STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225723	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43935 Based on observation, interview, and policy review, the facility failed to ensure a dignified existence was maintained for two individual Residents (#64 and #128) and for 16 residents in one unit hallway, out of 35 sampled residents. Specifically, the facility failed to: 1. Ensure a privacy bag was maintained on Resident #64's Foley catheter drainage bag; 2. Provide Resident #128 a dignified dining experience in his/her room by ensuring their urinal was not sitting next to their meal while they were eating; and 3. Ensure dignity was maintained for 16 residents on one unit who had a sign posted on every door indicating the rooms were out of order for service from a pest control company. Findings include: Review of the facility's policy titled Resident Rights, dated as revised 1/2024, indicated but was not limited to the following: - employees shall treat all residents with dignity; - residents at this facility have the right to a dignified existence and be treated with respect. 1. Review of the facility's policy titled Catheter Care of indwelling urinary [sic], dated as revised 4/2018, indicated but was not limited to the following: - catheter care will be performed in accordance with physician's or nursing order; - assemble equipment including privacy cover. Resident #64 was admitted to the facility in February 2024 with diagnoses including: obstructive and reflex uropathy (a blockage of normal urine flow) and chronic kidney disease. On 5/19/24 at 8:21 A.M., the surveyor observed Resident #64 in his/her bed with their Foley catheter drainage bag hanging on the bed frame visible from the hallway and not in a privacy bag. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/24 at 12:47 P.M., the surveyor observed Resident #64 with his/her Foley catheter bag visible and not in a privacy bag to obscure the contents of the bag and maintain the Resident's dignity. Review of the current (5/21/24) Physician's Orders for Resident #64 included but were not limited to the following: - indwelling urinary Foley catheter is in privacy bag and catheter leg strap on at all times, every shift (2/13/24). Review of the Treatment Administration Record (TAR) for Resident #64 for 5/1/24 through 5/21/24 indicated but was not limited to the following: - 53 of 60 opportunities for the catheter to be in a privacy bag were signed off as completed. During an interview on 5/21/24 at 8:27 A.M., Unit Manager (UM) #2 said residents with catheters should have them kept in a privacy/dignity bag and up off the floor at all times. She said she did notice Resident #64 did not have a privacy bag over his/her catheter drainage bag on Sunday, May 19th. She said the policy is for the catheter bags to be maintained in a privacy bag at all times unless the residents are wearing a leg bag and that was not followed in this instance. During an interview on 5/21/24 at 1:27 P.M., the Director of Nurses (DON) said the expectation is that catheter bags are in privacy bags to maintain the privacy and dignity of the Resident and that expectation was not met. 2. Resident #128 was admitted to the facility in May 2023 with diagnoses including: chronic respiratory failure with hypoxia, bipolar disorder and major depressive disorder. Review of the most recent Brief Interview for Mental Status (BIMS), dated 2/14/24, indicated the Resident is moderately cognitively impaired with a score of 8 out of 15. During an observation with interview on 5/19/24 at 8:28 A.M., the surveyor observed the Resident in bed with his/her breakfast tray in front of them on their overbed table with a urinal containing a yellow clear fluid sitting on the table to the left of the Resident's breakfast tray. Nurse #4 entered the Resident's room and removed the breakfast tray leaving behind the hot cereal in a bowl, she did not remove the urinal from the overbed table the Resident was eating off of. Resident #128 said the urinal gets left there in case it needs to be used, he/she said, I don't know why but I guess I have to keep it there and look at my pee while I eat. During an interview on 5/19/24 at 8:30 A.M., Resident #149, who is Resident #128's roommate, said the staff always leave Resident #128's urinal on the overbed table while both Resident's in the room are eating breakfast and lunch. The Resident said it was disgusting and he/she also has to look at the urinal during meals and the staff just don't care. On 5/19/24 at 12:46 P.M., the surveyor observed Resident #128 in bed with his/her lunch tray in front of them on the overbed table with the urinal on the table just to the left of the meal tray the Resident was eating off of. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/24 at 8:29 A.M., UM #2 said the staff frequently put the Resident's urinal on the overbed table but it should not be left there when they are serving meals. She said it was gross and a dignity issue. She said she is working on breaking this habit the staff have and feels it has improved, but still happens from time to time. She said the staff should always be removing the urinal from the table the Resident is going to eat off of. During an interview on 5/21/24 at 1:27 P.M., the DON said the Resident having a urinal on their overbed table with any meal, food, or drink on the table is unacceptable and a dignity concern and should not be happening. She said the expectation to maintain the Resident's dignity with dining was not met. 36542 3. On 5/19/24 at 8:18 A.M., the surveyor observed one hallway of a unit to have signs posted on eight rooms (with 16 residents currently in the rooms) indicating a pest company was servicing the room and the room was out of order until (with no date or time specified.) The surveyor observed residents actively in all eight rooms. During an interview on 5/19/24 at 8:19 A.M., Certified Nursing Assistant (CNA) #1 said the signs were up on each room because those rooms had active cockroaches and the pest control company would come to spray them periodically. She said when the pest company was spraying the rooms the residents in those rooms needed to leave the rooms for a couple of hours and the staff would fill in on the sign the date and times for when the residents could return to their rooms. She said the staff couldn't always find the signs, so they leave the signs up on the rooms to be ready for when the pest control company comes. During an interview on 5/20/24 at 12:22 P.M., Nurse #6 said the pest control company had just left the unit and they had not sprayed any of the rooms and none of the residents were required to leave their rooms. During an interview on 5/22/24 at 3:06 P.M., the Director of Maintenance said he was not sure why the signs were up on the resident rooms. He said the signs can be placed on the door either the night before or that morning to alert staff to have the residents out of the rooms and when the residents are able to return to their rooms. He said the pest control company was not scheduled to spray these rooms on 5/21/24, had not sprayed that hallway recently and did not spray the unit on 5/21/24. During an interview on 5/22/24 at 3:07 P.M., the Administrator said he thought the signs were up because the pest control company was coming on 5/21/24. The surveyor explained that the pest control company did not spray those rooms on 5/21/24. The Administrator said the signs should not have been up while blank and while the rooms were not out of service for pest control.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 36542 Based on interview and record review, the facility failed to ensure the Health Care Proxy (HCP) of Resident #15 maintained the right to refuse psychiatric services. Specifically, psychiatric services continued to be provided to Resident #15 following the HCP's decision to discontinue treatment from the contracted psychiatric services provider. Findings include: Review of the contracted Behavioral Health Services Agreement, effective 9/1/23, indicated the behavioral health agency agreed to observe the rights of residents in arranging for services and performing services. Review of a blank Consent for behavioral services indicated, by signing, the designated person agreed to the following: - consent to receive counseling and psycho-therapy services; - allows the therapists to conduct, plan, and direct treatment; - acknowledge that this consent will remain valid until explicitly revoked; and - authorize to bill and receive payments from the healthcare provider or any other third-party payers. Resident #15 was admitted to the facility in November 2013 with a diagnosis of dementia and had an activated HCP. During an interview on 5/19/24 at 1:00 P.M., the HCP of Resident #15 inquired if the surveyor was able to see the insurance claims submitted for Resident #15. She said she wanted to see what services the facility had been billing for as she believed the facility had been providing and billing for services for Resident #15 that had not been consented to. She said she had informed the facility that she did not want the Resident being seen by the behavioral health services provider. She said she had a working relationship with the primary Nurse Practitioner (NP) and preferred the primary NP to make decisions regarding changes in medications and did not want the Psychiatric NP to make treatment recommendations or to see Resident #15. Review of the medical record failed to include a signed consent form for the contracted behavioral health services. Review of the medical record indicated Resident #15 had been seen by the psychiatric NP on 3/5/24, 3/15/24, 3/26/24, 4/26/24, and 5/14/24. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 12:05 P.M., the Psychiatric NP said she was currently seeing Resident #15 for psychiatric services by offering therapy or behavioral interventions. She said the process for consent for services was for the facility to obtain the signed consent form and she did not know where this was kept. She said she was aware the HCP did not want psychiatric services and had addressed this in the Behavioral Health Resident Log (a binder kept on the unit for communication with the psychiatric services). Review of the Behavioral Health Resident Log, dated 3/26/24, indicated staff had reported falls for Resident #15 who continued to be anxious and the HCP was hesitant to make medication changes. The log indicated staff report patient's daughter (HCP) doesn't want psych to see patient. During a continued interview on 5/21/24 at 12:05 P.M., the Psychiatric NP said she did continue to provide services to Resident #15 following 3/26/24. During an interview on 5/21/24 at 1:35 P.M., the Director of Nurses said the facility was unable to locate the consent for behavioral health services for Resident #15. She said the contracted behavioral health services should not have continued to provide services to Resident #15 if they knew the HCP did not want the services.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on observation, interview and policy review, the facility failed to ensure residents in one of four dining areas experienced a dignified and homelike dining experience. Findings include: Review of the facility's policy titled Resident Meal Service and Dining, dated as revised 6/2018, indicated but was not limited to the following: - Residents are served food and beverages in manner that provides nourishing and attractive meals, dignity, and social interaction based on the resident references to the degree possible; - Minimizing excess noise; and - Staff distributes meals by serving meals to residents at the same table at the same time. On 5/21/24 at 12:10 P.M., the surveyor made the following observations on the [NAME] Two Unit dining room: - Dance music playing in the background, very loud in a different language (Spanish) and disruptive. - Nine Residents were seated at various tables in the [NAME] Two Unit dining room. - Staff members were delivering meal trays to the residents off the first lunch truck that had arrived on the unit. - At 12:23 P.M., six out of the nine residents in the dining room were served their lunch meal. One of two residents seated at the front table was not served a meal. One of one resident sitting at the middle table was not served a meal. One of two residents sitting at the left hand center table was not served a meal. During an interview on 5/20/24 at 12:27 P.M., Certified Nursing Assistant (CNA) #2 said the three residents still waiting for food is because their meal trays come up on the second truck. She said they used to be in different rooms and ever since the room change, they are now on different trucks and cannot be served at the same time as the rest of the residents eating in the dining room. On 5/20/24 at 12:33 P.M., the surveyor observed the second lunch truck arrive on the [NAME] Two Unit. - A Staff member exited the dining room and went to the truck to obtain the last three resident meal trays. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The last resident in the dining room was served their meal at 12:35 P.M., 25 minutes after the first six residents in the dining room were served their meals. During an interview on 5/20/24 at 12:40 P.M., CNA #2 said the music is not supposed to be so loud or in a language the residents cannot understand. She said no residents in the dining room at that time requested Spanish music. During an interview on 5/20/24 at 4:15 P.M., Unit Manager (UM) #3 said residents in the dining room are supposed to be served their meals at the same time for a home-like experience. She said some residents had room changes, and their meal trays are on different trucks. UM #3 said the residents should not have to listen to very loud music that they do not understand while they eat, the residents should have the choice of the music in the background. During an interview on 5/22/24 at 4:44 P.M., the Food Service Director (FSD) said residents are not supposed to be in the dining room watching other residents eat, while waiting for their food. She said they all should receive their trays on the same truck to ensure that does not happen. The FSD said the truck schedule was updated after the surveyor's observation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48084 Based on observations, record review, policy review, and interview, the facility failed to implement interventions on the Comprehensive Care Plan for two Residents (#4, #106), out of a sample of 35 residents. Specifically, the facility failed: 1. For Resident #4, to offload heels while in bed; and 2. For Resident #106, to respond promptly when assistance with toileting was requested. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated as last revised January 2024, indicated but was not limited to the following: - A comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial and functional needs. - The resident comprehensive care plan will identify problem areas and their causes as warranted and developing interventions that are targeted and meaningful to the resident. 1. Review of the facility's policy titled Prevention of Pressure Ulcers/Injuries, dated as last revised November 2017, indicated but was not limited to the following: - Provide support device and assistance as needed. - Support Surfaces and Pressure Redistribution: Select appropriate support surfaces based in resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. Resident #4 was readmitted to the facility in January 2024 with diagnoses including morbid obesity, diabetes mellitus with diabetic polyneuropathy (symptoms of numbness, weakness, and decreased sensation usually starting in feet/hands), and peripheral vascular disease (PVD-narrowing of blood vessels causing decreased blood flow). Review of the Minimum Data Set (MDS) assessment, dated 3/27/24, indicated Resident #4 had moderate cognitive impairment as evidenced by a score of 10 out of 15 on the Brief Interview for Mental Status (BIMS). Additionally, Resident #4 had treatments for care of pressure ulcers and was dependent on staff for assistance with positioning. Review of the Physician's Orders for Resident #4 indicated but were not limited to the following: - Off-Load feet when in bed as tolerated every shift for pressure relief (2/9/24). Review of the Comprehensive Care Plan indicated but was not limited to the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FOCUS: Resident has potential for pressure ulcer development related to disease process, history of ulcers, immobility, PVD, status post toe amputation, at times limited adherence to different types of off-loading devices. GOAL: Resident will not develop any new areas of skin breakdown. INTERVENTIONS: - Off-load feet when in bed as tolerated. The surveyor made the following observations: - 5/19/24 at 9:46 A.M., Resident lying in bed with heels resting directly on the off-loading/elevation pillow (not floating off the end of it). - 5/19/24 at 2:13 P.M., Resident lying in bed with heels resting directly on the off-loading/elevation pillow (not floating off the end of it). - 5/20/24 at 10:25 A.M., Resident lying in bed with heels resting directly on the off-loading/elevation pillow (not floating off the end of it). - 5/21/24 at 10:08 A.M., Resident lying in bed with heels resting directly on the mattress. Off-loading/elevation pillow leaning against the closet. - 5/21/24 at 12:59 P.M., Resident lying in bed with heels resting directly on the off-loading/elevation pillow (not floating off the end of it). During an interview on 5/21/24 at 10:08 A.M., Resident #4 said he/she uses the off-loading pillow in bed but did not know if heels should be on it or floating off the end. During an interview on 5/23/24 at 8:51 A.M., Nurse #5 said Resident #4 had an off-loading pillow and heels should be floating off the end of it, not resting on the pillow or the mattress. During an interview on 5/23/24 at 9:26 A.M., the Director of Nurses (DON) said when off-loading heels, they should be floating off the end of the pillow and not resting on the pillow or the bed. During an interview on 5/23/24 at 11:30 A.M., Nurse #10 and Unit Manager #1 said Resident #4's heels should be floating off the end of the off-loading pillow not resting on it or resting on the bed. During an interview on 5/23/24 at 3:30 P.M., the Wound Physician said heels should be floating off the end of the off-loading pillow and if they are resting on it, it defeats the purpose of off-loading the heels. 2. Review of the facility's policy titled Assessing Falls and their Causes, dated as last revised January 2018, indicated but was not limited to the following: - Review the residents care plan to assess for any special needs of the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Documentation: Appropriate interventions to prevent future falls. Review of the facility's policy titled Activities of Daily Living (ADLs), Supporting, dated as last revised September 2019, indicated but was not limited to the following: - 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 elimination (toileting). Resident #106 was admitted to the facility in April 2020 with diagnoses including cognitive communication deficit, difficulty walking, and dementia. Review of the MDS assessment, dated 4/24/24, indicated Resident #106 had moderate cognitive impairment as evidenced by a score of 11 out of 15 on the BIMS. Additionally, he/she required assistance with ambulation and toileting and had a history of recent falls. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: INCONTINENCE: Resident has a potential for complications associated with frequent bowel and bladder incontinence. INTERVENTIONS: Offer to assist with toileting throughout the day. FOCUS: Self-care deficit related to generalized weakness, decreased range of motion, and decreased attention span. INTERVENTIONS: - Toilet Use: Dependent FOCUS: Resident is at risk for falls related to deconditioning, generalized weakness, and impaired safety awareness. INTERVENTIONS: - Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The Resident needs prompt response to all requests for assistance. - Remind resident to have rolling walker at all times, call for assistance from staff, and staff to respond to call light promptly. The surveyor made the following observations: - 5/19/24 at 9:55 A.M., Resident #106 requested assistance from the Surveyor to go to the bathroom. The Surveyor advised Resident #106 they could not assist with toileting but would seek assistance. The Surveyor walked into the hallway and requested assistance for Resident #106 from Nurse #10. The surveyor then returned to the Resident's room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/19/24 at 10:15 A.M., Resident #106 was still waiting for assistance to go to the bathroom, no staff member had entered the room since the surveyor requested assistance 20 minutes earlier. The surveyor went back into the hallway to seek assistance. Nurse #10 was not in sight. Certified Nursing Assistant #4 was in the hallway, the surveyor requested assistance with toileting for Resident #106 and she said she would go and help. - 5/19/24 at 10:25 A.M., staff entered the room, closed the door, and provided care (30 minutes after the initial request). - 5/20/24 at 12:05 P.M., the Surveyor was walking by the room and Resident #106 waved for assistance. The surveyor entered the room, Resident #106 was grabbing at his/her pants and brief visibly in distress and fidgeting in the bed, said they had to go to the bathroom and was already wet, thinks they moved their bowels, and needed to be toileted and changed. He/she said, Someone came in a little while ago, but they don't believe me, they did not even check, they just left, and I am not supposed to go alone. - 5/20/24 at 12:10 P.M., the surveyor advised Nurse #11 the Resident was requesting assistance with toileting/incontinent care and was restless in the bed grabbing at his/her pants/brief. - 5/20/24 at 12:25 P.M., staff entered the room to provide care (15 minutes after the surveyor requested assistance). During an interview on 5/19/24 at 12:47 P.M., Resident #106 said they had a fall in the bathroom toileting themself because it takes staff a long time to answer the call light. He/She said they are supposed to wait for someone to come help but they have to wait a long time and they don't always make it to the bathroom. During an interview on 5/21/24 at 1:02 P.M., Nurse #11 said call lights and requests for assistance with toileting should be handled promptly and 15-30 minutes is not acceptable. During an interview on 5/21/24 at 1:07 P.M., Unit Manager #1 said call lights and requests for assistance with toileting should be handled promptly and 15-30 minutes is not acceptable. During an interview on 5/23/24 at 10:20 A.M., the DON said call lights should generally be answered within five minutes and toileting requests should be handled as soon as possible if not immediately when requested. She said requests for assistance with toileting should be handled promptly and 15-30 minutes is not acceptable for anyone especially for Resident #106. She said the fall care plan indicated to toilet/provide assistance promptly, that was an intervention to prevent future falls and they need to ensure they are meeting his/her needs and 15-30 minutes is not promptly.

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F 0658 Level of Harm - Actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 48084 Based on record review, interview, observation, and policy review, the facility failed to provide services that met professional standards of quality for four Residents (#4, #117, #2, and #110), out of a total sample of 35 residents. Specifically, the facility failed: 1. For Resident #4 to accurately transcribe and implement orders for changes in pressure and non-pressure wound treatments (Wound Site #8, #9, #10, #11 ,#12, #13, #14, #15, and #16), resulting in Wound Site #9 progressing from a non-pressure wound to a Stage 3 pressure ulcer; 2. For Resident #117, to accurately transcribe and implement orders for changes in pressure wound treatments; 3. For Resident #2, to accurately transcribe and implement orders for changes in pressure wound treatments; and 4. For Resident #110, to accurately transcribe and implement orders for changes in pressure wound treatments. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. - In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Charting and Documentation, dated as revised 10/2019, included but was not limited to the following: -All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, should be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. -The following information is to be documented in the resident medical record: Treatments or services performed. -Documentation of procedures and treatments will include care-specific details (continued on next page)

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Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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F 0658 Level of Harm - Actual harm Residents Affected - Some	Review of the facility's policy titled Pressure Ulcer/Injury Risk Assessment, dated as last revised 4/2018, indicated but was not limited to the following: -If a new skin alteration is noted, initiate a pressure/non pressure form related to the type of alteration noted. -The following information should be recorded in the resident's medical record utilizing facility forms: the condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified; documentation in the medical record addressing Physician notification if new skin alteration noted with change of plan of care, if indicated. 1. Resident #4 was admitted to the facility in January 2010, and recently readmitted in January 2024 with diagnoses including morbid obesity, diabetes mellitus with diabetic polyneuropathy (symptoms of numbness, weakness, and decreased sensation usually starting in feet/hands), and peripheral vascular disease (PVD-narrowing of blood vessels causing decreased blood flow). Review of the Minimum Data Set (MDS) assessment, dated 3/27/24, indicated Resident #4 had moderate cognitive impairment as evidenced by a score of 10 out of 15 on the Brief Interview for Mental Status (BIMS). Additionally, Resident #4 had skin treatments and was dependent on staff for assistance with positioning. Review of the comprehensive care plan indicated but was not limited to the following: FOCUS: Pressure Ulcer: Ulceration or interference with structural integrity of layers of skin. GOAL: Show no signs of infection through review date; Show reduction in size/stage of pressure ulcer. INTERVENTIONS: Consult and treatment by Certified Wound Doctor or Certified Wound Nurse as needed (PRN), monitor for changes and update provider, offload heels as tolerated when in bed, offload wounds as tolerated, treatments as ordered, and turn/reposition as needed. Review of the medical record indicated Resident #4 was followed by a Wound Care Physician at the facility. a. Site #8-Stage 2 Pressure Wound of the Right Buttock. (Partial thickness loss of dermis (middle layer of skin) presenting as a shallow open ulcer with a red or pink wound bed, without slough (yellow/white material in wound bed) or bruising) Review of the initial Wound Evaluation and Management Summary, dated 12/5/23 indicated the following: -Site #8-Stage 2 Pressure Wound of the Right Buttock measured 3 x 2 cm x depth is unmeasurable due to presence of tissue overgrowth. Review of the Wound Evaluation and Management Summaries (18 visits) indicated the following: -Start of Care for Site #8 was 12/5/23 and the area resolved on 4/30/24. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	-Of the weekly wound care recommendations made 5 of 11 were transcribed accurately as recommended, 6 of 11 were not transcribed accurately and 6 visits no change was needed; the visit on 4/30/24 the area was resolved. Review of the Treatment Administration Record (TAR) from 12/5/23-4/30/24 indicated the facility failed to complete the treatment ordered on the TAR 30 of 266 opportunities. b. Site #9-Non-Pressure Wound Sacrum (area at the lower spine) (Moisture Associated Skin Damage (MASD)-caused by prolonged exposure to various sources of moisture including urine or stool, perspiration, wound exudate (drainage), mucus, saliva, and their contents). Review of the initial Wound Evaluation and Management Summary, dated 12/5/23 indicated the following: - Site #9-Non-Pressure Wound Sacrum measured 2 x 1 x 0.1 cm. Review of the Wound Evaluation and Management Summaries (20 visits) indicated the following: -Start of Care for Site #9 was 12/5/23 and the area is still currently under the care of the Wound Physician for the Pressure Wound. -The wound was reclassified due to exacerbation from MASD to a Stage 3 Pressure Ulcer (Full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed; slough may be present but does not obscure the depth of tissue loss) on 2/8/24. -Of the weekly wound care recommendations made 5 of 18 were transcribed accurately as recommended, 13 of 18 were not transcribed accurately and 2 visits no change was needed. Review of the TAR from 12/5/23-5/22/24 indicated the facility failed to complete the treatment ordered on the TAR 4 of 66 opportunities. c. Site #10-Unstageable Wound of the Right Lateral Foot. (Full thickness pressure injury in which the base is obscured by slough and/or eschar (dead tissue that dries and becomes adherent to the wound)) Review of the initial Wound Evaluation and Management Summary, dated 12/5/23, indicated the following: -Site #10-Unstageable Wound of the Right Lateral Foot measured 2.5 x 1.5 cm x depth not measurable due to presence of non-viable tissue and necrosis. Review of the Wound Evaluation and Management Summary, dated 1/16/24, indicated but was not limited to the following: - Site #10-Stage 3 Pressure Wound of the Right Lateral Foot measured 3.5 x 2.5 x 0.1 cm with moderate serous drainage. Wound Progress: Not at Goal. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	-Recommendation: Apply calcium alginate and silver sulfadiazine and cover with gauze island border dressing twice daily. Off-load wound, float heels in bed. The surface area of the wound was four times larger than the previous visit and the wound now had 20% thick adherent devitalized necrotic tissue (not present on previous visit (1/2/24)). Review of the nursing progress notes failed to indicate staff had identified the decline in the wound and notified the Physician since the previous visit (1/2/24). Review of the TAR failed to indicate the order was obtained for the new treatment as recommended by the wound physician. The order written for Silver Sulfadiazine failed to include the calcium alginate or a dressing. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the nursing progress notes indicated Resident #4 had been diagnosed with influenza on 1/16/24 and treatment was initiated. He/she spiked a temp on 1/18/24 and was transferred to an acute care hospital. The Resident was hospitalized from 1/18/24-1/26/24. Review of the History and Physical, dated 1/18/24, indicated: -Treatment for Sepsis (life-threatening complication of an infection) without septic shock is likely secondary to urinary tract infection (UTI) and right foot ulcer. Review of the Hospital Discharge Summary, dated 1/26/24, indicated: -Infectious Disease Consult 1/18/24-reason Sepsis. -Podiatry Consult 1/18/24-reason right lateral foot ulcer, ?osteomyelitis. -Sepsis secondary to right foot ulcer. Could not do the MRI. Per Infectious Disease (ID) will do two weeks of intravenous (IV) Ceftriaxone (antibiotic). -Discharge Data: Sepsis with acute organ dysfunction. -Discharge Diagnosis: Right foot infection. -Discharge Information: Skin Comment: Pressure Injury Right Lateral Foot: Cleanse with normal saline or wound cleanser, apply protective skin barrier spray/wipe or skin barrier cream, protect with foam dressing, change every other day, or as needed. Review of the nursing progress note, dated 1/26/24, indicated the change in treatment per hospital orders and IV antibiotics for right foot sepsis. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	Review of the TAR failed to indicate the wound care order was obtained per the discharge instructions from the hospital. The Silver Sulfadiazine treatment remained in effect since ordered on 1/17/24, still without the calcium alginate or a dressing. Review of the nursing progress notes failed to indicate the Physician declined the recommendation from the hospital discharge instructions. Review of the Wound Evaluation and Management Summaries (18 visits) indicated the following: -Start of Care for Site #10 was 12/5/23 and the area resolved on 4/30/24, and exacerbated on 5/23/24, pending evaluation on 5/24/24. -Of the weekly wound care recommendations made 6 of 11 were transcribed accurately as recommended, 5 of 11 were not transcribed accurately and 6 visits no change was needed; the final on 4/30/24 the area was resolved. Review of the TAR from 12/5/23-4/30/24 indicated the facility failed to complete the treatment ordered on the TAR 40 of 234 opportunities. d. Site #11-Non-Pressure Wound of the Right Thigh (trauma/from brief) Review of the initial Wound Evaluation and Management Summary, dated 12/19/23, indicated the following: -Site #11-Non-Pressure Wound of the Right Thigh measured 2.5 x 2.5 cm x depth not measurable due to presence of tissue overgrowth. Review of the Wound Evaluation and Management Summaries (5 visits) indicated the following: -Start of Care for Site #11 was 12/19/23 and the area resolved on 1/31/24. -Of the weekly wound care recommendations made 1 of 4 were transcribed accurately as recommended, 3 of 4 were not transcribed accurately; the visit on 1/31/24 the area was resolved. Review of the TAR from 12/19/23-1/31/24 indicated the facility failed to complete the treatment ordered on the TAR 3 of 14 opportunities. e. Site #12-Stage 3 Pressure Wound of the Left Buttock. Review of the initial Wound Evaluation and Management Summary, dated 1/31/24, indicated the following: -Site #12-Stage 3 Pressure Wound of the Left Buttock measured 4.5 x 1 x 0.1 cm. Review of the Wound Evaluation and Management Summaries (3 visits) indicated the following: -Start of Care for Site #12 was 1/31/24 and the area resolved on 2/13/24. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	-Of the weekly wound care recommendations made 0 of 2 were transcribed accurately as recommended, 2 of 2 were not transcribed accurately; the visit on 2/13/24 the area was resolved. Review of the TAR from 1/31/23-2/13/24 indicated the facility failed to complete the treatment ordered on the TAR 3 of 14 opportunities. f. Site #13-Skin Tear of the Right Shin. Review of the initial Wound Evaluation and Management Summary, dated 1/31/24 indicated the following: -Site #13-Skin Tear of the Right Shin measured 2 x 3 cm x depth unmeasurable due to presence of tissue overgrowth. Review of the Wound Evaluation and Management Summaries (2 visits) indicated the following: -Start of Care for Site #13 was 1/31/24 and the area resolved on 2/8/24. -Of the weekly wound care recommendations made 0 of 1 were transcribed accurately as recommended, 1 of 1 were not transcribed accurately; the visit on 2/8/24 the area was resolved. Review of the TAR from 1/31/23-2/8/24 indicated the facility failed to obtain an order for a treatment. g. Site #14-Stage 3 Pressure Wound of the Left Buttock. Review of the initial Wound Evaluation and Management Summary, dated 2/20/24, indicated the following: -Site #14-Stage 3 Pressure Wound of the Left Buttock measured 1.5 x 1 cm x depth unmeasurable due to presence of tissue overgrowth. Review of the Wound Evaluation and Management Summaries (5 visits) indicated the following: -Start of Care for Site #14 was 2/20/24 and the area resolved on 3/19/24. -Of the weekly wound care recommendations made 1 of 2 were transcribed accurately as recommended, 1 of 2 were not transcribed accurately and 2 visits no change was needed; the visit on 3/19/24 the area was resolved. Review of the medical record indicated that from 2/20/24-3/4/24 the facility failed to obtain an order for a treatment to the left buttock. Review of the physician's orders indicated that on 3/4/24 an order was obtained for the left buttock. (14days after the onset of the wound) Review of the TAR from 3/4/24-3/19/24 indicated the facility failed to complete the treatment ordered on the TAR 6 of 32 opportunities. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	Review of the Pressure Ulcer Evaluations, dated 2/21/24, failed to indicate a pressure area to the left buttock. h. Site #15-Non-Pressure Wound of the Right Buttock (MASD). Review of the medical record indicated a previous area to the right buttock had resolved on 5/1/24. Review of the initial Wound Evaluation and Management Summary, dated 5/14/24, indicated the following: -Site #15-Non-Pressure Wound of the Right Buttock (MASD) measured 3 x 2 cm x depth unmeasurable due to presence of tissue overgrowth. Review of the Wound Evaluation and Management Summaries (1 visits) indicated the following: -Start of Care for Site #15 was 5/14/24 and the area is still currently under the care of the Wound Physician. Review of the TAR from 5/14/23-5/22/24 indicated the facility failed to complete the treatment ordered on the TAR 1 of 7 opportunities. i. Site #16-Non-Pressure Wound of the Right Thigh (trauma/from brief). Review of the initial Wound Evaluation and Management Summary, dated 5/14/24, indicated the following: -Site #16-Non-Pressure Wound of the Right Thigh (trauma/from brief) measured 4.5 x 0.5 x 0.1 cm. Review of the Wound Evaluation and Management Summaries (1 visits) indicated the following: -Start of Care for Site #16 was 5/14/24 and the area is still currently under the care of the Wound Physician. Review of the TAR from 5/14/23-5/22/24 indicated the facility failed to complete the treatment ordered on the TAR 1 of 6 opportunities. During an interview on 5/21/24 at 4:06 P.M., Unit Manager #1 said the Wound Doctor comes weekly and usually rounds with Nurse #5, then she would get the recommendations from the Wound Doctor and write/obtain all the orders. She said the non-pressure and pressure ulcer evaluations trigger to be done weekly once initiated and every area should have one done weekly. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	During a telephone interview on 5/23/24 at 8:51 A.M., Nurse #5 said she does the weekly wound rounds with the Wound Doctor and writes the orders. She said typically the Attending Physician or NP goes with whatever the Wound Doctor recommends unless it is something out in left field but that rarely happens. Nurse #5 was not in the building during the interview and did not have access to the medical records at the time of the interview. She said she couldn't speak to the recommendations that were not done prior to her taking over in late April but said if her name is on the current orders then she wrote them. She was unable to speak to why the orders from May were not written and/or did not match the Wound Doctor Recommendations as they should because the physician did not disagree with the recommendations. During an interview on 5/23/24 at 9:26 A.M., the DON said the general process is the Nurse rounds with the Wound Doctor, then obtains orders and write them per the Wound Doctor Recommendations and completes the weekly pressure/non-pressure evaluations. She said there is no process in place at this time to ensure orders are transcribed correctly and treatments are implemented but there needs to be one. Additionally, she said she expects treatments to be done per the physician's order and signed off on the TAR and there should not be blanks (treatment not signed off as administered) on the TAR. The DON and Consulting Staff #1 confirmed with chart review multiple treatments as noted above were not implemented correctly or at all and they should have been. Given the number of errors noted, not every treatment was reviewed by the DON and Consulting Staff #1 for accuracy. She said the number of things not done correctly was concerning. Additionally, the DON said the orders should match the recommendation unless the Attending disagreed and in that case there should be a progress note written and there are no notes indicating such. She also said if the recommendation is unclear, or a secondary dressing was not written on the recommendation, then the nurse should be calling the Wound Doctor for clarification. During an interview on 5/23/24 at 9:26 A.M., the DON and Consulting Staff #1 confirmed with chart review that multiple treatments as noted above were not implemented correctly or at all and they should have been. Given the number of errors noted, not every treatment was reviewed by the DON and Consulting Staff #1 for accuracy. During an interview on 5/23/24 at 12:40 P.M., Unit Manager #1 said she expects treatments to be done per the physician's order and signed off on the TAR. During an interview on 5/23/24 at 3:30 P.M., the Wound Doctor said her expectation is for the Nurse to obtain and write the orders per the recommendations made and if they need clarification to call her. She said the Attending Physicians/NP's always go with whatever is recommended and she has never had any issues with them disagreeing with what she recommended. Refer to F684 and F686 36542 2. Resident #117 was admitted to facility in April 2024 with a pressure ulcer to the coccyx (bone at the end of the spine). Review of the Minimum Data Set (MDS) assessment, dated 4/30/24, indicated Resident #117 was dependent on staff for all activities of daily living (ADLs) and mobility. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	Review of the care plans indicated Resident #117 had a stage 3 (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue) pressure ulcer to the coccyx with interventions of administering treatments as ordered, utilize an air mattress, and to follow facility protocol for the prevention/treatment of skin breakdown. Review of the admissions paperwork indicated Resident #117 was admitted with a pressure wound to the coccyx with a treatment order to cleanse with normal saline, pat dry, apply wound gel with silver, followed by Calcium Alginate with silver, apply skin prep to peri-wound (the skin around the wound) and cover with a super absorbent dressing, two times per day and as needed. Review of the Treatment Administration Record (TAR) for April 2024 indicated the treatment from admission was not completed as ordered on the following days: -4/19/24 (day and evening shift) -4/21/24 (day shift) -4/22/24 (day shift) Review of the Wound Evaluation and Management Summary from the Consultant Wound Physician, dated 4/23/24, indicated the following: Stage 3 pressure ulcer of the left coccyx: measuring 3 centimeters (cm) in length by 1 cm in width by 0.1 cm in depth, with light serous (watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage) drainage with 100% granulated tissue. Treatment Plan: Discontinue wound gel with silver, Calcium Alginate with silver and super absorbent dressing. Start Silver Sulfadiazine (an antibiotic cream used to treat or prevent serious skin infections) twice per day with a gauze island border dressing. During an interview on 5/22/24 at 3:17 P.M., Nurse Practitioner #2 said the primary physicians defer to the Wound Physician for treatments and she had not declined any recommendations for Resident #117. Review of the TAR for April 2024 indicated no treatment was provided to the stage 3 pressure ulcer on 4/24/24. Review of the April 2024 TAR indicated a new treatment order was written on 4/24/24 to start on 4/25/24: cleanse the coccyx with normal saline, apply Silver Sulfadiazine cream to area and cover with gauze island border dressing once per day, and not twice per day as indicated by the Wound Physician. The treatment was provided once per day from 4/25/24 through 4/29/24. Review of the Wound Evaluation and Management Summary from the Consultant Wound Physician, dated 4/30/24, indicated the following: Stage 3 pressure ulcer of the left coccyx: measuring 2.5 cm in length by 1 cm in width by 0.1 cm in depth, with light serous drainage with 80% granulated tissue and 20% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture). (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	Treatment Plan: Continue Silver Sulfadiazine twice per day with a gauze island border dressing. Review of the TAR for May 2024 indicated no treatment was provided to the stage 3 pressure ulcer on 5/1/24. Review of the May 2024 TAR indicated the treatment order for the coccyx pressure ulcer was re-written on 5/1/24 to include documentation requirements including wound descriptions. The treatment order continued to be in place for once per day and not twice per day as indicated by the Wound Physician. Review of the Wound Evaluation and Management Summary from the Consultant Wound Physician, dated 5/7/24 indicated the following: Stage 3 pressure ulcer of the left coccyx: measuring 3 cm in length by 1 cm in width by 0.2 cm in depth, with moderate serous drainage with 80% granulated tissue and 20% slough. Treatment Plan: Discontinue Silver Sulfadiazine twice per day; Start Alginate Calcium with silver and Collagen Powder, once per day, followed by the gauze island border dressing. Review of the TAR for May 2024 indicated no treatment was provided to the stage 3 pressure ulcer on 5/8/24. Review of the May 2024 TAR indicated the new treatment order for the coccyx pressure ulcer was written on 5/8/24 as indicated by the Wound Physician. The TAR indicated this treatment was not provided on 5/11/24 and 5/12/24. Review of the Wound Evaluation and Management Summary from the Consultant Wound Physician, dated 5/14/24, indicated the following: Stage 3 pressure ulcer of the left coccyx: measuring 2.3 cm in length by 1 cm in width by 0.2 cm in depth, with moderate serous drainage with 80% granulated tissue and 20% slough. Treatment Plan: Continue Alginate Calcium with silver and Collagen Powder, once per day, followed by the gauze island border dressing. Review of the TAR for May 2024 indicated no treatment was provided to the stage 3 pressure ulcer on 5/15/24. Review of the May 2024 TAR indicated the treatment order for the coccyx pressure ulcer was re-written on 5/15/24 to start on 5/16/24 as follows: normal saline, apply Collagen Powder followed by Calcium Alginate and cover with gauze island border dressing; indicating the treatment no longer included silver in the Calcium Alginate. The treatment was not provided on 5/18/24 or 5/20/24. During an interview on 5/22/24 at 12:15 P.M., Nurse #3 said she always completes the treatments for Resident #117 and could not say why the treatments were not completed on days she was working, such as 5/11/24 and 5/15/24. She said if a treatment order was discontinued prior to her completing the order and the next treatment order did not start until the following day there was no way for her to be alerted by the electronic medical record that a treatment needed to be completed. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	During an interview on 5/23/24 at 8:51 A.M., Nurse #5 said she was not sure why the treatments were not completed as ordered by the nurses and that she does not check the TAR to ensure wound treatments are completed as ordered and would not know if treatments are not being completed. She said all treatment orders should have been written to reflect the treatment plan indicated by the Wound Physician and she was not sure why they were not. Refer to F686 49425 3. Resident #2 was admitted to the facility in April 2019 with diagnoses of Type 2 Diabetes and a stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) to the coccyx (area below the spine). Review of the MDS assessment, dated 5/1/24, indicated Resident #2 scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating Resident #2 cognition was severely impaired. Review of Section M: Skin Conditions of the MDS assessment indicated the Resident had a Stage 4 pressure ulcer/injury. The assessment also indicated Resident #2 was receiving pressure ulcer/injury care including the application of non-surgical dressings and ointments. Review of the care plans for Resident #2 indicated the Resident had a Stage 4 pressure ulcer to the coccyx with interventions to consult certified wound MD or Nurse as needed and monitor for changes and update provider. Review of the April 2024 Medication and Treatment Administration Records (MAR and TAR) indicated the following treatment order for the coccyx was initiated on 4/25/24: Cleanse area to coccyx with wound cleanser, apply Santyl (debriding ointment used to rid wound bed of dead tissue), Collagen Sheet (stimulates growth of new tissue), and Calcium Alginate (absorbent gel forming debriding agent to rid wound bed of dead tissue). Cover with gauze island border dressing, change daily and as needed soilage on day shift. Review of the medical record indicated Resident #2 was seen by the Wound Physician Consultant on 4/30/24. Review of the Wound Evaluation Management Summary indicated Resident #2 had a Stage 4 pressure injury to the coccyx measuring 6 centimeters (cm) in length by 6 cm in width by 1.5 cm in depth. The treatment recommendation was to change the treatment to apply Collagen Sheet, Alginate Calcium with Silver, and cover with gauze island border dressing daily for 23 days. Review of the Nursing Progress Note, dated 5/1/24, indicated Resident #2 was seen by the Wound Physician with wound measurements and treatments updated. MD and guardian aware of changes and in agreement with plan of care. Review of the Pressure Ulcer Evaluation, dated 5/1/24, indicated there was a new order for the pressure injury to the coccyx to apply Collagen Sheet, followed by Alginate Calcium with Silver, cover with a gauze island with border dressing and change daily. Review of the May 2024 MAR and TAR indicated a new treatment order was initiated on 5/1/24 for the coccyx area: (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	-Cleanse area to coccyx with wound cleanser, apply Collagen Sheet followed by Calcium Alginate. Cover with gauze island border dressing. Change daily and as needed for soilage. Review of the May 2024 MAR and TAR failed to indicate Alginate Calcium with Silver was initiated. Review of the 5/7/24 Wound Evaluation and Management Summary from the Wound Physician indicated to continue the Collagen sheet, followed by Alginate Calcium with Silver, cover with gauze island border dressing daily for 16 days. Review of the Nursing Progress Notes, dated 5/8/24, indicated Resident #2 was seen by the Wound Physician with measurements and treatments updated. MD and guardian aware of plan of care and agree. Review of the Pressure Ulcer Evaluation, dated 5/8/24, indicated to continue current treatment order of Collagen Sheet, followed by Alginate Calcium with Silver, cover with gauze island border dressing daily. Review of the 5/14/24 Wound Evaluation and Management Summary from the Wound Physician indicated to continue the Collagen sheet, followed by Alginate Calcium with Silver, cover with gauze island border dressing daily for 9 days. Review of the Nursing Progress Notes, dated 5/15/24, indicated Resident #2 was seen by the wound physician with measurements and treatments updated. MD and guardian aware of plan of care and agree. Review of the Pressure Ulcer Evaluation, dated 5/15/24, indicated to continue current treatment order of collagen sheet, followed by Alginate Calcium with Silver, cover with gauze island border dressing daily. Review of the May 2024 MAR and TAR failed to indicate the treatment of Alginate Calcium with Silver was implemented between 5/1/24 and 5/21/22. Review of the Nursing Progress Notes, dated 5/21/24, indicated Resident #2 wound orders were updated by Nurse Practitioner related to Alginate Calcium being unavailable at this time, use Alginate Calcium with Silver, until Alginate Calcium is available, guardian in agreement. Review of the May 2024 MAR and TAR indicated a new order: -Cleanse area to coccyx with wound cleanser, apply Collagen Sheet followed by Calcium Alginate with Silver, cover with gauze island border dressing. Change daily and as needed for soilage. Review of the May 2024 MAR and TAR failed to indicate a treatment was completed on 5/21/24 to the coccyx. The TAR was blank. Review of the Nursing progress notes, dated 5/21/24, failed to indicate a treatment was completed to the coccyx. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Some	During an interview on 5/21/24 at 1:42 P.M., Unit Manager (UM) #3 said the facility ran out of Alginate Calcium and they notified the Nurse Practitioner (NP), and the order was updated to include Alginate Calcium with Silver. The surveyor and UM reviewed wound physician's recommendations together and she said the order was in the system incorrectly, and it should have always included Alginate Calcium with Silver since 5/1/24. During an interview on 5/22/24 at 2:31 P.M., Nurse #9 said the standard of practice would be to document completion of the treatment on the TAR. She said she will also document in a nursing progress note if she has more information to add regarding the treatment she provided. Nurse #9 said she must have forgotten to document after completing the treatment to Resident #2 coccyx area. During an interview on 5/22/24 at 3:17 P.M., Nurse Practitioner #2 said she defers to the wound physician for wound recommendations. She said she has not declined any wound recommendations for Resident #2. During an interview on 5/22/24 at 4:22 P.M., UM #3 said the process for a nurse to follow once completing a treatment would be to sign off on the TAR. The surveyor and UM #3 reviewed the TAR and Nursing Progress Notes together and she said the nurse did not document completion of the treatment in the medical record on 5/21/24. During an interview on 5/23/24 at 9:05 A.M., Nurse #5 said she regularly conducted wound rounds with the wound physician. She said the wound physician would give her verbal recommendations and send over the Wound Evaluation and Management Summary with the written recommendations, and she reviewed them with the PCP. Nurse #5 said the PCP did no [TRUNCATED]

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 48362 Based on interviews, record review, and policy review, the facility failed to promote and manage the delivery of safe nursing care in accordance with accepted Standards of Nursing Practice by failing to identify and address a change in condition and provide necessary care and treatment for three Residents (#36, #34, and #4), out of a total sample of 35 residents. Specifically, the facility failed: 1. For Resident #36, to provide proper care and treatment of a non-pressure right heel wound including accurately implementing the Wound Consultant's recommendations; 2. For Resident #4, to implement and complete treatments as ordered for: a. Site #9-Non-Pressure Wound Sacrum (Moisture Associated Skin Damage-MASD), resulting in the wound progressing to a Stage 3 pressure ulcer, b. Site #11-Non-Pressure Wound of the Right Thigh (trauma/from brief), c. Site #13-Skin Tear of the Right Shin, d. Site #15-Non-Pressure Wound of the Right Buttock (MASD), and e. Site #16-Non-Pressure Wound of the Right Thigh (trauma/from brief); and 3. For Resident #34, to ensure weekly weights were obtained for the management of congestive heart failure (CHF- progressive heart disease that affects pumping action of the heart muscles which leads to fatigue, shortness of breath). Findings include: 1. Review of the facility's policy titled Pressure Ulcer/Injury Risk Assessment, dated as last revised 4/2018, indicated but was not limited to the following: - If a new skin alteration is noted, initiate a pressure/non-pressure form related to the type of alteration noted. - The following information should be recorded in the resident's medical record utilizing facility forms: the condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified; documentation in the medical record addressing Physician notification if new skin alteration noted with change of plan of care, if indicated. Resident #36 was admitted to the facility in August 2022 with diagnoses including morbid obesity and muscle weakness. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated 4/9/24, indicated Resident #36 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS). The MDS indicated Resident #36 required assistance from staff to perform activities of daily living, including but not limited to bed mobility and transfers. The MDS also indicated Resident #36 was at risk for alteration in skin. During an observation with interview on 5/20/24 at 12:30 P.M., the surveyor observed Resident #36 resting in bed, lying on his/her back. Resident #36 said he/she has an area to his/her right heel which opens and closes frequently. Resident #36 said he/she had a traumatic injury to his/her right heel several years ago when this all started. The surveyor did not observe a dressing on Resident #36's right heel. Review of Resident #36's Physician's Orders indicated the following: - 2/23/23: Weekly Skin Assessment by Licensed Nurse, every Friday day shift. Review of the Weekly Skin Evaluation assessment, dated 3/27/24, indicated Resident #36 had a right heel area open with treatment in place. Further review of the Weekly Skin Evaluation assessments continued to indicate Resident #36 had a right heel area on 4/7/24, 4/15/24, 4/22/24, 4/29/24, 5/6/24, and 5/14/24. Review of the Resident #36's Physician's Orders, in place from 3/6/23 to 4/1/24, indicated: - Skin prep bilateral heels every shift every day for prevention. Review of the medical record from 3/27/24 through 4/9/24 failed to indicate treatment orders addressing Resident #36's open non-pressure right heel wound. Review of the Wound Consultant's notes, dated 4/9/24, indicated the following: - Resident #36 had a non-pressure wound of right heel, partial thickness with an etiology of trauma/injury. - The objective of the Wound Consultant treatment was to manage exudate (drainage) and maintain healing. - The wound duration was noted to be greater than 3 days. - Wound size: 1.5 centimeters (cm) x 1.0 cm x not measurable depth due to presence of tissue overgrowth. The total surface area of the wound was 1.5 cm squared. The wound has light serous (clear) drainage. - Dressing treatment plan: collagen sheet with silver, gauze island border dressing changed once daily. Review of Physician's Orders following the Wound Consultant visit on 4/9/24, failed to indicate treatment orders were put in place for the open non-pressure right heel wound based on the recommendations made during the visit. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Review of the Wound Consultant's notes, dated 4/16/24, indicated the following: - Resident #36 had a non-pressure wound of right heel, full thickness with an etiology of trauma/injury. - The objective of the Wound Consultant treatment was to maintain healing. - The wound duration was noted to be greater than 10 days. - Wound size: 2.5 cm x 2.0 cm x 0.05 cm with a total surface area of 5.00 cm squared. The wound had moderate serosanguinous (bloody) drainage. The wound bed contained 50% slough (necrotic (dead) tissue that is green, yellow, tan, or brown, and may be moist, loose, or stringy) and 50% granulation (healthy) tissue. - Wound progress was noted to be not at goal. - Dressing treatment plan: collagen sheet with silver, gauze island border dressing and skin prep to surrounding skin once daily. Review of the Physician's Orders following the Wound Consultant visit on 4/16/24, indicated treatment orders for the non-pressure right heel wound were put in place as recommended by the Wound Consultant on 4/17/24, 21 days after the non-pressure right heel wound was identified. Review of the Wound Consultant's notes, dated 4/30/24, indicated the following: - Resident #36 had a non-pressure wound of right heel, full thickness with an etiology of trauma/injury. - The wound duration was noted to be greater than 38 days. - Wound size: 3.5 cm x 2.0 cm x not measurable due to presence of tissue overgrowth. The total surface area of the non-pressure right heel wound was 7.00 cm squared. The wound had light serosanguinous drainage. The wound bed contained 100% granulation tissue. - Dressing treatment plan: collagen sheet with silver, gauze island border dressing and skin prep to surround skin once daily. Review of the Wound Consultant's notes indicated the non-pressure right heel wound progress was not at goal. The non-pressure right heel wound surface area grew from 5.00 cm squared on 4/16/24 to 7.00 cm squared on 4/30/24 (total increase in surface area of 2.00 cm squared). Review of Wound Consultant notes from 5/7/24, indicated the non-pressure right heel wound progress was improved as evidenced by decreased surface area (3.00 cm squared) and physician's orders including treatment recommendations for collagen sheet with silver, gauze island border dressing with skin prep to surrounding skin once daily were in place. Review of the Wound Consultant's notes, dated 5/14/24, indicated the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	- Resident #36 had a non-pressure wound of right heel, full thickness with an etiology of trauma/injury. - Objective of the Wound Consultant treatment was to maintain healing. - The wound duration was noted to be greater than 38 days. - Wound size: 1.0 cm x 1.0 cm x not measurable due to presence of tissue overgrowth. The total surface area of the non-pressure right heel wound was 1.00 cm squared. The wound had light serous drainage. The wound bed contained 100% granulation tissue. - Dressing treatment plan: collagen sheet with silver, gauze island border dressing and skin prep to surrounding skin once daily. Review of Physician's Orders following the Wound Consultant's visit on 5/14/24, failed to include the collagen sheet with silver as recommended for the open non-pressure right heel wound. Further review of the medical record failed to indicate why the recommendation for the collagen sheet with silver was left off the active physician's order. Review of the Treatment Administration Record (TAR) failed to include collagen sheet with silver as the active treatment order for Resident #36 after 5/15/24 as recommended by the Wound Consultant. During an interview on 5/21/24 at 8:32 A.M., Unit Manager (UM) #1 said the Wound Consultant comes in once a week, typically either Tuesday or Friday. UM #1 said typically Nurse #5 completes wound rounds with the Wound Consultant unless they are unavailable. During an interview on 5/21/24 at 12:43 P.M., Nurse #5 said she completes weekly wound rounds with the Wound Consultant and updates the medical record based on her recommendations. Nurse #5 said she will clarify recommendations with the resident's MD/NP and update the orders as needed. Nurse #5 said Resident #36 had an old traumatic injury to the right heel before entering the facility. Nurse #5 said the area to the right heel tends to re-open frequently and requires intervention to heal due to the area being fragile. Nurse #5 said she was not certain when Resident #36's non-pressure right heel wound re-opened. Nurse #5 reviewed the medical record for Resident #36 and said the Wound Consultant recommended a treatment of collagen sheet with silver, gauze border island dressing and skin prep to the surrounding skin on 5/14/24. Nurse #5 said the current active physician's order for Resident #36 did not include a collagen sheet with silver, but all collagen sheets in the facility included silver. On 5/21/24 at 2:25 P.M., the surveyor observed the following: - Nurse #6 gathered wound supplies from the treatment cart (including barrier paper, non-sterile 4x4 gauze pads, normal saline, collagen sheet and gauze island border dressing) at the door of Resident #36's room and set up on the overbed table after wiping it down with bleach. - Unit Manager #1 entered the room, donned gloves, and assisted Resident #36 in lifting his/her right leg off the bed. - Nurse #6 cleaned the wound bed with normal saline wash and patted it dry with gauze. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	- Nurse #6 placed the collagen sheet over the wound on the right heel. - Nurse #6 covered the area with the gauze island border dressing. During an interview on 5/21/24 at 2:36 P.M., Nurse #6, UM #1 and the surveyor reviewed the collagen sheet packaging which failed to indicate the collagen sheet had silver. UM #1 said the collagen sheet placed on Resident #36 during the dressing change did not have silver in it as per the Wound Consultant's recommendation from 5/15/24. UM #1 said the collagen sheet with silver is in a different packaging. UM #1 reviewed the Wound Consultant's recommendations from 5/15/24 and said the order should include collagen sheet with silver. During an interview on 5/21/24 at 2:48 P.M., UM #1 said when a resident has a new skin area identified, the MD/NP should be notified, and any orders given should be put into the medical record. UM #1 said the nurse would then document in a note the changes identified in the resident's skin. UM #1 and the surveyor reviewed the medical record for Resident #36. UM #1 said there was no nursing note documentation from 3/27/24 for Resident #36's non-pressure right heel wound, but there should be. UM #1 said Resident #36 was not seen by the Wound Consultant until 4/9/24. UM #1 said the first order put into the medical record related to the treatment of Resident #36's non-pressure right heel wound was on 4/17/24. UM #1 said she would not expect there to be that kind of delay in treatment. During an interview on 5/22/24 at 10:48 A.M., NP #1 said recommendations from the Wound Consultant are reviewed by the providers. NP #1 said Wound Consultant recommendations would be approved for treatment unless there were any issues in which they would document the need for the change. During an interview on 5/22/24 at 11:43 A.M., the Director of Nursing (DON) said when a new skin area or re-opened skin area is found on a resident the nurse would notify the MD/NP for treatment orders. The DON said the resident's profile would also be updated to identify the need for the Wound Consultant to follow the area. The DON said the Wound Consultant follows any resident in the facility with open skin issues/concerns. The DON said once the Wound Consultant sees the resident, any recommendations would be reconciled with the MD/NP and put in place for treatment. The DON and the surveyor reviewed the findings as related to Resident #36. The DON said Resident #36 should not have gone without a treatment to an open area to the right heel. The DON said skin prep to an open area was not an appropriate treatment. The DON said orders should be reconciled based on the recommendations given by the Wound Consultant. The DON said the orders for Resident #36 needed to be reconciled again with the MD/NP for not being accurate. During an interview on 5/22/24 at 3:11 P.M., the Wound Consultant said she typically comes into the facility on a weekly basis. The Wound Consultant said Nurse #5 typically completes wound rounds with her, but if she is unavailable the Unit Managers are available to complete rounds. The Wound Consultant said she will assess the wound, update the nurse regarding the status of the wound and make any treatment recommendations. The Wound Consultant said the current order for Resident #36 should include a collagen sheet with silver. The Wound Consultant said she was not updated regarding Resident #36 receiving a treatment without the collagen sheet. 48084 2. Review of the facility's policy titled Pressure Ulcer/Injury Risk Assessment, dated as last revised 4/2018 indicated but was not limited to the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	-If a new skin alteration is noted, initiate a pressure/non pressure form related to the type of alteration noted. -The following information should be recorded in the resident's medical record utilizing facility forms: the condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified; documentation in the medical record addressing Physician notification if new skin alteration noted with change of plan od care, if indicated. Resident #4 was admitted to the facility in January 2010, and recently readmitted in January 2024 with diagnoses including morbid obesity, diabetes mellitus with diabetic polyneuropathy (symptoms of numbness, weakness, and decreased sensation usually starting in feet/hands), and peripheral vascular disease (PVD-narrowing of blood vessels causing decreased blood flow). Review of the MDS assessment, dated 3/27/24, indicated Resident #4 had moderate cognitive impairment as evidenced by a score of 10 out of 15 on the BIMS. Additionally, Resident #4 had skin treatments and was dependent on staff for assistance with positioning. Review of the comprehensive care plan indicated but was not limited to the following: FOCUS: Resident has incontinence related to decreased motivation to toilet and weakened bladder tone. GOAL: Resident will remain free from skin breakdown due to incontinence. INTERVENTIONS: Brief Use for containment and dignity; Incontinent care and apply barrier cream with incontinent care. FOCUS: Resident has a self-care deficit related to decreased motivation and obesity. INTERVENTIONS: Bed Mobility and Positioning-Totally dependent; Turning and Repositioning every two hours and as needed. FOCUS: Resident has potential for pressure ulcer development related to disease process, history of ulcers, immobility, obesity, diabetes, and incontinence. GOAL: Resident will not develop any new areas of skin breakdown. INTERVENTIONS: Administer preventative skin care as ordered. Review of the medical record indicated Resident #4 was followed by a Wound Care Physician at the facility. a. Site #9-Non-Pressure Wound Sacrum (area at the lower spine) (MASD-caused by prolonged exposure to various sources of moisture including urine or stool, perspiration, wound exudate (drainage), mucus, saliva, and their contents). Review of the weekly skin check, dated 12/4/23, indicated a shearing area to the coccyx (area at the base of spine-just below the sacrum) with a treatment in progress. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Review of the nursing progress notes failed to indicate the area on the coccyx was reported to the physician. Review of the physician's orders/TAR failed to indicate a treatment for the coccyx area was ordered. Review of the Wound Evaluation and Management Summary, dated 12/5/23, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 3 x 1 centimeter (cm) x depth not measurable due to tissue overgrowth, open ulceration with light serous drainage (pale yellow/transparent drainage). Duration over three days. -Recommendation: Apply Silver sulfadiazine (antimicrobial cream to prevent infection) and calcium alginate (antibacterial product for wound drainage) twice daily, cover with gauze island border dressing. The new area identified on the 12/4/23 weekly skin check as shearing of the coccyx by the nurse, did not have a treatment in place at the time of the skin check, nor was one implemented when the area was discovered. The area was evaluated by the Wound Physician on 12/5/23 and determined to be MASD of the sacrum. Review of the TAR indicated the order was implemented on 12/6/23. Review of the Wound Evaluation and Management Summary, dated 12/19/23, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 1 x 1 x 0.1 cm, open areas with exposed dermis (middle layer of skin). -Recommendation: Apply Collagen powder (wound filler to aid in formation of healthy tissue) daily, cover with gauze island border dressing twice daily. Review of the TAR failed to indicate the order was obtained for the new treatment as recommended. The order for silver sulfadiazine and calcium alginate remained in effect. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 12/26/23, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 1 x 0.5 x 0.1 cm, open areas with exposed dermis. -Recommendation: Apply Collagen powder daily, cover with gauze island border dressing twice daily. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Review of the TAR indicated the order was implemented on 12/27/23 as follows: Sacrum-Cleanse with wound cleanser, pat dry, apply skin prep (forms a barrier between skin and adhesive to help preserve skin integrity) to surrounding skin, apply collagen powder to wound bed and cover with gauze island border dressing twice daily. (8 days after it was recommended) Further review of the December 2023 TAR indicated the treatments were not signed off as administered 7 out of 53 opportunities. Review of the Wound Evaluation and Management Summary, dated 1/16/24, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 1.5 x 0.5 x 0.1 cm, open areas with exposed dermis. Wound Progress: Not at goal. -Recommendation: Apply silver sulfadiazine and cover with gauze island border dressing twice daily. Review of the TAR indicated the order was implemented on 1/17/24 as follows: silver sulfadiazine apply to sacrum topically twice daily. No dressing was ordered as recommended to cover the wound. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of a dressing to cover the wound. The Resident was hospitalized from 1/18/24-1/26/24. Further review of the January 2024 TAR indicated the treatments were not signed off as administered 6 out of 45 opportunities. Review of the Wound Evaluation and Management Summary, dated 1/31/24, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 1.5 x 0.4 x 0.1 cm, open areas with exposed dermis. Wound Progress: Not at goal. -Recommendation: Apply Collagen Sheet with silver (advanced dressing for management of wounds to reduce/prevent infection) and cover with gauze island border dressing twice daily. Review of the TAR failed to indicate an order was obtained for the collagen sheet with silver treatment as recommended. The order for silver sulfadiazine remained in effect. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 2/8/24, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) was exacerbated and was now a Stage 3 Pressure Wound (full thickness tissue loss, subcutaneous fat may be visible but not bone, tendon, or muscle) and measured 1. 5 x 2 x 0.1 cm with moderate serous drainage. (continued on next page)

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Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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F 0684 Level of Harm - Actual harm Residents Affected - Some	-Recommendation: Apply Santyl (debriding agent to rid the wound of necrotic (dead) tissue and aid in healing) followed by calcium alginate and cover with gauze island border dressing daily. Review of the TAR failed to indicate an order was obtained for the Santyl and calcium alginate treatment as recommended. The order was written for Santyl Ointment-Apply to sacrum topically every day for wound care on 2/12/24. The order failed to contain the calcium alginate or a dressing to cover the wound. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 2/13/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 6 x 2 x 0.1 cm with moderate serous drainage. Wound Progress: Not at Goal. -Recommendation: Apply Calcium Alginate once daily and silver sulfadiazine twice daily cover with gauze island border dressing twice daily. The order was written as follows: Cleanse wound with wound cleanser, apply silver sulfadiazine to wound bed, apply calcium alginate then cover with gauze island border dressing twice daily. Review of the Wound Evaluation and Management Summary, dated 2/20/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 2 x 1 x 0.1 cm with light serous drainage. -Recommendation: Silver sulfadiazine twice daily cover with gauze island border dressing twice daily. -Skin substitute (alternative to a skin graft used to aid in healing of wounds not responding to typical treatment) wound candidate evaluation. Review of the TAR failed to indicate the silver sulfadiazine treatment as recommended. The previous order for silver sulfadiazine and calcium alginate remained in effect. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Further review of the February 2024 TAR indicated treatments were not signed off as administered 4 out of 57 opportunities. Review of the Wound Evaluation and Management Summary, dated 3/1/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 2 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at goal. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	-Recommendation: Primary Dressing: Silver sulfadiazine apply once weekly. If dressing falls off use silvadene and a border gauze daily. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The order from 2/13/24 was still in effect as it was not changed on 2/20/24 as recommended or on 3/1/24 as recommended. An order for silver sulfadiazine and cover with gauze island border twice daily was written on 3/4/24, also not per the recommendation made on 3/1/24 by the wound physician, the instructions pertaining to the skin substitute and full dressing were not included in the order. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 3/8/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 1.5 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at goal. -Recommendation: Primary Dressing: If dressing falls off use silvadene and a border gauze daily. Xeroform gauze once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The previous incorrect order from 3/4/24 remained in effect until 3/11/24. On 3/11/24 orders were written as follows: -Maintain dressing to sacrum area, if dressing falls off apply the as needed (PRN) treatment of silver sulfadiazine with border gauze daily. -Cleanse area to sacrum wound with wound cleanser, apply silver sulfadiazine to wound followed by border gauze daily PRN if dressing falls off. The incorrect order from 3/4/24 remained in effect until 3/11/24, therefore the newly applied skin substitute graft from 3/8/24 was disturbed that evening and the wrong treatment continued until 3/11/24, when an order was written to maintain the sacrum dressing (which had already been disturbed) and therefore should have had daily dressing changes until the next wound physician visit and it did not. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Review of the Wound Evaluation and Management Summary, dated 3/19/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 4 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at goal. -Recommendation: Primary Dressing: If dressing falls off use silvadene and a border gauze daily. Collagen sheet with silver apply once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. On 3/20/24 orders were written as follows: -Maintain dressing to sacrum area, if dressing falls off apply the PRN treatment of collagen sheet with silver followed by border gauze daily. Every shift for sacrum dressing. -Maintain restorigin/border gauze dressing to sacrum until wound MD in to re-evaluate, check placement every shift. If soilage is noted to the border gauze, change the border gauze as needed (see PRN order) if entire dressing falls off, refer to PRN collagen sheet with silver every shift for sacrum wound. The TAR failed to indicate an order for if dressing falls of use silvadene and border gauze daily. The order was written for a collagen sheet with silver followed by a border gauze daily. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Further review of the March 2024 TAR indicated treatments were not signed off as administered 6 out of 21 opportunities. Review of the Wound Evaluation and Management Summary, dated 4/9/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 2 x 1 x 0.1 cm with light serous drainage. -Recommendation: Primary Dressing: If dressing falls off use silvadene and a border gauze daily. Collagen sheet with silver apply once weekly. For the week of 4/15 apply Collagen AG and a border gauze once daily. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The incorrect orders written 3/20/24 remained in effect. The additional order for the week of 4/15/24 as indicated above was not written until 4/17/24 and initiated on 4/18/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 4/23/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 2 x 1 x 0.1 cm with light serous drainage. -Recommendation: Primary Dressing: Collagen sheet with silver apply once weekly. Calcium Alginate once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The order was written for daily dressing changes as follows: Cleanse area to sacrum wound with wound cleanser, pat dry, apply skin prep to surrounding skin, apply collagen AG sheet with silver and calcium alginate sheet to wound followed by a border gauze dressing every day shift for wound care. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 4/30/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 1.2 x 1 x 0.1 cm with light serous drainage. -Recommendation: Primary Dressing: Collagen sheet with silver apply once weekly. Hydrocolloid sheet (satin) (moisture-retentive dressing with gel properties and waterproof to isolate wound from bacteria contaminants) once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The orders written included the gauze island border dressing and not the hydrocolloid sheet. The order written 5/1/24 read as follows: -Maintain the Restorigin/Border gauze dressing to sacrum wound until Wound MD in to re-evaluate, check placement every shift. If soilage is noted to the border gauze change the border gauze as needed (see PRN order). If entire dressing falls off, refer to PRN Collagen sheet with silver every shift for sacrum wound. Review of the TAR indicated the wound descriptors including the drainage amount/type and wound bed. These descriptors were documented on daily basis, indicated the wound bed was exposed and assessed daily. Additionally, the PRN order to change the dressing for soilage and the PRN order if the entire dressing falls off were not signed off as administered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Further review of the April 2024 TAR indicated treatments were not signed off as administered 3 out of 13 opportunities. Review of the Wound Evaluation and Management Summary, dated 5/7/24, indicated but was not limited to the following: -[TRUNCATED]

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48084 Based on observations, interviews, record review, and policy review, the facility failed to ensure four Residents (#4, #2, #110, and #117), out of a total sample of 35 residents, received care and treatment to promote healing of pressure injuries. Specifically, the facility failed: 1. For Resident #4, to implement and complete treatments as ordered for: a. Site #8-Stage 2 Pressure Wound (partial thickness loss of dermis presenting as a shallow open ulcer with red/pink wound bed, without slough (yellow/white material in wound bed) or an intact, open, or ruptured blister) of the Right Buttock, b. Site #9-Non-Pressure Wound Sacrum (area at the lower spine) (MASD-Moisture Associated Skin Damage-caused by prolonged exposure to various sources of moisture including urine or stool, perspiration, wound exudate (drainage), mucus, saliva, and their contents) that progressed to a Stage 3 Pressure Wound (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss), c. Site #10-Unstageable (due to necrosis) (pressure ulcer known but is not stageable due to coverage of the wound bed by slough or eschar (dead tissue typically brown, tan, or black and may be crusty) of the Right Lateral Foot and failed to implement effective pressure relieving interventions by off-loading heels/feet, d. Site #12-Stage 3 Pressure Wound of the Left Buttock, and e. Site #14-Stage 3 Pressure Wound of the Left Buttock; and 2. For Resident #2, to implement and complete treatments as ordered for a stage 4 pressure injury (full thickness skin loss extending through the fascia (thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber, and muscle in place) with considerable tissue loss. There may be muscle, bone, tendon, or joint involvement) to the coccyx (bone at the end of the spine); 3. For Resident #110, to address wound physician's recommendations timely for care and treatment of a stage 4 pressure injury to the coccyx; and 4. For Resident #117, to implement and complete treatments as ordered to a stage 3 pressure ulcer on the coccyx and to implement an effective pressure relieving intervention. Findings include: Review of the facility's policy titled Pressure Ulcer/Injury Risk Assessment, dated as last revised 4/2018 indicated but was not limited to the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-Risk Factors that increase a resident's susceptibility to develop or not to heal Pressure Ulcer/Pressure Injury (PU/PI) include but are not limited to: Impaired/decreased mobility, the presence of previously healed pressure ulcers/injuries (areas of healed stage 3 or 4 PU/PI are more likely to have recurrent breakdown), exposure of skin to urinary or fecal incontinence, and co-morbid conditions, such as end stage renal disease or diabetes. -If a new skin alteration is noted, initiate a pressure/non pressure form related to the type of alteration noted. -The following information should be recorded in the resident's medical record utilizing facility forms: the condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified; documentation in the medical record addressing Physician notification if new skin alteration noted with change of plan of care, if indicated. Review of the facility's policy titled Prevention of Pressure Ulcers/Injury, dated as last revised 11/2017, indicated but was not limited to the following: -Assess the resident on admission for existing PU/PI risk factors. Repeat the risk assessment weekly and upon changes in condition. -Inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living (ADLs). -Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) -Reposition resident as indicated on the care plan. -Keep the skin clean and free of exposure to urine and fecal matter. -At least every two hours, reposition residents who are reclining or dependent on staff for repositioning. -Provide support devices and assist as needed. -Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. Review of the facility's policy titled Dressings, Dry/Clean, dated 4/2018, indicated but was not limited to the following: -Verify that there is a physician's order for this procedure. -Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs. -Check the treatment record. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	1. Resident #4 was admitted to the facility in January 2010, and recently readmitted in January 2024 with diagnoses including morbid obesity, diabetes mellitus with diabetic polyneuropathy (symptoms of numbness, weakness, and decreased sensation usually starting in feet/hands), and peripheral vascular disease (PVD-narrowing of blood vessels causing decreased blood flow). Review of the Minimum Data Set (MDS) assessment, dated 3/27/24, indicated Resident #4 had moderate cognitive impairment as evidenced by a score of 10 out of 15 on the Brief Interview for Mental Status (BIMS). Additionally, Resident #4 had skin treatments and was dependent on staff for assistance with positioning. Review of the comprehensive care plan indicated but was not limited to the following: FOCUS: Resident has incontinence related to decreased motivation to toilet and weakened bladder tone. GOAL: Resident will remain free from skin breakdown due to incontinence. INTERVENTIONS: Brief Use for containment and dignity; Incontinent care and apply barrier cream with incontinent care. FOCUS: Resident has a self-care deficit related to decreased motivation and obesity. INTERVENTIONS: Bed Mobility and Positioning-Totally dependent; Turning and Repositioning every two hours and as needed. FOCUS: Resident has potential for pressure ulcer development related to disease process, history of ulcers, immobility, obesity, diabetes, and incontinence. GOAL: Resident will not develop any new areas of skin breakdown. INTERVENTIONS: Administer preventative skin care as ordered. FOCUS: Pressure Ulcer: Ulceration or interference with structural integrity of layers of skin. GOAL: Show no signs of infection through review date; Show reduction in size/stage of pressure ulcer. INTERVENTIONS: Consult and treatment by Certified Wound Doctor or Certified Wound Nurse as needed (PRN), monitor for changes and update provider, offload heels as tolerated when in bed, offload wounds as tolerated, treatments as ordered, and turn/reposition as needed. Review of the medical record indicated Resident #4 was followed by a Wound Care Physician at the facility. a. Site #8-Stage 2 Pressure Wound of the Right Buttock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the weekly skin check, dated 12/4/23, indicated a shearing area to the coccyx (area at the base of spine-just below the sacrum) with a treatment in progress; there was no indication of a right buttock wound. Review of the Wound Evaluation and Management Summary, dated 12/5/23, indicated but was not limited to the following: - Site #8-Stage 2 Pressure Wound of the Right Buttock measured 3 x 2 centimeters (cm) depth was not measurable due to presence of tissue overgrowth with light serous drainage (pale yellow/transparent drainage). Duration: over three days -Recommendation: Silver sulfadiazine (antimicrobial cream to prevent infection) and calcium alginate (antibacterial product for wound drainage), cover with gauze island border twice daily. Review of the Physician's Orders/treatment administration record (TAR) indicated the order was implemented on 12/6/23. Review of the Wound Evaluation and Management Summary, dated 12/19/23, indicated but was not limited to the following: - Site #8-Stage 2 Pressure Wound of the Right Buttock measured 2 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at Goal. -Recommendation: Apply Collagen powder (wound filler to aid in formation of healthy tissue) once daily and cover with gauze island border twice daily. Review of the Treatment Administration Record (TAR) failed to indicate the order was obtained for the new treatment. The previous order for silver sulfadiazine and calcium alginate remained in effect. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 12/26/23, indicated but was not limited to the following: - Site #8-Stage 2 Pressure Wound of the Right Buttock measured 3 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at Goal. -Recommendation: Apply Collagen powder once daily and cover with gauze island border twice daily. Review of the TAR indicated the order was obtained for the new treatment (7 days after the initial recommendation on 12/19/24). Further review of the December 2023 TAR indicated the treatments were not signed off as administered 7 out of 53 opportunities. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the Wound Evaluation and Management Summary, dated 1/16/24, indicated but was not limited to the following: - Site #8-Stage 2 Pressure Wound of the Right Buttock measured 0.5 x 0.7 x 0.1 cm with light serous drainage. Wound Progress: Not at Goal. -Recommendation: Silver sulfadiazine and cover with gauze island border twice daily. Review of the TAR failed to indicate the order was obtained for the new treatment. The order did not contain a dressing as recommended by the wound physician. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. The Resident was hospitalized from 1/18/24-1/26/24. Further review of the January 2024 TAR indicated the treatments were not signed off as administered 7 out of 47 opportunities. Review of the Wound Evaluation and Management Summary, dated 1/31/24, indicated but was not limited to the following: - Site #8-Stage 3 Pressure Wound of the Right Buttock measured 7 x 3 x 0.1 cm with light serous drainage. Wound Progress: Exacerbated due to recent hospitalization . -Recommendation: Collagen sheet with silver and cover with gauze island border twice daily. Review of the TAR failed to indicate the order was obtained for the new treatment. The order for Silver Sulfadiazine remained in effect, still with no dressing as recommended on 1/16/24 from the Wound Physician. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 2/8/24, indicated but was not limited to the following: - Site #8-Stage 3 Pressure Wound of the Right Buttock measured 3 x 3.5 x 0.1 cm with moderate serous drainage. -Recommendation: Santyl (debriding agent to rid the wound of necrotic (dead) tissue and aid in healing) and calcium alginate once daily and cover with gauze island border twice daily. Review of the TAR failed to indicate the order was obtained for the new treatment. The order for Silver Sulfadiazine remained in effect, still with no dressing as recommended on 1/16/24 from the Wound Physician. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	On 2/12/24 an order was written for Santyl to the right buttock once daily. The order failed to include the calcium alginate or the dressing. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 2/13/24, indicated but was not limited to the following: - Site #8-Stage 3 Pressure Wound of the Right Buttock measured 2 x 1.5 x 0.1 cm with light serous drainage. -Recommendation: calcium alginate once daily, silver sulfadiazine twice daily and cover with gauze island border twice daily. The entire order was written to be changed twice daily on 2/14/24. Review of the Wound Evaluation and Management Summary, dated 2/20/24, indicated but was not limited to the following: - Site #8-Stage 3 Pressure Wound of the Right Buttock measured 1.5 x 1 x 0.1 cm with light serous drainage. -Recommendation: silver sulfadiazine and cover with gauze island border twice daily. Review of the TAR failed to indicate the order was obtained for the new treatment per the wound doctor's recommendations. The previous order for silver sulfadiazine and calcium alginate remained in effect. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Further review of the February 2024 TAR indicated the treatments were not signed off as administered 3 out of 57 opportunities. Review of the Wound Evaluation and Management Summary, dated 3/1/24, indicated but was not limited to the following: - Site #8-Stage 3 Pressure Wound of the Right Buttock measured 1.5 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at Goal. -Recommendation: silver sulfadiazine and cover with gauze island border twice daily. The order was written on 3/4/24. (14 days after the initial recommendation was made.) Further review of the March 2024 TAR indicated the treatments were not signed off as administered 7 out of 62 opportunities. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the Wound Evaluation and Management Summary, dated 4/9/24, indicated but was not limited to the following: - Site #8-Stage 3 Pressure Wound of the Right Buttock measured 2 x 1 x depth is unmeasurable due to tissue overgrowth with light serous drainage. Wound Progress: Not at Goal. -Recommendation: Collagen sheet with silver (advanced dressing for management of wounds to reduce/prevent infection) once daily cover with gauze island border twice daily. The order was obtained as recommended by the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 4/16/24, indicated but was not limited to the following: - Site #8-Stage 3 Pressure Wound of the Right Buttock measured 1.4 x 1.2 x 0.05 cm. -Recommendation: Collagen sheet with silver cover with gauze island border daily. The order was obtained as recommended by the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 4/30/24, indicated but was not limited to the following: - Site #8-Stage 3 Pressure Wound of the Right Buttock-RESOLVED Further review of the April 2024 TAR indicated the treatments were not signed off as administered 6 out of 47 opportunities. b. Site #9-Non-Pressure Wound Sacrum (MASD). Review of the weekly skin check, dated 12/4/23, indicated a shearing area to the coccyx with a treatment in progress. Review of the nursing and physician progress notes failed to indicate the area on the coccyx was reported to the physician. Review of the physician's orders/TAR failed to indicate an order for a treatment to the coccyx. Review of the Wound Evaluation and Management Summary, dated 12/5/23, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 3 x 1 cm x depth not measurable due to tissue overgrowth, open ulceration with light serous drainage. Duration over three days. -Recommendation: Apply Silver sulfadiazine and calcium twice daily, cover with gauze island border dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	The new area identified on the 12/4/23 weekly skin check as shearing of the coccyx by the nurse, did not have a treatment in place at the time of the skin check, nor was one implemented when the area was discovered. The area was evaluated by the Wound Physician on 12/5/23 and determined to be MASD of the sacrum. Review of the TAR indicated the order was implemented on 12/6/23. Review of the Wound Evaluation and Management Summary, dated 12/19/23, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 1 x 1 x 0.1 cm, open areas with exposed dermis (middle layer of skin). -Recommendation: Apply Collagen powder daily, cover with gauze island border dressing twice daily. Review of the TAR failed to indicate the order was obtained for the new treatment as recommended. The order for silver sulfadiazine and calcium alginate remained in effect. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 12/26/23, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 1 x 0.5 x 0.1 cm, open areas with exposed dermis. -Recommendation: Apply Collagen powder daily, cover with gauze island border dressing twice daily. Review of the TAR indicated the order was implemented on 12/27/23 as follows: Sacrum-Cleanse with wound cleanser, pat dry, apply skin prep (forms a barrier between skin and adhesive to help preserve skin integrity) to surrounding skin, apply collagen powder to wound bed and cover with gauze island border dressing twice daily. (8 days after it was recommended) Further review of the December 2023 TAR indicated the treatments were not signed off as administered 7 out of 53 opportunities. Review of the Wound Evaluation and Management Summary, dated 1/16/24, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 1.5 x 0.5 x 0.1 cm, open areas with exposed dermis. Wound Progress: Not at goal. -Recommendation: Apply silver sulfadiazine and cover with gauze island border dressing twice daily. Review of the TAR indicated the order was implemented on 1/17/24 as follows: silver sulfadiazine apply to sacrum topically twice daily. No dressing was ordered as recommended to cover the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of a dressing to cover the wound. The Resident was hospitalized from 1/18/24-1/26/24. Further review of the January 2024 TAR indicated the treatments were not signed off as administered 6 out of 45 opportunities. Review of the Wound Evaluation and Management Summary, dated 1/31/24, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) measured 1.5 x 0.4 x 0.1 cm, open areas with exposed dermis. Wound Progress: Not at goal. -Recommendation: Apply Collagen Sheet with and cover with gauze island border dressing twice daily. Review of the TAR failed to indicate an order was obtained for the collagen sheet with silver treatment as recommended. The order for silver sulfadiazine remained in effect. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 2/8/24, indicated but was not limited to the following: - Site #9-Non-Pressure Wound Sacrum (MASD) was exacerbated and was now a Stage 3 Pressure Wound and measured 1.5 x 2 x 0.1 cm with moderate serous drainage. -Recommendation: Apply followed by calcium alginate and cover with gauze island border dressing daily. Review of the TAR failed to indicate an order was obtained for the Santyl and calcium alginate treatment as recommended. An order was written for Santyl Ointment-Apply to sacrum topically every day for wound care on 2/12/24. The order failed to contain the calcium alginate or a dressing to cover the wound. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 2/13/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 6 x 2 x 0.1 cm with moderate serous drainage. Wound Progress: Not at Goal. -Recommendation: Apply Calcium Alginate once daily and silver sulfadiazine twice daily cover with gauze island border dressing twice daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	The order was written as follows: Cleanse wound with wound cleanser, apply silver sulfadiazine to wound bed, apply calcium alginate then cover with gauze island border dressing twice daily. Review of the Wound Evaluation and Management Summary, dated 2/20/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 2 x 1 x 0.1 cm with light serous drainage. -Recommendation: Silver sulfadiazine twice daily cover with gauze island border dressing twice daily. -Skin substitute (alternative to a skin graft used to aid in healing of wounds not responding to typical treatment) wound candidate evaluation. Review of the TAR failed to indicate the silver sulfadiazine treatment as recommended. The previous order for silver sulfadiazine and calcium alginate remained in effect. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Further review of the February 2024 TAR indicated treatments were not signed off as administered 4 out of 57 opportunities. Review of the Wound Evaluation and Management Summary, dated 3/1/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 2 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at goal. -Recommendation: Primary Dressing: Silver sulfadiazine apply once weekly. If dressing falls off use silvadene and a border gauze daily. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The order from 2/13/24 was still in effect as it was not changed on 2/20/24 as recommended or on 3/1/24 as recommended. An order for silver sulfadiazine and cover with gauze island border twice daily was written on 3/4/24, also not per the recommendation made on 3/1/24 by the wound physician, the instructions pertaining to the skin substitute and full dressing were not included in the order. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 3/8/24, indicated but was not limited to the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- Site #9-Stage 3 Pressure Wound and measured 1.5 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at goal. -Recommendation: Primary Dressing: If dressing falls off use silvadene and a border gauze daily. Xeroform gauze once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The previous incorrect order from 3/4/24 remained in effect until 3/11/24. On 3/11/24 orders were written as follows: -Maintain dressing to sacrum area, if dressing falls off apply the as needed (PRN) treatment of silver sulfadiazine with border gauze daily. -Cleanse area to sacrum wound with wound cleanser, apply silver sulfadiazine to wound followed by border gauze daily PRN if dressing falls off. The incorrect order from 3/4/24 remained in effect until 3/11/24, therefore the newly applied skin substitute graft from 3/8/24 was disturbed that evening and the wrong treatment continued until 3/11/24, when an order was written to maintain the sacrum dressing (which had already been disturbed) and therefore should have had daily dressing changes until the next wound physician visit and it did not. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 3/19/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 4 x 1 x 0.1 cm with light serous drainage. Wound Progress: Not at goal. -Recommendation: Primary Dressing: If dressing falls off use silvadene and a border gauze daily. Collagen sheet with silver apply once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. On 3/20/24 orders were written as follows: -Maintain dressing to sacrum area, if dressing falls off apply the PRN treatment of collagen sheet with silver followed by border gauze daily. Every shift for sacrum dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-Maintain restorigin/border gauze dressing to sacrum until wound MD in to re-evaluate, check placement every shift. If soilage is noted to the border gauze, change the border gauze as needed (see PRN order) if entire dressing falls off, refer to PRN collagen sheet with silver every shift for sacrum wound. Review of the TAR failed to indicate an order for if dressing falls of use silverdene and border gauze daily. The order was written for a collagen sheet with silver followed by a border gauze daily. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Further review of the March 2024 TAR indicated treatments were not signed off as administered 6 out of 21 opportunities. Review of the Wound Evaluation and Management Summary, dated 4/9/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 2 x 1 x 0.1 cm with light serous drainage. -Recommendation: Primary Dressing: If dressing falls off use silvadene and a border gauze daily. Collagen sheet with silver apply once weekly. For the week of 4/15 apply Collagen AG and a border gauze once daily. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The incorrect orders written 3/20/24 remained in effect. The additional order for the week of 4/15/24 as indicated above was not written until 4/17/24 and initiated on 4/18/24. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 4/23/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 2 x 1 x 0.1 cm with light serous drainage. -Recommendation: Primary Dressing: Collagen sheet with silver apply once weekly. Calcium Alginate once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary Dressing: Gauze Island border once weekly. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The order was written for daily dressing changes as follows: Cleanse area to sacrum wound with wound cleanser, pat dry, apply skin prep to surrounding skin, apply collagen AG sheet with silver and calcium alginate sheet to wound followed by a border gauze dressing every day shift for wound care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 4/30/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 1.2 x 1 x 0.1 cm with light serous drainage. -Recommendation: Primary Dressing: Collagen sheet with silver apply once weekly. Hydrocolloid sheet (satin) (moisture-retentive dressing with gel properties and waterproof to isolate the wound from bacteria contaminants) once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The orders written included the gauze island border dressing and not the hydrocolloid sheet. The order written 5/1/24 read as follows: -Maintain the Restorigin/Border gauze dressing to sacrum wound until Wound MD in to re-evaluate, check placement every shift. If soilage is noted to the border gauze change the border gauze as needed (see PRN order). If entire dressing falls off, refer to PRN Collagen sheet with silver every shift for sacrum wound. Review of the TAR indicated the wound descriptors including the drainage amount/type and wound bed. These descriptors were documented on daily basis, indicated the wound bed was exposed and assessed daily. Additionally, the PRN order to change the dressing for soilage and the PRN order if the entire dressing falls off were not signed off as administered. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Further review of the April 2024 TAR indicated treatments were not signed off as administered 3 out of 13 opportunities. Review of the Wound Evaluation and Management Summary, dated 5/7/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 1.1 x 0.7 x 0.1 cm with light serous drainage. -Recommendation: Primary Dressing: Collagen sheet with silver apply once weekly. Hydrocolloid sheet (satin) once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Review of the TAR failed to indicate an order was obtained for the treatment as recommended. The incorrect order from 5/1/24 remained in effect. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the TAR indicated the wound descriptors including the drainage amount/type and wound bed. These descriptors were documented on daily basis, indicated the wound bed was exposed and assessed daily. Additionally, the PRN order to change the dressing for soilage and the PRN order if the entire dressing falls off were not signed off as administered. Review of the nursing and physician progress notes failed to indicate the Physician declined the recommendation of the Wound Physician. Review of the Wound Evaluation and Management Summary, dated 5/14/24, indicated but was not limited to the following: - Site #9-Stage 3 Pressure Wound and measured 1 x 0.7 x 0.1 cm with light serous drainage. -Recommendation: Primary Dressing: Calcium Alginate once weekly. Collagen sheet with silver apply once weekly. Skin substitute application (Restorigin) apply once weekly. DO NOT REMOVE or disturb the wound bed. Change the secondary dressing with care per recommendations. The skin substitute graft will be re-evaluated by the wound physician during the next visit. Secondary dressing: Hydrocolloid sheet (satin) apply three times weekly. Rev[TRUNCATED]

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 48084 Based on observations, interview, record review, and policy review, the facility failed to implement interventions timely after significant weight loss was identified for one Resident (#61) with an unplanned significant weight loss (5.23% in 1 month to 17.82% in 6 months), out of a total sample of 35 residents. Specifically, the facility failed to: -Respond to a Registered Dietitian (RD)'s dietary recommendation to decrease the dose of Remeron (an antidepressant used at a lower dose as an appetite stimulant), from 22.5 milligrams (mg) to 7.5 mg to stimulate appetite and promote weight gain, -Consider additional weight monitoring timely per policy, and -Consider additional interventions to curb further weight loss, resulting in continued significant weight loss over a period of seven months (October 2023 through May 2024). Findings include: Review of the facility's policy titled Weight Measurement, dated as last revised 4/4/19, indicated but was not limited to the following: -All residents with significant weight changes will have verification of weight measurement for accuracy and documentation purposes. If verification of weight change indicates significant weight change (suggested parameters for evaluating significance of unplanned weight and undesired weight loss are: 5% in 30 days, 7.5% in 90 days, and 10% in 180 days) the resident and/or family representative and interdisciplinary team (IDT) will be notified, and the plan of care will be revised as appropriate. -Residents with significant unintended weight changes will be added to weekly weights x 4 weeks or until weight stabilizes. Resident #61 was admitted to the facility in May 2018 and readmitted to the facility in April 2023 with diagnoses including Parkinson's disease (disorder of the central nervous system that affects movement), muscle weakness, anorexia, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment, dated 3/20/24, indicated Resident #61 was cognitively intact as evidenced by a score of 14 out of 15 on the Brief Interview for Mental Status (BIMS), needed set up assistance with meals, was taking an antidepressant, and had weight loss. Review of the Physician's Orders indicated the following: -Regular Diet, mechanical soft texture, and thin liquids. Fortified pudding at dinner and small portions. (3/31/21) -House Supplement 60 milliliters (ml) twice daily (Resident refuses increased volume). (3/20/24) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Weekly weights times 4 weeks. (5/8/24) -Remeron 22.5 mg by mouth one time a day related to major depressive disorder. (12/17/20) (administered at 8:00 P.M.) -Prozac 10mg (antidepressant) one time a day related to major depressive disorder. (6/6/23) (administered at 8:00 A.M.) Review of the Medication Administration Record (MAR) for April 2024 indicated Resident #61 rarely consumed all 60 ml of the House Supplement. Review of the MAR for May 2024 indicated he/she consumed 60 ml of House Supplement 75% of the time. Review of the Weight Summary indicated the following: (Height 61 inches / Ideal Body Weight: 105 pounds (lbs.) / Body Mass Index 15.9) -10/3/23 weight 101 lbs. -11/3/23 weight 98 lbs. -12/4/23 weight 95 lbs. -1/2/24 weight 92 lbs. -2/1/24 weight 89.5 lbs. -3/1/24 weight 87 lbs. -4/9/24 weight 83 lbs. -4/19/24 weight 86 lbs. -4/26/24 weight 88 lbs. -5/1/24 weight 85 lbs. -5/8/24 weight 84 lbs. -5/16/24 weight 81.5 lbs. -The weight loss from October 2023 to January 2024 was 9 lbs. or 8.91% in three months indicating significant weight loss. -The weight loss from October 2023 to April 2024 was 18 lbs. or 17.82% in six months indicating significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The weight loss from November 2023 to May 2024 was 16.5 lbs. or 16.84% in six months indicating significant weight loss. -The weight loss from April 2024 to May 2024 was 4.5 lbs. or 5.23% in one month indicating significant weight loss. The facility failed to implement weekly weights per policy in January 2024 when Resident #61 had significant weight loss in a three-month period and the Resident continued to lose weight. Weekly weights were not implemented until April 2024, three months after a significant weight loss should have been identified and weekly weights implemented. During an interview on 5/19/24 at 9:30 A.M., Resident #61 said they had a poor appetite and did not eat very much. Additionally, he/she said they knew he/she had lost weight and while he/she did not necessarily want to gain it all back he/she did not want to lose more weight. Resident #61 said he/she did not like the heavy supplement drinks and sometimes his/her son brings something from a local coffee shop as he had this morning. Resident #61 did not eat all of it and had the rest wrapped in the coffee shop bag for later. Resident #61 said the staff set up the tray and he/she can feed themselves; he/she said finger food are easiest to eat because his/her hands are a little shaky (from Parkinson's) and for that reason he/she does not eat soup because it will spill trying to maneuver the spoon to his/her mouth. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Resident exhibits preoccupation with food and weight, makes negative remarks about self and body image, and limits intake due to diagnosis of anorexia. INTERVENTIONS: -Administer and monitor the effectiveness and side effects of medications as ordered. -Dietician to continue to monitor in establishing adequate nutritional intake. -Dietician/Social Worker 1:1 check-ins as desired/appropriate. -Psych services as ordered/needed. FOCUS: Nutrition GOAL: No significant weight loss. INTERVENTIONS: Administer medications as ordered. Monitor/Document for side effects and effectiveness. -Provide fortified food/supplements for added calories. -Registered Dietician to evaluate and make diet change recommendations as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the meal intake report indicated Resident #61 consumed 50-100% of meals most of the time in the last 30 days. Review of the Physician's Progress Note, dated 4/2/24, indicated the Plan and Recommendations for a Nutritional Assessment to be conducted (if not already complete) to optimize caloric intake, considering feeding difficulties. Review of RD #4's Progress Notes indicated but were not limited to the following: -4/12/24: On 4/9 weight was 83 lbs.; On 10/3 weight was 101 lbs. which is weight loss of 18 lbs. in the past six months 17.8% considered significant. Average intake 76-100%. Receives fortified pudding at dinner, house supplement 60 ml twice daily and prefers small portions. On Remeron 22.5 mg for depression. May want to consider decreasing Remeron to 7.5 mg for appetite stimulant. Weight loss is not ideal. RD recommends to continue current plan of care. RD available for follow up. MD/NP notified. Discussed in risk. -4/26/24: On Remeron 22.5 mg for depression. Weight loss is not ideal. RD recommends to continue current plan of care. RD available for follow up. MD/NP notified. Discussed in risk. -5/3/24: On Remeron 22.5 mg for depression. May want to consider decreasing Remeron to 7.5 mg for appetite stimulant. Weight loss is not ideal. RD recommends to continue current plan of care. RD available for follow up. MD/NP notified. Discussed in risk. -5/8/24: On Remeron 22.5 mg for depression. May want to consider decreasing Remeron to 7.5 mg for appetite stimulant. Weight loss is not ideal. RD recommends to continue current plan of care. RD available for follow up. MD/NP notified. Discussed in risk. Further review of the Dietitian's Progress Notes failed to indicate any additional interventions/recommendations were made while waiting for the repeated recommendation for review of the Remeron dose by the provider. RD #4 no longer works at the facility and was not available to speak with during the survey. Review of the Nursing and Physician's Progress notes from April and May 2024 failed to address continued weight loss, failed to indicate the repeated recommendation by the RD to decrease the Remeron dose to be used for appetite stimulant due to significant weight loss was addressed by the provider, or any other interventions were put in place. During an interview on 5/21/24 at 1:07 P.M., Unit Manager #1 said when the dietitian makes recommendations, they flag them and tell us, then we get an order from the physician. She said she did not know why the recommendation to adjust the dose of Remeron was not addressed timely. She said she wrote it in the communication book on 5/7/24 but it should have been addressed prior to that as the first note from the dietitian was on 4/12/24 almost a month prior. Additionally, she said after writing it in the communication book for the Nurse Practitioner (NP) on 5/7/24, the NP deferred to psych to review the recommendation. Review of the communication log indicated the NP requested a psych eval on 5/7/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Psych Visit Request log indicated an entry on 5/7/24 for Resident #61 to be seen and the reason was listed as dietitian recommendation to decrease Remeron. Review of the Psych Practitioner's notes failed to indicate the dietary recommendation was addressed. During an interview on 5/21/24 at 1:07 P.M., Unit Manager #1 said she put it in the book for psych, and psych did see Resident #61 but did not understand the rationale to decrease the Remeron, so it was not addressed or discussed further. During an interview on 5/21/24 at 1:48 P.M., RD #1 said he was unsure of this Resident's case as he was new to this staff position and was not here at the time the recommendation was made. During an interview on 5/21/24 at 1:48 P.M., the Regional Dietitian said the process is to make recommendations, discuss them with the team and at the weekly risk meeting. The recommendations should not be repeated without follow-up with staff and providers. She said the process needs improvement. Additionally, she said the facility has had a few (3-4) different dietitians filling in, so it was not consistent for follow up. She said Resident #61 has had significant weight loss and has a history of anorexia so they should also be looking for more fortified food to supplement calories. She said she and RD #1 would have to look further into this to see why the recommendation to decrease the Remeron had not been addressed for going on six weeks now and the Resident continued to lose weight. She said the ideal dose of Remeron when used as an appetite stimulant is 7.5-15 mg and the Resident was on a higher dose. During an interview on 5/22/24 at 10:55 A.M., the Psychiatric NP said the Unit Manager had asked her to review the dosage of the Remeron at the request of the RD because the Resident was losing weight. She said she wanted to discuss it with the RD, but she was not there that day, so she told the Unit Manager she wanted to discuss this with the RD first but had not heard from them. During an interview on 5/22/24 at 11:20 A.M., RD #1 said he had not been told the Psych NP wanted to discuss the Remeron. During an interview on 5/22/24 at 11:21 A.M., RD #2 said she had been covering two days a week for the last 10 weeks. She said she had not made the initial recommendation for the Remeron and had not heard that the Psych NP wanted to discuss the Remeron with anyone. During an interview on 5/22/24 at 11:35 A.M., Unit Manager #1 said when the recommendation for decreasing the Remeron was made from the RD she did not know the rational, so she was unable to explain it to the Psychiatric NP. She said she talked to one of the RDs asking if she could speak to the Psychiatric NP, but the RD said she was not the one to make the recommendation and therefore could not speak to the Psychiatric NP. She said she was not sure what the plan was for follow up after this.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43935 Based on observation, interview, record review, and policy review, the facility failed for two Residents (#128 and #87), out of a sample of 35 residents, to maintain and store respiratory equipment in a safe and sanitary way. Specifically, the facility failed: 1. For Resident #128, to label and date oxygen tubing; and 2. For Resident #87, to store and change a nebulizer mask and tubing in accordance with physician's orders. Findings include: Review of the facility's policy titled Oxygen Administration, dated as revised 1/2024, indicated but was not limited to the following: - the purpose of the procedure is to provide guidelines for safe oxygen administration; - verify the physician's order in place; and - store tubing in a plastic bag marked with date. 1. Resident #128 was admitted to the facility in May 2023 with diagnoses which included: chronic respiratory failure with hypoxia (low blood oxygen levels), chronic obstructive pulmonary disease (disease restricting air flow and causing breathing difficulty), and emphysema (a disorder effecting the exchange of carbon dioxide and oxygen in the lungs). Review of the most recent Brief Interview for Mental Status (BIMS), dated 2/14/24, indicated the Resident is moderately cognitively impaired with a score of 8 out of 15. During an observation with interview on 5/19/24 at 8:28 A.M., the surveyor observed Resident #128 in bed with 2 liters (L) of Oxygen (O2) by nasal cannula (nc) in place. The surveyor observed the oxygen tubing to be unlabeled and undated and slightly discolored with a yellow tint; attached to the oxygen concentrator was a respiratory storage bag dated 4/18/24. During an interview on 5/19/24 at 8:30 A.M., Nurse #4 said the process for changing oxygen tubing is that it is changed weekly on Wednesdays and is labeled and dated at that time. She observed the oxygen tubing currently in use by Resident #128 and said the tubing should be labeled and is not; therefore, there is no way to tell how old the tubing is and it would need to be changed. Nurse #4 observed the respiratory storage bag and said that it should have been changed as well and was not. She said there is a risk of germs with old tubing and storage bags and both needed to be changed for this Resident. Review of the Physician's Orders as of 5/21/24, for Resident #128, indicated but were not limited to the following: - change oxygen tubing weekly date and initial every night shift every Wednesday. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 8:31 A.M., Unit Manager (UM) #2 said the policy is for all oxygen tubing and respiratory storage bags to be changed, labeled, and dated weekly. She said she was made aware of the situation with Resident #128's oxygen tubing and it appears the policy was not followed. During an interview on 5/21/24 at 1:29 P.M., the Director of Nurses (DON) said the expectation is that oxygen tubing is changed weekly and labeled and dated at that time, she said although the tubing was signed off each week it was unlabeled and dated and therefore the expectation for maintaining the oxygen tubing was not met. 2. Resident #87 was admitted to the facility in March 2023 with diagnoses including: dyspnea (shortness of breath) and asthma (a disease in which the airways become narrow and swollen making it difficult to breathe). Review of the most recent BIMS, dated 3/6/24, indicated the Resident is moderately cognitively impaired with a score of 9 out of 15. During an interview with observation on 5/19/24 at 8:42 A.M., the surveyor observed the Resident's nebulizer (a device used to deliver inhaled medications in a fine mist) mask and tubing to be sitting on the bedside table, on top of but not stored in a respiratory storage bag labeled and dated 3/1. The Resident said he/she uses the nebulizer every day and mostly at night. He/she said they are unsure if the staff change the tubing and mask and can't remember it happening recently. The surveyor observed the mask and tubing to be dry, lying open to air, germs and environmental debris, not securely stored in the respiratory storage bag. On 5/19/24 at 4:05 P.M., the surveyor observed the nebulizer mask and tubing for Resident #87 lying on top of the bedside table on top of the respiratory storage bag. The mask and tubing were dated 3/1 and observed to be dry and left open to environmental debris and germs, not stored in the storage bag. Review of the Physician's Orders for Resident #87, dated 5/21/24, indicated but were not limited to the following: - change nebulizer mask and tubing weekly, date and place in dated plastic bag when not in use every evening shift (2/14/24). - ipratropium-albuterol solution 0.5 -2.5 milligrams per milliliter inhale orally by nebulizer every four hours as needed for wheezing or cough (2/19/24). Review of the Medication Administration Record (MAR) for Resident #87 for 5/1/24 through 5/21/24 failed to indicate the Resident used their as needed nebulizer treatment throughout the month. Review of the Treatment Administration Record (TAR) for Resident #87 for 5/1/24 through 5/21/24 indicated but was not limited to the following: - The weekly mask and tubing change with storage in the plastic bag was signed as completed 17 of 20 opportunities (as the order is signed off each evening). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 8:31 A.M., UM #2 viewed photographs, taken by the surveyor, of the old nebulizer mask and tubing for Resident #87 dated 3/1. She said the tubing and mask should have been changed weekly and stored in a respiratory storage bag and it was evident that the policy was not followed for this Resident; the tubing and mask were old. During an interview on 5/21/24 at 1:29 P.M., the DON said the expectation is that nebulizer masks and tubing should be changed and dated weekly, when oxygen tubing is not in use it should be stored in a respiratory storage plastic bag. She observed the photographs of the equipment dated 3/1 for Resident #87 and said the use of an old mask and tubing that is not stored appropriately is an infection control concern and highly unacceptable. She said the expectation was not followed for the nebulizer being stored in a sanitary way or for the mask and tubing to be changed. She said regardless of the TAR being signed off it was clear the order and process were not followed as they should have been.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 36542 Based on interview, record review, and policy review, the facility failed to ensure monthly medication regimen reviews were maintained as part of the permanent medical record and failed to ensure recommendations made by the pharmacy consultant were addressed timely for one Resident (#89), out of five residents selected for an unnecessary medication review. Findings include: Review of the facility's policy titled Medication Regimen Review, effective August 2020, indicated but was not limited to the following: - Resident-specific irregularities are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate. - Recommendations are acted upon and documented by the facility staff and/or the prescriber. - The prescriber accepts and acts upon recommendation or rejects provides an explanation for disagreeing. Resident #89 was admitted to the facility in September 2023. Review of the medical record indicated on 2/16/24 Resident #89 had a new order for Ativan (Lorazepam) 1 milliliter (an antianxiety medication) every four hours as needed for anxiety. Review of the monthly reviews from the Pharmacist Consultant indicated recommendations were made on 4/1/24 and 5/5/24. Review of the electronic and paper medical record failed to include the Consultant Pharmacist Recommendation to Prescriber form. During an interview on 5/21/24 at 10:50 A.M., the Director of Nurses said the process was for the recommendations to be left in a folder for the attending physician to review for changes and then the nursing staff would place the signed forms in the medical record. The surveyor requested copies of the April and May recommendations. Review of the Consultant Pharmacist Recommendation to Prescriber form, dated 4/1/24 indicated Resident #89 had an order for Lorazepam, give one milliliter by mouth every four hours as needed for anxiety without a stop date and to re-assess the as needed order and consider discontinuation or document continued need for therapy and specify stop date. Review of the Consultant Pharmacist Recommendation to Prescriber form, dated 5/5/24 indicated Resident #89 had an order for Lorazepam, give one milliliter by mouth every four hours as needed for anxiety without a stop date and to re-assess the as needed order and consider discontinuation or document continued need for therapy and specify stop date. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 1:30 P.M., the Director of Nurses said the physician had not reviewed the pharmacy recommendations for Resident #89 for April 2024 and May 2024. She said she was not sure why they were not addressed by the physician timely.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 36542 Based on record review and staff interview, the facility failed to ensure residents who use psychotropic medications, as needed, were limited to 14 days, or extended beyond 14 days with a documented clinical rationale and duration, for one Resident (#89), out of five residents selected for unnecessary medication review. Findings include: Review of the facility's policy titled Psychotropic Medication, dated as last revised in July 2023, indicated but was not limited to the following: -the need to continue as needed (PRN) doses of psychotropic medications beyond 14 days requires that the practitioner document the rational for the extended order. The duration of the PRN order will be indicated in the order. Resident #89 was admitted to the facility in September 2023 with a diagnosis of anxiety. Review of the medical record indicated on 2/16/24 Resident #89 had a new order for Ativan (Lorazepam) 1 milliliter (an antianxiety medication) every four hours as needed for anxiety with an end date listed as indefinite. Review of the Consultant Pharmacist Recommendation to Prescriber indicated the pharmacy consultant completed a medication regimen review on 4/1/24 and 5/5/24 for the continued use of Lorazepam PRN. The medication review indicated PRN orders for psychotropic medication were limited to 14 days with the exception that the prescriber documented their rationale in the medical record and indicated the duration for the PRN order. The forms did not indicate if the physician agreed or disagreed with the recommendation and were not signed by a physician. During an interview on 5/21/24 at 1:32 P.M., the Director of Nurses said the April and May 2024 pharmacy recommendations had not been addressed by a physician. She said the Lorazepam order had continued to not have a duration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 36542 Based on policy review, record review, and interview, the facility failed to ensure one Resident (#15) was free from a significant medication error, from a sample of 35 residents. Specifically, the facility failed to ensure a beta blocker (used to treat high blood pressure and heart failure) was administered to the Resident as ordered by the physician. Findings include: Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered nurse and Practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered nurse and practical nurse incorporate into the plan of care, and implement prescribed medical regimens. A nurse licensed by the Board shall not administer any prescription drug or non-prescription drug to any person in the course of nursing practice except as directed by an authorized prescriber. A nurse licensed by the Board shall document the handling, administration, and destruction of controlled substances in accordance with all federal and state laws and regulations and in a manner consistent with accepted standards of practice. Resident #15 was admitted to the facility in November 2013 with diagnoses of hypertension (high blood pressure) and atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat). Review of the care plans indicated Resident #15 had an alteration in cardiac status including hypertension and ventricular tachycardia (abnormal heart rhythm) with an intervention to take medications as ordered. Review of the current Physician's Orders included an order for Carvedilol 6.25 milligrams (mg), give twice per day for paroxysmal ventricular tachycardia and to hold the medication if the heart rate is less than 60. Review of the Medication Administration Record (MAR) for May 2024 indicated the Carvedilol was given outside of the physician prescribed parameters on the following days: 5/1/24 at 8:00 A.M. with a heart rate of 55 5/1/24 at 6:00 P.M. with a heart rate of 55 5/2/24 at 8:00 A.M. with a heart rate of 55 5/9/24 at 8:00 A.M. with a heart rate of 59 5/17/24 at 8:00 A.M. with a heart rate of 58 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/17/24 at 6:00 P.M. with a heart rate of 58 5/20/24 at 8:00 A.M. with a heart rate of 58 5/20/24 at 6:00 P.M. with a heart rate of 58 During an interview on 5/21/24 at 2:20 P.M., the Director of Nurses said the Carvedilol should have been held when the heart rate was less than 60 and the order was not followed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43935 Based on observation, interview, and policy review, the facility failed to store medications in the H2 High Side medication cart in a safe manner in accordance with standards of practice out of four observed medication carts. Specifically, the facility failed to ensure medications were not pre-poured and left in the medication cart in unlabeled containers. Findings include: Review of the facility's policy titled Storage of Medications, dated as revised 8/2020, indicated but was not limited to the following: - all medications dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label On 5/22/24 at 12:33 P.M., the surveyor, with Nurse #7 present, observed a small, plastic medication administration cup, unlabeled, with a capsule in it in the third drawer of the H2 High Side medication cart. Nurse #7 said the capsule was Lyrica (medication used to treat pain caused by nerve damage) for Resident #52 and she had popped it to administer it to the Resident but then had to take a phone call and placed it in the drawer to administer later. She said she wouldn't usually do that but did this time. During an interview with observation on 5/22/24 at 12:38 P.M., Unit Manager #3 observed the pre-poured capsule in the small, plastic administration cup and said it was not acceptable for staff to pre-pour medications or store them in the medication cart in that manner. Review of the Medication Administration Record (MAR) for Resident #52 indicated the Resident had an order to receive Lyrica, 1 capsule, 150 milligrams by mouth three times a day at 9:00 A.M., 2:00 P.M., and 8:00 P. M. During an interview on 5/22/24 at 2:02 P.M., the Staff Development Coordinator said medications should never be pre-poured in a medication cart and it was against the standard of practice for medication administration. During an interview on 5/22/24 at 4:12 P.M., the Director of Nurses said the expectation is that medications are stored in a secure manner and medications are never pre-poured and left in the medication cart, as doing so is a safety concern and not an acceptable practice for medication administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on observation, policy review, and interview, the facility failed to follow their policy and professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to properly label and date food products and maintain safe and clean equipment in two of four nourishment kitchenettes. Findings include: Review of the facility's policy titled Food and Supply Storage, dated as revised ,d+[DATE], indicated but was not limited to the following: - Food, non-food items, and supplies used in food preparation and service shall be stored in such a manner as to maintain safety and sanitation of the food or supply. - Do not store food, dishware (including disposables), and paper products: Under unshielded sewer lines or leaking water lines, or lines which water has condensed. - Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by dates. - Follow recommendations from the manufacturer when indicated on the product for storage time and storage location. - Discard food that exceeds their use-by date or expiration date, or incorrectly stored such that it is unsafe or its safety is uncertain. On [DATE] at 9:10 A.M., the surveyor observed the following on the [NAME] Two Unit Kitchenette: - The inside of the freezer had food splatter and food debris on the bottom, and left-hand side. On the right side of the inside freezer wall, there was food splatter with strands of hair stuck on it. - The refrigerator had three cartons of Almond Unsweetened milk, opened, with an expiration date of [DATE], and a one-gallon container labeled Tropicana orange juice, opened, with an expiration date of [DATE]. On [DATE] at 10:32 A.M., the surveyor observed the following on the Riverside Two Unit Kitchenette: - Inside of the freezer a sandwich, in a plastic bag, without a date or resident identification label. - One 20-fluid ounce bottle of Gatorade, frozen, without a date or resident identification label. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One box of spoons and a pink plastic container filled with plastic silverware, stored under the sink, next to the plumbing piping. During an interview on [DATE] at 10:39 A.M., the Regional Food Service Director (RFSD) said the kitchenettes are supposed to be cleaned and stocked daily by the dietary staff. She said they are supposed to clean the inside of the freezer and refrigerator. The RFSD said the dietary staff is responsible for removing and disposing of any foods that are not labeled, dated, or expired. During an interview on [DATE] at 10:48 A.M., the RFSD said nothing is supposed to be stored under the sink due to the high risk of contamination. She said all food items stored in the kitchenettes must be labeled and dated. The RFSD said drinks should never be stored in the freezer, even if they are labeled and dated.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on record review, hospice contract review, and interviews, the facility failed to ensure hospice services were provided in accordance with the agreement between hospice and the facility for one Resident (#77), out of a total sample of 35 residents. Specifically, the facility failed to provide ongoing documentation, and maintain a complete medical record of services to ensure prompt and effective communication and continuity of care for the Resident. Findings include: Review of the facility's policy titled Hospice Services, dated as last revised ,d+[DATE], indicated but was not limited to the following: - Our facility will coordinate care provided to the resident with hospice staff. - Obtaining the following information from hospice: a. The most recent hospice plan of care. b. Physician certification and recertification. Review of the Facility and Hospice Agreement, dated [DATE], indicated but was not limited to the following: -Plan of Care means a written care plan established, maintained, reviewed, and modified, if necessary, at intervals identified by the Interdisciplinary Group (IDG). - Coordination of Care: Hospice and Facility shall communicate with one another regularly and as needed for each particular hospice patient. Each party is responsible for documenting such communication in its respective clinical records. - Responsibilities of Hospice: At minimum, Hospice shall provide the following information to Facility for each hospice patient residing at the Facility: a. Plan of Care, Medications, and Orders. The most recent Plan of Care, medication information and physician orders specific to each hospice patient residing at the Facility. b. Certifications. Physician certifications and recertifications of terminal illness. - Records: Creation and Maintenance of Records: Each clinical record shall completely, promptly, and accurately document all services provided to, and events concerning, each Hospice patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders pursuant to this agreement and discharge summaries. Each record shall document that the specific services are furnished in accordance with this agreement and shall be readily accessible and systematically organized to facilitate retrieval by either party. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #77 was admitted to the facility in [DATE] with diagnoses including Hereditary Factor VIII Deficiency (hemophilia, a blood disorder affecting the ability to clot properly). Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #77 had moderate cognitive impairment as evidenced by score of 10 out of 15 on the Brief Interview for Mental Status (BIMS). Additionally, he/she was receiving Hospice services. Review of the Physician's Orders indicated Resident #77 had been admitted to Hospice services [DATE] with a diagnosis of Hereditary Factor VIII Deficiency. Review of the Comprehensive Care Plan indicated Resident #77 was receiving Hospice Services. Review of the Hospice Binder for Resident #77 failed to include a current Physician Plan of Care and failed to include recent progress notes from the Hospice providers. The recertification in the binder was dated [DATE] and had a certification period of [DATE] through [DATE]. The binder did not include the [DATE] or the [DATE] recertifications as required. Additionally, the last provider visit note in the binder was dated [DATE]. There were no visit notes between [DATE] and [DATE] as required. During an interview on [DATE] at 1:02 P.M., Nurse #11 said Hospice usually handles the documents and the Unit Manager coordinates with them. Additionally, she said the current certification is not in the binder, only the one from [DATE], and there are no visit notes since [DATE], and those should be in the binder. During an interview on [DATE] at 4:06 P.M., Unit Manager #1 said Hospice puts the documents in the binder. She said the binder should have the admission certification and all recertifications, as well as the progress notes from each provider. She said the recertification in the chart expired [DATE] and the last note was from [DATE]. Additionally, she said hospice was here today and brought the new recertification but that was all they brought so the record is still incomplete. During an interview on [DATE] at 8:05 A.M., the Director of Nurses (DON) said Hospice is responsible for putting the documentation in the binder. She said the binder should have admission certification and all subsequent recertifications, and all visit notes from the providers, including nursing, nursing assistants, chaplain, and social worker. Additionally, she said the facility should have all the current documents and plan of care in the binder and they do not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43935 Based on observation and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to: 1. Ensure policy and procedures for Enhanced Barrier Precautions (EBP) were developed and implemented, effective 4/1/24 as required; 2. Ensure staff handle linens in a sanitary way in the laundry room to maintain their cleanliness; 3. Provide a clean space to store resident medications, as two of two medication rooms observed had medication storage cabinets with a splattered substance in the cabinets; 4. Ensure EBP personal protective equipment (PPE) requirements were followed by previously educated staff while performing wound care for two Residents #2 and #110; and 5. Ensure staff maintained proper PPE use during wound care/dressing change for Resident #4. Findings include: 1. Review of the Centers for Medicare and Medicaid Services (CMS), Quality, Safety, and Oversight (QSO) Reference #QSO-24-08-NH memo dated 3/20/24, indicated but was not limited to the following: - SUBJECT: EBP in Nursing Homes to prevent spread of multi-drug resistant organisms (MDROs). - In July 2022, the Centers for Disease Control (CDC) released recommendations for implementation of PPE use in nursing homes to prevent spread of MDROs, and therefore CMS is updating its infection prevention and control guidance accordingly. The recommendations now include the use of EBP during high contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status. - EBP are indicated for residents with wounds and/or indwelling medical devices. - Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. - EBP should be used for any resident who meets the above criteria, wherever they reside in the facility. - EBP is employed when performing the following high contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. - Effective Date: 4/1/2024 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/24 at 9:59 A.M., the Director of Clinical Operations said the EBP policy was recently written by the company and has not yet been provided to the facilities and is awaiting corporate approval. She said the Infection Preventionist (IP) had already started education and determined who needed to be on EBP but the process was not implemented fully since there was no policy available at this time. During an interview on 5/20/24 at 10:50 A.M., the IP said the facility had not implemented the use of EBP as they should have on 4/1/24 and she was not aware of the change until after the effective date. She said she did begin educating the staff on the process on 5/17/24 after she had watched the CDC webinar and printed the available slides to use as training. She said she identified 56 residents who would meet criteria and should be on EBP as of 5/16/24 and needed to order supplies to roll out the program. She said none of the residents in the facility are on EBP at this time as they should be and she is still waiting on a policy from the corporate office but would try to get one. During a follow up interview on 5/22/24 at 9:58 A.M., the IP said the company still has not provided the facility with an EBP policy at this time and none of the identified residents are on EBP as they should be. The facility was unable to provide the survey team with an EBP policy for the facility at the time of exit on 5/23/24. 2. During a tour of the laundry room on 5/20/24, the surveyor made the following observations: - At 10:14 A.M., Laundry Personnel #2 was observed to drop dry clean linen on the floor while removing it from the dryer, she then picked it up and placed it on the folding table with the other clean dry linen, she was asked if the linen was dirty after touching the floor and said she didn't know, she placed the linen back into the to be washed pile once she was prompted by the Laundry Manager. - At 10:27 A.M., Laundry Personnel #3 was observed to drop a clean wet towel and two clean wet facecloths from the transport bin from the washer to the dryer area. She then picked the linens up off the floor and proceeded to attempt to throw them into the dryer, the Laundry Manager intervened telling her it needed to be washed and the floor was considered dirty, Laundry Personnel #3 shrugged her shoulders and threw the wet linens into a to be washed pile. During an interview on 5/20/24 at 10:29 A.M., the Laundry Manager said she was newer to the role of manager and was responsible for training the staff. She said the floor is dirty and linen that has fallen on the floor would need to be rewashed and she was still working on training her staff. During an interview on 5/20/24 at 10:47 A.M., the IP was made aware of the surveyor's observations in the laundry room and said laundry personnel should not be picking clean linen up off the floor for use and the floor was inherently dirty and therefore any linens that touched the floor would be required to be rewashed and not put into circulation. She said the laundry staff were not following the basic principles of infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/24 at 9:56 A.M., the Regional Laundry Manager said she was made aware of the surveyor's observations and concerns from the previous day and said the floor is considered dirty and any linen that falls on the floor is therefore dirty and would need to go for a rewash. She said many of the laundry staff and manager were new and needed further training. She said she was unsure if there was a policy specific to the circumstances on infection control, but if she found one, she would provide it to the survey team. No general infection control or handling of linen in the laundry room policy could be provided to the survey team prior to their exit of the facility on 5/23/24. 3. On 5/22/24 at 12:41 P.M., the surveyor inspected the H2 medication room with Nurse #1, and observed the following: - a cabinet in the room which held medications for the residents on the unit including over the counter bulk medications and resident specific medications; - a brown, splattered substance in the back left corner of the cabinet that had dripped down the side wall and culminated into a small pool of dried substance on the bottom of the shelf. During an interview at the time of the inspection, Nurse #1 said he did not know what the substance was. On 5/22/24 at 1:01 P.M., the surveyor inspected the H3 medication room with Nurse #8, and observed the following: - a cabinet in the room which held medications for the residents on the unit including over the counter bulk medications and resident specific nebulizer medications; - a brown, splattered substance in the back left corner of the cabinet, across the interior of the cabinet door and pooled drips of the dried substance on the bottom of the shelf. During an interview at the time of the inspection, Nurse #8 said she did not know what the substance that had splattered in the cabinet was but that it was disgusting and needed to be cleaned. During an interview on 5/22/24 at 1:07 P.M., Nurse #2 observed the brown, splattered substance in the cabinet with the residents' medications and said the substance was unknown to her, but they probably should not be storing the residents' medications in a dirty cabinet and it didn't seem sanitary. She said the cabinet needed to be cleaned. During an interview with observation on 5/22/24 at 1:19 P.M., Unit Manager #3 observed the dirty medication room cabinets and said she was unsure what the substance was but thought it may be glue and said it looks gross and that the shelves needed to be cleaned since resident medications are stored on that shelf. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 2:02 P.M., the IP said medication storage areas should be kept clean and sanitary to ensure medications are not contaminated by any unknown substance. She said storing resident medications in the unclean cabinets was an infection control concern and the cabinets needed to be cleaned and remain that way. She said she would try to locate a general infection control guidelines policy for the facility and provide it to the survey team. During an interview on 5/22/24 at 4:12 P.M., the Director of Nurses (DON) said the staff informed her of the concerns regarding the medication storage cleanliness and told her they thought perhaps the substance was glue. She observed the photographs of the cabinets taken by the surveyor and said the substance did not appear to be glue, was not by a fixture and appeared to be splattered all over the walls and door of the shelves. She said it appeared that a bottle had fallen over or exploded in the cabinet. She said resident medications should not be stored in that manner and it was unsanitary and an infection control concern and it needed to be addressed. During a follow up interview on 5/23/24 at 8:33 A.M., the IP said she could not locate a general guidelines infection control policy for the facility. 49425 4. Review of the Centers for Medicare and Medicaid Services (CMS), Quality, Safety, and Oversight (QSO) Reference #QSO-24-08-NH memo dated 3/20/24, indicated but was not limited to the following: - SUBJECT: EBP in Nursing Homes to prevent spread of multi-drug resistant organisms (MDROs). - In July 2022, the Centers for Disease Control (CDC) released recommendations for implementation of PPE (which recommended gown and glove use) in nursing homes to prevent spread of MDROs, and therefore CMS is updating its infection prevention and control guidance accordingly. The recommendations now include the use of EBP during high contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status. - EBP is employed when performing the following high contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. - Effective Date: 4/1/2024 A. Resident #2 was admitted to the facility in April 2019 with diagnoses including type II diabetes and a stage IV pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) to the coccyx. Review of the Minimum Data set (MDS) assessment, dated 5/1/24, indicated Resident #2 scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating Resident #2's cognition was severely impaired. Review of Section M: Skin Conditions of the MDS assessment indicated the Resident had a stage IV pressure ulcer/injury. The assessment also indicated Resident #2 was receiving pressure ulcer/injury care including the application of non-surgical dressings and ointments. Review of the current Physician's Orders for May 2024 included the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cleanse area to coccyx with normal saline (NS), apply collagen sheet followed by calcium alginate with silver. Cover with gauze island border dressing. Change daily and as needed soilage. On 5/21/24 at 2:03 P.M., the surveyor observed Nurse #9 provide wound care to Resident #2's pressure ulcer to the coccyx as follows: - Nurse #9 entered Resident #2's room with Unit Manager (UM) #3 and they both performed hand hygiene and donned (put on) gloves. - Nurse #9 cleansed the bedside table, placed a barrier on the table, placed supplies on the barrier, doffed (removed) her gloves, performed hand hygiene and donned new gloves. - UM #3 lifted Resident #2's hospital gown, and assisted Resident #2 onto his/her right side and held Resident #2 on their side up against UM #3 throughout the dressing change. - Nurse #9 and UM #3 were not observed to don a protective gown. - Nurse #9 applied the treatment as ordered doffed her gloves and performed hand hygiene. - Nurse #9 donned new gloves and provided incontinence care to Resident #2. - UM #3 then lowered Resident #2's hospital gown, placed him/her onto their back, doffed her gloves and performed hand hygiene. - At no time throughout the treatment or the incontinence care did Nurse #9 or UM #3 don a protective gown. Review of the in-service summary of education sheet. dated 5/17/24 and signed by Nurse #9 and UM #3, indicated the following education was provided: - Enhanced Barrier Precautions: what was reviewed: What residents would require EBP, Reviewed Center Medicare Services (CMS) information, what is high contact activities, Department Public Health (DPH), webinar information, Signage, Personal Protective Equipment (PPE) totes, and who is responsible to stock totes. During an interview on 5/21/24 at 3:55 P.M., Nurse #9 said she recently attended an in-service on Enhanced Barrier Precautions (EBP) and the need to wear a protective gown while performing wound care. She said she did not use one because the facility has not provided her with gowns yet. During an interview on 5/21/24 at 4:02 P.M., UM #3 said the personal protective equipment needed for wound care includes a protective gown and gloves. She said the facility is going to be implementing it soon. UM #3 said she recently attended an in-service explaining wound care is considered high contact care, and she should have worn a gown. She said she did not wear a gown as she should have because the gowns are not available yet. B. Resident #110 was admitted to the facility in March 2024 with diagnosis including Type two Diabetes and a stage 4 pressure ulcer to the coccyx. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 5/1/24, indicated Resident #110 scored 3 out of 15 on the BIMS indicating Resident #110's cognition was severely impaired. Review of Section M: Skin Conditions of the MDS assessment indicated the Resident had a Stage 4 pressure ulcer/injury. The assessment also indicated Resident #110 was receiving pressure ulcer/injury care. Review of the current Physician's Orders for May 2024 included the following: - Cleanse coccyx wound with normal saline, apply a collagen sheet followed by calcium alginate with silver and cover with a gauze island border dressing. Change daily and as needed for soilage. On 5/23/24 at 11:16 A.M., the surveyor observed Nurse #9 provide wound care to Resident #110's stage 4 pressure ulcer to the coccyx as follows: - Nurse #9 entered Resident #110's room with UM #3 and they both performed hand hygiene and donned gloves. -Nurse #9 cleansed the bedside table, placed a barrier on the table, placed supplies on the barrier, doffed her gloves, performed hand hygiene, and donned new gloves. - UM #3 lifted Resident #110's hospital gown, and assisted Resident #110 onto his/her right side leaning up against UM #3 throughout the dressing change. - Nurse #9 and UM #3 were not observed to don a protective gown. - Nurse #9 applied the treatment as ordered doffed her gloves and performed hand hygiene. - UM #3 lowered Resident #110's hospital gown, placed him/her onto their back, doffed her gloves and performed hand hygiene. - At no time throughout the treatment did Nurse #9 or UM #3 don a protective gown. During an interview on 5/23/24 at 11:30 P.M., UM #3 said her expectation is to wear a gown and gloves while providing wound care. She said there was no gown available for use. During an interview on 5/23/24 at 12:18 P.M., the DON said wound care is considered a high contact care activity, and gowns and gloves should be worn while providing care. She said the facility has not implemented EBP yet. The DON said she is aware they should be following EBP guidelines. She said the facility is in the process of implementing it soon, and all staff will be supplied with gowns along with gloves, once EBP use is rolled out. During an interview on 5/23/24 at 12:48 P.M., Consulting Staff #1 said the nursing staff did not use a gown because the facility has not fully implemented EBP yet. She said the facility is aware of the EBP guidelines and the need for protective gowns and gloves to be worn for all high contact care activities. 48084 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the facility's policy titled Dressings, Dry/Clean, dated April 2018, indicated but was not limited to the following: - Wash and dry hands thoroughly. - Put on clean gloves. Loosen tape and remove soiled dressing. - Pull glove over dressing and discard into plastic biohazard bag. - Sanitize hands or wash and dry hands thoroughly. Resident #4 was readmitted to the facility in January 2024 with diagnoses including morbid obesity and diabetes mellitus with diabetic polyneuropathy (symptoms of numbness, weakness, and decreased sensation usually starting in feet/hands). Review of the MDS assessment, dated 3/27/24, indicated Resident #4 had moderate cognitive impairment as evidenced by a score of 10 out of 15 on the BIMS. Additionally, Resident #4 had treatments for care of pressure ulcers. Review of the Physician's Orders indicated but were not limited to the following: - Sacrum Wound: Clean with wound cleanser, apply collagen sheet with silver followed by calcium alginate. Cover with hydrocolloid sheet. Change only hydrocolloid sheet every two days. Remove the hydrocolloid sheet. Wash with normal saline, apply skin prep to peri wound. Allow skin prep to dry. Cover with hydrocolloid sheet every day shift every two days. Do not remove or disturb the wound bed. Change secondary dressing with care. Restorigin (skin substitute graft) will be re-evaluated by MD. (5/22/24) On 5/23/24 at 11:40 A.M., the surveyor observed Nurse #10 perform Resdient #4's dressing change with Unit Manager #1 present, which included but was not limited to the following: - Nurse #10 did hand hygiene and put on clean gloves. - Nurse #10 removed the soiled dressing and disposed of it in the trash. - Nurse #10 removed one glove and disposed of it in the trash. - Nurse #10 then reached into the trash and retrieved the soiled dressing. - Nurse #10, holding the dressing with his one gloved hand, proceeded to touch and pull the dressing apart and inspect the drainage on the soiled dressing with his bare/ungloved hand. - Nurse #10 again disposed of the soiled dressing in the trash, followed by the one glove remaining. Nurse #10 was not available for interview immediately after the dressing change was complete. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225723	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 12:40 P.M., Unit Manager #1 said Nurse #10 should not have touched the soiled dressing with his bare/ungloved hand. She said he should have had gloves on both hands to handle and inspect the soiled dressing and was going to speak to him when he was available. During an interview on 5/23/24 at 1:45 P.M., the DON said Nurse #10 should not have handled the soiled dressing with his bare/ungloved hand. She said he was not following current infection control practice as staff should be wearing gloves to handle soiled dressings.