STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225743	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baker-Katz Skilled Nursing and Rehabilitation Ctr	194 Boardman Street Haverhill, MA 01830

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 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. 45343 Based on record reviews, observations and interviews, the facility failed to ensure resident centered care plans were implemented for one Resident (#43) out of a total sample of 14 residents. Specifically, for Resident #43, the facility failed to implement TED hose (compression stockings) as ordered by the Physician. Findings include: Resident #43 was admitted to the facility in November 2022 with diagnoses that included cerebral infarction due to embolism of right middle cerebral artery, aortic aneurysm, and essential primary hypertension. Review of Resident #43's most recent Minimum Data Set (MDS) assessment, dated 3/21/24, indicated Resident #43 scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she has severe cognitive impairment. On 6/03/24 at 12:15 P.M., the surveyor observed Resident #43 seated in the dining room eating his/her lunch. Resident #43 was not wearing compression stocking on his/her legs. On 6/05/24 at 7:43 A.M., the surveyor observed Resident #43 seated in his/her room waiting to go to breakfast. Resident #43 was not wearing compression stockings on his/her legs. Review of Resident #43's nursing notes on 6/5/24 at 10:59 A.M., failed to indicate the Resident refused to wear his/her compression stockings. Review of Resident #43's care plan initiated 5/25/23 indicated the following: -Focus: Resident #43 has impaired cardiac with hypertension. -Intervention: Teds stockings on every AM and remove every bedtime. Further review of Resident #43's active physician order, dated 4/03/23 indicated Teds stockings on every AM and remove every bedtime every day and evening shift for to minimize syncopal (fainting) episodes. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/05/24 at 9:52 A.M., Nurse (#1) said Resident #43 wears an abdominal binder because of his/her syncopal episodes, but that she was unaware Resident #43 requires the use of compression stockings. During an interview on 6/05/24 at 9:43 A.M., with Resident #43's Certified Nursing Assistant (CNA) #2, she said that she was not aware that Resident #43 was supposed to wear compression stockings. During an interview on 6/05/24 at 10:05 A.M., the Director of Nursing said the nurse and CNA should follow each resident's plan of care and would expect the compression stockings to be applied per the physician's order.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 41105 Based on record review, policy review and interview, the facility failed to ensure a plan of care was developed for Trauma Informed Care with individualized interventions, for two Residents (#3 and #41) who have a history of Post Traumatic Stress Disorder (PTSD), out of a total sample of 14 residents. Findings include: The facility policy titled Trauma Informed Care, undated, indicated the following: -Traumatic event(s) cause an over-reactive adrenaline response influencing receptor sites. This creates biological changes in the brain. These biological changes persist long after the traumatic event(s). Future situations can make the person be hyper-responsive to these situations. Stress hormones suppress hypothalamic activity which can then create symptoms. Essentially maladaptive learning has been created in the brain. Interventions include: -Utilize all team resources to identify areas of trauma ad triggering events-stimuli -Identify and avoid behavioral triggers -Decrease stimuli that have negative effects 1. Resident #3 was admitted to the facility in January 2018 and had diagnoses that include anxiety disorder, major depressive disorder and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/21/24, indicated that Resident #3 scored a 3 out of 15 on the Brief Interview for Mental Status exam (BIMS), indicating the Resident had severely impaired cognition. The MDS further indicated that Resident #3 had verbal and physically aggressive behavior toward others 4-6 days a week. Review of the most recent PTSD and Trauma Assessment, dated 3/20/24, indicated the following: -Resident #3 has a history of both physical and sexual assault/abuse; The assessment failed to indicate Resident specific triggers for retraumatization. Review of the current PTSD care plan indicated the following: FOCUS: Trauma Care plan At risk for psycho-social decline as evidenced by history of trauma r/t (related to) victim of physical abuse. INTERVENTIONS: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Allow resident to identify positive experiences in their life and successes as a resource such as when they are feeling anxious and overwhelmed. Encourage positive association with resources and name positive sensations that are calming or relaxing when discussing the resource; -Daughters and family are supportive and encourage to have continual contact and arrange for visitation if requested; -Encourage resident to participate in daily activities. Resident #3 enjoys listening to music, watching movies, visiting with dtrs/family, socializing with staff/1:1 visits; -Encourage resident to verbalize their feelings and offer 1:1 support. Involve social service if negative thoughts are being voiced. Provide 1:1 counseling services and psychiatric support. Behavioral Health services as needed; -Nursing staff to assess mood and effect daily. Encourage resident to access staff for support if mood and effect are out of normal limits. The PTSD care plan failed to identify resident specific triggers that may be stressors or may prompt recall of the previous traumatic event and retraumatization. Review of the most recent Psych Note, dated 5/24/24, indicated: -Staff report Resident #3 can be periodically anxious, yelling out, resistance to care, and selective with meds. Review of the Social Service clinical progress notes, dated 3/21/24, 1/04/24, 10/11/23, and 7/18/23, all indicate the following: -Resident #3 acknowledges a history of trauma related to physical and sexual abuse. Review of the current Kardex (resident specific care instructions) indicated Resident #3 was dependent on staff for care. Review of the Treatment Administration Record (TAR) indicated that Nursing documented: -In May 2024 was resistive to care 4 times on the day shift, 16 times on the evening shift -In June 2024 was resistive to care 3 of 4 days on the day shift During an interview on 6/05/24 at 7:47 A.M., Resident #3's Certified Nursing Assistant (CNA) #1 said Resident #3 required total care and was very private. CNA #3 said that Resident #3 wanted the curtain pulled around his/her bed and if it isn't she would hear Resident #3 scream. CNA #1 was not aware if Resident #3 had a preference for female caregivers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/05/24 at 8:58 A.M., Social Worker (SW) #1 said a care plan should be created upon admission for residents with a history of PTSD including information obtained from the resident and family regarding specific areas that may trigger the resident to become retraumatized. SW #1 said that she completes a PTSD assessment upon admission and quarterly, that identifies resident specific triggers, and that she tells staff to always consider trauma if a resident becomes distressed in situations. SW #1 said Resident #3 doesn't understand English so I don't communicate with him/her as much as I do other people but that the Resident had a very supportive family. SW #1 said that in this case she hadn't discussed the PTSD with the family although the family was very involved. SW #1 further said that she thinks Resident #3 prefers only female caregivers and that she will review Resident #3's care plan which sounds like it is generic. During a follow-up interview on 6/05/24 at 9:48 A.M., SW #1 said she updated Resident #3's care plan to reflect Resident #3's preference for female only caregivers, which should have been an intervention in place on the care plan, but was not. During an interview on 6/05/24 at 10:03 A.M., the Director of Nursing (DON) said that it was her expectation that residents care plans be individualized when they have PTSD with resident specific triggers. 45763 2. Resident #41 was admitted to the facility in April 2024 with diagnoses including anxiety, depression and PTSD (Post Traumatic Stress Disorder). Review of the most recent Minimum Data Set (MDS) assessment, dated 4/07/24, indicated that Resident #41 scored a 9 out of 15 on the Brief Interview for Mental Status exam (BIMS), indicating the Resident was moderately cognitively impaired. Further review of the MDS indicated that the Resident felt down, depressed, or hopeless nearly every day. Review of the most recent PTSD and Trauma Assessment, dated 4/03/24, indicated the following: -Resident #41 had a history of both physical and sexual assault/abuse on at least two occasions. -Resident #41 scored a 0 on section D, indicated the Resident did not acknowledge any ongoing signs of trauma. -Resident #41 does not discuss his/her trauma and that information regarding the trauma was provided by the Resident's son. The assessment failed to indicate Resident specific triggers for retraumatization, and failed to indicate that potential triggers were assessed during the biopsychosocial evaluation with his/her son. Review of Resident #41's PTSD care plan indicated the following: FOCUS: Trauma Care plan: at risk for psycho-social decline as evidence by PTSD, history of trauma r/t (related to) victim of sexual violence. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS: -Acknowledge resident's physical response to anxiety, fear, etc. -Encourage resident to participate in daily activities she enjoys. -Encourage resident to verbalize their feelings and offer 1:1 support. Involve social services if negative thoughts are being voiced. The PTSD care plan failed to identify resident specific triggers that may be stressors or may prompt recall of the previous traumatic event and retraumatization. Review of the social Service clinical progress note, dated 4/04/24, indicated that Resident #41 had a history of PTSD, and that the Resident's son acknowledged that the Resident had a history of trauma related to sexual assault. Further review of the progress note indicated that the PHQ9 (Patient Health Questionnaire, a self-administered questionnaire that can be used to screen, diagnose, monitor, and measure the severity of depression) indicated the presence of minimal depression symptoms with a score of three, acknowledging the Resident felt down most of the time. During an interview on 6/05/24 at 8:58 A.M., Social Worker (SW) #1 said a care plan should be created upon admission for residents with a history of PTSD including information obtained from the resident and family regarding specific areas that may trigger the resident to become retraumatized. SW #1 said a PTSD and Trauma Assessment would be completed on admission and quarterly which should include potential triggers for retraumatization; SW #1 said that if triggers were assessed and no triggers could be identified that this would be documented in the PTSD and Trauma Assessment. SW #1 said that if a Resident was depressed that trauma would be considered as a possible source. SW #1 said that potential triggers for retraumatization would be assessed even if the Resident scored a 0 on section D of the PTSD and Trauma Assessment. SW #1 said that if a Resident had a history of sexual assault that an intervention for female-only caregivers would be added to the Resident's care plan. During a follow-up interview on 6/05/24 at 9:48 A.M., SW #1 said she updated Resident #41's care plan to include an intervention for female only caregivers, which should have been an intervention in place on the care plan, but was not. During an interview on 6/05/24 at 10:03 A.M., the Director of Nursing (DON) said that it is her expectation that residents care plans be individualized when they have PTSD, with resident specific triggers.