STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225767	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Brooksby Village	400 Brooksby Village Drive Peabody, MA 01960

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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. 45763 Based on observations, interviews, and record reviews, the facility failed to provide a dignified experience for Residents on one of two units. Specifically, the facility failed to ensure that staff did not speak a foreign language while in the presence of, and while providing care for, Residents on the Terrace unit. Findings include: Review of the facility policy, titled Resident Rights - Continuing Care, dated June 2023, indicated the following: - Residents have the right to be treated with respect and dignity. During the Resident group meeting on 12/19/24 at 1:30 P.M., three out of three primarily English-speaking Residents said that staff have spoken in a foreign language to each other in front of them. On 12/18/24 at 4:46 P.M., the surveyor observed two staff members speaking a foreign language to each other within a primarily English-speaking Resident in the common area of the Terrace unit. On 12/18/24 at 5:18 P.M., the surveyor observed two staff members speaking a foreign language to each other while one of the staff members was providing feeding assistance to a Resident in the Terrace unit dining area, there were five Residents at the table between the two staff members and an additional three Residents within earshot of the staff. The surveyor observed a Resident say I don't speak that in response to the staff members speaking a foreign language to each other. On 12/18/24 at 5:23 P.M., the surveyor observed two staff members speaking a foreign language to each other within earshot of eight Residents in the Terrace unit dining room during dinner service. During an interview on 12/20/24 at 8:27 A.M., Nurse #3 said she had witnessed staff speaking in a foreign language to each other in the hallways and near the kitchen/dining area of the Terrace unit in the past. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/20/24 at 9:52 A.M., the Director of Nursing (DON) said Resident care areas are English speaking only and that staff should not be speaking in a foreign language to each other within earshot of Residents; the DON said that she knew that staff spoke in a foreign language to each other as she had witnessed this in the past.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADLs) for dependent residents for one Residents (#32) out of a total sample of 18 residents. Specifically, for Resident #32, the facility failed to provide supervision while eating. Findings include: Resident #32 was admitted to the facility in April 2024 with diagnoses including atrial fibrillation, muscle weakness, repeated falls and unspecified abnormalities of gait and mobility. Review of Resident #32's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 10 out of a possible 15 indicating he/she has moderate cognitive impairment. Further review of Resident #32's MDS indicated that the Resident requires partial/moderate assist with activities of daily living and has no history of refusing care. On 12/18/24 at 9:56 A.M., the surveyor observed Resident #32 sitting up in his/her bed with his/her bedside table in front of him/her with his/her breakfast tray on it. Resident #32's head of bed was positioned at an approximate 45-degree angle causing the resident to have to reach for his/her breakfast on the table. The Resident was attempting to eat Cheerios, there were Cheerios spilled all over the bedside table with spilled milk spots also on the table. There were no staff members in the room providing supervision or assistance. During the same observation at 10:19 A.M., the Resident's breakfast tray was in the same position, Resident #32 was sleeping in his/her bed holding a cup of hot coffee in his/her right hand that was slightly spilling over the edge on the bedside table. No staff members were in the room providing supervision or assistance. On 12/19/24 at 9:35 A.M., the surveyor observed Resident #32 sitting in his/her bed with his/her breakfast tray in front of him/her on the bedside table. There were no staff in the room or hallway outside of his/her room providing supervision. On 12/20/24 at 9:48 A.M., the surveyor observed Resident #32 sitting in his/her bed with his/her breakfast tray in front of him/her on the bedside table. There were no staff in the room or hallway outside of his/her room providing supervision. Review of Resident #32's Dining and eating/swallowing nutritional status, oral and dental care plan, dated 10/22/24, located in the electronic medical record and in the Resident's room indicated the following: - Goal: I will receive encouragement to dine independently at each meal daily, I will receive cueing for meals daily, I will dine safely. - I require the following level of assistance: supervision. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's document titled Occupational Therapy Evaluation and Plan of Care with a certification start date of 4/22/24 indicated the following: - Reason for referral: Patient is referred to Occupational Therapy (OT) with decreased safety and activity strength/endurance. He/she will benefit from skilled OT services to improve safety, balance, strength, and endurance for safety with modified ADL and DC (discharge) planning. - ADL Skills: Self-feeding: Status: Supervision Review of Resident #32's document titled Occupational Therapy Evaluation and Plan of Care with a certification start date of 12/5/24 indicated the following: - Reason for referral: Resident is referred to Occupational Therapy with need for increased assist in self-feeding. He/she will benefit from OT services to assess self-feeding for set up and DME (durable medical equipment) recommendations. - ADL Skills: Self-feeding: Status: Supervision During an interview on 12/20/24 at 8:31 A.M., Certified Nursing Assistant (CNA) #3 said Resident #32 needs supervision with meals and we watch him/her from the hallway if he/she needs anything. CNA #3 said he was not sure if Resident #32 has trouble swallowing or just needs general assistance with eating. During an interview on 12/20/24 at 8:35 A.M., CNA #2 said we check the resident's care plans to know what level of care they need. CNA #2 said Resident #32 does not need supervision with meals and he/she does good with eating. During an interview on 12/20/24 at 8:51 A.M., Nurse #7 said Resident #32 likes to eat his/her meals in his/her room and he/she makes a big mess while eating. She continued to say he/she only needs his/her meals set-up and does not need supervision with his/her meals but will probably need it soon. Nurse #7 said Resident #32 will need to eat in the dining room when he/she needs supervision with meals because we usually do not have the staff for a one-to-one supervision if a resident likes to eat in their rooms and requires supervision. Nurse #7 and the surveyor reviewed Resident #32's care plan and she said he/she should be receiving supervision while eating. During an interview on 12/20/24 at 12:29 P.M., the Director of Nursing (DON) said the Resident's care plan should be followed and Resident #32 should be receiving supervision while he/she is eating, and staff need to be on the same page for Resident #32's dining needs. The DON continued to say Resident #32 should be sitting in an upright position while he/she is eating. The DON then said a resident can choke in a moment's notice which is why supervision is important if a resident requires it.

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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 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48990 Based on observations, interviews, and record review, the facility failed to ensure its staff provided treatments in accordance with professional standards of practice for one Resident (#12) out of a total sample of 18 residents. Specifically, for Resident #12: 1. The facility failed to ensure a wound clinic appointment was re-scheduled to obtain new wound treatment interventions when requested by the Nurse Practitioner for a deteriorating right lower extremity wound, resulting in the wound continuing to deteriorate. 2. The facility failed to implement the physician's order to apply z-guard (a protective moisture barrier ointment) before soaking the right lower extremity wound in dakin's solution (a solution containing diluted bleach used topically in wound to reduce the risk of infection), resulting in pain and deterioration of the wound. 3. The facility failed to ensure the right lower extremity wound was assessed and measured weekly, as indicated in the Resident's plan of care, resulting in the facility not being aware the wound was increasing in size. 4. The facility failed to ensure its staff obtained a physician's order for coban (a self-adhesive compression wrap) prior to its application to the Resident's bilateral lower extremities, resulting in a new blister. Findings include: Resident #12 was admitted to the facility in May 2024 with diagnoses including diabetes, end stage renal disease, and traumatic right lower extremity wound. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/15/24, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS indicated Resident #12 required substantial/maximal assistance with lower body dressing and required the application of nonsurgical dressings. 1. On 12/18/24 at 8:38 A.M., the surveyor observed Resident #12 sitting on the side of his/her bed. Resident #12 said he/she has had a wound on his/her right lower leg since May 2024 that was very painful. Resident #12 said he/she was followed by a wound doctor at the wound clinic but hadn't been in a while and wasn't sure why. Resident #12 said he/she was concerned about the wound getting worse and being more painful, especially during dressing changes. Review of Resident #12's hospital discharge summary, dated 11/12/24, indicated: - Principal discharge diagnoses and Hospital problems: sepsis, leg cellulitis. - Discharge follow up appointment request: 5-7 Days, Wound care. Review of Resident #12's physician's order, dated 11/19/24, indicated: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	- Specialist visit, add consult, wound center, dated 11/19/24. Review of Resident #12's progress note from Nurse Practitioner #1, dated 12/11/24, indicated: - Wound worse iwht [sic] slough again. needs to fu (follow up) with wound center. Review of Resident #12's physician's order, dated 12/11/24, indicated: - Arrange wound center f/u (follow up) re (regarding) nonhealing RLE (right lower extremity) wound with recurrent slough + (and) dependent lymphedema. Review of Resident #12's physician's order, dated 12/16/24, indicated: - Needs f/u appt (appointment) @ (at) wound center secondary to wound decline since lymphedema present again. During an interview on 12/20/24 at 9:57 A.M., Nurse #6 said Resident #12 needed a wound clinic appointment because his/her right lower extremity wound was worsening with slough, pain, and swelling since he/she returned from the hospital, which was on 11/12/24. During an interview on 12/20/24 at 1:08 P.M., Nurse #3 said Resident #12 needed a wound clinic appointment because the right lower extremity wound had been worsening since he/she returned from the hospital on 11/12/24. Nurse #3 said she wasn't sure why he/she wasn't going to the wound clinic anymore. Nurse #3 said she had recently asked Resident #12 why he/she hadn't been going to the wound clinic, but the Resident wasn't sure either. Nurse #3 said the unit secretary usually makes the wound clinic appointments but had been on vacation for a week or two and they didn't schedule anyone to cover her position during her time off. Nurse #3 said it's really a mess up there on that unit and no one knows what's going on. During an interview on 12/20/24 at 10:23 A.M., Nurse Practitioner (NP) #1 said when Resident #12 came back from the hospital, he/she had a wound clinic appointment scheduled as ordered on the hospital discharge summary, but the family canceled it because of the thanksgiving holiday. NP #1 said that was why she wrote the order to make a wound clinic appointment on 11/19/24, because that was when she first realized it needed to be re-scheduled. NP #1 said she found out the appointment was never made on 12/11/24 and since the wound was worsening, she wrote another order for staff to arrange a wound clinic appointment. NP #1 said on 12/16/24 she wrote the third order to arrange the wound clinic appointment because there was still no appointment made, and the Resident really needed to be seen for the worsening right lower extremity wound. NP #1 said this Resident was very complex and had been followed by the wound clinic for this right lower extremity wound for a long time. NP #1 said the wound treatment needed to be changed because the wound was worsening, the current treatment was causing pain, and the current treatment not being tolerated by the Resident. NP #1 said she did not feel comfortable changing it herself because Resident #12 was so complex and really needed to be seen by the wound clinic for a new intervention. NP #1 said Resident #12 was signed onto hospice this week because of the right lower extremity wound, lymphedema, and pain from it. 2. Review of dakin's 0.5% solution manufacturers guidelines indicated the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	- For wound management, use as an irrigant (a liquid used to wash away debris), cleanser, or the wetting agent for a wet-to-moist dressing. Protect surrounding intact skin with a moisture barrier ointment or skin sealant as needed. Review of Resident #12's physician's order, dated 11/13/24, indicated: - Dakin's Solution 0.5%, once daily starting 11/13/24, Notes: Gently cleanse RLE (right lower extremity) cellulitis area with Normal saline. Pat dry. Apply z-guard (a moisture barrier ointment) to healthy skin around Cellulitis area. Then apply gauze moistened with half strength Dakins solution. Let soak for 20 minutes then remove and apply DPD (dry protective dressing) and wrap daily. On 12/19/224 at 11:25 A.M., the surveyor observed Nurse #6 perform a wound dressing change on Resident #12's right lower extremity with NP #1. After removing the soiled dressing, Nurse #6 cleansed the area with normal saline. Nurse #6 then applied gauze moistened with dakin's solution 0.5% to the wound without applying z-guard first. Resident #12 expressed pain during the twenty minutes that this dakin's solution was soaking on his/her wound. After the dakin's moistened gauze was removed, Nurse #6 applied z-guard to the reddened skin surrounding the wound followed by a dry protective dressing. During a follow-up interview on 12/19/24 at 12:03 P.M., Nurse #6 reviewed the physician's order with the surveyor and said she should have applied the z guard before applying the dakin's moistened gauze because dakin's solution can irritate healthy tissue and macerate the skin while it's soaking causing damage. Nurse #6 said Resident #12 does not usually tolerate the full 20 minutes of soaking because the pain caused by the dakin's. During an interview on 12/19/24 at 1:01 P.M., Nurse #5 said he frequently completes Resident #12's right lower extremity wound treatment. Nurse #5 said he applies z-guard after the soaking the wound with the dakin's moistened gauze. Nurse #5 reviewed the physician's order with the surveyor and said he should have applied the z-guard before the dakin's solution based on the specific wording of the physician's order. Nurse #5 said he was unaware that dakin's solution could damage healthy tissue. Nurse #5 said Resident #12 does not usually tolerate the full 20 minutes of soaking because the pain caused by soaking the wound in dakin's solution. Review of Resident #12's medication administration record (MAR), dated 11/20/24 to 12/19/24, indicated the order for Dakin's Solution 0.5%, once daily starting 11/13/24, Notes: Gently cleanse RLE cellulitis area with Normal saline. Pat dry. Apply z-guard to healthy skin around Cellulitis area. Then apply gauze moistened with half strength Dakins solution. Let soak for 20 minutes then remove and apply DPD and wrap daily was documented as: - Completed by Nurse #5 on 11/22/24, 11/25/24, 11/27/24, 11/30/24, 12/1/24, 12/2/24, 12/3/24, 12/6/24, 12/11/24, 12/12/24, 12/16/24, and 12/19/24 (12 times in last 30 days). During an interview on 12/19/24 at 1:15 P.M., Nurse #4 said she frequently completes Resident #12's right lower extremity wound treatment. Nurse #4 said she always applied z-guard after the soaking the wound with the dakin's moistened gauze, not before. Nurse #4 said she was unaware that dakin's solution could damage healthy tissue and thought the z-guard was put on after to protect the skin because it's red. Nurse #4 said Resident #12 does not usually tolerate the full 20 minutes of soaking because the pain caused by soaking the wound in dakin's solution. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #12's medication administration record (MAR), dated 11/20/24 to 12/19/24, indicated the order for Dakin's Solution 0.5%, once daily starting 11/13/24, Notes: Gently cleanse RLE cellulitis area with Normal saline. Pat dry. Apply z-guard to healthy skin around Cellulitis area. Then apply gauze moistened with half strength Dakins solution. Let soak for 20 minutes then remove and apply DPD and wrap daily was documented as: - Completed by Nurse #4 on 11/20/24, 11/21/24, 11/23/24, 11/24/24, 11/26/24, 12/4/24, 12/5/24, 12/7/24, 12/8/24, 12/10/24, and 12/13/24 (11 times in last 30 days). Based on nurse interviews and the review of Resident #12's medication administration record (MAR), dated 11/20/24 to 12/19/24, indicated that the healthy skin was not protected with z-guard prior to application of dakin's solution 23 times in the past 30 days. During an interview on 12/19/24 at 1:27 P.M., the Director of Nursing (DON) said dakin's is like pouring bleach into someone's wounds. The DON said its caustic and painful. The DON said z-guard should be applied as a barrier to the healthy tissue to protect it from the dakin's solution because dakin's solution could damage the healthy tissue. The DON said the treatment should have been performed in the order specified in the physician's order. The DON said applying dakin's solution without protecting the surrounding health skin with a barrier cream could cause the wound to enlarge and deteriorate. During an interview on 12/20/24 at 10:23 A.M., Nurse Practitioner (NP) #1 said Resident #12's wound was worsening over the past month with development of slough. NP #1 said dakin's solution may not be as effective if not applied for the full 20 minutes of soaking. NP #1 said the dakin's solution could damage surrounding tissue if not protected. NP #1 said based on the wound measurements from the dressing change completed on 12/19/24 the right lower extremity wound was larger, and this is another sign of the wound worsening. NP #1 said she was unaware the physician's order specified to apply dakin's soaked gauze after the application of z-guard, but since the order specified it should have been completed in the specified order. NP #1 said the z-guard should have been applied prior to soaking in dakin's moistened gauze. 3. Review of the facility policy titled 'Skin Integrity Program', dated January 2024, indicated: - If the guest/resident/patient is admitted with a wound the nurse will complete Wound Assessment in the electronic medical records on admission, weekly, and as needed. Documentation will include description of wounds (color drainage, odor, etc.) - Provider is notified by licensed nurse if the wound does not show improvement. Review of Resident #12's physician's order, dated 11/13/24, indicated: - Dakin's Solution 0.5%, once daily starting 11/13/24, Notes: Gently cleanse RLE cellulitis area with Normal saline. Pat dry. Apply z-guard (a moisture barrier ointment) to healthy skin around Cellulitis area. Then apply gauze moistened with half strength Dakins solution. Let soak for 20 minutes then remove and apply DPD (dry protective dressing) and wrap daily. Review of Resident #12's physician's orders failed to indicate any physician's orders to assess or measure his/her right lower extremity wound weekly. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #12's care plan, dated 11/24/24, indicated: - Weekly wound assessment and measurement. - My nurse will monitor my RLE (right lower extremity) wound for s/s (signs or symptoms) of worsening or improvement. Review of Resident #12's wound assessment, dated 11/21/24, indicated: - Wound location: Right Posterior Lowerleg [sic] - Length: 12 centimeters (cm) - Width: 10 cm - Wound bed description: Epithelialization, Granulation. Review of Resident #12's progress note from Nurse Practitioner #1, dated 12/11/24, indicated: - Wound worse iwht [sic] slough again. needs to fu (follow up) with wound center. Review of Resident #12's wound assessment, dated 12/19/24, indicated: - Wound location: Right Posterior Lowerleg [sic] - Length: 12.5 centimeters (cm) - Width: 11 cm - Wound bed description: Slough Review of Resident #12's medical record failed to indicate any wound assessments completed between the time of 11/21/24 wound assessment to 12/19/24 wound assessment. During a follow-up interview on 12/19/24 at 12:03 P.M., Nurse #6 said wounds should be assessed and measured during wound rounds by a nurse and Nurse Practitioner (NP) #1. Nurse #6 said if wound rounds were unable to be completed, then another staff nurse should measure and assess the wounds. Nurse #6 said nurses should always notify the physician/NP of any changes in wounds. Nurse #6 said the wound assessments should be documented in wound assessments or in a nurses note. Nurse #6 reviewed Resident #12's medical record and said there were no wound assessments or measurements since 11/21/24 but there should have been. Nurse #6 said the wound is now larger and is worsened with slough since the last assessment documented 11/21/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 12/20/24 at 10:23 A.M., Nurse Practitioner (NP) #1 said she has been unable to participate in the weekly wound rounds during the past month because of time constraints. NP #1 said it was her expectation that a nurse should assess and measure the wound weekly and notify her of any changes. NP #1 was unaware that the wound measurements from 12/19/24 were larger than the last documented wound assessment documented on 11/21/24 and said she would have expected to be notified if a wound was larger. During an interview on 12/19/24 at 1:27 P.M., the Director of Nursing (DON) said wounds should be measured and assessed weekly by the wound team and the results should be documented in the medical record. 4. Review of Resident #12's physician's order, dated 12/12/24, indicated: - Ace Wrap, Arrange Wound Clinic Center follow up Re (regarding)- non healing RLE (right lower extremity) wound with recurrent slough and dependent lymphedema, once daily. On 12/19/224 at 11:25 A.M., the surveyor observed Resident #12's left lower extremity with Nurse #6 and Nurse Practitioner (NP) #1. Resident #12's left lower extremity was wrapped in Kerlix (gauze), coban (a self-adhesive compression wrap), and then ace wrap (a fabric compression wrap). Nurse #6 and NP #1 said physician's orders are required for coban to be applied. Nurse #6 removed all dressings and wraps from Resident #12's left lower extremity and said there was a new large serous (clear fluid) filled blister that measured was 6.5 centimeters (cm) long and 3.5 cm wide. NP #1 said that blister had never been there before and was caused by the friction from the coban. During an interview on 12/19/24 at 1:01 P.M., Nurse #5 said coban requires a physician's order. Nurse #5 was unaware there was not an order for coban, and the nurses have been applying coban to his/her bilateral lower extremities for a long time. Nurse #5 said coban should never be applied under an ace wrap because they would double compress which can cause complications such as poor wound healing and blisters. Nurse #5 said he usually puts on just the coban instead of an ace wrap and wasn't sure why a nurse had applied the coban and ace wrap, but they shouldn't have. During an interview on 12/19/24 at 1:27 P.M., the Director of Nursing (DON) said coban required a physician's order and should not have been applied without one. The DON said coban was not an alternative to an ace wrap and never should have been used. During an interview on 12/20/24 at 10:23 A.M., Nurse Practitioner (NP) #1 said coban should never be used under an ace wrap. NP #1 said the double compression of the coban and ace wrap absolutely could have caused that new blister to form.

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	225767	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Brooksby Village	400 Brooksby Village Drive Peabody, MA 01960

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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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observations, interviews and record review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for four Residents (#30, #52, #1, and #12) out of a total of 18 sampled residents. Specifically: 1. For Resident #30 the facility failed to ensure that the Resident's air mattress was set to the correct setting to promote wound healing. 2. For Resident #52, the facility failed to ensure a stage 2 coccyx pressure ulcer was assessed and measured weekly, as indicated in the Resident's plan of care and failed to have a physician's order for an air mattress. 3. For Resident #1, the facility failed to ensure a Stage 2 pressure injury to the left buttock was assessed and measured weekly, as indicated in the Resident's plan of care. 4. For Resident #12, the facility failed to ensure a left heel pressure related deep tissue injury (DTI) was assessed and measured weekly, as indicated in the Resident's plan of care. Findings Include: Review of the facility policy titled 'Skin Integrity Program', dated January 2024, indicated the following: - Pressure reducing/relieving mattresses or cushions are used for guests/residents/patients identified at high risk or who have open wounds. - A care plan is developed to address cultural preferences & individualized approaches for the maintenance of skin integrity which will include addressing any nutritional needs, pressure reducing/relieving devices and actions to promote circulation/prevent pressure areas. - If the guest/resident/patient is admitted with a wound the nurse will complete Wound Assessment in the electronic medical records on admission, weekly, and as needed. Documentation will include description of wounds (color drainage, odor, etc.) - Provider is notified by licensed nurse if the wound does not show improvement. - When wound is healed, final nurses note is completed in medical record- the wound application is updated to reflect healed status and care/service plan is updated to reflect change. 1. Resident #30 was admitted to the facility in March 2022 with a diagnosis of Dementia. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #30 scored a 4 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated Resident #30 was at risk for developing pressure injuries, had a stage 4 pressure ulcer (Stage 4 pressure ulcers are defined as deep wounds that may impact muscle, tendons, ligaments, and bone), and a pressure reducing device on his/her bed. Review of Nurse Practitioner (NP) #1's most recent provider note, dated 11/27/24, indicated Resident #30 had a coccyx ulcer. Review of Resident #30's wound clinic documentation, dated 12/6/24, indicated the Resident had a wound on his/her coccyx and required a low air loss mattress on his/her bed. Review of Resident #30's most recent wound clinic documentation, dated 12/18/24, indicated the Resident had a Stage 4 pressure ulcer on his/her coccyx and recommended no changes to the Resident's orders. Review of Resident #30's holistic care plan, dated 10/28/24, indicated the Resident had a pressure ulcer on his/her coccyx with the following approach: - Low air mattress assure is working and set to 140 lbs. (pounds) every shift. Review of Resident #30's most recent weight reading, dated 12/21/24, indicated the Resident weighed 118.6 lbs. On 12/19/24 at 8:22 A.M., the surveyor observed the nurse exit Resident #30's room. During an interview and observation on 12/19/24 at 8:27 A.M., the surveyor observed Resident #30 lying in bed; the Resident's air mattress was set to 260 lbs. Resident #30 said that his/her bed was not comfortable. On 12/19/24 at 3:20 P.M., the surveyor observed Resident #30 in bed, his/her air mattress was set to 260 lbs. On 12/19/24 at 5:00 P.M., the surveyor observed Resident #30 in bed, his/her air mattress was set to 260 lbs. During an interview on 12/20/24 at 8:06 A.M., Certified Nursing Aide (CNA) #4 said Resident #30 had a wound, and that nurses are responsible for adjusting the air mattress settings. During an interview on 12/20/24 at 8:18 A.M., Nurse #3 said Resident #30 had an air mattress as an intervention for the wound on his/her coccyx. Nurse #3 said the air mattress should be checked every shift and that the air mattress should be set to the Resident's weight. Nurse #3 said that if the air mattress was not set to 140 lbs. that it would need to be adjusted to 140 lbs. Nurse #3 said that if the air mattress was set too high/was too firm that it would defeat the purpose of using an air mattress as it would provide the same pressure as a regular mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/20/24 at 9:52 A.M., the Director of Nursing (DON) said air mattresses should be set to the Residents weight, checked every shift, and adjusted if not at the correct weight setting. 45984 2. Resident was admitted to the facility in November 2024 with diagnoses that included cystitis, chronic atrial fibrillation and Parkinson's disease. Review of Resident #52's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident was unable to complete the Brief Interview for Mental status exam indicating severe cognitive impairment. Further review of Resident #52's MDS indicated that he/she was admitted to the facility with one stage 2 pressure injury and was dependent on staff for activities of daily living. During an observation on 12/18/24 at 9:38 A.M., Resident #52 was observed to be sleeping in his/her bed. There was an air mattress pump present and turned on and functioning. There was no setting for a resident's weight, there was a scale ranging from soft to firm, Resident #52's air mattress was set to the sixth indicator above the soft setting. During an observation on 12/23/24 at 8:33 A.M., Resident #52 was observed to be sleeping in his/her bed. There was an air mattress pump present and turned on and functioning. There was no setting for a resident's weight, there was a scale ranging from soft to firm, Resident #52's air mattress was set to the sixth indicator above the soft setting. Review of Resident #52's physician's order, dated 11/18/24, indicated the following: - Skin Assessment (by nursing), weekly skin check, one time weekly 7am - 3pm Further review of Resident #52's physician's orders failed to indicate an order for the use of an air mattress with settings or parameters. Review of Resident #52's skin care plan, dated 11/29/24, indicated the following: - Goal: My pressure injury will show evidence of healing. - Approaches: Dressing and treatments as ordered, weekly wound assessment and measurement. - Care Plan Approaches: Inspect my skin during personal hygiene and report redness or breaks in skin. Review of Resident #52's treatment administration record (TAR) for November and December 2024 indicated that the Resident had a skin assessment signed off by nursing on 11/18/24, 11/25/24, 12/2/24, 12/9/24 and 12/16/24. The TAR failed to indicate any description of Resident #52's pressure ulcer including wound measurements. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #52's nursing progress notes indicated the following: - Dated 11/18/24: Pressure ulcer on coccyx, no other open areas - Dated 11/20/24: Healing stage pressure ulcer - Dated 11/20/24: delivery of air mattress and extra-long bed Review of Resident #52's physician's progress note, dated 11/20/24, indicated the following: - assess for 0.5 cm round superficial granulated wound. Furthe review of Resident #52's physician's progress notes failed to indicate wound measurements or progression of the wound. Review of Resident #52's Wound Assessment, completed by Nurse Practitioner (NP) #1, dated 11/20/24 indicated the following: - Onset date: 11/18/24 - Wound type: pressure injury, Description: Stage 2 - Wound Edges, Margins and size: Length (cm) (centimeters) 0.5, Width (cm) 0.5, Depth (cm) 0.10 - Comment: Stage 2 pressure injury to coccyx measuring 0.5cm x 0.5cm x 0.1cm. Peri wound red/blanchable. No drainage. Further review of Resident #52's electronic medical record, physical record and care plan inside the resident's room failed to indicate that the stage 2 pressure injury was assessed or had documented measurements since the initial wound assessment on 11/20/24. During an interview on 12/20/24 at 12:49 P.M., Nurse Practitioner (NP) #1 said nurses are to document the wounds on the weekly skin assessment. NP #1 said she was conducting weekly wound rounds but had not been doing them in a few weeks because she can't always get to it and said the charge nurse left in November. NP #1 said if a wound was worse, she would enter a progress note in the medical record, however, the nurses will let the Director of Nursing (DON) know the details. NP #1 said nurses document details of the skin assessment in the medical record and said it should not be left blank with no information regarding skin. During an interview on 12/23/24 at 8:38 A.M., Nurse #5 said weekly skin assessments are done on Resident's shower days and the Certified Nursing Assessments (CNAs) do them and if they see something on a Resident's skin they would let nursing know. Nurse #5 continued to say that skin assessments should be documented in the nursing progress notes if any areas are identified. Nurse #5 said Resident #52 was admitted to the facility with a pressure injury on his/her coccyx. Nurse #5 said he would expect this area to be documented in weekly skin assessments since it was known upon his/her admission. Nurse #5 and the surveyor reviewed Resident #52's medical record and did not identify any weekly skin assessments. Nurse #5 further said Resident's need a physician's order for an air mattress, and it is set to the resident's weight. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/23/24 at 9:29 A.M., the DON said she would expect nursing to document any skin findings if they were identified in the TAR and it should get populated in the Resident's medical record. The DON said she was not sure why no skin documentation was present in Resident #52's medical record therefore it cannot be monitored. The DON further said Resident #52 should have a physician's order for an air mattress with parameters for what setting it should be set at. She continued to say an air mattress should be set to a resident's weight. The DON said wounds are discussed at morning meeting and during weekly risk meeting to track wounds. During an interview on 12/23/24 at 9:56 A.M., the Administrator said risk meetings are held weekly and said residents who have new wounds or are admitted with wounds are added to the high risk meeting to keep track of how the residents are progressing and said the clinical team will review the status each week. Review of the most recent weekly risk meeting notes relating to pressure ulcer injuries did not include Resident #52's stage 2 pressure ulcer to the coccyx. The facility provided an audit titled Review of Pressure Ulcer High Risk Rounds Audit indicating which residents were at risk for pressure ulcers in the facility. Resident #52 was not mentioned in the audit. 48671 3. Resident #1 was admitted to the facility in March 2024 with the following diagnoses including congestive heart failure and acute kidney failure Review of the most Minimum Data Set (MDS) assessment, dated 12/11/24, indicated that Resident #1 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, and required extensive assistance from staff for activities of daily living tasks. Further review of the MDS indicted Resident #1 had one Stage 2 pressure injury and was at risk for pressure areas requiring a pressure reducing device for chair, pressure reducing device for bed, pressure ulcer/injury care, application of non-surgical dressings and application of ointments/medications. Review of Resident #1's holistic care plan assessment for skin integrity, dated 12/3/24, indicated the following: -Desensitized to pain or pressure moisture associated skin damage excoriation. Interventions: -Encourage me to elevate my feet. -Apply Z-Guard (skin protecting cream) to the buttocks reddened area q (every) shift. -Assist the resident with repositioning and offloading buttocks. -Weekly wound assessment and measurement. -Inspect my skin during personal hygiene and report redness or breaks in skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor me for response to care and alter care delivery to improve tolerance. -Notify provider of any signs of infection. -Assess and treat incontinence. Approaches: -Apply Z-Guard cream to the buttocks reddened area q shift. -Offload resident while in bed and OOB (out of bed). -Optifoam (foam dressing used in wound care) to L (left) lower buttock, changed QOD (every other day) On 12/20/24 at 12:35 P.M., the surveyor observed Resident #1 sitting in a wheelchair in his/her room. The Resident's feet were not elevated. Review of the nursing clinical notes dated 11/26/24, indicated the following: The CNA (certified nursing assistant) providing care for the resident alerted this nurse about an open area on the residents lower left buttock. While assessing the resident I noted a stage 2 pressure injury and measured it at 0.7cm (centimeters) x 0.8cm. Resident was offloaded and Z-guard was applied to surrounding skin, optifoam applied to cover wound bed. HCP (health care proxy) updated via phone call. NP (nurse practitioner) updated via clipboard. No c/o (complaints of) pain or discomfort reported by resident while providing care. New orders: 1. Left lower buttocks pressure injury, NS (normal saline) wash, pay [sic] dry and apply optifoam QOD. 2. Offload resident left buttocks while in bed + OOB. Review of the Wound assessment dated [DATE], indicted: Left Buttocks, acquired since admission, Stage 2 pressure injury. Length (cm) 0.70, Width (cm) 0.80, Depth (cm) 0.00. Noted new pressure injury to lower left buttocks while doing evening care. Resident offloaded. optifoam applied to area pending further assessment. Need supervisor review- yes. Review of the Nurse Practitioner note, dated 11/27/24, indicated the following: -New buttock wound, small open blister. Assessment/Plan: Wound of right buttock, initial encounter. Cont. (continue) optifoam needs frequent incont. (incontinence) mgt (management) d/t (due to) diuresis and cog (cognitive) impairment/apathy/gen (general) deconditioning. Nsg (nursing) updated. Follow Up: 1 week. Review of the medical record indicated the nurse practitioner progress note was inconsistent with the documented Stage 2 left buttock wound. Review of the physician orders indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Skin Assessment one time weekly. Weekly skin check. Dated 3/9/24 -Elevate area if possible by shift. Offload left buttocks due to Stage 2 pressure injury while in bed + OOB. Dated 11/26/24 --Optifoam every two days. Left lower buttock pressure injury. NS wash, pat dry and apply optifoam every other day and as needed. Dated 11/26/24 Review of the clinical progress noted dated 12/11/24, indicated: -Resident triggered for a significant change upon further review and confirmed weight loss in addition to a new pressure area (Stage 2 on L buttocks). IDT (interdisciplinary team), NP and PCP (primary care physician) made aware. Review of the medical record failed to indicate weekly skin checks were being completed after Resident #1 developed a Stage 2 pressure injury to the left buttock identified on 11/26/24. The weekly skin assessment, dated 11/30/24, 12/7/24, 12/14/24, and 12/21/24 failed to indicate any documentation, assessments or measurements of the Stage 2 pressure injury. Review of the treatment administration record (TAR) for November and December 2024, indicated staff had checked off that the weekly skin assessment was completed on the date ordered by the physician, but failed to document the skin assessment information. The skin assessment, wound tool and clinical progress note failed in indicate any documented skin assessment data including observatios of the skin, wound measuring and status of the Stage 2 pressure injury. During an interview on 12/20/24 at 12:38 PM., Nurse #1 said Resident #1 had a Stage 2 pressure area to his/her buttock, and a physicians order for Z-Guard. Nurse #1 reviewed the medical record with the surveyor and said staff should be documenting the weekly skin assessments in the medical record and not just signing off that the assessment was done. Nurse #1 said the last documented skin assessment was in the wound tool assessment on 11/26/24, when the area was reported by the CNA and said a skin assessment of the Stage 2 wound should have been documented and completed weekly with measurements and a full skin assessment. Nurse #1 said no skin assessment or wound documentation has been completed since 11/26/24 and said physician orders should have been followed and documented. Nurse #1 said Residents with wounds are looked at during weekly wound rounds with the Nurse Practitioner but they haven't been doing wound rounds because the former unit manager left in November. During an interview on 12/20/24 at 12:49 P.M., Nurse Practitioner (NP) #1 said she has not seen Resident #1's wound in a few weeks and said she does not know the current status. The NP said nurses are to document the wounds on the weekly skin assessment and said Resident #1 is high risk for wounds because he/she is heavily incontinent and immobile. NP #1 said she was conducting weekly wound rounds but has not been doing them in a few weeks because she can't always get to it and said the charge nurse left in November. The NP said if a wound was worse, she would enter a progress note in the medical record, however, the nurses would let the DON know the details. NP #1 said nurses document details of the skin assessment in the medical record and said it should not be left blank with no information regarding skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/20/24 at 1:07 P.M., Nurse #7 said Resident #1 had a wound to left buttock that was healed and said she had not completed the dressing change yet. On 12/20/24 at 1:34 P.M., the surveyor observed Nurse #1 and Certified Nursing Assistant (CNA) #5 provide incontinence care to Resident #1. Resident #1's incontinence brief was removed, and the surveyor observed the following: -One closed left buttock wound with dried scabbed over skin that was white in the center, with surrounding outside areas of erythema (redness). -Resident #1's coccyx area had intact skin with localized erythema and darker pink tones across the coccyx and upper left and right buttocks. The skin was wrinkled with visible indentations from the incontinent brief. Surrounding skin to both buttocks had scattered areas of raised redness lines. Nurse #1 said the dime size area on the left buttock is where the stage 2 pressure area was and said the area in the middle looked closed but the wound has redness around it. Nurse #1 said the pressure area to the coccyx is red and needs to be offloaded and said the Resident scratches a lot and that is why he/she has redness across his/her bottom. Nurse #1 said she would expect to see the two skin issues on the weekly skin assessment and wound tracking tool. Review of the nursing clinical note dated 12/20/24, indicated: Skin to buttocks assessed today. Stage 2 to left lower buttock resolved. Dime size area red but blanchable. Optifoam order discontinued. Skin to coccyx noted to be red but blanchable. Z-Guard applied. Will continue to offload as ordered. Second nursing note indicated New Orders: Discontinue treatment to left lower buttock. Area resolved. Apply Z-Guard to bilateral buttocks and coccyx with AM and PM care as prn (as needed). During an interview on 12/23/24 at 9:18 A.M., the Director of Nurses (DON) said weekly skin assessments are signed off on the TAR (treatment administration record) or written in the clinical progress note and said she expects skin assessments to be documented as ordered and not just checked off as completed. The DON said Resident #1 should have documented measurements and descriptions of the area completed weekly. The DON said weekly wound rounds are completed by the nurse practitioner and the unit manager and are documented in the wound tool assessment. The DON said nurses will document the full skin assessment in the medical record if a new area is found and let the nurse practitioner know, and the resident would be added to weekly wound rounds. The DON said wounds are discussed at morning meeting and during weekly risk meeting to track wounds. During an interview on 12/23/24 at 9:56 A.M., the Administrator said risk meetings are held weekly and said residents who have new wounds or are admitted with wounds are added to the high risk meeting to keep track of how the residents are progressing and said the clinical team will review the status each week. Review of the most recent weekly risk meeting notes did not include Resident #1 and contained no information related to the Stage 2 pressure injury to the left buttocks. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/23/24 at 10:27 A.M., the Administrator said residents at risk with wounds should be identified and discussed and said she did not know that weekly wound rounds were not happening with NP #1 and said her expectation was that they would be happening weekly. The Administrator said Resident #1 should have been added to the weekly risk meeting when the new stage 2 pressure area developed on 11/26/24 and said she expects physician orders to be followed and documented. 48990 4. Resident #12 was admitted to the facility in May 2024 with diagnoses including diabetes, end stage renal disease, and traumatic right lower extremity wound. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/15/24, indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS indicated Resident #12 had one unstageable pressure injury related to deep tissue injury. Review of Resident #12's plan of care related to skin integrity, dated 11/19/24, indicated: - Unstageable DTI (deep tissue injury) L (left) heel. To be offloaded while in bed AAT (at all times). 0.5 cm (centimeters) x 1 cm. - Weekly wound assessment and measurement. Notify provider of any signs of infection. Review of Resident #12's physician's order, initiated 11/15/25, indicated: - Monitor L (left) heel DTI (deep tissue injury) until resolved, each shift. Review of Resident #12's medication administration record (MAR), dated 11/15/24 to 12/19/24, indicated the physician's order to Monitor L (left) heel DTI (deep tissue injury) until resolved was documented as implemented each shift but failed to include any description, assessment, or measurements of the wound. Review of Resident #12's wound assessment, dated 11/26/24, indicated: - Wound location: Left Posterior Heel - Onset Date: 11/15/24 - Wound Type: Pressure Injury - Description: Suspected Deep Tissue Injury - Length: 0.50 cm - Width: 1.00 cm Review of Resident #12's wound assessment, dated 12/19/24, indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Wound location: Left Posterior Heel - Onset Date: 11/15/24 - Wound Type: Pressure Injury - Description: Suspected Deep Tissue Injury - Length: 0.50 cm - Width: 0.50 cm Review of Resident #12's medical record failed to indicate any wound assessments completed between the time of 11/21/24 wound assessment to 12/19/24 wound assessment. Further review of Resident #12's medical record, including the wound application, nurses notes, and care plan, failed to indicate the left heel pressure injury had healed during that time frame. On 12/19/224 at 11:25 A.M., the surveyor observed Resident #12's left heel with Nurse #6 and Nurse Practitioner (NP) #1. Resident #12's left lower extremity was wrapped in kerlix (gauze), coban (a self-adhesive compression wrap), and then ace wrap (a fabric compression wrap). Before removing any dressings on the left heel, Nurse #6 and NP #1 said there were no wounds on Resident #12's left heel and they have not been monitoring, measuring, or assessing any wounds on the left heel. After removing all wraps, Nurse #6 and NP #1 said there was an unstageable pressure ulcer measuring 0.5 cm by 0.5 cm, but they had not been assessing or measuring it because it was stable eschar. During a follow-up interview on 12/19/24 at 12:03 P.M., Nurse #6 said all pressure wounds, including unstageable pressure ulcers and suspected deep tissue injuries, should be assessed and measured during wound rounds by a nurse and Nurse Practitioner (NP) #1. Nurse #6 said any nurse can measure and assess the wounds if for some reason the wound rounds are unable to be completed, and if this occurs the nurse should notify the physician/NP of any changes. Nurse #6 said the wound assessments should be documented in under wound assessments or in a nurses note. Nurse #6 reviewed Resident #12's medical record and said there were no wound assessments or measurements of the left heel pressure ulcer since 11/26/24 but there should have been because it never resolved. During an interview on 12/20/24 at 10:23 A.M., NP #1 said she has been unable to participate in the weekly wound rounds during the past month because of time constraints. NP #1 said it was her expectation that a nurse should assess and measure all wounds weekly and notify her of any changes. During an interview on 12/19/24 at 1:27 P.M., the Director of Nursing (DON) said wounds should be measured and assessed weekly by the wound team and the results should be documented in the medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation, record review, and interview, the facility failed to ensure an environment free from accidents and hazards, for two Residents (#31 and #32) out of a total sample of 18 Residents. Specifically: 1. For Resident #31, the facility failed to ensure that the Resident had a urinal within reach per the Resident's care plan after the Resident had fallen and sustained a wrist fracture attempting to self-toilet in his/her bathroom. 2. For Resident #32, the facility failed to ensure that the Resident had non-skid strips and a fall mat next to the bed as ordered by the physician and as stated in the plan of care. Findings Include: Review of the facility policy titled Fall Management, dated April 2023, indicated the following: - To minimize and/or decrease the risk of falls through an interdisciplinary of guest/resident and to develop individualized care/service plan approaches. - Each guest/resident's will be assessed using the Holistic Assessment for potential risk for falls on admission, re-admission, significant change of condition and post falls. - Care/Service Plan will be developed using individualized approaches identified during assessment process. - If a fall occurs the following steps will be taken: - Review care/service plan for appropriateness of approaches and/or modify/add approaches if necessary. - Nurse will review new approaches with designated Care Associate - DON and/or designee will review 24 hour report and audit falls documentation to ensure it is complete and accurate, to include completion of investigative protocols, review of care plan and updating of Holistic Assessment 1. Resident #31 was admitted to the facility in November 2018 with a diagnosis of Alzheimer's Disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #31 scored a 0 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated Resident #31 needed some help with ambulation. (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 Resident #31's fall incident report, dated 10/3/24, indicated that at 6:50 A.M. a Certified Nursing Aide (CNA) had found that Resident #31 had gotten him/herself back into bed after falling. The incident report indicated that the Resident said he/she had fallen on his/her way back from the bathroom. Further review of the incident report indicated the Resident had sustained a laceration to the right temporal and occipital areas of his/her head and swelling to his/her left wrist; the Resident was sent to the emergency department for further evaluation. Review of the incident report indicated the Resident had returned to the facility with a discharge diagnosis of a left wrist fracture. Review of Resident #31's falls care plan, dated 10/11/24, indicated the following interventions: - Keep urinal next to bed. - Keep urinal within reach of bed. On 12/19/24 at 8:02 A.M., the surveyor observed Resident #31 in his/her room in bed, there was no urinal within reach of the Resident's bed. On 12/20/24 at 8:11 A.M., the surveyor entered Resident #31's room, the surveyor observed Resident #31 self-ambulating back to bed from the bathroom; Resident #31 said I just got up to take a piss. The surveyor observed that there was no urinal in the room or within reach of the Resident's bed. During an interview on 12/20/24 at 9:19 A.M., CNA #5 said Resident #31 had fallen in October attempting to self-toilet, and that the Resident often attempts to self-toilet in his/her room by walking to the bathroom. During an interview and observation on 12/20/24 at 8:18 A.M., Nurse #3 said Resident #31 was at risk for falling and that she would expect a urinal to be kept at bedside per the Resident's care plan. The nurse and surveyor observed Resident #31 in his/her room, Nurse #3 said that she could not find the urinal and that she would have to go get one. Nurse #3 said that if the Resident refused his/her urinal she would expect that to be documented. Review of Resident #31's medical record failed to indicate the Resident had refused to keep a urinal in his/her room. During an interview on 12/20/24 at 9:52 A.M., the Director of Nursing (DON) said she would expect interventions in place to prevent falls to be implemented. 45984 2. Resident #32 was admitted to the facility in April 2024 with diagnoses including atrial fibrillation, muscle weakness, repeated falls and unspecified abnormalities of gait and mobility. Review of Resident #32's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 10 out of a possible 15 indicating he/she has moderate cognitive impairment. Further review of Resident #32's MDS indicated that the Resident required partial/moderate assist with activities of daily living and has no history of refusing care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor requested all of Resident #32's incident reports relating to falls since being admitted to the facility. Review of Resident #32's incident reports indicated that the Resident has had 10 falls in the facility since being admitted in April 2024. Review of Resident #32's fall incident report, dated 5/23/24, indicated the following: - Detail event type: fall, lowered to the floor. - Event description and presence of injury: Aids went into room to weigh resident and he/she attempted to get up and slid OOB (out of bed). Aid intercepted fall and lowered resident to floor. - Steps taken to Prevent Recurrence (Actions): Non-skid strips placed on floor next to bed to prevent sliding The surveyor made the following observations: - On 12/18/24 at 9:56 A.M., 12/19/24 at 8:58 A.M., and 12/20/24 at 8:31 A.M., Resident #32 was observed laying in his/her bed in his/her room unsupervised. There was no fall mat on either side of the resident's bed nor were there any non-skid strips on either side of Resident #32's bed. Review of Resident #32's Falls Care plan in the electronic medical record with an assessment date of 10/22/24 indicated the following: - These devices will assist me: Fall mat - side - Care Plan Approach(es): - non-skid strips placed on floor next to bed to prevent sliding Review of Resident #32's physician's orders failed to indicate an order for a fall mat or non-skid strips at the bed side. Review of Resident #32's care plan in a binder hanging on the wall beside the door upon entering his/her room with an assessment date of 10/22/24 indicated the following: - These devices will assist me: Fall mat - side - Care Plan Approach(es): - non-skid strips placed on floor next to bed to prevent sliding During an interview on 12/20/24 at 8:31 A.M., Certified Nursing Assistant (CNA) #3 said he does not remember if Resident #32 has had any falls since being in the facility. CNA #3 said he looks at the binders upon entering each residents' room to know what level of care they need or he will ask nursing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/24 at 8:35 A.M., CNA #2 said she will check the care plans for what type of care each resident needs or she will ask nursing. CNA #3 said she remembers Resident #32 having some falls in the past. During an interview on 12/20/24 at 8:51 A.M., Nurse #7 said when a resident has a fall their interventions and care plans will get updated and they will be implemented. She continued to say she was not sure if the binder upon walking into Resident #32's room is accurate. Nurse #7 said Resident #32 has had some falls since his/her admission into the facility, he/she tried to get up when he/she should not. Nurse #7 and the surveyor reviewed Resident #32's care plans and Nurse #7 said the Resident should have a fall mat and non-skid strips at his/her bedside while in his/her bed. During an interview on 12/20/24 at 9:10 A.M., the Director of Nursing (DON) said when a resident has a fall the nurse will complete a post-fall assessment and complete an incident report which includes new interventions and updates to the resident's care plan. The DON then said the post-fall assessment gets signed off by nursing and then reviewed by the supervisor who signs it and then it gets sent to the DON for review who will sign it and finally sends it to the Administrator for final review. The DON continued to say everything in Resident #32's falls care plan is up to date. During the interview, the Assistant DON (ADON) called the DON on the telephone, the DON asked the ADON if the facility uses non-skid strips because resident rooms have carpet and the ADON said the facility does use them.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48990 Based on observations, interviews, and record review, the facility failed to provide respiratory care services in accordance with professional standards of practice for one Resident (#310), out of a total sample of 18 residents. Specifically, the facility failed to obtain a physician's order for the use of a Continuous Positive Airway Pressure (CPAP) machine (a machine used to treat sleep apnea) for Resident #310 who had a diagnosis of sleep apnea. Findings include: Review of the facility policy titled 'Respiratory Equipment', dated January 2024, failed to indicate policy regarding physician's orders necessary for CPAP use. Resident #310 was admitted to the facility in December 2024 with diagnoses including obstructive sleep apnea and diabetes. There was no Minimum Data Set (MDS) assessment available for Resident #310 at the time of survey. Review of Resident #310's nursing progress note, dated 12/10/24, indicated: - Resident is resting; CPAP on and safety maintained. Review of Resident #310's physician progress note, dated 12/11/24, indicated: - He/she has been using CPAP every night. Review of Resident #310's care plan related to Respiratory and Cardiac, dated 12/11/24, indicated: - I will need assistance to put on CPAP/BiPAP. Review of Resident #310's active physician's orders failed to indicate any orders for CPAP. On 12/18/24 at 12:04 P.M., the surveyor observed Resident #310 in bed. Resident #310 said he/she had just finished napping. Resident #310 said he/she likes to use his/her CPAP during daytime naps but had not been able to use it during this nap because there was no water in the CPAP chamber. Resident #310 said staff sometimes assists with setting up the CPAP when he/she uses it at bedtime, but sometimes they don't and then he/she cannot wear it. There was a CPAP on Resident #310's bedside table with tubing attached and in a bag, dated 12/10/24. On 12/19/24 at 7:06 A.M., the surveyor observed Resident #310 asleep in bed not wearing CPAP, which was located on the bedside table with tubing attached and in a bag, dated 12/10/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 11:02 A.M., Nurse #5 said any resident who uses a CPAP should have a physician order stating its use and specific care or settings required. Nurse #5 said he knew Resident #310's CPAP was brought in shortly after his/her admission on 12/10/24 and had been using it at night. Nurse #5 said the nurses should have checked to make sure physician's orders were in place but it must have been missed. During an interview on 11:03 A.M., Resident #310 told Nurse #5 and the surveyor that his/her daughter brought it in shortly after he/she arrived on 12/10/24. Nurse #5 visualized the CPAP tubing in the bag, dated 12/10/24, and said that type of bag was provided by the facility so staff must have known the CPAP was here when it was placed in the bag and dated 12/10/24. During an interview on 12/19/24 at 11:19 A.M., Nurse #4 said the CPAP orders should have been put in when it arrived but it must have been missed. Nurse #4 said if the nurse saw it on the bedside they should have checked the order and obtained one if there was not one. During an interview on 12/19/24 at 1:58 P.M., the Director of Nursing (DON) said physician's orders for CPAP use should have been put in place before Resident #310 used the CPAP, or at minimum within 24 hours.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48990 Based on interviews, record review, staff education review, and facility assessment review, the facility failed to ensure the nursing staff were trained and demonstrated the competencies and skill sets necessary to provide the level and types of care and services needed as outlined in the Facility Assessment. Specifically, the facility failed to ensure licensed nursing staff were trained and demonstrated competency related to wound care. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Review of the Facility Assessment Tool, dated 11/21/24, included but was not limited to the following: - Services and Care Offered: Integumentary System: Skin ulcers, Injuries. - Services and Care We Offer Based on our Resident's Needs: Skin integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). The facility assessment failed to indicate what specific nurse competencies are required to provide services and care that the facility offered. Review of facility policy titled 'Health Services Education and Training', dated April 2023, indicated: - Supervisors/managers will complete competency reviews to validate employee knowledge and ability to completed tasks. Review of facility document titled 'Nursing Orientation Knowledge and Skill Checklist', undated, indicated the following items should be included during orientation: - Performs dressing changes according to policy and procedure, using good infection control techniques. Throughout the recertification survey (12/18/24 through 12/20/24 and 12/23/24) the surveyors identified multiple concerns regarding wound care including: - failure to assess and measure wounds weekly. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- failure to implement enhanced barrier precautions during wound care. - failure to implement pressure ulcer prevention interventions. - failure to implement wound treatments following physician's orders. - failure to notify provider of new wounds or changes in wounds. - failure to complete weekly skin checks. The surveyor reviewed staff education files for wound competencies for 10 licensed nurses who were responsible for wound care in the facility: - 7 out of 10 failed to have wound competencies completed since date of hire. During an interview on 12/23/24 at 9:19 A.M., the Director of Nursing (DON) said the staff development nurse should be responsible for staff competencies and training, but the role is currently vacant, and she is currently covering the position. The DON said all nurses in the building are responsible for wound care. The DON said upon hire every nurse is required to demonstrate wound competency on a Competency checklist titled 'Dressing Change Competency Checklist' which is in addition to the 'Nursing Orientation Knowledge and Skill Checklist'. The DON was unaware that 7 of the 10 nurses did not have record of wound competency being demonstrated but should have. During a follow-up electronic correspondence on 12/24/24 at 1:49 P.M, the Administrator said her expectation would be that nurses have clinical competencies, including wound competencies, completed upon hire.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 48990 Based on Facility Assessment review and staff interview, the facility failed to identify resources based on the resident population to determine the necessary care, support services, and educational resources (in-servicing) needed to care for residents. Specifically, the facility failed to address education resources and include a competency-based approach, including competencies necessary upon orientation and/or annually, to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. Findings include: Review of the Facility Assessment Tool, dated 11/21/24, failed to indicate specific nurse competencies required to provide any of the services and care the facility offered. Review of facility policy titled 'Health Services Education and Training', dated April 2023, indicated: - Supervisors/managers will complete competency reviews to validate employee knowledge and ability to completed tasks. During an interview on 12/23/19 at 9:19 A.M., the Director of Nursing (DON) was unaware that the facility assessment should include nursing competencies required to ensure staff is able to provide competent care/services the facility provides. The DON said the staff development nurse should be responsible for staff competencies and training, but the role is currently vacant, and she is currently covering the position. The DON was unaware of all competencies staff are required to be completed upon hire and was unable to locate a list of specific demonstrated competencies required by all staff during the survey. During an interview on 12/23/24 at 10:44 A.M., the Administrator was unaware that the facility assessment should include nursing competencies required to ensure staff is able to provide competent care/services the facility. The Administrator said all competencies are guided by the home office but was unable to locate a list of specific demonstrated competencies required by all staff during the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48990 Based on observation, interviews, and policy review, the facility failed to ensure transmission-based precautions were followed to prevent the spread of infections. Specifically, the facility failed to ensure staff appropriately donned (put on) a precaution gown while performing wound care for a Resident on enhanced barrier precautions (EBP). Findings include: Review of the facility policy titled 'Enhanced Barrier Precautions Standard Operating Procedure, dated June 2023, indicated: - Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (personal protective equipment) (e.g., gown and gloves): For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. Review of sign titled Enhanced Barrier Precautions, which is posted at the room entrance door for residents on enhanced barrier precautions, indicated, but was not limited to: - Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities: wound care: any skin opening requiring a dressing. On 12/19/224 at 11:25 A.M., the surveyor observed Nurse #6 and Nurse Practitioner (NP) #1 perform a wound dressing change and wound care for a Resident with a chronic traumatic wound, which had a large amount of drainage, and an unstageable pressure ulcer. There was a sign posted at this Resident's doorway which indicated Enhanced Barrier Precautions. Nurse #6 and NP #1 did not don a precaution gown and wore only gloves during the wound dressing change. During a follow-up interview on 12/19/24 at 12:03 P.M., Nurse #6 said the Resident was on enhanced barrier precautions and she should have worn a gown during wound care but did not. During an interview on 12/19/24 at 1:27 P.M., the Director of Nursing (DON) said enhanced barrier precautions are required for wound care and dressing changes for wounds with drainage and/or are chronic. The DON said a precaution gown should have been worn during wound care for any resident with a sign on the doorway indicating they required enhanced barrier precautions.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Brooksby Village	400 Brooksby Village Drive Peabody, MA 01960

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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 48990 Based on review of the Facility Assessment, employee education record review, and interviews, the facility failed to implement mandatory training on Quality Assurance and Performance Improvement (QAPI) for 15 employees. Findings include: Review of the Facility Assessment, dated 11/1/24, failed to indicate mandatory QAPI training. Review of 15 employee education files for 5 certified nurse assistants (CNAs) and 10 licensed nurses indicated: - 0 out of 15 direct care employees had documentation they had completed QAPI training during their employment. During an interview on 12/23/24 at 9:03 A.M., the Administrator said the facility does not provide any QAPI training to employees.