br><br>b) non-compliance with standard precautions.<br><br>c) cognitive deficits that restrict or interfere with the resident's ability to maintain precautions.<br><br>-When transmission-based precautions are implemented, the infection preventionist (or designee):<br><br>>ensures that protective equipment (i.e. gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility's policy titled Isolation - Categories of Transmission-Based Precautions, dated 2001, indicated:<br><br>-Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.<br><br>-Contact Precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified.<br><br>>Staff and visitors wear gloves (clean, non-sterile) when entering the room.<br><br>>Gloves are removed and hand hygiene performed before leaving the room.<br><br>>Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed.<br><br>-Droplet Precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning).<br><br>-Masks are worn when entering the room.<br><br>-Gloves, gowns, and goggles are worn if there is risk of spraying respiratory secretions.<br><br>1. Resident #100 was admitted to the facility in August 2024 with diagnoses of bacteremia, acidosis, Extended Spectrum Beta Lactamase (ESBL) and muscle weakness.<br><br>Review of the Minimum Data Set (MDS) Assessment, dated 2/20/25, indicated Resident #100:<br><br>-had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 0 out possible of 15 points.<br><br>-was rarely or never understood/understands<br><br>-was dependent on staff with toileting<br><br>-required assistance of staff with dressing and personal hygiene<br><br>On 4/17/25 at 8:57 A.M., the surveyor observed the following:<br><br>-Contact Precaution sign posted outside Resident #100's door which indicated:<br><br>>Everyone must clean their hands, including before entering the room and when leaving the room.<br><br>-Providers and staff must also:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | >Put on gloves before room entry, discard gloves before room exit.<br><br>>Put on gown before room entry, discard gown before room exit.<br><br>-Certified Nurses Aide (CNA) #1 standing in the Resident's room and assisting Resident #100 with eating.<br><br>-CNA #1 was not observed to be wearing a gown and/or gloves.<br><br>-CNA #1 was observed lowering the Resident's head of the bed and repositioning the Resident's pillow.<br><br>-CNA #1 exited the room with the Resident's tray and placed the tray in the delivery truck that was in the hallway, outside of the Resident's room.<br><br>During an interview on 4/17/25 at 9:08 A.M., CNA #1 said that she was not aware Resident #100 was on contact precautions. CNA #1 said she did not observe the sign outside the door before she entered Resident #100's room to assist the Resident with eating. CNA #1 said there was no need to wear a gown and gloves since she only assisted the Resident with feeding.<br><br>During an interview on 4/17/25 at 9:11 A.M., Nurse #1 said Resident #100 was on contact precautions for VRE (Vancomycin Resistant Enterococci [type of bacteria that has become resistant to the antibiotic Vancomycin]) present in the Resident's rectum and wounds. Nurse #1 said that CNA #1 should have adhered to the contact precaution sign outside the Resident's room and worn a gown and gloves before entering the Resident's room, but she did not.<br><br>2. Resident #101 was admitted to the facility in November 2024 with diagnoses including tracheostomy, Dysarthria following Cerebral Infarction, Chronic Systolic Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), hemiplegia and hemiparesis and muscle weakness.<br><br>Review of the Minimum Data Set (MDS) Assessment, dated 2/10/25, indicated Resident #101:<br><br>-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of a total possible score of 15<br><br>-was dependent on staff for toileting<br><br>-required assistance of staff with dressing and personal hygiene<br><br>Review of Resident #101's April 2025 Physician's orders indicated:<br><br>-Maintain Droplet/Contact Precautions every shift pending RSV (Respiratory Syncytial Virus - respiratory infection that affect the nose, throat and lungs) /COVID/FLU swab every shift, dated 4/18/25.<br><br>-Levaquin (antibiotic) Oral Tablet Give 250 milligram (mg) by mouth, one time a day for Pneumonia until 4/25/25, started 4/19/25.<br><br>On 4/22/25 at 8:23 A.M., the surveyor observed the following:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Contact and Droplet Precaution signs outside of Resident #101's room.<br><br>-Droplet Precaution sign which indicated:<br><br><Everyone must make sure their eyes, nose and mouth are fully covered before room entry, remove face protection before room exit.<br><br>-The PPE supplies available for use, were in a bag inside the Resident's room, hanging on the Resident's bathroom door.<br><br>-CNA #2 entered the Resident's room without donning a gown, mask or gloves.<br><br>-At 8:24 A.M., a female staff member entered the Resident's room without donning a mask, gown or gloves.<br><br>-Resident #101 was observed sneezing, coughing and spitting out phlegm into tissues and placing the used tissues on his/her bedside table.<br><br>During an interview on 4/22/25 at 8:44 A.M., Nurse #1 said Resident #101 had an order for contact and droplet precautions because the Resident had a pending RSV/COVID/FLU tests that had not resulted. Nurse #1 said the Resident had active productive cough and sneezing and was required to be maintained on contact and droplet precautions until the specimen had resulted from the lab. At this time, the surveyor observed Housekeeper #1 enter the Resident's room and did not don a face mask, gloves or gown. Nurse #1 said that Housekeeper #1 should have donned a face mask, gown and gloves before she entered the room, but she did not. During an interview at the time, Housekeeper #1 was unable to explain the proper use of the required PPE when the surveyor asked.<br><br>During an interview on 4/22/25 at 9:03 A.M., CNA #2 said he was not aware that Resident #101 was ordered for contact and droplet precautions and that he should have worn a mask, gloves and gown before entering the Resident's room, but he had not done so.<br><br>During an interview on 4/22/25 at 2:37 P.M., the Staff Development Coordinator (SDC) said the Personal Protective Equipment (PPE) should be placed at the entrance of Resident #101's room and not on the bathroom door inside the Resident's room. The SDC said this would have alerted the staff to stop and observe the signs that were at the entrance of the Resident's door. The SDC further said that the PPE supplies placed in the Resident's room that were hanging at the bathroom door meant staff would have to enter the Resident's room before they would notice the need to wear PPE.<br><br>50138<br><br>3. Review of the facility's policy titled Enhanced Barrier Precautions, revised December 2024, included but was not limited to:<br><br>-EBP's will be used in these conditions .<br><br><For residents with an indwelling medical device.<br><br>*Indwelling medical devices include Central Lines (PICC lines)<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -EBP's require gowns and gloves for all high contact care including .<br><br><Device care or use<br><br>*Central Lines (PICC lines)<br><br>Resident #343 was admitted to the facility in April 2025 with diagnoses including bacteremia and osteomyelitis.<br><br>Review of the Resident's medical record included but was not limited to:<br><br>-The Resident had intravenous access to the left upper extremity with a non-valved, double lumen PICC line at the time of admission.<br><br>-The Resident was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of a total possible score of 15.<br><br>Review of the Resident's Person-Centered Care Plan, revised 4/8/25, included:<br><br>-Potential for complications at PICC line site with interventions including EBP for PICC use.<br><br>Review of Resident #343's April 2025 Physician's orders indicated:<br><br>-Maintain EBP every shift.<br><br>-Ampicillin Sodium Injection Solution (antibiotic medication) Reconstituted, 2 gm (Gram) intravenously every four hours for infection for 28 days (start date 4/9/25, end date 5/7/25).<br><br>-Heparin (medication used to prevent blood clotting) Lock Flush Solution 10 unit/ml, use 5 ml intravenously as needed for new adm [sic] flush after each use with 0.9% Sodium Chloride 10 ml then Heparin 10 units/ml 5 ml, effective 4/9/25.<br><br>-Sodium Chloride (Normal Saline) Solution 0.9%, use 10 ml intravenously as needed for IV therapy flush at least every 8 hours and PRN to maintain catheter patency, effective 4/9/25.<br><br>-Sodium Chloride (Normal Saline) Solution 0.9%, use 10 ml intravenously as needed for IV therapy flush before each use, effective 4/9/25.<br><br>On 4/22/25 at 2:12 P.M., the surveyor observed the following:<br><br>-EBP signage posted on Resident #343's doorway.<br><br>-A Supply of gloves, gowns, face shields and masks hung on the front of the Resident's doorway.<br><br>-Nurse #4 cleansed her hands with alcohol-based sanitizer, donned clean gloves and entered the Resident's room.<br><br>-Nurse #4 was not observed to don a gown.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Nurse #4 was observed disconnecting the Resident's PICC line from a completed antibiotic infusion of Ampicillin.<br><br>-Nurse #4 was observed to cleanse both PICC line lumens with an alcohol prep pad, then flush both lumens with 10 ml Normal Saline followed by 5 ml of 10 unit/ml Heparin.<br><br>-Nurse #4 then clamped both of the Resident's PICC line lumens, discarded the syringes into a Biohazard container, removed her gloves and cleansed her hands with alcohol-based hand sanitizer and exit the Resident's room.<br><br>During an interview on 4/22/25 at 2:24 P.M., Nurse #4 said that Resident #343 had EBP orders in place because the Resident had a foot wound. Nurse #4 said that EBP's were needed when Nurses did wound care for the Resident's foot wound and nothing else. The surveyor and Nurse #4 observed the EBP signage posted to the Resident's doorway that indicated:<br><br>-ENHANCED BARRIER PRECAUTIONS. EVERYONE MUST:<br><br><Clean their hands, including before entering and when leaving the room.<br><br>-PROVIDERS AND STAFF MUST ALSO:<br><br><Wear gloves and gowns for the following High-Contact Resident Care Activities:<br><br>*Device care or use: Central Line<br><br>Nurse #4 said she should have had a gown on when flushing the Resident's PICC line but did not. Nurse #4 said that EBP were required to prevent Residents from getting infections from the staff.<br><br>During an interview on 4/22/25 at 2:37 P.M., the SDC said EBP was needed for Resident #343 because the Resident had a PICC line. The SDC said that gown and gloves must be worn when the Resident's PICC line was being used or flushed. The SDC said that EBP's were needed to prevent medication resistant organism transmission to Residents with indwelling devices like PICC lines. The SDC said Nurse #4 should have had gloves and a gown on when providing care to the Resident's PICC line. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741<br><br>Based on interview, and record review, the facility failed to ensure a Pneumococcal Vaccine was administered after consent was obtained to administer the vaccination for one Resident (#50), out of five residents sampled for immunizations.<br><br>Specifically, for Resident #50, the facility failed to administer a Pneumococcal Vaccine after the Resident's activated Health Care Proxy (HCP) consented to the Resident receiving a Pneumococcal Conjugate Vaccine (PCV).<br><br>Findings include:<br><br>Review of the facility policy titled Procedure of Pneumococcal Vaccine, dated 3/22, indicated the following:<br><br>-Administration of the Pneumococcal Vaccine are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.<br><br>Review of the CDC's website, Pneumococcal Vaccine Timing for Adults, www.cdc.gov/Pneumococcal/index.html, dated 10/24 indicated the following:<br><br>-Adults over the age of 50 who have received a Pneumococcal Polysaccharide Vaccine (PPSV23) should receive a PCV20 (Pneumococcal Conjugate Vaccine/ Prevnar 20: vaccine used to protect against 20 types of pneumococcal bacteria that commonly cause serious infections) or PCV21 (Pneumococcal Conjugate Vaccine/ Prevnar 21: vaccine used to protect against 21 types of pneumococcal bacteria that commonly cause serious infections) after one year from the last dose of PPSV23.<br><br>Resident #50 was admitted to the facility in April 2022 with diagnoses including Delusional Disorder and a history of a Cerebrovascular Accident (CVA-Stroke).<br><br>Review of the Documentation of Resident Incapacity Form, signed by the Physician on 5/19/22, indicated Resident #50's Health Care Proxy (HCP: designated person to make medical decisions when a person was no longer able to) was activated.<br><br>Review of the facility Informed Consent for Pneumococcal Vaccine, signed by Resident #50's activated HCP on 2/7/24, indicated:<br><br>-It is recommended that adults over the age of [AGE] years who have not previously received a PCV vaccine .should receive a PCV vaccine (either PCV20 or PCV15) .<br><br>-Resident #50's HCP consented to Resident #50 being administered a PCV Vaccine on 2/7/24.<br><br>Review of Resident #50's Massachusetts Immunization Information System (MIIS) Vaccine Administration Record indicated Resident #50 was administered PPSV23 Vaccine on 6/10/19.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225720 | A. Building<br>B. Wing | 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Millbury | 312 Millbury Avenue<br>Millbury, MA 01527 |

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

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|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of Resident #50's medical record failed to indicate documentation that Resident #50 had been administered a PCV Vaccine as consented to by the Resident's HCP on 2/7/24.<br><br>During an interview on 4/24/25 at 11:25 A.M., the Clinical Services Coordinator said Resident #50 should have been administered a PCV vaccine within a couple days of his/her HCP consenting to the vaccination, and this was not done. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>42741<br><br>Based on interview, and record review, the facility failed to provide pertinent information pertaining to COVID-19 vaccinations for one Resident (#50), out of five residents sampled for immunizations.<br><br>Specifically, for Resident #50, the facility failed to:<br><br>1. indicate whether the Resident and/or Resident's Representative were provided education regarding the benefits and potential risks associated with COVID-19 Vaccine.<br><br>2. whether the Resident and/or Resident's Representative consented to or declined the COVID-19 Vaccine.<br><br>Findings include:<br><br>Review of the facility policy titled Coronavirus Disease (COVID-19)-Vaccination of Residents, revised 5/23, indicated the following:<br><br>-Documentation and Reporting:<br><br>>The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>-That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine .<br><br>-Signed consent .<br><br>Resident #50 was admitted to the facility in April 2022 with diagnoses including Delusional Disorder and a history of a Cerebrovascular Accident (CVA-Stroke).<br><br>Review of the Documentation of Resident Incapacity form, signed by the Physician on 5/19/22, indicated Resident #50's Health Care Proxy (HCP: designated person to make medical decisions when a person was no longer able to) was activated.<br><br>Review of the Informed Consent for COVID-19 Vaccine, signed by Resident #50's activated HCP on 2/4/25 indicated the following acknowledgement boxes were left blank on the form:<br><br>-I have been provided with and have read (or had read to me) this vaccine consent form and any additional information concerning COVID-19 vaccination, including any applicable fact sheets related to specific vaccines .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -I acknowledge that I have had a chance to ask questions of a medical professional about this vaccine. I understand how the vaccine will be administered. I understand the known risks and potential benefits of receiving the vaccine, and understand there may be risks to the vaccine not known at this time. I consent to the COVID-19 vaccine administration.<br><br>-I have been provided with information, and given a chance to ask questions of a medical professional regarding COVID-19 vaccine. I DO NOT consent to the COVID-19 vaccine administration at this time.<br><br>During an interview on 4/24/25 at 11:25 A.M., the Clinical Services Coordinator said Resident #50's Informed Consent for COVID-19 Vaccine was incomplete and did not indicate whether Resident #50's HCP received education relative to the benefits and potential risks associated with the COVID-19 vaccine or if the HCP consented to or declined for Resident #50 to have the COVID-19 vaccine. The Clinical Services Coordinator said this information should have been documented on the Consent Form so staff knew the HCP was informed about the COVID-19 vaccine and if the HCP consented to Resident #50 receiving the COVID-19 vaccine or declined the COVID-19 vaccine. |