STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225763	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palmer Healthcare Center	250 Shearer Street Palmer, MA 01069

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 50138 Based on observation, record and policy review, and interview, the facility failed to ensure respect (regard for the feelings, wishes, rights, and traditions of others) and dignity (the state or quality of being honored or respected) for one Resident (#3), out of total sample of 17 residents. Specifically, for Resident #3, the facility had video monitoring in the Resident's bedroom without consent (agreement to do something), with video images of the Resident's body visible on a monitor screen in the Unit nursing station placing Resident #3 at risk for an undignified existence. Findings include: Review of facility policy titled Dignity, dated 5/28/21, indicated: -Each resident shall be cared for in a manner that promotes and enhances his/her sense of wellbeing .and feelings of self-worth and self-esteem. -Residents are treated with dignity and respect at all times. -The facility culture supports dignity and respect .by honoring choices, preferences, values, and beliefs. This begins with admission and continues throughout the residents stay. -Individual needs and preferences .are identified though the assessment process. -Residents private space and property are respected at all times. Resident #3 was admitted to the facility in June 2020, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment). Review of the Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated Resident #3 had severe cognitive impairment as evidenced by a score of zero out of a total score of 15 on the Brief Interview for Mental Status (BIMS) exam. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's comprehensive medical record indicated appointment of Guardianship (a court appointed person who makes important personal and healthcare decisions for an adult who lacks the capacity to make their own decisions) for incapacitated person, effective 1/12/23. On 9/24/24 at 8:15 A.M., the surveyor observed Resident #3 lying in bed covered by bed sheets/blankets, a dresser at the foot of the bed and a video camera located on top of the dresser that was on and pointed at the Resident's bed. On 9/24/24 at 11:03 A.M., the surveyor observed an image of Resident #3 lying in bed playing on a video monitor screen display located behind the nurses station. On 9/24/24 at 2:19 P.M., the surveyor observed that the privacy curtain of Resident #3 was pulled closed partially around the Resident's bed. The surveyor observed that Resident #3 was lying in bed and was uncovered and undressed from the waist up, exposing his/her chest. The surveyor observed the video camera located on top of the dresser was on and aimed at the Resident's bed. On 9/24/24 at 2:25 P.M., the surveyor observed the video monitor screen display behind the nurses station playing the image of Resident #3 lying in bed with his/her chest exposed. Review of Resident #3's comprehensive medical record did not indicate: -Assessment of need for video monitoring. -Physician order for video monitoring. -Consent for video monitoring. -Comprehensive, person-centered care plan for video monitoring. During an interview on 9/24/24 at 2:34 P.M., Activity Assistant #1 said that the video monitor was in place because Resident #3 sometimes rolls out of bed to put themselves on the floor. Activity Assistant #1 said the video monitor helped the staff watch Resident #3 from the nurses station. Activity Assistant #1 said the video monitor in the Resident's room had been in place for several months, and the monitor did not record. During an interview on 9/24/24 at 3:00 P.M., the Director of Nursing (DON) said she was unaware of how long the video monitor had been in place or why it was being used for Resident #3. The DON said that she was unable to provide evidence that an assessment had been completed, a consent had been obtained from the Resident's Guardian, a Physician order was in place, or that a comprehensive person-centered care plan had been developed for the video monitoring of Resident #3. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 9/25/24 at 8:00 A.M., the DON said Resident #3 has had the video monitoring in place since February 2024 per the Nursing Progress Note dated 2/18/24. The DON said Resident #3 did not have the ability to make his/her own choices due to Dementia. The DON further said the facility did not have a policy on video monitoring and the Resident's Guardian was not asked to provide consent for the use of video monitoring of the Resident. The DON said before the video monitor was put into place, the facility should have obtained consent for video monitoring from the Guardian, obtained an order from Resident #3's Physician and developed a comprehensive person-centered care plan related to the video monitoring. The DON said video monitoring without consent was a dignity concern, because video monitoring did not respect Resident #3's private space.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 45435 Based on observation, interview, record and policy review, the facility failed to provide reasonable accommodation of resident needs for one Resident (#207), out of a total sample of 17 residents. Specifically, the facility failed to provide Resident #207, who was identified as being at risk for falls, with access to his/her call bell at all times to allow the Resident to call for staff assistance when needed. Findings include: Review of the facility policy titled, Call Bells, dated 5/28/21 indicated the following: -Purpose: to have a communication system to allow residents to call for assistance. -Place call bell/light within reach of resident . Resident #207 was admitted to the facility in September 2024, with diagnoses including Parkinson's Disease (a progressive degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), Diabetes Mellitus (DM - disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood), and urinary frequency. Review of the Brief Interview for Mental Status (BIMS) Assessment, dated 9/20/24, indicated the Resident was cognitively intact as evidenced by a score of 13 out of a total score of 15. Review of the Rehabilitation Screen, dated 9/20/24, indicated the Resident was able to transfer and ambulate with a walker and the assistance of one staff member. Review of the Fall Risk assessment, dated 9/20/24, indicated the Resident was at risk for falls. Review of the Fall Risk Care Plan, dated 9/21/24, indicated an approach was to keep the call bell in reach of the Resident. On 9/26/24 at 8:42 A.M., the surveyor observed the Resident sitting in his/her room in a wheelchair next to the bed with the overbed table in front of him/her. The surveyor observed that the Resident's call bell was hanging behind the bed and was not within reach. The Resident said he/she was comfortable in the wheelchair and that he/she had stayed in the wheelchair too long the previous day. When the surveyor asked the Resident how staff would be notified if he/she wanted to get out of the wheelchair, the Resident said he/she would press the button. The Resident was observed to look around the room, reach toward the bed, and said that he/she would wheel out to the room door to get help but that it might take him/her a month to do so. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 9:12 A.M., the surveyor observed the Resident was sitting in his/her room in a wheelchair and eating their breakfast meal. The surveyor observed that the call bell was still hanging behind the bed, and was not within reach of the Resident if he/she needed to call for staff assistance. During an interview on 9/26/24 at 11:06 A.M., the Director of Nursing (DON) said call bells should always be in reach of the Residents in their rooms.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 45435 Based on observation, interview, record and policy review, the facility failed to provide treatment and care in accordance with professional standards relative to the proper setting of pressure reducing and relieving devices for two Residents (#37and #2) who were at risk of skin breakdown. Specifically, the facility failed to: 1. For Resident's #37, maintain the pressure-reducing air mattress settings as ordered by the Physician. 2. For Resident #2, to ensure the Physician's order for an air mattress was implemented for the Resident who was bed bound, identified as being at increased risk for skin breakdown, and had a history of skin breakdown. Findings include: Review of the facility policy titled Support Surface Guideline, dated 5/28/21, indicated the following: -The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. -Redistributing support surfaces prevent skin breakdown, promote circulation and provide pressure relief or reduction. -Support surfaces are modifiable. Individual resident needs differ. -Elements of support surfaces that are critical to pressure ulcer prevention and general safety include pressure redistribution, moisture control, shear reduction, heat dissipation/temperature control, friction control, infection control, flammability, and life expectancy. 1. Review of the Panacea Air Ease Mattress Owner's Manual, dated 2022 - 2024, indicated the following: -Firmness dial: Turn the dial to adjust the pressure within the mattress, clockwise to increase pressure; counterclockwise to decrease pressure. -The recommended pressure settings correspond to the user weight values around the dial. Resident #37 was admitted to the facility in August 2021, with diagnoses including Alzheimer's Disease (a progressive disease beginning with mild memory loss and leading to the loss of the ability to carry on a conversation and respond to the environment, involves parts of the brain that control thought, memory, and language) and Epilepsy (also known as seizure disorder - is a brain disorder that causes recurring seizures). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Assessment, dated 7/25/24, indicated the Resident had the following: -Brief Interview for Mental Status (BIMS) assessment score of zero out of 15, indicating the Resident had severe cognitive impairment. -was dependent on staff for all activities of daily living (personal hygiene, grooming, dressing, toileting, transferring and eating). -was dependent for mobility (the ability to change and control the body position). -weight was 137 pounds (lbs) and had weight gain of five percent or more in the last month or ten percent or more in the last six months. -presence of one, unhealed, stage two pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister). -used a pressure-reducing device in bed and received pressure injury care. Review of the Physician's orders, dated September 2024, indicated the following: -Air mattress set to 135, check for correct setting and function every shift, start date 8/22/24. Review of the Medication Administration Record (MAR), dated September 2024, indicated the following: -Air mattress set to 135 - check for correct setting and function every shift. -checks for correct setting and function was documented as being done every shift for 9/1/24 through 9/25/24. Review of the Care Plan, titled Risk for Alteration in Skin Integrity, revised 8/23/24, indicated the approach was to use an Air Mattress per MD (Physician) order. Review of the Wound Care Consultation, dated 7/26/24, indicated the following: -Follow-up on pressure ulcer to right heel. Left heel is resolved with intact epithelial tissue. -Recommend nursing to apply skin prep to bilateral heels every shift. Keep LAL (air mattress) in place. On 9/24/24 at 9:37 A.M., the Resident was observed lying in bed and a Panacea Air Ease Mattress was in place with the setting dial set to 85 pounds. The surveyor observed a sticker on the air mattress pump indicating to set the dial to 135 pounds. On 9/25/24 at 9:56 A.M., the Resident was observed lying in bed, and an air mattress was in place with the setting dial set to 85 pounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 9/25/24 at 10:29 A.M., the surveyor and Nurse #1 observed the Panacea Air Ease Mattress in place on Resident #37's bed. Nurse #1 said the bed was set wrong and should be set for 135 pounds. Nurse #1 further said that she had only worked at the facility for six weeks and she was not aware the Resident had a history of pressure ulcers. During an interview on 9/25/24 at 10:29 A.M., the Director of Nursing (DON) said Resident #37's air mattress should have been set for 135 pounds and not 85 pounds. The DON further said that when a Resident was prescribed an air mattress, their weight was obtained, and a label is put on the pump indicating what the setting should be. The DON said the Nurses should be checking and correcting the setting if needed every shift. 37400 2. Resident #2 was admitted to the facility in December 2022, with diagnoses including Adult Failure to Thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity,) and Protein-Calorie Malnutrition (insufficient intake of both energy and protein). Review of the Panacea Air Element Mattress Owner's Manual indicated the following under Operations: -The pressure adjustment knob controls the air pressure in the mattress. Turning the know clockwise will increase the pressure; counterclockwise decreases the pressure. -Higher pressures will support heavier residents. -The pressure should be adjusted according to individual comfort levels. -You can generally check if the pressure is suitable for a resident by sliding one hand beneath the air cells at level of the resident's buttocks. The air cells will alternately inflate and deflate. You should feel slight contact with the buttocks when the air cells beneath the buttocks deflate. Review of the Skin Integrity Care Plan, initiated 12/14/22, indicated the Resident was at risk for alteration in his/her skin related to chronic incontinence, cognitive impairment, Moisture Associated Skin Damage (MASD: inflammation or skin erosion caused by prolonged exposure to a source of moisture) and history of venous ulcers (caused by problems with blood flow/circulation). Further review of the Skin Integrity Care Plan included the following intervention: -Air mattress to bed, see the Physician's order for the setting, initiated 12/30/22. Review of the MDS Assessment, dated 8/29/24, indicated Resident #2: -had clear speech, was able to make self understood, understands others. -was dependent on staff for positioning. -was at risk for pressure ulcers (localized skin and soft tissue injuries that develop due to prolonged pressure) and had a pressure reducing device in place for his/her bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the September 2024 Physician's orders included the following: -Bed bound per patient request, initiated 4/21/23 -Air mattress to be set at 120/150 (pounds or lbs.). See arrow on the device and check for function/setting every shift, initiated 8/22/24 On 9/24/24 at 9:51 A.M., the surveyor observed Resident #2 lying in bed with an air mattress in place and set to 210 lbs. The surveyor observed an arrow sticker on the setting box of the air mattress was pointing at the line between 120 and 150 lbs. On 9/25/24 at 8:28 A.M., the surveyor observed Resident #2 lying upright in bed. The air mattress was observed set at 210 lbs. An arrow sticker was observed on the setting box of the air mattress and was pointing at the line between 120 and 150 lbs. During an interview at the time Resident #2 said the mattress was uncomfortable. Review of the September 2024 Monitoring Administration Record included the following Physician's Order: -Air Mattress to be set at 120/150 (lbs.). See arrow on the device. Check for the function and setting every shift. Further review of the Monitoring Administration Record indicated the nursing staff verified that the air mattress was at the correct setting on 9/24/24 and 9/25/24. During an interview on 9/25/24 at 2:31 P.M., Nurse #2 said Resident #2 had reddened blanchable (skin turns white when pressure is applied and is a sign that the patient's position needs to be changed as there is potential for capillary damage if pressure is not relieved) areas on his/her back and required staff assistance with care and repositioning. Nurse #2 said the Resident had an air mattress in place that the nursing staff check every shift to ensure it was at the correct setting. Nurse #2 said the Nurse would check to ensure the Resident's air mattress was functioning and set at the correct setting. When the surveyor relayed observations from 9/24/24 and 9/25/24, Nurse #2 said she was unaware that the mattress was not at the correct setting. Nurse #2 further said that the Resident's mattress was set to his/her weight, and if it not set appropriately, it could put the Resident at risk for skin breakdown. During an interview on 9/25/24 at 4:19 P.M the DON said she was made aware that Resident #2's air mattress was not set to the Physician's ordered setting.

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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. 37400 Based on observation, interview, record and policy review, the facility failed to provide supervision and an environment free of accident hazards for one Resident (#1), out of a total sample of 17 residents. Specifically, the facility failed to ensure that Resident #1 was provided with supervision, when the Resident who was determined as being at risk for elopement was observed outside of the facility in close proximity of a parking lot without staff supervision. Findings include: Review of the the facility policy titled Wandering and Elopement, dated 6/11/21, indicated: -the facility strives to promote resident safety by maintaining a process to screen all residents for risk of elopement and implement preventative strategies for those identified at risk. The policy also included the following: -If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Resident #1 was admitted to the facility in March 2018, with diagnoses including Bipolar Disorder with psychotic features (a mood disorder that features extreme shifts in mood that include emotional highs [mania or hypomania] and lows [depression], during which hallucinations or delusions can occur), Dementia with behavioral disturbance (progressive disease with impairment in memory and functioning that includes symptoms such as Depression, Anxiety, psychosis, agitation, aggression, disinhibition, and sleep disturbances), hearing loss, bilateral Glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of the eye called the optic nerve [which sends visual information from the eye to the brain]) and Presbyopia (the gradual loss of the eye's ability to focus on nearby objects). Review of the Activities Care Plan, initiated 6/5/24, indicated the Resident needed a quiet relaxing environment and included the following intervention: -Offer Resident patio time when weather is permitting . can go on the patio without staff supervision (dated 6/5/24) Review of the Elopement Risk Assessment, dated 8/17/24, indicated Resident #1 was identified as at risk for elopement based on the following factors: -Verbally abusive -Psychiatric diagnosis (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Elopement Risk Assessment included the following interventions: -Activities -Redirection -Special Care Unit . secured unit -Identification band on the Resident -Photograph posted Review of the Minimum Data Set (MDS) Assessment, dated 8/22/24, indicated Resident #1: -had moderate difficulty hearing -had severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 7 out of 15 -utilized a walker -required substantial/maximum assistance of staff with ambulating 50 feet Review of the Elopement Care Plan, initiated 8/27/24, indicated Resident #1 was at risk and included the following interventions, dated 8/27/24: -Complete elopement assessment quarterly and as needed. -Complete Resident elopement sheet and put in the elopement book located at the nurses station. -Provide activities and assist with redirecting the Resident from attempting to leave the building. On 9/24/24 at 10:57 A.M., the surveyor observed Resident #1 seated in a chair on the patio located outside of the facility. The surveyor observed that the Resident's walker was positioned next to him/her and that there were no staff members outside the facility in the Resident's vicinity. The surveyor also observed that there was an open gate from the patio which lead to the sidewalk, a ramp and then a parking lot and the main road located near the facility. During an interview on 9/24/24 at 10:59 A.M., Certified Nurses Aide (CNA) #2 said the facility assesses residents to ensure they were able to go outside. CNA #2 said if Resident #1 wanted to go outside, the staff would use the keypad located inside the facility near the door (which led to the patio) to unlock the door and then open the door to allow the Resident outside. CNA #2 said the Resident ambulates with his/her walker and knows how to ring the doorbell on the outside patio door when he/she wanted to come back into the facility. CNA #2 said the door was locked from the outside of the building, so the doorbell was required in order to alert the staff that the Resident wanted to come back inside the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Elopement Book, located at the nurses station, included a photograph and physical characteristics description of Resident #1 and indicated that he/she was an elopement risk. On 9/25/24 at 11:56 A.M., the surveyor observed Resident #1 seated in a chair outside on the patio with a walker positioned next to him/her. The surveyor did not observe any staff on the patio at the time. On 9/26/24 at 1:02 P.M., the surveyor and the Director of Nursing (DON) observed the facility door that lead to the patio. There were no residents on the patio at the time as it was raining, and the gate that lead from the patio, sidewalk and then ramp to the facility parking lot was observed to be open. The DON said that facility staff, visitors and vendors use this entrance to the facility. The DON said in order to enter the facility, they (person) would need to ring the doorbell located outside the door and staff would unlock the door using the keypad inside of the building to allow entrance. The DON said residents were able to go outside and sit without staff assistance but would need staff to unlock the door to let them back into the facility. The DON further said the patio gate should be closed when residents are outside to ensure the residents safety. During a follow-up interview on 9/26/24 at 3:23 P.M., the DON said the residents used to have scheduled time outside that was supervised by staff, but this had been stopped for quite a while. The DON said although there are staff located in the activity/dining room (which was in view of the patio), there were often a lot of residents in the activity/dining room with activities/events occurring so supervision of the residents who were seated outside may not be occurring. The DON said Resident #1 was considered an elopement risk and should be supervised by staff to ensure his/her safety. The DON said the gate on the patio was also a concern as it was open and could be unlatched by residents when closed.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 37400 Based on observation, interview, record and policy review, the facility failed to provide food that was designed to meet the individual needs of one Resident (#2) out of a total sample of 17 residents. Specifically, the facility failed to ensure that Resident #2 was provided with the Physician's prescribed diet consistency of mechanical soft consistency (altered diet in which foods difficult to chew are chopped, ground, shredded, cooked or altered in some way to make them easier to chew and swallow) when the Resident was offered regular consistency items not allowed on his/her diet and pureed (texture modified diet where foods have been altered so that they have a smooth, cohesive, pudding-like consistency) meal items that was not ordered or the Resident's preference. Findings include: Review of the facility policy titled Therapeutic Diet Orders, dated 6/15/20, indicated it was the policy of the facility to assure that residents receive and consume foods in the appropriate form .as prescribed by the Physician and/or as assessed by the interdisciplinary team (IDT) to support the resident's treatment, plan of care in accordance with his/her goals and preferences. The policy also included the following: -therapeutic diets will be based on the individual needs of the resident and must be prescribed by the Physcian or delegate . -will be provided to residents in the appropriate form. Review of the facility Diet Manual, titled Diet Manual: A Nutritional Handbook and Training Guide for Long Term Care, dated 2/10/21, included the following under Ground Diet: -for individuals who had difficulty chewing or swallowing regular textured foods -foods that are difficult to chew are chopped, ground, shredded, cooked or altered in some way to make them easier to chew or swallow --Breads and cereals are allowed on this menu -meats should be very tender, finely chopped or ground and well moistened . -regular bread items should be finely chopped into 1/8 inches (in) . -well cooked, moistened, boiled, baked or mashed potatoes, well cooked noodles in sauce (chopped to 1/8 in) . -vegetables should be soft, well cooked, and easily mashed with a fork . (continued on next page)

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	225763	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palmer Healthcare Center	250 Shearer Street Palmer, MA 01069

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-allowed fruits include soft, canned, or cooked fruits or ripe soft bananas, which are finely chopped to 1/8 in . -poached, scrambled eggs and cottage cheese are acceptable -danish pastry, sweet rolls, pancakes, french toast, breads, well moistened with syrup or sauce to form a slurry -avoid: any sticky foods peanut butter . Resident #2 was admitted to the facility in December 2022, with diagnoses including Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment, weight loss, decreased appetite or poor nutrition and inactivity) and Protein-Calorie Malnutrition (insufficient intake of both energy and protein), and Dysphagia (difficulty swallowing). Review of the Speech Language Pathology (SLP) Discharge Summary, dated 6/2/24, indicated Resident #2 was evaluated for swallowing and analysis of diet texture and made the following recommendation upon discharge from therapy: -Resident unable to follow verbal cues and safety precautions needed to further advance diet for soft salad sandwiches . Review of the Resident Food Preference Assessment Form, dated 6/10/24, indicated Resident #2 did not like the texture consistency of his/her diet . Review of the Minimum Data Set (MDS) Assessment, dated 8/29/24, indicated Resident #2 understands, was able to make self understood, and was on a mechanically altered (altered texture to allow for easier chewing or swallowing) diet. Review of the Nutritional Assessment, dated 8/30/24, indicated Resident #2 was: -on a mechanically altered diet and disliked the diet texture -had weight loss over six months that was not significant -considered a moderate nutritional risk Review of the September 2024 Physician's orders included the following, initiated 5/4/24: -Diet: Regular -Consistency: Dysphagia Mechanical Soft (Level 2) -Liquids: thin liquids with meals (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 9:51 A.M., the surveyor observed Resident #2 lying in bed. During an interview at the time, the Resident said he/she was on a puree diet and hated it. The Resident said the food was crappy, watery and mixed together and he/she did not like that. On 9/25/24 at 8:28 A.M., the surveyor observed the Resident lying upright in bed. An overbed table was positioned in front of him/her and a breakfast tray that contained a pureed brown colored scoop of food (pureed pancake) and ground sausage. During an interview at the time, the Resident said the food was horrible, was like glue, and that he/she was not even sure what the brown mound of food (while pointing to it) was on his/her plate. Review of the Resident's meal ticket included the following: Regular-Ground diet. On 9/25/24 at 12:18 P.M., the surveyor observed Resident #2 lying in bed. An overbed table was positioned in front of him/her and a lunch tray was present and contained ground meat, a pureed orange substance (sweet potato), cooked scoop of spinach and a cup of pureed pineapple. During an interview at the time, the Resident said he/she was unable to eat the food and had requested a sandwich from the facility staff. The surveyor observed the Staff Development Coordinator (SDC) get a peanut butter and jelly sandwich with no crust for Resident #2 at this time. During an interview on 9/25/24 at 1:46 P.M., Certified Nurse Aide (CNA) #1 said the Resident was on a modified diet and often does not eat his/her food. CNA #1 said other staff bring in special items for him/her like the Vienna sausages and tuna packets for him/her to eat. CNA #1 said when the Resident doesn't eat, he/she will stack the food on his/her plate and return it to the kitchen. On 9/26/24 at 8:54 A.M., the surveyor observed Resident #2 lying in bed with breakfast tray positioned in front of him/her on an overbed table. The Resident's breakfast plate contained a pile of finely ground up pumpkin spice muffin and a small container of finely ground up fruit. During an interview at the time, the Resident said he/she was very upset about the food provided and did not understand why the muffin and fruit were ground up the way it was. On 9/26/24 at 1:22 P.M., the surveyor observed Dietary Aide #1 deliver a lunch tray for Resident #1 at the nurses station. Nurse #2 was present at the nurses station and was observed to check the lunch tray. A small container of egg salad was observed on the plate and a wrapped peanut butter and jelly sandwich with no crust. Nurse #2 said she did not think Resident #1 was able to have the peanut butter and jelly sandwich and removed it from the plate. Dietary Aide #1 said she would provide another small container of egg salad. During an interview on 9/26/24 at 1:23 P.M., Dietary Aide #1 said the cook was responsible for placing the Resident's food on the plate. Dietary Aide #1 said if a staff member requests food items for a resident, she checks with the cook to ensure the food is appropriate prior to sending it to the unit to be given to the resident. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 3:51 P.M., the Food Service Director (FSD) said he was familiar with Resident #2 because he/she would pile uneaten food items on his/her meal plate. The FSD said he was unaware of any diet concerns expressed by the Resident and said his/her current diet was Dysphagia Mechanical Soft which was the Ground Diet in the facility diet manual. The surveyor relayed observations from 9/25/24 and 9/26/24 and the Resident's concerns about the meal items provided. The FSD said the pancake provided on 9/25/24 should have not been pureed, it should been cut up and moistened. The FSD also said that the muffin provided on 9/26/24 should also have been moistened and not ground up on the plate. The FSD said the pureed orange food item for lunch on 9/25/24 was sweet potato. The FSD said he was not sure if the nursing staff are provided education on the diets provided in the facility and that sandwiches were not allowed on the Resident's diet, especially sandwiches which contain peanut butter which was sticky. During an interview on 9/26/24 at 5:15 P.M., the Staff Development Coordinator (SDC) said the nursing staff check meal trays and distribute them to residents. The SDC said she was not aware of any diet education that was provided to nursing staff about the facility used diet consistencies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 37400 Based on observation, interview, and policy review, the facility failed to maintain a clean and sanitary environment in the main facility kitchen to prevent contamination and the spread of foodborne illnesses. Specifically, the facility staff failed to ensure that: 1) equipment in the facility kitchen was clean and free of dust and debris. 2) hair restraints were worn to prevent potential physical contamination of food/fluids. 3) the facility dish machine was appropriately tested for temperature and sanitation requirements by Dietary Staff when the minimum sanitation requirements were not met, putting the facility residents at risk for contamination and foodborne illnesses. Findings include: Review of the facility policy titled Kitchen Sanitation, dated [DATE], indicated the food service area is maintained in a clean and sanitary manner. The policy included the following: -All kitchen, kitchen areas and dining areas are kept clean, free from garbage and debris . -All utensils, counters, shelves and equipment are kept clean . -All equipment, food contact services and utensils are cleansed and sanitized using heat or chemical sanitizing solutions. -Dishwashing machines are operated according to manufacturer's instructions. Review of the facility policy titled Hair Restraint, dated [DATE], indicated: >compliance to local and federal food service codes requires that anyone within the kitchen, who will have close contact with the preparation or service of food, food storage areas, equipment will keep hair effectively/appropriately restrained to include facial hair. >The purpose of hair restraint is to prevent hair from contacting food and food equipment surfaces, and to deter food service employees from touching their hair. >The policy also included the following: -The Food Service Director (FSD) will provide disposable hair nets and beard guards at all times. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Hair nets will be located just outside, or just inside, of the entrances of the kitchen. Review of the Dish machine Instructions, located on the facility dish machine, included the following: -Testing Parts Per Million (PPM) on Low Temperature Dish Machine: -Run dish machine ,d+[DATE] cycles. -Ensure machine is at the appropriate temperatures: Wash 120 or higher degrees Fahrenheit (F), Rinse 120 or higher degrees F. -Use Precision Chlorine test paper directly after machine finishes rinse cycle. -Ensure hands are dry and test strips are not expired. -With dry hands, place test strip against the rinsing arm inside of the dish machine for 1 second. -Match the color of the strip (should turn dark purple color) with the index on the test strip tube. -PPM has to be between ,d+[DATE] PPM per manufacturers guidelines. -If the temperature and/or PPM are not within standards, do not run dishes through the machine. Contact FSD or Maintenance immediately . During an initial kitchen tour on [DATE] at 7:30 A.M., the surveyor observed the following: -two fans observed in the kitchen that were dust laden -shelf under the portable air conditioner unit was dusty -utensil rack with clean kitchen utensils which was located over the cooks preparation area was dusty -clear stacked storage containers which were not dry inside and had clear evidence of moisture During an interview on [DATE] at 7:34 A.M., Dietary Aide #4 said the clear containers that had been stacked and were not thoroughly dried were from the previous night. Dietary Aide #4 said the containers should not have been stacked while wet and there would be a concern for mold and bacterial growth. During a follow-up visit to the facility kitchen on [DATE] at 1:42 P.M., the surveyor observed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-the [NAME] was preparing food for dinner and did not have a hair restraint in place. During an interview at the time, the [NAME] said she should have put on a hair net prior to working in the kitchen. -utensil rack with clean kitchen utensils which was located over the cooks preparation area remained dusty. -Dietary Aide #2 was observed running the dish machine after lunch. During an interview of the process for checking the temperatures and sanitation requirements, Dietary Aide #2 said the temperature was checked after running ,d+[DATE] racks of dishes through the machine. Dietary Aide #2 said the chemical sanitizer should also be checked when using the dish machine but she had not checked it yet. Dietary Aide #2 proceeded to take a test strip and test the water inside the dish machine after a rack of dishes had commenced and compare the color on the strip to the guidance on the test strip tube. The color of the test strip was observed to be black and Dietary Aide #2 said the PPM was reading 200 which was too high. Dietary Aide #2 further said that she was never educated on when to check the chemical sanitizer and had already run two of the three lunch trucks with resident dirty dishes/trays through the machine. At this time, Dietary Aide #1 who was assisting with the dish machine said they should not continue to use the machine and should contact the FSD and maintenance. On [DATE] at 2:09 P.M., the surveyor, Maintenance Worker #1, the FSD and Executive Director, re-checked the facility dish machine using the test strips in the kitchen. After checking the water with a test strip in the dish machine, Maintenance Worker #1 showed the results obtained on the test strip which was observed to have no color (indicating there was no chemical sanitizer present). Upon inspection of the test strip tube, the surveyor observed there was no expiration date listed. The FSD said he would check his office to find a new tube of test strips in order to re-check the chemical sanitizer to determine if the dish machine could be used. During a follow-up interview on [DATE] at 3:51 P.M., the FSD said he checked the dish machine test strips and they were expired. The FSD said he was able to find additional unopened test strips which were not expired and the dish machine was re-checked and still indicating there was no chemical sanitizer present. The FSD said the dish machine temperatures and chemical sanitizer should be checked prior to running dishes through to ensure it was at the appropriate levels. The FSD further said that hair restraints should be worn by all staff when in the kitchen. The FSD said the fans should be cleaned monthly and were not routinely being cleaned. The FSD said he was currently working on a kitchen cleaning schedule to ensure areas were sanitary and free of dust/debris.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, interview, record and policy review, the facility failed to ensure that one Resident (#3) out of a total sample of 17 residents was free from accidental risk of injury or entrapment. Specifically, the facility failed to ensure the scoop mattress (a mattress with raised edges on all four sides to prevent accidental rolling out of bed) being used for Resident #3 was compatible with the bed frame when there was a significant gap between the scoop mattress and foot board, placing the Resident at risk for injury or entrapment. Findings include: Review of facility policy titled Bed Safety, dated 5/28/21, indicated: -Our facility shall strive to provide a safe sleeping environment for the resident. -The residents sleeping environment shall be assessed by the interdisciplinary team (IDT), considering resident safety, medical conditions, comfort, freedom of movement, as well as input from the resident's family regarding sleeping habits and bed environment. -The facility shall identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g. [exempli gratis (for example)] altered mental status). -The facility shall provide inspection by maintenance staff of all beds . to identify risks and problems including potential entrapment risks. Resident #3 was admitted to the facility in June 2020 with a diagnosis of Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #3 had severe cognitive impairment as evidenced by a score of zero out of a possible total score of 15 on the Brief Interview for Mental Status (BIMS) exam. Review of Resident #3's comprehensive medical record indicated appointment of Guardianship (a court appointed person who makes important personal and healthcare decisions for an adult who lacks the capacity to make their own decisions) for incapacitated person, effective 1/12/23. On 9/24/24 at 8:15 A.M., the surveyor observed Resident #3 lying in bed on a scoop mattress with a large gap space between the foot board and the end of the mattress. On 9/24/24 at 1:47 P.M., the surveyor observed Resident #3 lying in bed on a scoop mattress with a large gap space present at the foot of bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 8:37 A.M., the surveyor observed Resident #3 lying in bed on a scoop mattress with a large gap space present at the foot of bed. The surveyor measured the gap space area on the Resident's bed which was nine inches from the edge of mattress to the foot board. During an interview on 9/25/24 at 10:22 A.M., Certified Nurses Aide (CNA) #1 said Resident #3 could move around in bed independently and had fallen out of bed in the past. CNA #1 said the facility took away the air mattress the previous week because Resident #3 did not like it and replaced the air mattress with the scoop mattress instead. CNA #1 said the scoop mattress that was in place was shorter than most other mattresses that were used in the facility. Review of Resident #3's September 2024 Physician's orders indicated that the air mattress had been discontinued from use on 9/24/24. During an interview and observation on 9/25/24 at 11:10 A.M., Maintenance Staff #1 said the maintenance staff were responsible for changing mattresses at the facility and were not notified of the Resident's mattress change from over the weekend. Maintenance Staff #1 said the scoop mattress that was placed on Resident #3's bed was not compatible with the bed frame and was too small. Maintenance Staff #1 said the small scoop mattress had created a big gap at the foot of the bed which was concerning and could place Resident #3 at risk for being hurt or entrapped. During an interview on 9/26/24 at 9:47 A.M., the Director of Nursing (DON) said a weekend staff Nurse had changed out the mattress for Resident #3. The DON could not provide evidence that an audit for safety had been completed at the time of the mattress change. The DON said there was no facility policy for bedframe or mattress audits, but audits did occur quarterly by the maintenance department. The DON said a whole house audit of mattress safety was last completed on 9/3/24, and was not scheduled to occur again until 12/3/24.