STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225736	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Nursing & Rehabilitation Center	90 Greenwood Street Wakefield, MA 01880

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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. Based on observations and interviews, the facility failed to provide a dignified dining experience for Residents in the facility's dining room. Specifically, the facility to ensure dependent Residents were fed at the same time while sitting together in the dining room.Findings include:Review of the facility policy titled Residents' Rights, undated, indicated the following:- As a Resident of a long-term care facility you have the right: to be treated with dignity and respectReview of the facility policy titled Supervision of Resident Nutrition, undated, indicated:-Residents needing assistance in eating must be promptly assisted upon being served. The surveyor made the following observations throughout the survey period in the facility's main dining room:- On 8/5/25 at 12:21 P.M., during lunch service, two residents dependent on staff for eating were sitting at the same table in the dining room. A staff member sat down to help the first resident while the second resident sat at the table with his/her tray in front of him/her unable to eat. The second resident attempted to open the lid to his/her meal but was unable to. At 12:36 P.M., 15 minutes after, staff started to assist the other resident at the table, a different staff member sat down with the second resident to assist with eating lunch.- On 8/6/25 at 8:29 A.M., during breakfast service, at a table with three Residents, two independent residents were served breakfast at 8:18 A.M., at 8:23 A.M., a third resident who is dependent on staff was served breakfast at the same table. While the two independent residents were eating breakfast, the third dependent resident began falling asleep at the table with his/her meal in front of him/her. A staff member came to assist the resident at 8:30 A.M., 12 minutes after the two independent residents were served breakfast.- On 8/6/25 at 8:32 A.M., during breakfast service at a different table, two residents who were dependent on staff for assistance while eating were seated together. Both residents received their trays at 8:27 A.M., the first resident received assistance with eating at 8:27 A.M., the second resident sat at the table with his/her meal in front of him/her for seven minutes until a staff member came to provide assistance with eating.- On 8/6/25 at 12:13 P.M., during lunch service, two residents were sitting together. These two residents who are dependent on staff for assistance while eating, received their meals. At 12:16 P.M., the first resident received assistance from staff to eat while the second resident was sitting at the table with his/her meal in front of him/her. At 12:27 P.M., 14 minutes after receiving his/her tray and 11 minutes after his/her tablemate started receiving assistance, a staff member entered the dining room to provide assistance with the second resident's meal.- On 8/7/25 at 8:22 A.M., during breakfast service, two residents were sitting together. These two residents who are dependent on staff for assistance while eating, received their meals. The first resident had a staff member assist them with eating promptly. The second resident at the table, did not receive assistance from another staff member until 8:29 A.M., seven minutes later.During an interview on 8/7/25 at 10:41 A.M., Certified Nursing Assistant (CNA) #2 said if residents are sitting at the same table they should be eating their food at the same time.During an interview on 8/7/25 at 8:53 A.M., CNA #3 said staff members should be feeding residents at the same time if they are sitting at the same table.During an interview in 8/7/25 at 11:36 A.M., the Activities Assistant said dependent residents sitting at the same table should ideally be assisted at the same time so they can eat at the same time.During an interview on 8/7/25 at 12:31 P.M., the Director of (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing said all residents deserve a dignified dining experience and should be fed at the same time as tablemates when sitting together.

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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. Based on observations and interview, the facility failed to ensure staff members served meals to Residents in the facility's dining room under sanitary conditions with acceptable hand hygiene practices.Findings include:Review of the facility policy titled Feeding Policy, undated, indicated the following:- Feeding Technique: 2. Treat resident with dignity and respect, 3. Wash handsReview of the facility policy titled Hand Hygiene Policy, undated, indicated the following:- After Resident Contact: When? Clean your hands after touching a resident and his/her immediate surroundings when leaving the resident's side.The surveyor made the following observations throughout the survey period in the facility's main dining room:- On 8/5/25 at 12:22 P.M., during lunch, the Activities Assistant was sitting between two Residents at a dining room table. The Activities Assistant was alternating feeding two residents at the same time without performing hand hygiene between feeding each resident. The Activities Assistant then left the table to help another resident at a different table by adjusting his/her shoulders for positioning and then left to get a pillow with her bare hands to further help in positioning. The Activities Assistant then returned to the original two residents and continued to alternate feeding between them, no hand hygiene was done. At 12:36 P.M., the Activities Assistant left from feeding the two residents to help a different resident at a different table with feeding. No hand hygiene was completed.- On 8/6/25 at 8:34 A.M., during breakfast service, a staff member was observed setting up trays for Residents. The staff member touched multiple Resident's straws with bare hands where the Resident's mouth will touch the straw. The Residents were then observed being assisted with meals and drink from the straws where staff touched them with bare hands.- On 8/6/25 at 12:15 P.M., during lunch service, a staff member touched the resident's straw where the mouth will touch with bare hands. The Resident then proceeded to take a sip from the straw.- On 8/6/25 at 12:16 P.M., the Activities Assistant was sitting between two Residents alternating feeding them without performing hand hygiene between feeding each resident. One of the Resident's was observed coughing as the Activities Assistant's hand was near his/her mouth. At 12:19 P.M., the Activities Assistant left the table to assist another Resident at a different with cutting up his/her food using the resident's utensils, no hand hygiene was completed before this. The Activities Assistant then went back to the original table to alternate feeding the two residents, no hand hygiene was performed prior to this. At 12:26 P.M., the telephone rang in the dining room, the Activities Assistant picked up the phone with bare hands and then resumed assisting the two residents with feeding, no hand hygiene was done. The Activities Assistant then left the dining room to get ice cream, and then resumed assisting the two residents with feeding, no hand hygiene was done.- On 8/7/25 at 8:22 A.M., during breakfast service, staff members were observed setting up trays and touched Resident's straws with bare hands where the Resident's mouths would touch the straws. The Residents then proceeded to drink from the straws.During an interview on 8/7/25 at 10:04 A.M., the Housekeeping Manager who was observed assisting residents with meals said she used to be a Certified Nursing Assistant (CNA) in the facility, but she still helps assisting residents with meals. The Housekeeping Manager said staff need wash hands before assisting residents with meals and only one resident should be fed at once, she proceeded to say we (the facility) do not feed two residents at once.During an interview on 8/7/25 at 8:53 A.M., CNA #3 aid staff need to perform hand hygiene before assisting residents with meals and staff should not be touching utensils or straws where the resident's mouth will touch.During an interview on 8/7/25 at 10:41 A.M., CNA #2 said staff need to perform hand hygiene before assisting residents with meals and staff should not be touching utensils or straws where the resident's mouth will touch.During an interview on 8/7/25 at 11:36 A.M., the Activities Assistant said she should be performing hand hygiene between feeding residents, and she should not be feeding two residents at the same time. The Activities Assistant further said she should not be touching straws with her hands where the Resident's mouth will touch, and she said if she walks away from feeding (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents then she should wash her hands before resuming feeding assistance.During an interview on 87/25 at 12:31 P.M., the Director of Nursing (DON) said Residents can be fed at the same time but only if the staff member is using different hands. The surveyor shared the dining observations, and the DON said staff should have been performing hand hygiene between feeding residents and upon leaving residents to perform another task. The DON then said staff member's hands should be touching where Resident's mouths will touch when setting up trays.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to document in the medical record that residents above the age of [AGE] years old received Pneumococcal immunizations for 4 out of 5 sampled residents. Specifically, the facility failed to document in the medical record when the residents received the Pneumococcal vaccine, the vaccine name, the lot number, and the expiration date. Findings include: A review of the facility policy titled ?Pneumonia immunization policy' with no revision date indicated the following:-Licensed staff will review immunization consent form and educational materials with resident or responsible party being sure all risks and benefits are understood.-Check for allergies which may preclude vaccination.-Administer vaccine as ordered.-Document on MAR, medication administration and site.-Document in Nurse's notes, consent form, and immunization form resident vital signs, vaccine name, lot number, expiration date, injection site, resident response to injection, and resident/responsible party education, and if applicable, declination of the vaccine.CDC (Center for Disease Control and Prevention) guidelines for Pneumococcal vaccines indicate the following:The CDC recommends that adults aged 65 years and older residing in nursing homes or long-term care facilities receive both a pneumococcal conjugate vaccine (PCV) and a pneumococcal polysaccharide vaccine (PPSV23). For those who have not previously received a PCV, the recommendation is to start with PCV15 or PCV20, followed by PPSV23 at least one year later. For adults who have received a previous PCV (like PCV13), shared clinical decision-making with a healthcare provider is recommended to determine the best vaccination approach. Review of the 4 residents' immunization records indicated the following:-2 out of the 4 residents indicated that their Pneumonia vaccines were current on admission, but the medical record failed to include any information about what type of Pneumonia vaccine or date administered.-2 out of the 4 resident's HCPs (Health Care Proxies) indicated that the resident's Pneumonia vaccines were current on admission, but the medical record failed to include any information about what type of Pneumonia vaccine or date administered.During an interview and record review on [DATE] at 9:28 A.M., the Infection Preventionist/Director of Nurses (IP/DON) reviewed the immunization record with the surveyor, she said she had checked off in the immunizations report sheet dated 10/2024 that the 4 residents had received their Pneumonia vaccines but she did not have actual dates, vaccine name, lot number and expiration date of the vaccines documented in the immunization record. The IP/DON said she relies on responsible parties and resident families to provide the actual documentation of the residents' Pneumonia vaccines at admission. The IP/DON said she does not call the resident's health care providers in the community to obtain this information. She said she relies on the family members and responsible parties to do so. The IP/DON said she is not able to access the MIIS (Massachusetts Immunization Information System) because her access is expired so she cannot verify whether these 4 residents were offered Pneumonia vaccines.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to implement a physician's order for the use of Geri Sleeves as ordered for one Resident (#14) out of a total sample of 15 Residents. Specifically, the facility failed to ensure Resident #14 was wearing Geri Sleeves as indicated by the physician's order.Findings include:Review of the facility policy titled Physician Order Policy, undated, indicated the following:- Policy Statement: All physician orders must be documented, dated and signed by a licensed practitioner authorized to prescribe in accordance with applicable laws and facility protocols.- Procedure: Order Types - Physician orders may include: Medication orders, Treatment and therapy orders.- Documentation: Orders must be promptly transcribed to the resident's medical record and Medication Administration Record (MAR)/Treatment Administration Record (TAR).- All orders must be reviewed by the charge nurse before implementation.Resident #14 was admitted to the facility in December 2023 with diagnoses including Alzheimer's disease and dementia.Review of Resident #14's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 3 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident is totally dependent on staff for all activities of daily living.The surveyor made the following observations:- On 8/5/25 at 8:23 A.M., 10:35 A.M. and 12:14 P.M., Resident #14 was sitting in his/her wheelchair in the dining room. Resident #14's forearms were visible, no Geri sleeves were being worn.- On 8/6/25 at 7:35 A.M., Resident #14 was observed being wheeled out of his/her room by a Certified Nursing Assistant (CNA) into the dining room. Resident #14's forearms were visible, and no Geri Sleeves were being worn. At 10:22 A.M. and 12:46 P.M., Resident #14 was observed sitting in the dining room in his/her wheelchair, his/her forearms were visible, and no Geri Sleeves were being worn.- On 8/7/25 at 8:22 A.M. and 9:23 A.M., Resident #14 was observed sitting in the dining room in his/her wheelchair, his/her forearms were visible, and no Geri Sleeves were being worn.Review of Resident #14's phsyician's order dated 2/27/25 indicated the following:- Apply Geri Sleeves to BUE (bilateral upper extremities) every shift, may remove for AM and PM (morning and evening) care and toileting after meals.Review of Resident #14's Kardex (a care card indicating the level of care a resident needs) failed to indicate the usage of Geri Sleeves.Review of Resident #14's pressure ulcer care development care plan dated 11/30/24 indicated the following intervention that was handwritten in:- apply Geri Sleeves to BUE every shift. May remove for AM and PM care.Review of Resident #14's medical record failed to indicate any documentation of Resident #14 removing his/her Geri Sleeves.During an interview on 8/7/25 at 10:41 A.M., CNA #2 said if a resident requires Geri Sleeves then a CNA will put them on a resident during morning care. CNA #2 then said Resident #14 does not need Geri Sleeves anymore.During an interview on 8/7/25 at 11:14 A.M., CNA #1 said (with translation assistance from CNA #2) said she provided Resident #14 morning care this morning. CNA #1 then said Resident #14 is totally dependent on care and she did not put Geri Sleeves on Resident #14 and she did not know if the Resident is supposed to wear them.During an interview on 8/7/25 at 12:24 P.M., the Director of Nursing (DON) said Resident #14 should be wearing Geri Sleeves as ordered. The DON said Resident #14 has purpura (purple spots or patches on the skin or mucous membranes, caused by bleeding under the skin) and his/her skin is very frail and thin, and the Geri Sleeves are meant to protect his/her skin from injury.During an interview on 8/7/25 at 12:40 P.M., Nurse #1 said Resident #14 should be wearing Geri Sleeves if that is what the physician's order says. Nurse #1 said CNAs and nurses put them on Resident #14 and if the Resident removes them it needs to be documented.REF F842

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews and record review, the facility failed to provide the necessary activities of daily living (ADLs) for one Resident (#26) out of 15 total sampled residents. Specifically, the facility failed to provide necessary supervision and assistance with eating.Findings include:Review of the facility policy titled Activities of Daily Living (ADLs), Supporting, undated, indicated:-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: Dining (meals and snacks).Review of the facility policy titled Supervision of Resident Nutrition, undated, indicated:-Residents needing assistance in eating must be promptly assisted upon being served.Resident #26 was admitted to the facility in December 2024 with diagnoses including a history of aspiration pneumonia (a respiratory infection that occurs when food, saliva, or stomach acid enters the airway accidentally) and dementia.Review of the most recent Minimum Data Set (MDS) assessment, dated 7/7/25, indicated Resident #26 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS also indicated Resident #26 required supervision or touching assistance with eating.Review of Resident #26's plan of care related to activity of daily living self-care performance deficit, revised 1/29/25, indicated:-EATING: Resident #26 is supervised.Review of Resident #26's plan of care related to nutritional problems, revised 1/29/25, indicated:-Resident has a history of aspiration pneumonia.-Monitor/document/report PRN (as needed) and s/sx (signs/symptoms) of dysphagia (difficulty swallowing): pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals.Review of Resident #26's plan of care related to nutrition risk, undated with last goal date of July 2025, indicated Resident #26 had a nutritional risk r/t (related to) swallowing disorder/aspiration risk and had a history of aspiration pneumonia. This plan of care further indicated:-Provide encouragement/cueing/assist with feeding if needed.Review of Resident #26's assessment titled Nutritional Quarterly Assessment, dated 7/16/25, indicated:-Feeding ability: Supervised.Review of Resident #26's current Certified Nurse Assistant (CNA) care card (a form indicating the level of assistance needed for resident care), undated, failed to indicate Resident #26 required supervision or assistance while eating.Review of Resident #26's active physician's order failed to indicate the level of assistance needed with eating.On 8/5/25 at 8:38 A.M., the surveyor observed Resident #26 eating rice crispies cereal in milk, and raisin bread toast alone in his/her room. Resident #26 said staff recently helped him/her with every meal because he/she often coughs during meals and is afraid of choking. Resident #26 said he/she was upset because he/she wants staff to help. On 8/5/25 from 8:42 A.M. to 8:47 A.M., the surveyor observed Resident #26 continue to eat breakfast without any staff within view of the Resident. At 8:47 A.M., the Housekeeping Manager entered Resident #26's room and began to assist him/her with eating. During a follow-up interview on 8/7/25 at 10:14 A.M., the Housekeeping Manager said she often assists with meals and used to be a Certified Nurse Assistant (CNA) in the facility. The Housekeeping Manager said she gets instructions about what type of assistance or level of supervision is required for each Resident from the nurse before she assists them with meals. The Housekeeping Manager said Resident #26 did not require supervision with meals, but since the facility policy is to check on every resident to and assist if necessary, during those rounds she determined Resident #26 was having trouble eating, as he/she does at times, so she began to assist him/her with breakfast on 8/5/25 at 8:47 A.M.On 8/6/25 at 8:24 A.M., Resident #26 had a breakfast tray in front of him/her and was eating raisin bread toast and rice crispies cereal in milk alone in his/her room when Nurse #2 entered the room to administer his/her medications. Resident #26 said he/she had trouble swallowing his/her pills and it took multiple swallow attempts and multiple sips of water to swallow the pills. Nurse #2 then exited the room and Resident #26 continued to eat his/her breakfast alone in the room without any staff within view.On 8/6/25 from 8:36 A.M. until 8:49 A.M., the surveyor (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed Resident #26 eating raisin bread toast and rice crispies cereal in milk alone in his/her room without any staff within view of the Resident.On 8/6/25 at 12:12 P.M., the surveyor observed Resident #26 eating a hotdog on a bun, coleslaw, and beans in his/her room without any staff present or within view of the Resident. The Resident's son was present and said staff is supposed to sit with Resident #26 because he/she needs encouragement and assistance to eat. Resident #26's son said that the Resident will often not eat enough of the meal and instead of staff sitting with the Resident and assisting with the meal, they just take the tray away with much of it uneaten. On 8/7/25 from 8:18 A.M. to 8:30 A.M., the surveyor observed Resident #26 eating raisin bread toast alone in his/her room, there was also a bowl of rice crispies cereal in milk in front of him/her. There was no staff within view of the Resident. During this time, several staff members walked past Resident #26's room, but no one looked into the room or checked on the Resident. Resident #26's hands were shaking, and he/she appeared to be having trouble with bringing the raisin bread toast to his/her mouth. Resident #26 coughed six times during this observation.On 8/7/25 at 8:31 A.M., Resident #26 said he/she was coughing while eating and was afraid of choking. Resident #26 said he/she had been coughing for a few days. Resident #26 said he/she had a bad right shoulder and was right-handed, which makes it difficult to feed him/herself. Resident #26 said he/she often gets tired trying to feed him/herself and cannot finish the meal because he/she is too tired to continue. Resident #26 said his/her hands shake and it's difficult to bring the food to his/her mouth. Resident #26 said his/her drinks are too heavy and cannot lift them without assistance. Resident #26 demonstrated this to the surveyor with a full cup of hot coffee, which begun to spill when he/she tried to lift it. Resident #26 further said he/she really wants to eat the rice crispies but cannot because he/she can't find the spoon, which was sitting in the bowl of rice crispies. Resident #26 said he/she has told staff many times that he/she needs assistance with meals, but that staff keep leaving the tray and walking away. Resident #26 said I just wish they would help me eat. During an interview on 8/7/25 at 10:18 A.M., Nurse #1 said resident care needs, such assistance or supervision while eating, is communicated to the CNAs by the CNA care cards and through nursing report. Nurse #1 said if there are changes or increased needs required it is the nurse's responsibility to update both the care card and the Resident care plan. Nurse #1 said the CNA care card and Resident care plan should always match.During an interview on 8/7/25 at 10:39 A.M., Certified Nurse Assistant (CNA) #2 said she consistently cares for Resident #26 and knows him/her very well. CNA #2 said Resident #26 requires a staff member to always be in the room with him/her while eating because he/she requires supervision and assistance with meals. CNA #2 said Resident #26 has trouble eating because he/she has weakness in his/her right arm and his/her hands shake. CNA #2 said Resident #26 not only gets tired during meals but cognitively has trouble with eating and finding things on the tray, such as the spoon.During an interview on 8/7/25 at 10:54 A.M., Nurse #2 said she consistently cares for Resident #26 and knows him/her well. Nurse #2 said if a resident requires supervision with meals, that means someone should always be close by and within view of the resident in case they need help. Nurse #2 said CNAs get resident care information from the CNA care cards but was unsure where they were located. Nurse #2 was unaware that Residents had care plans or where they would be located. Nurse #2 said she had no idea how to find out what level of assistance Resident #26 required with meals but expected the CNAs to check in with each resident each meal and provide what level of care they required. Nurse #2 said she noticed Resident #26 often requested more assistance with meals during the last couple weeks. The surveyor and Nurse #2 reviewed Resident #26's medical record and visualized the care plan. Nurse #2 said they did not match because the care plan indicated Resident #26 should be supervised while eating, but the care card did not indicate the need for supervision. Nurse #2 said she was unaware of who is responsible for updating the Resident's care plan and ensuring that they matched the Resident's CNA care card.During an interview on 8/7/25 at 11:35 A.M., the Director of Nursing (DON) said the care plan is the most accurate reflection of care needed, and interventions listed on it should always be followed, or revised as necessary. The DON said CNA (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care cards and the care plan should always match and nursing should update them as necessary. The DON said if the care plan stated Resident #26 required supervision with eating, it should have been provided. The DON defined supervision as the Resident always being within direct view of a staff member while eating.

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	225736	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Nursing & Rehabilitation Center	90 Greenwood Street Wakefield, MA 01880

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to obtain a physician's order for treatment for a newly developed stage 2 pressure ulcer for one Resident (#13) out of a total sample of 15 Residents. Specifically, the facility failed to obtain an order for zinc oxide cream before using it to treat a newly developed stage 2 pressure ulcer on Resident #13's right buttock.Findings include:Review of the facility policy titled Physician Order Policy, undated, indicated the following:- Policy Statement: All physician orders must be documented, dated and signed by a licensed practitioner authorized to prescribe in accordance with applicable laws and facility protocols.- Procedure: Order Types - Physician orders may include: Medication orders, Treatment and therapy orders.- Documentation: Orders must be promptly transcribed to the resident's medical record and Medication Administration Record (MAR)/Treatment Administration Record (TAR).- All orders must be reviewed by the charge nurse before implementation.Review of the facility policy titled Pressure Ulcer Policy and Treatment Protocol, undated, indicated the following:- Stage II: Partial Thickness Skin Loss Involving Epidermis. - Call Physician or NP, Document on skin condition report weekly, and treatment record. Nurses notes as needed.Resident #13 was admitted to the facility in March 2025 with diagnoses including Parkinson's disease and dementia.Review of Resident #13's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident has a Brief Interview for Mental Status score of 3 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident was dependent on staff for all activities of daily living, had one stage 2 pressure ulcer and was at risk of developing pressure ulcers.During the survey period, Resident #13 was observed sleeping in his/her bed with an air mattress pump operating at the correct setting.Review of Resident #13's record indicated a document titled Wound or Pressure Ulcer Identification & Progress Notes with a date of onset of 7/28/25 which indicated the following:- Location: R (right) inner buttock- Date: 7/28/25, size: 1.5 cm Length x 0.5 cm width x 0.1 depth, deepest anatomical stage 2 (circled). Handwritten under the section periwound states inner buttocks red. Under the Comments sections indicated the following handwritten notes: 1.5 x 0.5 x 0.1 open area noted R inner buttock no drainage, area moist.- Date: 8/4/25: size 0.75 cm length x 0.25 width x 0.1 depth, deepest anatomical stage 2 (circled). Handwritten under the section periwound states moist slight redness.Review of Resident #13's treatment and medication record sheets for the month of August 2025 failed to indicate any treatment for the documented stage 2 pressure ulcer on the right buttock.Further review of Resident #13's treatment record sheets for July 2025 indicated the following order: L (left) buttocks apply zinc QD (every day) until healed. The order was documented as being healed on 7/24/25 and was discontinued.Review of Resident #13's weekly skin checks dated 7/29/25 and 8/5/25 indicated that Resident #13's skin was intact with no abnormalities documented.Review of Resident #13's care plan for potential for pressure ulcer development related to immobility dated 4/1/25 indicated the following:- Focus: 7/28/25 open area R inner buttock (this was handwritten in)- Goal: area will heal without complications (this was handwritten in)- Interventions: Air mattress on bed, check function and setting as ordered (this was handwritten in).Review of Resident #13's document titled Norton Plus Pressure Ulcer Scale indicated that the Resident scored a 10 on 6/16/25, the document stated that a score of 10 or below indicated high risk of pressure ulcers.During an interview on 8/6/25 at 11:09 A.M., Nurse #1 and Nurse #2 said Resident #13 had a new open area to his/her buttock that has been there for about a week, they said they are unsure if it is open. Nurse #1 and Nurse #2 said staff put on zinc when they change the Resident.During an observation of Resident #13's wound on 8/6/25 at 1:27 P.M., with the wound nurse and Nurse #2, the surveyor observed a pea-sized, dark pink open wound bed area with residual white surrounding it on the Resident's right buttock, no dressing was on the area. Nurse #2 said the area is open and has been open for over a week. Nurse #2 said when it opened she did not obtain a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new order for zinc oxide cream. The Wound Nurse then said she is responsible for measuring wounds and she was notified on 7/28/25 that the wound opened and she assessed it. The Wound Nurse then said she did not notify the provider to get any new physician's orders because it is not her responsibility, it is the floor nurse's responsibility. The Wound Nurse then told the surveyor the right buttock wound is an open stage 2 wound and she asked the nurses who told her they previously had a physician's order for zinc but it was discontinued on 7/24/25 and no new order was reinstated when this wound open on 7/28/25 but an order should have been requested from the provider.During an interview on 8/6/25 at 1:27 P.M., the Director of Nursing (DON) said if a change in skin is noted then a nurse should notify the provider and get a physician's order and the physician's order needs to be documented in the Resident's record. The DON said because Resident #13's wounds open so frequently, she did not think a physician's order was needed for Resident #13's stage 2 pressure ulcer on his/her right buttock.During an interview on 8/7/25 at 7:10 A.M., Certified Nursing Assistant (CNA) #4 said she has worked in the facility for four years and she is Resident #13's primary CNA. CNA #4 said she applied zinc oxide cream to Resident #13's coccyx as a preventative measure, CNA #4 pulled out the zinc oxide cream from the Resident's dresser to show the surveyor. CNA #4 said if she were to notice any new skin conditions she would tell a nurse, CNA #4 said she does not know of any recent skin abnormalities on Resident #13.During a telephone interview on 8/7/25 at 9:18 A.M., the Nurse Practitioner (NP) said if any new skin area or pressure ulcer is observed on a Resident then the NP or Medical Doctor (MD) needs to be notified to obtain a physician's order for treatment, and she relies on the nurses to contact her. The NP told the surveyor she does not recall anyone telling her that Resident #13 has developed a skin opening on his/her right buttock. The NP said she was in the building on 7/29/25 but did not see Resident #13 because she did not know about the right buttock skin opening.During a telephone interview on 8/7/25 at 9:27 A.M., the facility's Medical Director (MD) said he would expect to be contacted if a Resident developed any new open skin area so he can put in a physician's order for treatment. The MD then said he does not remember being contacted by the facility regarding Resident #13's right buttock pressure ulcer and the facility should be documenting when they do contact the MD or NP. The MD then said if the facility is using zinc oxide as the primary treatment for a pressure ulcer then they need to contact the MD or NP to obtain an order so they can track the usage of it and the progress of the skin condition.During an interview on 8/7/25 at 10:10 A.M., Nurse #1 said she does not think a physician's order is needed to use zinc oxide cream as treatment for Resident #13's pressure ulcer.During an interview on 8/7/25 at 11:23 A.M., the DON said when nurses perform weekly skin checks it should be from a Resident's head to toe, therefore the right buttock area should have been documented. The DON then said she was only aware of Resident #13's left buttock pressure ulcer which healed in June. The DON said she just inputted an order for zinc yesterday but there should have been one implemented when the area was first identified.During the interview with the DON, the DON provided a fax from the MD dated and time-stamped 8/7/25 at 11:00 A.M. indicating that the right buttock area responds well to zinc ointment and should be continued as the treatment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews and record review, the facility failed to maintain a safe environment for one Resident (#22) out of a total sample of 15 residents. Specifically, the facility failed to implement a padded side rail while Resident #22 was in bed to protect from injury.Findings include:Resident #22 was admitted to the facility in August 2023 with diagnoses including dementia and malnutrition.Review of the most recent Minimum Data Set (MDS) assessment, dated 6/30/25, indicated Resident #22 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. On 8/5/25 at 7:23 A.M., and 2:08 P.M., and on 8/6/25 at 6:43 A.M., the surveyor observed Resident #22 in bed with his/her right side rail in place. This right side rail had no padding during each of these observations.Review of Resident #22's physician's order, initiated 8/23/24, indicated:-Padded 1/2 (half) side rail: on right side up when in bed. Review of Resident #22's care plan, revised 1/21/25, indicated the Resident pushes staff away during hands on care. The care plan failed to indicate the use of a padded side rail.During an interview on 8/6/25 at 7:27 A.M., Certified Nurse Assistant (CNA) #2 said Resident #22 flails his/her arms while in bed. CNA #2 said Resident #22 requires a side rail pad on the right side to protect his/her skin from injury. CNA #2 said the side rail pad was not on when she started his/her shift today and so she had just applied it. CNA #2 showed the surveyor the blue side rail pad at this time.During an interview on 8/6/25 at 7:34 A.M., Nurse #2 said Resident #22 has fragile arm skin and requires a pad on his/her right side rail to protect his/her skin. Nurse #2 said it should always be in place when Resident #22 is in bed, but that sometimes CNAs forget to put it back on.During an interview on 8/6/25 at 8:45 A.M., CNA #2 and the surveyor visualized the skin on Resident #22's arms. There were two bruises on his/her left arm. There was one bruise and one scab on his/her right arm. CNA #2 said they were probably caused by Resident #22 flailing his/her arms.During an interview on 8/6/25 at 9:37 A.M., the Director of Nursing (DON) said Resident #22's right side rail pad should have been in place as ordered.During an interview on 8/7/25 at 1:14 P.M., the DON said the facility does not have a policy regarding padded side rails.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure staff maintained accurate medical records for one Resident (#14) out of a total sample of 15 Residents. Specifically, the facility documented that the Resident was wearing Geri Sleeves when he/she was not.Findings include:Resident #14 was admitted to the facility in December 2023 with diagnoses including Alzheimer's disease and dementia.Review of Resident #14's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 3 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident is totally dependent on staff for all activities of daily living.The surveyor made the following observations:- On 8/5/25 at 8:23 A.M., 10:35 A.M. and 12:14 P.M., Resident #14 was sitting in his/her wheelchair in the dining room. Resident #14's forearms were visible, no Geri sleeves were being worn.- On 8/6/25 at 7:35 A.M., Resident #14 was observed being wheeled out of his/her room by a Certified Nursing Assistant (CNA) into the dining room. Resident #14's forearms were visible, and no Geri Sleeves were being worn. At 10:22 A.M. and 12:46 P.M., Resident #14 was observed sitting in the dining room in his/her wheelchair, his/her forearms were visible, and no Geri Sleeves were being worn.- On 8/7/25 at 8:22 A.M. and 9:23 A.M., Resident #14 was observed sitting in the dining room in his/her wheelchair, his/her forearms were visible, and no Geri Sleeves were being worn.Review of Resident #14's physician's order dated 2/27/25 indicated the following:- Apply Geri Sleeves to BUE (bilateral upper extremities) every shift, may remove for AM and PM (morning and evening) care and toileting after meals.Review of Resident #14's Kardex (a care card indicating the level of care a resident needs) failed to indicate the usage of Geri Sleeves.Review of Resident #14's pressure ulcer care development care plan dated 11/30/24 indicated the following intervention that was handwritten in:- apply Geri Sleeves to BUE every shift. May remove for AM and PM care.Review of Resident #14's medical record failed to indicate any documentation of Resident #14 removing his/her Geri Sleeves.Review of Resident #14's Treatment Record Sheet on 8/5/25, 8/6/25 and 8/7/25 indicated that staff signed off as Resident #14 wearing Geri Sleeves as ordered by the physician when the Resident was not wearing them.During an interview on 8/7/25 at 10:41 A.M., CNA #2 said if a resident requires Geri Sleeves then a CNA will put them on a resident during morning care. CNA #2 then said Resident #14 does not need Geri Sleeves anymore.During an interview on 8/7/25 at 11:14 A.M., CNA #1 said (with translation assistance from CNA #2) said she provided Resident #14 morning care this morning. CNA #1 then said Resident #14 is totally dependent on care and she did not put Geri Sleeves on Resident #14 and she did not know if the Resident is supposed to wear them.During an interview on 8/7/25 at 12:24 P.M., the Director of Nursing (DON) said Resident #14 should be wearing Geri Sleeves and if he/she is not then staff should not be documenting that he/she is.During an interview on 8/7/25 at 12:40 P.M., Nurse #1 said Resident #14 should be wearing Geri Sleeves and if he/she is not then staff should not be documenting that he/she is.