STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225208	A. Building B. Wing	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106 Based on observation, record review, and staff interview, the facility failed to provide services to maintain resident dignity and promote the highest quality of life for four Residents (#13, #59, #37, and #31), out of a total sample of 33 residents. Specifically, the facility failed to: 1. Provide daily grooming of facial hair for Resident #13; 2. Provide daily grooming of facial hair and provide services to obtain a haircut for Resident #59; 3. Provide Prevalon boots that are clean and not badly worn for Resident #37; and 4. Ensure proper footwear was provided for Resident #31. Findings include: 1. Resident #13 was admitted to the facility in December 2020 with diagnoses of coronary heart disease and heart failure. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 3/16/21, indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating that the Resident was cognitively intact. The Resident received scheduled anticoagulant (blood thinning) medication daily. During an interview on 6/9/21 at 11:30 A.M., Resident #13 said his/her electric razor broke about two weeks ago and he/she has the money to purchase a new one, but the staff will not assist him/her. Resident #13 said he/she only has one family member who has dementia, so they can't help. Resident #13 said he/she takes Coumadin (blood thinner) and really needs a new electric razor because the staff will not shave him/her with a regular razor. The surveyor observed Resident #13 to have significant facial hair growth. During an interview on 6/11/21 at 8:39 A.M., Business Office staff #1 said yesterday she was informed by social services that Resident #13 was requesting his/her personal funds to purchase a razor and had sufficient funds to purchase an electric razor. (continued on next page)

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 6/11/21 at 12:35 P.M., Unit Manager #2 said she was not aware Resident #13's electric razor was broken. The surveyor and Unit Manager #2 then interviewed Resident #13. Resident #13 said he/she has not had a shave in over a week and he/she has asked multiple staff for assistance in purchasing a new electric razor. Resident #13 said, I just want a shave. During an interview on 6/11/21 at 12:40 P.M., Certified Nursing Assistant (CNA) #8 said she can't shave Resident #13 because he/she is on Coumadin. CNA #8 said she was aware Resident #13 wanted to purchase a new electric razor and had not had a shave in a while, but she did not tell Unit Manager #2. During an interview on 6/11/21 at 1:27 P.M., Social Worker #1 said a note was placed under her door approximately two weeks ago by the Occupational Therapist informing her that Resident #13 needed a shave and was requesting help purchasing a new electric razor. Social Worker #1 called Resident #13's listed responsible party in the medical record and the family member questioned if Resident #13 really needed a new razor and would call back with an answer, but never called back. Social Worker #1 said Resident #13 was his/her own person, but she called the family member to check. Social Worker #1 added, the Activities Director was supposed to order an electric razor for Resident #13, but she never did. During an interview on 6/15/21 at 2:07 P.M., Unit Manager #2 said Resident #13 is his/her own person and could make decisions on purchasing an electric razor. 2. Resident #59 was admitted to the facility in November 2020 with a diagnosis of coronary artery disease. Review of the most recent MDS assessment, dated 3/16/21, indicated that Resident #59 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating that the Resident was cognitively intact. During an interview on 6/11/21 at 12:15 P.M., Resident #59 said he/she is past needing a shave because the beard is too long and he/she needs a haircut, but he/she doesn't have any money. The surveyor observed Resident #59 lying in bed with long, disheveled hair and a full over grown beard. During an interview on 6/11/21 at 2:45 P.M., Unit Manager #2 said Resident #59 is his/her own person and will let you know if he/she wants a shave or haircut. Unit Manager #2 and the surveyor interviewed Resident #59. Resident #59 said he/she used to get shaved and maintained a goatee when he/she first came to the facility, but they stopped shaving him/her and now has a full beard. Resident #59 said he/she usually maintains a buzz cut hair style, but has been unable to get his hair cut at the facility. Resident #59 said the Occupational Therapist (OT) just made an appointment to get his/her hair cut next week, but he/she does not have any money. Resident #59 said he he/she would be happy if the staff just gave him/her a buzz cut. During an interview on 6/11/21 at 12:55 P.M., Certified Nursing Assistant (CNA) #6 said he used to shave Resident #59 when he was on the morning shift and is not sure why he/she is not getting shaved now. CNA #6 said the previous Director of Nurses (DON) would not let the staff cut resident's hair and there was no hairdresser for a long time. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/21 at 1:33 P.M., the Activity Director said we have not had a hairdresser in the building for a long time, but one is starting next week. 15218 3. Resident #37 was admitted to the facility in May 2013 with diagnoses that included high blood pressure and advanced dementia. Review of Resident #37's Minimum Data Set (MDS), dated [DATE], indicated the Resident had significant short and long term memory loss, and required extensive assistance by two staff in all aspects of care. Resident #37's current physician orders included bilateral Prevalon boots to be worn at all times. (Prevalon boots are used to protect the heels. They offer continuous pressure relief of the resident's heels. The blue Prevalon boots are designed out of soft, stuffed material and are strapped onto the heel and foot). On 6/9/21 from 11:38 A.M. until 12:45 P.M., the surveyor observed Resident #37 sitting in a chair, in a reclined position and placed in the hallway. Resident #37 was wearing bilateral Prevalon boots. The surveyor observed that both boots had stuffing coming out, many holes in each boot and the boots were soiled. During the observation, a staff person was assisting the Resident to eat in the hallway. There was no interactions between the staff and the Resident, and staff did not notice the stuffing coming out of the Prevalon boots. On 6/10/21 at 10:17 A.M., the surveyor observed Resident #37 wearing the bilateral Prevalon boots. Resident #37 was reclined in a chair in the hallway. The Prevalon boots were dirty and stuffing was popping out of multiple holes of both boots. Each boot had four to five holes. On 6/11/21 at 9:20 A.M., the surveyor observed Resident #37 seated in a chair in the hallway. The Resident was wearing the Prevalon boots, and the stuffing was popping out of all the holes. The boots remained soiled. During an interview on 6/15/21 at 12:20 P.M., CNA #1 said the boots were put on the Resident when he/she got out of bed. The surveyor inquired about the care and condition of the boots and CNA #1 shrugged her shoulders. On 6/15/21 from 1:45 P.M. through 3:30 P.M., the surveyor observed Resident #37 in the day room on Unit C. Resident #37 was reclined in a chair sleeping with the Prevalon boots on. Both boots were dirty and the stuffing was popping out of the holes. A staff member was observed sitting in the room and there was no interaction with the Resident and she did not notice the soiled and worn boots. 4. Resident #31 was admitted to the facility in April 2021 with diagnoses that included dementia, failure to thrive and a history of falls. Review of Resident #31's Minimum Data Set (MDS), dated [DATE], indicated the Resident had significant short and long term memory loss, was inattentive in his/her thoughts and required physical assistance of staff in all aspects of care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/21 between 9:30 A.M. and 1:20 P.M., 6/10/21 between 10:30 A.M. and 4:00 P.M. and on 6/11/21 between 8:00 A.M. and 10:30 A.M., the surveyor observed Resident #31 with no shoes on or wearing any type of footwear. Resident #31 was barefoot and wandered up and down the hallways, into rooms, the dining room, and bathrooms. Review of the medical record failed to identify that Resident #31 chose not to wear any type of footwear or that he/she refused to wear footwear and wanted to be barefoot. During an interview on 6/11/21 at 9:00 A.M., CNA #2 said she did not know if the Resident had any shoes. On 6/11/21 at 10:30 A.M., Unit Manager (UM) #1 was heard on the phone talking about Resident #31's lack of footwear. Following the telephone call, the surveyor asked UM #1 if the Resident had shoes. UM #1 did not answer the question, but said the Resident did not like wearing them. The surveyor asked if she could locate the documentation in the Resident's record. UM #1 said, No. UM #1 did not clarify if Resident #31 did not have shoes, did not like to wear shoes, refused to wear shoes, or that he/she was exercising his/her right to not wear shoes. Review of the medical record indicated UM #1 had called Resident #31's invoked Health Care agent on 6/1/21. The progress note indicated she informed the Health Care agent the Resident refused to wear shoes, slipper socks or shoes. The progress note indicated the Health Care agent said the Resident would wear socks around the house. There was no additional information indicating the Resident choice was to never wear footwear. On 6/15/21, 6/16/21, 6/17/21 and 6/24/21, the surveyor observed Resident #31 between the hours of 7:00 A.M. and 3:30 P.M. and at no time was the Resident wearing any type of footwear and was barefoot. Staff were not observed attempting to put footwear on the Resident and the medical record lacked evidence that Resident #31 refused to wear anything on his/her feet or that he/she had shoes, slippers or non-skid socks offered (as none could be located in the Resident's room).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106 Based on observations and resident and staff interviews, the facility failed to store the personal belongings of all residents who resided on Unit A and were moved to Unit B during facility construction in a clean, safe and dignified manner and failed to allow residents to retain their personal belongs during construction for two Residents (#55,#23) out of a total sample size of 33 residents. Specifically, the facility failed to allow the following residents access to their personal property during construction: 1. Resident #55 his/her computer, radio and working television; and 2. Resident #23 to his/her personal clock. Findings include: During an interview on 6/17/21 at 3:35 P.M., the Administrator said all residents on Unit A were moved to Unit B on 6/1/21 as part of the facility renovation plan. 1. Resident #55 was admitted to the facility in February 2021 with diagnoses including acute and chronic heart failure, anxiety and depressive disorder. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 5/25/21, indicated that Resident #55 had a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating the Resident was cognitively intact. The MDS also indicated Resident #55 required assist of two people for bed mobility and transfers. During an interview on 6/9/21 at 9:25 A.M., Resident #55 said they never get him out of bed and he has nothing from his old room. Resident #55 said he lies in bed all day waiting for something to happen. During an interview on 6/16/21 at 1:35 P.M., Resident #55 told the surveyor and MDS Nurse since moving over to Unit B, approximately three weeks ago, he/she lies in bed everyday with nothing to do. Resident #55 pointed to the television on the far left wall (across from the second bed) and said it doesn't work and if it did, I could not see or hear it. MDS Nurse asked Resident #55 what he/she would like from his old room and Resident #55 said for starters, I would like my computer, my radio and the television that works. 10249 2. Resident #23 was admitted to the facility in June 2017 with a diagnosis of cerebral palsy. Review of the annual Minimum Data Set (MDS), dated [DATE], indicated that the Resident identified that it is very important how you take care of your personal belongings or things. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's quarterly MDS, dated [DATE], indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating that the Resident was cognitively intact. The MDS also indicated that the Resident was totally dependant for all activities of daily living. During an interview on 6/15/21 at 10:42 A.M., Resident #23 said when he/she was transferred to a new room on Unit B, due to facility renovation on 6/1/21, his/her clock was not brought to the new room with other personal possessions. The Resident said that he/she has been asking staff for the clock, but getting no response. The Resident finds it difficult to know what time it is and does rely on the clock daily. During an interview on 6/16/21 at 10:00 A.M., the MDS nurse said that she would refer the information to the maintenance department. Refer to F 675

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41065 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations of resident needs and preferences for two Residents (#44 and #13) out of a total sample of 33 residents by: 1) Failing to accommodate weekly and biweekly showers related to water temperatures and; 2) Failing to assist a resident in purchasing an electric razor in a timely manner for daily shaving needs. Findings include: 1. Resident #44 was admitted to the facility in May 2017 with diagnoses that included adult failure to thrive and frequent falls. Review of the Resident's care plan for daily care/Activities of daily living (ADLs), with an revision date of 11/20/20 indicated the following: - Goal: to perform self care activities within limitations and to show no decline in current ADL status through the next review date (8/16/21). - Interventions: a) Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. b) Required extensive assistance, one staff assistance with bathing/showering. Review of the Nursing Assistant's daily assignment sheets indicated that Resident #44 was scheduled to have showers two times per week on Monday evenings (3:00 P.M.-11:00 P.M) and Thursday mornings (7:00 A.M.-3:00 P.M.). During an interview on 6/14/21 at 12:38 P.M., Resident #44 said he/she likes to have showers twice per week but last Thursday (6/10/21) he/she did not receive one. The Resident told the surveyor the water was too cold to take the shower and was hoping to have his/her second shower today. During a subsequent interview on 6/15/21 at 10:46 A.M., Resident #44 told the surveyor she never received his/her Monday shower (6/14/21). The Resident said the staff told her the water was not warm enough to take a shower and could only provide a bed bath. The Resident said, I would have loved my shower last night, even more so because I never received one last week. On 6/15/21 at 11:00 A.M., the surveyor checked the water temperature for 1 out of 2 shower rooms located on Unit B. The surveyor allowed the water to run for greater than two minutes and the thermometer registered 90.1 degrees Fahrenheit and felt lukewarm to the touch. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/15/21 at 11:00 A.M., a second surveyor simultaneously checked the water temperature in the bathroom of room [ROOM NUMBER] on Unit B. The room was located on the far end of the hallway, away from the shower room. The surveyor allowed the water to run for greater than two minutes and the thermometer registered 97 degrees Fahrenheit and felt lukewarm to the touch. During an interview on 6/15/21 at 11:34 A.M., Unit Manager #2 said Resident #44 did not receive her shower last evening because there was an issue with the water temperatures. She further said maintenance was trying to fix the problem but it has taken a long time to fix. 41106 2. Resident #13 was admitted to the facility in December 2020 with diagnoses of coronary heart disease and heart failure. Review of the quarterly MDS assessment, dated 3/16/21, indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that the Resident was cognitively intact. The Resident received scheduled anticoagulant medication daily. During an interview on 6/9/21 at 11:30 A.M., Resident #13 said his/her electric razor broke about two weeks ago and he/she has asked multiple staff for assistance to purchase another razor and no one has helped him/her. Resident #13 said, I only have one family member locally and he/she has dementia and can't help me. During an interview on 6/11/21 at 8:39 A.M., Business Office staff #1 said she was not aware until yesterday that Resident #13 was requesting his/her personal funds to purchase an electric razor. She said Resident #13 has sufficient funds to purchase an electric razor and he/she is their own person. During an interview on 6/11/21 at 12:35 P.M., Unit Manager #1 said she was not aware Resident #13's electric razor was broken or that Resident #13 had been requesting assistance to purchase a new electric razor. The surveyor and Unit Manager #1 then interviewed Resident #13. Resident #13 said he/she has the money to buy a new electric razor, but everyone he/she asked for help told him to speak to Unit Manager #2, but I don't know who Unit Manager #2 is and no one is helping me. During an interview on 6/11/21 at 12:40 P.M., Certified Nursing Assistant (CNA) #8 said, she can't shave Resident #13 because he/she is on Coumadin. CNA #8 said she did not inform Unit Manager #2 that Resident #13 was not being shaved or was requesting help to purchase a new electric razor. During an interview on 6/11/21 at 1:27 P.M., Social Worker #1 said a note was placed under her door two weeks ago by the occupational therapist informing her that Resident #13 needed a shave and was requesting help purchasing a new electric razor. Social Worker #1 called Resident #13's family member listed in the medical records as a contact and the family member questioned if Resident #13 really needed a new razor. Social worker #1 said the family member never returned her call. Social Worker #1 then said the Activities Director said she would order an electric razor for Resident #13, but she never did. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/15/21 at 2:07 P.M., Unit Manager #2 said Resident#13 is his/her own person and could make decisions on purchasing an electric razor and his/her family member did not need to be contacted for approval to purchase an electric razor.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 41106 Based on observations and interviews, the facility failed to assist a dependent resident to get out of bed for 1 Resident (#55), out of a total sample of 33 residents. Findings include: Resident #55 was admitted to the facility in February of 2021 with diagnoses which included acute/chronic heart failure. Review of the Minimum Data Set (MDS) assessment, dated 5/25/21, indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the Resident was cognitively intact. The MDS also indicated Resident #55 required assist of two people for bed mobility and transfers. During an interview on 6/9/21 at 9:25 A.M., Resident #55 said they never get him/her out of bed and he/she has nothing from his/her old room. Resident #55 said he/she lies in bed all day waiting for something to happen. On 06/10/21 at 11:00 A.M., the surveyor observed Resident #55 lying in bed looking up at the ceiling. During an interview on 6/11/21 at 12:20 P.M., Resident #55 said he/she still has not been helped out of bed. Resident #55 was observed lying on his/her back looking up at the ceiling. On 06/11/21 at 03:12 P.M., Resident #55 observed sleeping in his/her bed. During an interview on 6/15/21 at 02:00 P.M., Resident #55 said he/she still has not been helped out of bed. On 6/16/21 at 9:06 A.M., Resident #55 was observed lying bed on his/her back. During an interview on 6/16/21 at 1:25 P.M., the MDS Nurse said she usually does not work on Unit B and has not seen Resident #55 out of bed. She said when Resident #55 was on Unit A, he/she normally got out of bed for a couple hours on most days. The MDS Nurse said if Resident #55 wants to get out of bed, Resident #55 should be able to get out of bed every day. During an interview on 6/16/21 at 1:35 P.M., Resident #55 told the surveyor and MDS Nurse, since moving over to the B Unit, approximately three weeks ago, he/she lies in bed everyday with nothing to do. Resident #55 said he/she would like to get up in his/her wheelchair, but since he/she was moved over to the B Unit, the staff do not get him/her out of bed. During an interview on 6/17/21 at 3:35 P.M., the Administrator said all residents on the Unit A were moved to Unit B on 6/1/21 as part of the construction plan.

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106 Based on policy review, review of current guidance from Centers for Medicare and Medicaid (CMS), observations, and interviews, the facility failed to allow visitations for one Resident (#24), out of a total sample of 33 residents. Specifically the facility failed to: 1. Allow in person visitation to all residents to one outdoor visit for 45 minutes a week; and 2. Failed to accommodate one Resident's (#24) family's request for additional in person weekly visits. Findings include: Review of the facility policy titled Visitation Conditions During COVID-19 Outbreak, updated 3/14/21, indicated the following: -To allow safe visits between residents and their identified visitors that provide appropriate distancing and protective requirements as identified by Department of Public Health (DPH) and Centers for Medicare and Medicaid Services (CMS) in a designated visitation space. -To meet the physical, emotional, and spiritual needs of the residents through supportive visits from family and friends the facility will continue progressing through the structured phases of opening per DPH and CMS guidelines. -In person visitation (outdoor and indoor) will be allowed in a designated visitation space provided the following safety, care and infection control measures are in place. Review of the CMS guidance titled Nursing Home Visitation- COVID-19, updated 4/27/21, indicated the following: -While CMS guidance has focused on protecting nursing home residents from COVID-19, we recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents and their loved ones. - Outdoor Visitation: While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the resident and visitors are fully vaccinated against COVID-19. -Indoor Visitation: Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk COVID-19 transmission, These scenarios include limiting indoor visitation for: * Unvaccinated residents, if the nursing home's COVID-19 county positivity rate is >10% and <70% of the residents in the facility are fully vaccinated. (continued on next page)

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	225208	A. Building B. Wing	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	* Residents with confirmed COVID-19 infection, wether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; or *Residents in Quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine. -Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. -Indoor Visitation during an Outbreak: An outbreak exists when a new nursing home onset of COVID-19 occurs (i.e. a new COVID-19 case among resident or staff). This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 is contained to a single area in the facility. -Required Visitation: Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR 483.10(f)(4)(v). A nursing home must facilitate in-person visitation consistent with applicable CMS regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR 483.10(f)(4), and the facility would be subjected to citation and enforcement actions. 1. Resident #24 was admitted to the facility in June 2020 with a diagnosis of dementia with behavioral disturbances. Review of the quarterly Minimum Data Set (MDS) assessment, dated 3/30/21, indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) test, and the Resident had severe cognitive impairment. Review of COVID-19 county positivity rate for [NAME] County for 6/7/21 was 0.6%. Review of Resident #24's current care plan indicated Resident #24 was at risk for social isolation due to mass pandemic and state/federal guidance limiting activities, communal dining and visitation due to risk of transmission of COVID-19. Interventions included: -Visits will be provided both virtually and in person in accordance with state and federal guidelines. On 6/15/21 at 2:15 P.M., the surveyor observed Resident #24 sitting in a wheelchair by his/her window talking to family members through the window. The surveyor heard Resident #24 invite his/her family members inside to visit. Family Member #1 was heard telling Resident #24 they could not come in the building, they are only allowed to visit one time per week in person, the rest of the visits are through the window. The surveyor observed Family member #2 (spouse) having difficulty seeing into the window due to the height of the window and was observed waving his/her hands overhead to say hello. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/15/21 at 2:20 P.M., Family Member #1 said the facility limits visits to one in person visit per week on the front patio and they are limited to two guests per family visit and the visits are usually 30-40 minutes long. Family member #1 said he/she has complained to the Administrator and the Activity Director about the limited in person visitation schedule and has requested more than one in person visit per week, but nothing has changed. Family Member #1 said we use our one in person outdoor visit and then we visit through the window five to six times a week. Family Member #1 said the restrictions on family visitations and communication has been very frustrating. During an interview on 6/15/21 at 4:22 P.M., the Activity Director said we only have outdoor visits now, they did have indoor visits but they were stopped due to construction and a staff member testing positive for COVID-19 in May. Activity Director said now she has been told by administration there are no indoor visits allowed while construction is happening on Unit A. The Activity Director also said they have to limit the number of outdoor in person visits to one per family to make sure all residents have an opportunity to have visits. She said residents could have more than one in person visit a week if the slots were not full. The surveyor asked the Activity Director for the schedule logs of family visits. A review of the facility supervised weekly visitation schedule was reviewed May 19, 2021 thru June 15, 2021, and indicated there was not one day fully booked and 16 days that had at least four open visitation slots as indicated by the following: -Two days schedules were not provided -Zero of eight slots filled: One day -One of eight slots filled: Four days -Two of eight slots filled: Two days -Three of eight slots filled: Six days -Four of eight slots filled: Three days -Five of eight slots filled: Two days -Six of eight slots filled: Two days -Seven of eight slots filled: Two days -Eight of eight slots filled: Zero days During an interview on 6/24/21, the Staff Development Nurse said she does not know who made the rule, but she was told there was no indoor visitation allowed during construction. She said they do have outdoor visits, but was not sure of the limitations. She said as of 6/4/21, the building was COVID-19 free for 14 days.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 15218 Based on observation, interview, and document review, the facility failed to ensure the Resident Council's voiced needs, concerns and input into the activities, policies, and issues affecting their lives in the facility were considered and addressed. The facility failed to consider the resident's views and act upon the resident grievances and recommendations. Findings include: Resident Council is a vehicle for residents to bring about positive changes for all residents in the facility. The facility staff are required to consider the resident council views and act upon grievance and recommendations and attempt to accommodate them, to the extent practicable. On 6/9/21 at 7:00 A.M., the surveyor observed a posting in the lobby. The posting was not dated and stated the following: Attention Residents: Due to lockdown, we will go back to the independent care daily so you can choose your materials of choice for your own independent activity pursuits. Activity Assistant will do exercise in room if you want to keep up on morning routine. If there is something you would like that is not on the cart, please let me know. You can call me at extension XXXX. Also, we will be going around with the snack carts in the afternoon. Family have been notified that they can do Zoom or Facetime calls. When we start group programs we will resume with the special entertainments as well as the ice cream truck. During an interview on 6/9/21 at 9:40 A.M., the Activity Director said that she had not been scheduling the Resident Council Meeting as a group meeting, but had offered it one to one. The Activity Director said that she and her department conducted room visits and residents were asked if they had any concerns. The Activity Director said that this had not been an effective process, but if she did get a concern that she would provide a written form to the department head. She said the expectation would be for the department head to respond within 24 hours after receiving the written concern. The Activity Director said she would read the department's response at the next months resident council meeting. The Resident Council minutes included both group meetings and one to one meetings, for review, for the months of March 2021. April 2021, and May 2021. The Activity Director said she held activities based on when the facility was in lockdown. The Activity Director said the facility was currently in lockdown, no group activities were held and the residents had to stay locked in their rooms. During the group interview on 6/10/21 at 10:30 A.M. which included nine residents from one of two units. The residents said the facility communication with the residents was poor. The residents said their complaints/concerns brought forth by the Resident Council were not addressed or responded to and that none of their issues were new. The following concerns and grievances were reported during the interview on 6/10/21: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* The residents said they were all moved from Unit A to Unit B in May 2021. The residents said the communication about the move was poor between facility staff and the residents/responsible persons. The residents said that the move took place on one day and that most of their personal belongings were left behind. The residents said they have not been told when they would return to their prior rooms or when they could return to get their personal belongings. The residents said that they have asked the facility staff and have gotten no responses. *One resident said he/she had left without his/her toothbrush and basin. The resident had asked the staff to get the toothbrush and basin, they had not and the facility staff had not replaced the items. *The residents said they were worried about their belongings being left on Unit A unattended. *The residents said that the facility is on constant lockdown. The residents said the facility told them it was per the state and CDC (Center for Disease and Control and Prevention), that they were required them to be on lockdown. The residents defined lockdown to mean that they could not leave their room, no activities, no groups, no visits indoors or outdoors, only window and zoom visits. The residents said communication about what is going on is poor between the facility, residents and/or responsible persons. The residents said that the first activity, they have had in a long time was Bingo and that was held yesterday on 6/9/21. The residents said even if an activity is scheduled, it is often canceled due to staffing. The residents said that they lose out either way due to the lockdown or staffing. *The residents said the activity staff schedule their family visits and the visits are limited. The residents were not clear of how often and where visits were conducted, most said window visits and no indoor visits. *The residents said no snacks are offered and no snacks are available in the unit kitchenettes. * Residents said the food quality is awful, the food is cold, they do not get choices and there are limited choices when they are able to request an alternative. The residents said that facility staff are not helpful when they ask for assistance. *Resident #7 said on 6/6/21, he/she requested an alternate, a sandwich and that a staff threw an outdated sandwich at him/her. Resident #7 said the staff told the resident to eat the sandwich anyway, even though the sandwich was dated 6/2/21. Resident #7 said he/she had to yell and yell until he/she got assistance, as staff refused to get him/her help. *Residents reported not getting regular showers and often will not get a shower unless they ask for one. The residents said they have no regular schedule for a shower and this has been going on forever. The residents said the water is cold and if it is cold they do not get a shower and if there is not enough staff they do not get a shower. *Residents reported the activities programs provided, especially the independent cart and during lockdown were not of any interest to them. They said that staff did not do exercise in their rooms and that any suggestions made were not acted upon. The residents said they did not think there was an activity budget. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The residents said their grievances are not followed up on and their concerns reported at the resident council meetings remain unresolved and not addressed. Review of Resident Council meeting minutes, dated March 2021, April 2021 and May 2021, indicated repeated concerns which were expressed during the group interview on 6/10/21. The council minutes indicated the Activity Director informed facility staff of identified issues, but had no documentation which addressed unresolved and on-going concerns. Review of additional Resident Council meeting minutes, dated February 2020, July 2020, October 2020, November 2020, December 2020, January 2021 and February 2021, indicated consistent documentation of the same concerns, which were expressed during the group interview on 6/10/21. The Activity Director provided the minutes that she was able to locate and supporting documentation. Some of the council minutes indicated the Activity Director informed facility staff of identified issues, but there was no documentation that the issues were addressed and appropriately responded to the Resident Council. The Resident Council minutes indicated that the facility had no plate warmers to keep the food warm, a frequent complaint brought through the Resident Council. The facility had no plate warmers as of 6/10/21 and no plan to purchase a plate warmers, therefore not addressing the issue brought forward by the Resident Council. Other issues of missing clothing was known, and a label machine had been requested and not purchased. During an interview on 6/10/21 at 12:20 P.M., the Activity Director said that she facilitated the monthly Resident Council meetings, prepared the monthly minutes and informed the appropriate department head of the concerns presented by residents during the group meeting. The Activity Director said she would give the department head a concern form and expected the department head to complete the form and return the form to her. The Activity Director said she expected the form back within 24 to 48 hours, and then report back the next month to the Resident Council and document that she had. She said she was aware that many of the resident's issues brought forward were not resolved. The Activity Director said that she did not follow the grievance process for the Resident Council and did not view the process the same. She said she facilitated the form for the department head and expected the department head to resolve the issues. During a subsequent interview on 6/24/21 at 10:40 A.M., the Activity Director said the Resident Council concerns are not addressed by the facility and said for example the facility has not purchased plate warmers to keep the food warm. The Activity Director said it's a catch 22. The Activity Director said the residents bring up the issues and she gives the department head the forms, the forms come back and she reports the forms at the meeting. The Activity Director does not complete any concern as a grievance and said that it was the department heads responsibility to address the unresolved issues for the residents. Refer F 584, F 585, F 609, F 679, F 804, F 908, F 921.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41065 Based on record review and interview, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notices (SNF ABN) (CMS-10055) was provided to one Resident (#59), out of three sampled residents, as instructed by Centers for Medicare and Medicaid Services (CMS). Findings include: The SNF ABN (CMS-10055) notice is administered to a Medicare recipient when the facility determines that the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all the Medicare benefit days for that episode. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. Resident #59 was admitted to the facility in November 2020, under a skilled level of care. Review of the facility's census and Resident #59's Medicare Part A Discharge Minimum Data Set (MDS) indicated that he/she had a last covered day of 2/26/21. Review of the medical record failed to indicated that a Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice, form CMS-10055, was given to Resident #59 and/or the Resident's representative. During an interview on 6/10/21 at 2:32 P.M., MDS Nurse #1 said she checked Resident #59's medical record several times and could not locate the SNF ABN notice or the NOMNC.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15218 Based on observation and interview, the facility failed to ensure the residents have a safe, clean, comfortable, and homelike environment in which to reside. Findings include: During an interview on 6/10/21 at 10:30 A.M., nine residents from 1 out of 2 units participated in a group meeting with the surveyor. The residents said: -they were moved from Unit A to Unit B at the beginning of June 2021 and most of their personal belongings were left behind -their personal belongings included such items as: pictures, plants, decorations, clothing, toothbrushes, televisions, and radios -their belongings were piled in the hallway in bags and boxes or just thrown on top of beds or boxes. -they were told they could not go get their belongings and staff had not been cooperative. -they had not been told when they would return to Unit A and they had not been able to decorate their new rooms on Unit B with their personal belongings. Unit A: On 6/11/21 at 12:15 P.M., the surveyors observed the following on Unit A: -Residents' belongings were covered in dust, stored on the floor in bags and boxes or thrown on top of beds and bureaus, including pictures, paintings, televisions and radios. -Many of the bags and boxes were open, and dirt and dust was inside the storage containers. -Food items were mixed in with clothing and adaptive equipment. -Plants had dried up. -A radio, identified as a Resident's, was being used by an outside vendor painting and spackling rooms. The radio was covered in dust. -Many of the items were not labeled with a resident's name; it was difficult to determine who the bags belonged to. -The corridor was filled with bags, boxes, medical equipment, window treatments, and debris. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The residents' personal belongings were not stored properly to prevent infestation from pests, dust, or loss. During an interview on 6/11/21 at 12:30 P.M., the Administrator and Director of Nurses discussed the residents' concerns that their environment did not feel homelike and that their personal belongings were not accessible and being cared for by the facility. The Administrator said he needed to get the residents' their personal belongings. From 6/11/21 through 7/6/21, the surveyor observed Unit A and there was no change to the care of the residents' personal belongings. Unit B: On 06/10/21 at 10:59 A.M., 6/11/21 at 12:20 P.M., 6/14/21 at 12:45 P.M., 6/15/21 at 10:53 A.M. and 6/24/21 at 9:00 A.M., the surveyor observed Unit B, occupied by the residents, and made the following observations: -The top half of the exit door had a significant crack in the glass -room [ROOM NUMBER]: Window had one shade, no curtain or valance, the B bed had no privacy curtain, the A bed had no linens and the room had no clock -Rooms 27, 22, 24, and 21: There was no clock -room [ROOM NUMBER]: There were no bed linens -room [ROOM NUMBER]: Shade was broken -room [ROOM NUMBER]: The window had no shade, curtain, or valance -room [ROOM NUMBER]: There was no privacy curtain around bed A. Shade on the window was broken and on the ground. There was no clock. -room [ROOM NUMBER]: There were no curtains or valance on the window and the shade was ripped with multiple holes. -room [ROOM NUMBER]: There were electrical cables hanging out of the wall and the clock was sitting on a dresser. Bed A had no linens. -room [ROOM NUMBER]: There was a bulletin board lying on the bed on the left and the bed on the right had no linens. -room [ROOM NUMBER]: The window shade was torn, the privacy curtain was badly wrinkled, the air conditioning cover was missing, and 2 out of 2 screens on the windows were heavily covered in dust preventing a clear view. -room [ROOM NUMBER]: The first bed had no privacy curtain (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-room [ROOM NUMBER] B: The window had no shade. -The carpet between Unit B and Unit C was dirty. -One side of the hallway, the wall paper had been removed and spackle was visible. -There was a desk on the unit with a broken drawer. On 6/15/21 at 10:53 A.M., the surveyor observed the following in the Unit B shower room: -multiple dirty towels, bath products, a gait belt, and a plastic bag hanging on the safety railing -resident specific shoes and socks were sitting in a small puddle of water -a used facemask was on the floor next to the shoes and socks. On 06/15/21 at 2:30 P.M., the surveyor observed a film build up on the floor of the Unit B dining room, making it very slippery. The surveyor lost her footing twice. During an interview on 6/24/2021 at 8:30 A.M., the Director of Nurses and Staff Developer both said they were not aware of the problems observed by the surveyor that included missing privacy curtains, broken shades, rooms with no clocks, and cable wires hanging out of the walls. During an interview on 6/24/2021 at 9:20 A.M., Resident #22 said he/she needs a clock; it would be nice to know what time it is. On 6/30/21 at 8:47 A.M., the surveyor observed a large pile of construction materials in the left corner of the main dining room. The construction material included over 12 five gallon buckets, painting materials including brush extenders, tape, buckets, and a roll of wallpaper in a large wall covering pasting machine. A large pile of 29 brown boxes were observed with a roll of thick plastic and various other materials piled on the boxes. An extension cord was also observed along with a large yellow power tool sitting on top of multiple five gallon buckets. The Resident dining room was unable to be used for resident dining. Unit C: On 6/9/21 at 11:22 A.M., the surveyor made the following observations on Unit C: -room [ROOM NUMBER]: chair had a substance spilled down the front of the chair and was sticky. The window shade was torn and the floor was sticky. -room [ROOM NUMBER]: the window screen was removed from the window and placed next to the resident's bed, and the fall pad was dirty. -room [ROOM NUMBER]: the bureau was missing six knobs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Corridor to elevator: a Broda chair, mattress, chair, window screen, and a pill crusher was stored in the hallway, and they were dirty and/ or torn. -The heater cover was on the floor. Both the cover and the heater were dirty. -The scale was dirty. On 6/10/21 from 8:36 A.M. to 9:32 A.M., the surveyor made the following observations on Unit C: -room [ROOM NUMBER]: the overhead bed light had no pull cord attached and the wall behind the bed was dirty with a brown like substance -A two bag laundry cart was in the hallway. The piping that held the cart together was broken and the pieces were dirty and dragging on the floor. On 6/14/21 at 11:58 A.M., the surveyor observed the following on Unit C: -room [ROOM NUMBER]: The bureau had broken drawer that was hanging down; and open soap containers on nightstand accessible to residents with a diagnosis of dementia On 6/24/21 at 8:00 A.M., the surveyor observed the following on Unit C: -Rooms 40, 41, 42, 44, 48, and 53: had no resident name identifier or name plate outside the room -rooms [ROOM NUMBERS]: window shades had a large tear in them -room [ROOM NUMBER]: air conditioner unit had a large amount of debris in the vent -room [ROOM NUMBER]: Bed A had no mattress on the bed frame -Two open containers of lotion and soap sitting on a shelf by the nurse's station, accessible to residents with a diagnosis of dementia. On 6/11/21 at 11:45 A.M., the surveyor observed the handrails on all three units (A, B and C) to be wooden, worn, and had multiple rough spots. The surveyor got a splinter from the hand rail.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15218 Based on policy review, interview, document review, and record review, the facility failed to implement the facility's grievance policy. Specifically, the facility failed to: (1) thoroughly address grievances brought forth by the Resident Council; (2) notify administration as required if a grievance/complaint involves a potential violation of a resident right or allegation of neglect or abuse; and (3) investigate grievances identified in the Grievance log, and by Resident #22, and respond with a written report of findings within seven days. Findings include: Review of the facility's policy titled Grievances, revised September 2020, indicated the following: - Any resident, and/or his/her resident representative may file a grievance/complaint concerning their treatment, medical care, behavior of other resident(s) or staff member(s), missing property, theft of property, etc, without fear of discrimination, threat or reprisal in any form, and with the facility assistance. - Grievances and/or complaints may be submitted orally or in writing, and can be submitted through the Resident Council. - Upon receipt of a grievance and/or complaint, Administration/corresponding department will investigate and responds with a written report of findings within seven days. - The grievance officer coordinates adequate and timely handling of grievances/complaints and ensures resolution, corrective action and identified problems. - If a grievance/complaint involves a potential violation of a resident right or allegation of neglect or abuse, the administration staff is to be notified and as mandated to report by state law. 1. During an interview on 6/10/21 at 10:30 A.M., the surveyor met with nine residents, representing 1 out of 2 units. The residents said their complaints/concerns brought forth by the Resident Council were not addressed or responded to and that none of their issues were new. The residents said that missing laundry, cold food, snacks not being provided, no showers, cold water, delay in response to call lights, quality of food offered, menu errors, alternative meals not available, and housekeeping concerns were all on-going problems. In addition, the residents said that communication from the administration was poor; they received either no response from their Resident Council concerns or their issues remained unresolved. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident Council meeting minutes, dated February 2020, July 2020, October 2020, November 2020, December 2020, January 2021, February 2021, March 2021, April 2021, May 2021 and June 2021, indicated consistent documentation of some of the same concerns which were expressed during the group interview on 6/10/21. The council minutes indicated the Activity Director informed Facility staff of identified issues, but had no documentation which addressed unresolved and on-going concerns. During an interview on 6/10/21 at 12:20 P.M., and during a subsequent interview on 6/24/21 at 10:40 A.M., the Activity Director said that she facilitated the monthly Resident Council meetings, prepared the monthly minutes and informed the appropriate department head of the concerns presented by residents during the group meeting. The Activity Director said she would give the department head a concern form and expected the department head to complete the form and return the form to her within 24 to 48 hours. Then she would report back the next month to the Resident Council and document that she had. The Activity Director said that she did not follow the grievance process for the Resident Council. She said she facilitated the form for the department head and expected the department head to work with the administration to resolve the issues. The Activity Director said the Resident Council concerns/problems did not get resolved and were ongoing. The Activity Director said that she did what she was told by the administrative staff including stopping visits and activities when told. 2. During the group interview on 6/10/21 at 10:30 A.M., Resident #7 said he/she reported an incident on 6/6/21. Resident #7 said he/she requested an alternate to his/her meal. The staff brought back a sandwich and the staff threw an outdated sandwich at the resident. Resident #7 said the staff told the resident to eat the sandwich anyway, even though the sandwich was dated 6/2/21, and past its expiration date. Resident #7 said he/she had to yell and yell until he/she got assistance from another staff (identified as a nurse), as the staff refused to get him/her help. Review of the grievance log and reportable incidents indicated that the incident was not reported to the administrative staff, and the facility did not follow their policy and report the allegation of abuse to the state agency on 6/6/21. 3. Review of the grievance log and grievances for January 2021, February 2021, March 2021, April 2021, May 2021 and June 2021 - the following grievances were logged onto the monthly log reports: *On 4/1/21, the staff documented the resident reported missing a sweater. The grievance form indicated the sweater was not located and there was no resolution. *On 4/1/21, the staff documented the resident reported missing a pair of pants. The grievance form indicated the pants were not located and was signed that the resident wanted reimbursement on 5/26/21, but no evidence that the resident was reimbursed. *On 6/5/21, the staff documented the resident reported missing several tee shirts and needs a new razor. The staff completed a grievance form on 6/7/21, and indicated staff will look for tee shirts. No mention of razor. *On 6/7/21, the staff documented the resident reported missing a sweater and several tee shirts. The resident reported that the staff were putting his/her clothes on his/her roommate. The grievance form indicated some of the items were located and returned. There was no response to the clothing being worn by the roommate. The sweater was not located and there was no resolution. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No other grievances were filed per facility grievance log. During an interview on 6/9/21 at 9:30 A.M., the Activity Director said that she and the social worker share the responsibility of the grievances. The Activity Director said that there were staffing changes in the social work department and could not say when the last social worker left and the new social worker started. The Activity Director said she was a resident advocate and followed up on all resident requests and complaints. During an interview on 6/15/21 at 10:40 A.M., the Social Worker said she had been working at the facility for two weeks, and that there were communication problems. 41065 Resident #22 was admitted to the facility in April 2021 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), dementia and depression. Review of Resident #22's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating that he/she had moderately impaired cognition. The MDS further indicated that the Resident was able to make him/herself understood and was able to understand others. During an interview on 6/9/21 at 12:54 P.M., the surveyor observed Resident #22 wearing slipper socks and a hospital gown, tied at the neck and mid back. He/She was sitting in a wheelchair with a tray table placed in front. The Resident said he/she recently moved rooms and had been unable to find all his/her clothing. Resident #22 said I am missing five pairs of dark colored pants and several tops since the move. The Resident further said he/she notified the head nurse (later identified as Unit Manager #2), but had not heard anything further. During an interview on 6/14/21 at 9:50 A.M., Unit Manager #2 said since the move many personal items were left behind, so it is possible Resident #22 is missing pants. During an interview on 6/16/21 at 11:55 A.M., Social Worker #1 said Unit Manager #2 did inform her about Resident #22's missing clothing. The Social Worker said she did try to look for the pants but was unable to locate them. Social Worker #1 said she did not fill out the grievance form because she got too busy and could not locate a blank grievance form on the unit. She further said we need to be following up on all grievances for each resident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15218 Based on record review, document review, and staff interview, the facility failed to report an allegation of abuse to the administrator and the State Survey Agency, for one Resident (#7), out of a total sample of 33 residents. Findings include: Resident #7 was admitted to the facility in [DATE] with diagnoses that included coronary artery disease, high blood pressure, and chronic obstructive pulmonary disease. During an interview on [DATE] at 10:30 A.M., Resident #7 reported an allegation of abuse to the surveyor. Resident #7 said, on [DATE], a staff member threw a sandwich at him/her, after he/she requested an alternative to the meal. Resident #7 said the sandwich had an expiration date of [DATE], and he/she refused to eat the sandwich. Resident #7 said the staff told him/her to eat the sandwich even though it had expired. Resident #7 said when he/she asked for assistance, the staff refused. Resident #7 said he/she kept yelling until the nurse came. On [DATE] at 12:10 P.M., the surveyor reported the incident to the Director of Nurses (DON). On [DATE] at 3:10 P.M., the DON said she investigated the incident and the Resident was unable to identify which staff member threw the sandwich at him/her. The Director of Nurses asked the surveyor what she wanted her to do. The surveyor recommended she review the facility's policy. Review of the grievance form, dated [DATE], indicated that an incident occurred on [DATE], and both witness statements confirmed who the staff involved in the incident was. The nurse's statement indicated she heard Resident #7 from the hallway and went into the room to find out what was going on. Both staff said the Resident had requested an alternative meal and the sandwich provided was refused. Neither statement indicated why. The incident was not reported to the Administrator and the State Survey Agency, at the time of incident, or on [DATE] when reported to the Director of Nurses.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10249 Based on observation, staff interview, and record review, the facility failed to ensure that staff developed and implemented a comprehensive, person centered care plan for two Residents (#8 and #31), out of a total of 33 sampled residents. Specifically, 1) For Resident #8, the facility failed to implement a comprehensive care plan for the care and treatment of a central venous catheter and provide a [NAME] clamp (used to stop a bleed by closing off the vessel) at the Resident's bedside at all times for emergencies; and 2) For Resident #31, the facility failed to develop and implement a comprehensive care plan for (a) elopement risk and for (b) safety and dignity, as related to ambulating barefoot. Findings include: 1. Resident #8 was admitted to the facility with a diagnosis of End Stage Renal Disease (ESRD) and received renal dialysis treatments four times a week. Review of Resident #8's care plan, dated 3/20/21, indicated one of the ESRD interventions included: *[NAME] clamp located at bedside at all times for emergency bleeding related to dialysis catheter (initiated 5/6/21). Review of Resident #8's physician's orders indicated: -[NAME] clamp at bedside at all times for emergency bleeding related to (r/t) dialysis catheter, every shift. During an interview on 6/14/21 at 9:15 A.M., Resident #8 said he/she didn't know if there was a special clamp at the bedside for emergencies, and gave the surveyor permission to look in the drawers of the bedside table. The surveyor failed to locate a [NAME] clamp in the drawers or on the Resident's bureau, including the inside of the bureau drawers. During an interview on 6/15/21 at 12:30 P.M., Resident #8 said there was no clamp in the bedside table or bureau. During an interview on 6/16/21 at 9:55 A.M., Nurse #3 said that she could not find a [NAME] clamp at the Resident's bedside or in the Resident's room to be used in case of an emergency. 15218 2. Resident #31 was admitted to the facility in April 2021 with diagnoses that included dementia and a history of falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #31's Minimum Data Set (MDS), dated [DATE], indicated the Resident had significant short and long term memory loss, was inattentive in his/her thoughts, and required physical assistance of staff in all aspects of care. (a) Review of Resident #31's interdisciplinary care plans indicated a care plan identify the resident wanders aimlessly due to poor his/her cognition. The care plan was developed on 4/12/21 and revised on 4/21/21. The interventions were to allow safe wandering and ask simple questions. Review of the interdisciplinary notes dated, 4/10/21, 4/11/21, 4/15/21, 4/20/21 and 4/25/21 indicated Resident #31's exhibited wandering behavior. The progress notes indicated Resident #21 wanders in and out of rooms and is at risk for falls, is anxious, restless, requests to go, and is exit seeking. On 4/26/21, the nurse's note indicated Resident #31 is transferred to Unit C for safety. Unit C is a secured unit that provides a Wanderguard system and coded door system, to ensure safety for residents identified at risk for elopement. Record review indicated that Resident #31 was not evaluated for a Wanderguard and his/her plan of care for elopement had not been developed. Review of the interdisciplinary notes from 4/26/21 through 6/15/21 indicated minimum documentation of Resident #31's constant wandering on Unit C. On 6/9/21, 6/10/21, 6/11/21, 6/15/21, 6/16/21, 6/17/21 and 6/24/21, the surveyor observed Resident #31 between the hours of 7:00 A.M. and 3:30 P.M. wandering Unit C. Resident #31 often approached the surveyor and was cognitively impaired and his/her ability to move around Unit C was aimless and without an appreciation of his/her or others personal safety. Often the Resident would walk up to the exit door and attempt to open the door or wave at a staff to come and open the door. The Resident would lose interest and wander away. The staff was not observed promoting alternate interventions. During an interview on 6/17/21 at 3:00 P.M., Unit Manager#1 said she was supposed to have completed an evaluation and developed a comprehensive plan when the Resident was transferred to Unit C on 4/26/21, but had not gotten to it yet. The Resident had been on Unit C for 52 days without a plan of care for elopement. (b) On 6/9/21 between 9:30 A.M. and 1:20 P.M., 6/10/21 between 10:30 A.M. and 4:00 P.M. and 6/11/21 between 8:00 A.M. and 10:30 A.M., the surveyor observed Resident #31 barefoot, wandering up and down the hallways, into rooms, the dining room, and bathrooms. Review of Resident #31's medical record failed to identify the reason for Resident 31's lack of footwear. Review of Resident #31's interdisciplinary care plans failed to indicate that the facility developed a care plan to address the Resident's lack of footwear. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/21 at 10:30 A.M., the surveyor heard Unit Manager (UM) #1 talking on the phone about Resident #31's lack of footwear. Following the telephone call, the surveyor asked the Unit Manager if the Resident had shoes. UM #1 did not answer the question, but said the Resident did not like wearing them. UM said this was not documented in the Resident's medical record. UM #1 did not clarify if Resident #31 did not have shoes, did not like to wear shoes, refused to wear shoes, or if the Resident was exercising his/her right to not wear shoes. Review of nursing progress notes, dated 6/11/21, indicated UM #1 had called Resident #31's invoked Health Care agent to inform him/her of the Resident's refusal to wear shoes or slipper socks. The progress note indicated the Health Care agent said the Resident would wear socks around the house. There was no additional information indicating the resident's choice was to never wear footwear. On 6/15/21, 6/16/21, 6/17/21 and 6/24/21, between the hours of 7:00 A.M. and 4:00 P.M., the surveyor observed Resident #31 barefoot. Review of Resident #31's interdisciplinary care plans failed to indicate that the facility developed a care plan that addressed the Resident's lack of footwear.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41065 Based on observations, interviews, and record review, the facility failed to ensure that comprehensive care plans were reviewed and revised following the identification of residents at risk for wandering and an inoperable Wanderguard system to ensure residents remain safe and free from accidents and hazards for four Residents (#2, #18, #29, and #5), out of 11 residents identified as elopement risks, out of a total sample of 33 residents. Findings include: During an interview on 6/16/21 at 3:00 P.M., Life Safety Surveyor #1 said that the Wanderguard system on Unit C was inoperable, leaving residents at risk for elopement. On 6/16/21 at 3:24 P.M., the finding was brought to the Administrator's attention. Review of the facility's policy titled Elopement Prevention and Management, dated 3/1/16, indicated the following: - Determine if the resident is at risk for elopement - Include resident and family/responsible party in the development of the Plan of Care - Develop individualized interventions which may include the following: - Electronic monitoring/alarm systems - Environmental modifications - Protected list of names and photographs of those at risk for elopement - Psychosocial interventions - Regular rounds - Resident and family education - Staff interventions - Structured group activities - Review and revise Plan of Care as needed 1. Resident #2 was admitted to the facility in June 2019 with a diagnosis of dementia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated 3/2/21, indicated that Resident #2 was independent with ambulation and transfers; did not require the use of an assistive device; and wandering occurred 1-3 times within a 7-day time frame. Review of the physician's orders for Resident #2 indicated that he/she required the use of a Wanderguard anklet and staff was to check the placement every shift and function every day. Review of the elopement care plan, dated 6/28/19, indicated Resident #2 was at risk for elopement related to dementia/Alzheimer's disease. The goal was to ensure the Resident remains safe inside the facility. Interventions included the resident would wear a Wanderguard or other alert bracelets. Further review of the care plan failed to indicate that the care plan was reviewed and revised following the identification of the malfunctioning Wanderguard system. 2. Resident #18 was admitted to the facility in February 2020 with a diagnosis of dementia. Review of the MDS assessment, dated 3/23/21, indicated that the Resident was independent with transfers; a supervision with ambulation; did not require the use of an assistive device; and wandering occurred daily within a 7-day timeframe. Review of the physician's orders for Resident #18 indicated that he/she required the use of a Wanderguard anklet and staff was to check the placement every shift and function every day. Review of the elopement care plan, updated 10/1/20, indicated Resident #18 was at risk for elopement related to dementia/Alzheimer's disease. The goal was to ensure the resident remains safe inside the facility. Interventions included the Resident would wear a Wanderguard or other alert bracelets. Further review of the care plan failed to indicate that the care plan was reviewed and revised following the identification of the malfunctioning Wanderguard system. 3. Resident #29 was admitted to the facility in September 2020 with diagnoses that included Alzheimer's disease. Review of the MDS, dated [DATE], indicated Resident #29 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severe cognitive impairment. The MDS further indicated the Resident required supervision with ambulation and wandered daily. Review of the Elopement Risk Assessment, dated 4/8/21, indicated that Resident #29 was considered at risk for wandering/exit seeking and a wander detection system and care plan for risk if elopement should be implemented. Review of the physician's orders for Resident #29 indicated that he/she required the use of a Wanderguard anklet and staff was to check the placement every shift and function every day. Review of the wandering care plan, updated 10/15/20, indicated Resident #29 was at risk for wandering. The goal was to ensure the resident remains safe with fewer episodes of wandering. Interventions included the Resident would wear a Wanderguard bracelet on the right ankle. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the care plan failed to indicate that the care plan was reviewed and revised following the identification of the malfunctioning Wanderguard system. 4. Resident #5 was admitted to the facility in December 2017 with a diagnosis of Alzheimer's disease. Review of the MDS assessment, dated 3/2/21, indicated that the Resident required supervision with ambulation and the use of a rolling walker. Review of the Elopement Risk Assessment, dated 5/26/21, indicated Resident #5 had a history of elopement, that wandering occurred daily and that the Resident was considered at risk for wandering/exit seeking and a wander detection system and care plan for risk if elopement should be implemented. Review of the current physician's orders, dated 5/24/21, indicated an order for a Wanderguard to right ankle at all times and the check placement and function every shift. Review of the elopement care plan, dated 7/9/18, indicated that on 10/23/20 the care plan was resolved. The care plan failed to indicate an active care plan or revision of care plan to include the risk of elopement and wandering.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 10249 Based on observation, staff interview, and medical record review, the facility failed to ensure that staff met professional standards of practice for three Residents (#45, #1, and #36) from a total sample of 33 residents. Specifically, the facility failed to ensure that: 1. For Resident #45, medication was administered and documented; and 2. For Residents #1 and #36, staff followed physician's orders to apply pressure relieving booties. Findings include: 1. Review of the Medication Administration Policy (revised December 2019) indicated the following: -If a drug is withheld, refused, or given at a time other than scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. The policy did not indicate the process for an electronic medical record (EMR), which the facility is presently using. Resident #45 was admitted to the facility in March 2014 with diagnoses that included cancer. Review of the Minimum Data Set (MDS) assessment, dated 5/11/21, indicated a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating the Resident was cognitively intact. On 6/15/21 at 9:00 A.M., the surveyor observed Unit Manager #1 (UM #1) prepare medications for Resident #45. UM #1 identified that the medication Anastrozole (a non-steroidal aromatase inhibitor used in the treatment and prevention of breast cancer) 1 mg, scheduled to be administered at 9:00 A.M., was not available. During an interview on 6/15/21 at 9:05 A.M., UM#1 said that the process was to update the physician when the medication was not available and re-order the medication from the pharmacy. She said she would document in the Medication Administration Record (MAR) that the medication was not given. Review of the June 2021 MAR on 6/16/21 at 8:51 A.M. indicated that Resident #45 received the medication Anastrozole 1 mg on 6/15/21 at 9:00 A.M. During an interview on 6/16/21 at 8:51 A.M., UM#1 said the medication came in from the pharmacy after she had left for the day, but was not sure what time the medication arrived. UM#1 said she did sign off that the medication was given, but that was an error and she did not administer the medication. Review of the pharmacy packing slip indicated the medication was delivered on 6/15/21, but there was no time documented when it arrived at the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	15218 2. Resident #36 was admitted to the facility in October 2019 with diagnoses that included dementia. Review of the MDS assessment, dated 4/27/21, indicated Resident #36 scored 7 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. The MDS indicated the Resident required physical assistance with care. Review of Resident #36's current physician's orders indicated the following: -Booties to be worn at all times to off-load (to distribute the load to other areas which are not susceptible to pressure) heels every shift for skin integrity. -Skin prep and off-load bilateral heels while patient is in bed every shift for skin integrity. On 6/9/21 at 11:40 A.M., the surveyor observed Resident #36 in bed. The Resident was not wearing booties and his/her heels were not off-loaded. The booties were observed in a chair in the room. At 12:20 P.M., Resident #36 was in bed and his/her heels were not off-loaded. At 2:00 P.M., Resident #36's was in bed and his/her heels were not off-loaded. On 6/10/21 at 9:30 A.M., the surveyor observed Resident #36 in bed with one bootie on the right foot, and the left heel was not off-loaded. During an interview on 6/11/21 at 10:00 A.M., Unit Manager (UM) #1 provided the day shifts assignment sheet for 6/11/21 to the surveyor and said that most of the information was shared verbally at the beginning of each shift. UM #1 said she did not have consistent staff and today had only one regular staff scheduled on the shift. Review of the assignment sheet, dated 6/11/21, did not include the application of Resident #36's booties. On 6/11/21 at 10:00 A.M. and at 10:45 A.M., the surveyor observed Resident #36 in bed and a bootie was visible on the right foot. The left foot did not have a bootie on it and was not off-loaded. On 6/15/21 at 2:15 P.M., the surveyor observed Resident #36 in bed with one bootie on his/her right foot. The left foot did not have a bootie on it and was not off-loaded. 3. Resident #1 was admitted to the facility in February 2021 with diagnoses that included spinal stenosis. The MDS assessment, dated 3/3/21, indicated the Resident scored a 9 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The MDS indicated Resident #1 required physical assistance with care. Review of Resident #1's current physician's orders indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Air mattress to bed check function and placement every shift, make sure weight setting is appropriate every shift. -Off-load right heel off of bed with pillows every shift for unstageable pressure ulcer. -Prevalon Boots on when in bed every shift. Prevalon boots are designed out of soft, stuffed material and are strapped onto the heel and foot. Review of Resident #1's weight record indicated the Resident weighed 125.4 pounds on 6/10/21. On 6/9/21 at 10:40 A.M., the surveyor observed the air mattress setting was set at 180 and remained set on 180 on 6/10/21, 6/11/21, 6/15/21, 6/17/21 and 6/24/21. The setting on the air mattress was inaccurate for the resident's weight. On 6/11/21 at 1:10 P.M. and on 6/15/21 at 11:30 A.M., the surveyor observed Resident #1 in bed without Prevalon Boots on. Instead the Resident was using a cushion to raise the Resident's heels which was not properly positioned and did not allow for the off-loading of the Resident's heels.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 15214 Based on record review and staff interview, the facility failed to ensure that a discharge summary was completed for one Resident (#61), out of three closed record reviews, out of a total sample of 33 residents. Findings include: Resident #61 was admitted in December 2019 for short-term rehabilitation with diagnoses which included Parkinson's disease, muscle weakness, and hyperlipidemia. A discharge summary is a document that is required for residents who are discharged from a facility. The discharge summary is a recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. Review of Resident #61's closed/discharge record indicated that the Resident was discharged to another long-term care facility on 3/17/21. Further review of Resident #61's discharge record failed to indicate a discharge summary was available for review. During an interview on 6/16/21 at 11:03 A.M., the Medical Records Staff #1 examined the discharge record and said, It's a yellow paper. I don't see it. Medical Records Staff #1 said that a discharge summary was not completed for Resident #61.

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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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. 15218 Based on observation and interviews, the facility failed to ensure each resident was provided an environment to enhance a sense of well-being and self-worth, necessary to attain or maintain the highest practicable mental and psychosocial well-being. Specifically, the facility disregarded the residents' concerns to obtain their personal belongings and its impact on their personal well-being. Findings include: On 6/9/21 at 7:45 A.M., the surveyors observed no residents residing on Unit A, instead contractors were working on the unit. The surveyors observed the resident rooms and hallways lined with resident belongings such as clothing, televisions, radios, pictures; all were covered with dirt and dust. During a group interview on 6/10/21 at 10:30 A.M., nine residents stated they had all been moved from Unit A to Unit B. They said the facility had not provided much information about the move, they were not able to bring all their personal belongings with them, and they were not permitted to go back to the unit to retrieve them. The residents said that their televisions, computers, clothes, radios and other personal items have been left in piles in the hallway. One of the nine residents said he/she had left Unit A without his/her toothbrush and basin and had asked the facility to get it for him/her, but it's been nine days and no one has. The nine residents expressed their frustration about not being able to get their belongings, and their worry that their possessions were not being cared for respectfully. They expressed that the facility has a disregard for their personal property and well-being. Following the group interview, on 6/11/21 at 12:30 P.M., the surveyor met with the Administrator and Director of Nurses and reviewed the residents' concerns about the storage and access of their personal belongings on Unit A. The Director of Nurses said, that the residents would go over to Unit A to get their personal belongings and that was a problem. She offered no information or solution of when the residents would get their personal belongings, she just got up and left the interview. The Administrator said he agreed that the residents' personal belongings were not being cared for properly or stored properly. The Administrator did not say the residents would get access to their belongings or the facility would assist the residents, or when the residents would be moving back to their rooms. The Administrator did not address the resident's frustration and worry that their belongings were not being cared for and they could not access them. During an interview on 6/15/21 at 10:42 A.M., Resident #23 said he/she was moved from Unit A to Unit B, on 6/1/21, without all his/her personal belongings, which included his/her clock. Resident #23 said the room on Unit B has no clock and he/she finds it difficult to know the time. Resident #23 said he/she had relied on his/her clock daily and therefore had asked the facility multiple times for the clock, or a clock, and the facility had not honored his/her request. Resident #23 said he/she was not allowed to go to Unit A to get his/her clock. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/16/21 at 1:35 P.M., Resident #55 said he/she was moved on 6/1/21 from Unit A to Unit B, without his/her computer, radio or television. Resident #55 said since the move, for three weeks, he/she lays in bed everyday with nothing to do. Resident #55 pointed to the television in his/her rooms, which was on the far-left wall (across from the second bed) and said it doesn't work and if it did, I could not see or hear it from here. Resident #55 was asked what he/she would like from his/her room on Unit A and Resident #55 said, I would like my computer, my radio, and the television that works. On 6/15/21 at 10:30 A.M., the surveyors observed Unit A and there remained no change. The residents' personal belongings on Unit A had not been returned to the residents and remained piled on the floor and covered in dirt and dust. The surveyors informed the Administrator that the residents continued to report concerns about the situation and the facility's lack of response to the residents. During an interview on 6/16/21 at 2:50 P.M., Resident #49 asked Surveyor #4 to help him/her find his/her bag of belongings and his/her white, fleece sweater. Resident #49 said he/she thought the surveyor was the facility's administrator. The Resident told Surveyor #4 that he/she had been moved from Unit A to Unit B and had asked for help getting his/her personal belongings. The Resident was yelling and upset and said the facility did not help and no one returned his/her belongings. Resident #49 became increasingly agitated and said, I want to leave. On 6/16/21 at 2:55 P.M., Surveyor #3 and Surveyor #5 observed the following: -Resident #49 was seated in a wheelchair and Activity Staff #1 was speaking in a stern voice, standing over the Resident, pointing and waving her finger in an aggressive manner and directly into Resident #49's face. -The Activity Assistant was heard saying, Why did . you tell them [the surveyors] that you did not get your bag from the unit . The exchange between the Activity Assistant and Resident #49 escalated as their voices rose and Resident #49 was heard saying over and over he/she wanted his/her stuff, including the white sweater. -During the interaction, the Activity Staff had her finger pointed in the Resident's face in an intimidating manner. The Activity Staff #1 was heard telling the Resident, You have everything you need in your room. Surveyor #3 approached Resident #49 and Activity Staff #1. Resident #49 put his/her hands up and held head and said, I just want to get out of here, can you help me! Surveyor #3 asked Activity Staff #1 to stop and to take her hand out of the Resident's face as the Resident was visually upset and threatened. During an interview on 6/24/21 at 10:50 A.M., the Activity Director was asked if Resident #49's belongings were located on Unit A. The Activity Director said no they were not. She said that she was going to order Resident #49 a new, white fleece sweater soon. During follow up visits on 6/24/21 and 6/30/21, the survey team observed Unit A and the residents' personal belongings remained stored on the floor and covered in dirt and dust. The facility continued to show a repeated disregard for the residents' concerns and how it affects their quality of life.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 15218 Based on observations, interviews, and record review, the facility failed to provide an ongoing program of activities designed to meet resident's individual interests and needs and in accordance with the comprehensive assessment for residents residing on Unit C including three sampled Residents (#4, #29, and #48), out of a total sample of 33 residents. Specifically, 1) the facility failed to provide minimal programming for residents residing on Unit C, a long term secured care unit with multiple residents diagnosed with dementia; 2) for Residents #4, #29, and #48, the facility failed to implement a resident centered activities program to meet the needs of and support the physical, mental and psychosocial well-being of the residents. Findings include: During an interview on 6/9/21 at 10:30 A.M., Activity Director (AD) #1 said the facility had just started to look at resuming full group activities because of the lockdown (described as the state's mandate for residents to stay in their rooms during the COVID-19 pandemic). AD #1 said that she and her staff had been providing an independent cart daily, which enabled residents to choose activities that they wanted to do independently. She said this included coloring and reading. AD #1 said she and her staff provided room visits. On 6/9/21 from 9:30 A.M. through 12:40 P.M., the Surveyors (#1 and #2) observed the following on Unit C: -No activities took place during this time -No Activity Calendar could be located. The calendar is used to notify the residents of the upcoming events for the day. -At 10:40 A.M., five residents were sitting in the dining/ day room with one staff member. There was no activity going on. -Five residents were wandering in the hallway. The surveyor did not observe the staff engage with the residents, instead staff would wait until the residents wandered off or away from the exit doors. There were no activities to maintain their interest as an alternative to their wandering. On 6/10/21 from 10:00 A.M. to 10:30 A.M., the surveyor observed the following on Unit C: -No formal activity programs or room visits were conducted. -No Activity Calendar could be located. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Four residents were lined up outside the dining/ day room in their wheelchairs or Broda chairs (positioning chairs) and three additional residents were placed farther down the hall. The residents were not engaged in an activity; most were asleep. -Staff did not engage and interact with the residents wandering up and down the hallway. On 6/14/21 at 9:54 A.M., the surveyor observed a group of six residents seated in the dining/ day room. There were no activities going on and the television was on with no sound. The staff sat in a chair and failed to interact with the residents or adjust the volume of the television. On 6/15/21 at 1:30 P.M., Surveyor #1 observed Activity Assistant #3 engage six residents in an activity. She walked around the room and sang. At 2:24 P.M., Surveyor #3 observed Activity Assistant #3 put music on, while the television was still on, and leave the unit. A staff member sat in the room and watched the television. At 2:45 P.M. the music disc stopped and then the same music disc started again. The television remained on and the staff remained seated. At 3:45 P.M., Activity Assistant #3 gathered her belongings and then re-started the music (the same disc that had played three times). The activity assistant started dancing around the room, spent about five more minutes, and then left Unit C. During an interview on 6/16/21 at 9:20 A.M., AD #1 said that residents on Unit C are not provided a calendar and she does not post calendars or provide the staff with a calendar. AD #1 said that no programs were offered in the morning and that afternoon programs were often interrupted, because the activities department was shorthanded. She said the activity staff was often reassigned. Review of three months of calendars indicated: The program called Creative Corner was scheduled daily, Monday through Friday at 1:30 P.M., followed by Melody of Events, daily at 2:30 P.M. On 6/15/21, the surveyor did not observe either activity take place. During an interview on 6/24/21 at 10:50 A.M., AD #1 said it had been difficult (alluding to the pandemic) and said her department had been short staffed. The Activity Director said she was an advocate for the residents, but had to follow what she was told to do by her administration staff. AD #1 was unable to provide evidence that she had provided minimal activities for residents on Unit C. 10249 2a. Resident #4 was admitted to the facility in October 2015 with diagnoses that included dementia with behavioral disorders. Review of the Minimum Data Set (MDS) assessment, dated 3/20/21, indicated that Resident #4 is dependent on staff for Activity of Daily Living (ADLs) and dependent with transfers. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Activity Participation Review (quarterly), dated 5/12/21, indicated Resident #4 enjoyed people watching, enjoys music, and that activity staff will encourage on unit programs. Review of Resident #4's Activities Care Plan, revised on 6/15/21, indicated the following: -Activities staff will provide regular one to one visits -Activities will use positive body language, gentle touch, smile, soft voice, eye contact -Activities staff will keep interactions with Resident low key, calm voice, slow approach, simple directions, and minimal gesturing The surveyor made the following observations: -On 6/10/21 at 10:09 A.M., Resident #4 was sitting in a Broda Chair (positioning chair) on Unit C in the dayroom positioned with their back to the window. Room was dim. Television was on but with low volume. One Clinical Nursing Assistant (CNA) was sitting in a chair across the room. The CNA was not interacting with any of the residents present in the room. -On 6/14/21 at 9:54 A.M., Resident #4 was sitting in the Broda Chair on Unit C in the dayroom positioned with their back to the window. Television was on with no sound. Resident #4 was awake staring straight ahead. One CNA was sitting in the room in the corner and was not interacting with any residents. -On 6/14/21 at 11:49 A.M., Resident #4 was in the dayroom with no staff interaction or activities being presented. -On 6/15/21 at 12:30 P.M., Resident #4 was sitting in a Broda Chair in the dayroom at a table. The Resident was tapping his/her hands on the table. One staff member was in the room and did not interact with Resident #4 or attempt to find out why Resident was tapping his/her hands on the table. There were no activity programs going on at the time. During an interview on 6/16/21 at 9:40 A.M., AD #1 said that CNAs can utilize an activity box when there are no activities occurring on the unit. The Activity Director said there are activities on Unit C Tuesday, Wednesday and Thursday at 1:30 P.M. 2b. Resident #29 was admitted to the facility in September 2020 with diagnoses that include Alzheimer's disease. Review of the MDS assessment, dated 4/6/21, indicated that a Brief Interview for Mental Status (BIMS) was not conducted due to the Resident's cognitive status being severely impaired. Review of the Activity Progress note, dated 3/16/21, indicated the following: -Resident enjoys walking as well as going to small on unit groups. He/she enjoys the morning program with the music, movies, crafts, with the assistance of activity staff. Review of Resident's Activity Care Plan, dated 1/8/21, indicated the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Resident requires staff assistance with involvement of Activities related to cognitive deficits -Staff will build positive rapport with Resident -Staff will praise efforts -Staff will supply her with materials for her own independent activity pursuits -Will respect Resident's right to refuse programs The surveyor made the following observations: -On 6/10/21 at 9:30 A.M., Resident #29 was wandering up and down the hallway on Unit C. There were no activities occurring on the unit at the time. No independent activities were offered to the Resident at that time. -On 6/14/21 at 9:54 A.M., Resident #29 was wandering up and down the hallway holding hands with another resident. There were no activities being presented on the unit at that time. No staff members interacted with residents nor did they offer any on unit independent activities. -On 6/14/21 at 11:09 A.M., Resident #29 was standing in the middle of the hallway by him/herself. Two staff members walked by the Resident. Neither staff member stopped to assist the Resident or engage him/her in any type of activity. No activities were occurring on the unit at that time. During an interview on 6/16/21 at 9:40 A.M., the Activity Director said that CNAs can utilize an activity box when there are no activities occurring on the unit. The Activity Director said there are activities on Unit C Tuesday, Wednesday and Thursday at 1:30 P.M. 2c. Resident #48 was admitted to the facility in August 2018 with diagnoses that included vascular dementia with behavioral disturbances. Review of the most recent MDS assessment, dated 5/18/21, indicated Resident #48 required assistance with ADLs. The BIMS was not completed due to the Resident's cognitive status being severely impaired. Review of the Activity Participation review, dated 5/11/21, indicated Resident #48's activities are walking in the halls with other residents. He/she won't stay long in groups. He/she has a hard time focusing on a task. Staff will continue to motivate and encourage groups. Activity Plan Review indicated needs, strengths, and preferences remain appropriate/ current per care plan. Review of Resident #48's activity care plan indicated the following: -Activity staff will visit daily and form a comfortable and trusting relationship with Resident -Approach Resident in a friendly and calm manner -Respect rights to refuse (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When Resident is walking with a friend approach the friend to join Resident in groups The surveyor made the following observations on Unit C: -6/14/21 at 9:41 A.M. Resident #48 was walking up and down hall. A CNA did not interact with the Resident when they passed by him/her in the hall. No activities were occurring on unit at that time. -6/14/21 at 2:00 P.M. Resident #48 was sitting in a chair. He/she was playing with the bottom of their shirt. There was no observation of staff offering independent activities or interacting with the Resident. -6/15/21 at 11:00 A.M. Resident #48 was walking in the hall with another resident. The Resident was directed by staff to sit in a chair in the hall. Staff did not offer any independent activities to the Resident. During an interview on 6/16/21 at 9:40 A.M., the Activity Director said that CNAs can utilize an activity box when there are no activities occurring on the unit. The Activity Director said there are activities on Unit C Tuesday, Wednesday and Thursday at 1:30 P.M.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106 Based on record review and interview, the facility failed to provide medically-necessary transportation for one Resident (#59), out of a total sample of 33 residents. Specifically, Resident #59 was not transported to a scheduled pain clinic appointment causing the Resident undue physical distress. Findings include: Resident #59 was admitted to the facility in November of 2020 with diagnoses of chronic pain syndrome, osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy and interstitial pulmonary disease, chronic respiratory failure with hypoxia (low oxygen). Review of the Minimum Data Set (MDS) assessment, dated 3/16/21, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating the Resident was cognitively intact. Review of Resident #59's physician progress note, dated 5/3/21, indicated the following: Chronic pain disorder-Patient has a history of chronic pain and is on morphine sustained released 105 mg twice a day and morphine immediate release 60 mg every 6 hours PRN as needed. Resident also received Lyrica 200 mg three times a day for chronic peripheral neuropathy. Resident is reported to have knowledge of when his/her next dose of PRN (as needed) medication is able to be given. Behaviors concerning with substance abuse and tolerance. I recommend that he/she be referred to pain clinic and that his/her medications be considered for change including consideration of Suboxone for pain management. Review of Unit B schedule appointment book indicated that Resident #59 had a scheduled appointment on 5/19/21 at 1:00 P.M. at the Pain Management Clinic for chronic pain, severe bilateral osteoarthritis, and neuropathy. Review of the nursing progress notes, dated 5/18/21, indicated that the Unit Manager asked Resident #59 if he/she wanted to go out to the hospital and informed the Resident, the facility cannot give him/her more opioid than is scheduled and said Resident #59 has an order not to give PRN morphine within two hours of scheduled medication because of his/her respiratory status. Resident #59 agreed to go out to the hospital. When emergency medical services (911) arrived, the Resident refused to go and was eating, stating that he/she was not in pain but requested PRN morphine. During an interview on 06/11/21 at 10:28 A.M., Resident #59 said the last two nights the pain has been really bad. Resident #59 said she/he had a scheduled appointment with the pain clinic on 5/19/21, but the facility canceled the appointment because they could not provide transportation to the appointment. Review of the [NAME] Ambulance letter sent to the facility Administrator, dated 3/1/21, indicated the following: We regret to inform you that as of April 1, 2021, the facility contracted Ambulance Service will no longer be servicing the Charlwell House Health and Rehabilitation Center. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the local EMS report, for service on 5/18/21, indicated: Resident #59 was found seated in his/her wheelchair eating with no signs of pain or distress. Staff explained that the patient was in excruciating pain and they can't manage it at the facility. Emergency Medical Service (EMS) spoke with the patient and was told that the pain is chronic and no worse than usual and that he/she was supposed to have an appointment with a pain specialist tomorrow. Patient stated the staff canceled his/her appointment tomorrow because they cannot find him/her a ride from any private EMS company. Patient asked if he/she would like to go to the hospital to which he/she stated, I don't need to go to the hospital; I need to get to my appointment. Patient also told EMS that nursing staff asked patient so your pain is excruciating right? making quotations with her fingers as to make the degree of pain warrant a 911 emergency response. Staff brought to the room again and asked if this was an emergency and they stated yes, but offered no rationale. EMS asked about a non-emergency transport and they replied we have called them all and none will come to this area. Staff stated again that Resident #59 did not want to go and this is not an emergency. NA3 (EMS) cleared no emergency and obtained a patient refusal signature after patient refused assessment. During an interview on 06/16/21 at 08:35 A.M., Resident #59 said he/she is still experiencing a lot of pain. Resident #59 said when she/he gets the pain, it is a sharp pain and if it was a 10, it's now a 15 (scale 0-10). Resident #59 said she/he needs a hip replacement, but is unable to have the surgery due to her/his breathing difficulty. Resident #59 said physical therapy gave him a wheelchair with the best cushion, but because of the hip pain he/she can only sit up for one hour before he/she starts getting sharp hip pain. Resident #59 said he/she wanted to be seen in the pain clinic on 5/19/21 because they have helped him/her in past with pain relief by changing his/her medication doses or by receiving injections. During an interview on 06/16/21 at 08:40 A.M., The Director of Nurses (DON) said, at the time of the scheduled appointment on 5/19/21, the facility did not have a transportation contract for non-emergency appointments requiring medical supervision. The DON said the facility called 911, because Resident #59 said he/she was in excruciating pain. The DON said, when 911 arrived, Resident #59 refused to go to the hospital because he/she was eating. The DON said the pain clinic appointment was rescheduled to July 2021.

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	225208	A. Building B. Wing	07/06/2021

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 15218 Based on observation, record review, and interviews, the facility failed to: 1) provide adequate supervision for 10 Residents (#3, #6, #2, #41, #28, #18, #29, #48, #54 and #5) who have been assessed as being at risk for elopement. Specifically the facility failed: -To provide adequate supervision for residents who have been assessed as being at risk for elopement as its electronic system for monitoring residents with wandering behavior to prevent their elopement from a secure unit was not working, and the Facility had not initiated repairs or alternative methods of monitoring for elopement at the time of survey to ensure the resident's safety. -To initiate any interventions, provide education to staff or make changes to the plan of care to compensate for the lack of a functioning electronic monitoring system to ensure the safety of residents who are assessed to be at risk for elopement; and 2. ensure that supervision was provided to residents to prevent accidents, such as falls, and interventions were revised and implemented to prevent further falls with injury from occurring for one Resident (#44), out of a total sample of 33 residents. Findings include: 1. Review of the facility's elopement prevention polices, dated as revised February 2020, indicated the following: *The policy titled Elopement Prevention and Management indicated the facility strives to prevent resident elopement. *Elopement is defined as the ability of a resident who leaves the physical structure of the facility unattended and without the staff knowledge, and may enter into harm's way. *Wandering refers to cognitively impaired resident's ability to move about inside the facility aimlessly and without an appreciation of personal safety needs and who may enter into a dangerous situation. *The purpose of the policy is to identify residents at risk for elopement and develop individualized prevention and management intervention based on exit seeking elopement evaluations, and make frequent monitoring of the resident's whereabouts to assure he or she remains in the facility. *The evaluations are to complete prior to admission, on admission, re-admission, significant change and quarterly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*The facility staff are to develop an individualized plan with interventions which may include electronic monitoring/alarm system, environmental modifications, protected list of names and photographs of those at risk for elopement, psychological interventions, regular rounds, staff and family interventions and structured group activities. *The facility will assess both internal and external potential environmental risk factors including: elevators, exit doors, screens, stairwells and windows, maintain door alarms, wander control systems, highways and bodies of water, to ensure proper working order. *The facility will maintain a current list of names and photographs of residents identified at risk for elopement using the resident's demographic, and the facility will monitor their whereabouts. This will be validated through observation that the resident is wearing an electronic device and the interdisciplinary team will re-evaluate cognitively impaired residents who have attempted, unsuccessful or successfully to leave the facility without staff knowledge and determine the cause and re-evaluate interventions. *Staff will be educated on the elopement policy which included the assessment, monitoring and proper function of a wander bracelet. The facility conducts and tracks elopement drills at least quarterly which identify staff knowledge of the policy and the need for further education. Unit C was identified by the facility as the secured unit for those residents who are at risk for elopement when left unattended. The unit is equipped with door alarm codes to access and exit the unit and a Wanderguard System. The residents that are assessed to be at risk for elopement have a Wanderguard bracelet placed on their ankle or wrist. During multiple observations on 6/9/21, 6/10/21, 6/11/21, 6/14/21, 6/15/21, and 6/16/21, residents were observed wandering the unit. Resident #2, #29, #31 and #48 were observed wandering throughout the unit and attempting to open exit doors. The staff did not engage the residents, nor did they provide redirection away from the exit doors, elevator doors, unsafe areas, to maintain the wandering residents' safety. During an interview on 6/16/21 at 3:04 P.M., Maintenance Staff #1 said the Unit C electronic system for monitoring residents with Wanderguard bracelets was not working properly Maintenance Staff #1 said the facility had been aware that it had not been functioning for a long time. Maintenance Staff #1 could not provide the quarterly documentation that the Wanderguard System had been checked, per the facility policy to ensure proper functioning. Maintenance Staff #1 also said that he did not know what the facility staff had implemented for the residents with Wanderguards for their safety and to prevent them from exiting the building through the elevator. During an interview on 6/16/21 at 3:06 P.M., Unit Manager #1 (UM #1) said she did not have a list of residents who were at risk for elopement and could not identify which residents were at risk for elopement. After review of the resident's Physician Orders, UM#1 created a list of residents identified to be at risk for elopement. Review of the list indicated there were 10 residents who had been identified as at risk for elopement. UM #1 did not know the facility's procedure for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/16/21 at 3:24 P.M., Surveyor #2 informed the Administrator that the Wanderguard System was not working properly and Maintenance Staff #1 said it had not been working since July of 2020. The Administrator said to take what the maintenance staff said with a grain of salt. During an interview on 6/16/21 at 5:32 P.M., the Administer said he had no alternate plan in place for resident safety related to elopement risk and safety. On 6/17/21 at 7:30 A.M., the Director of Nurses said she did not know anything about the Wanderguard System not functioning correctly. During an interview on 6/17/21 at 9:00 A.M., the Staff Development Coordinator said she had no education for staff and could not provide the documentation for emergency preparedness which included elopement. Emergency preparedness or disaster plan includes a plan for locating a missing resident and the facility did not have one. She said the employee folders were empty files. On 6/17/21 at 11:25 A.M., Surveyor #3 entered the elevator without entering an access code. The surveyor was carrying a functional Wanderguard. The elevator door remained open for six seconds and an alarm was sounding but the door shut and the elevator descended to the basement. The surveyors did not observe staff respond to the alarm and check for elopement. The surveyor observed three exit doors to the outside. None of the doors were locked and none of the doors were alarmed. The three exit doors had access to the facility parking area which had direct access to a busy state divided highway. During an interview on 6/17/21 at 1:00 P.M., the surveyor asked the Administrator about the facility's safety plan for the Wanderguard System. The Administrator had no alternate plan in place for resident safety related to elopement risk. 41065 2. Review of the facility's policy titled Falls Management and Prevention, revised 1/2021, indicated the following: - A fall is the unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g , onto a bed, chair, or bedside mat) - The staff will implement goals and interventions with the resident/patient/family for inclusion in the interdisciplinary care plan based on the resident's individual needs - Communicate interventions to the care givers and resident/family - Review and revise IDT care plan when a change is identified, after an event - The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events etc. - If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention as resolved (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- If the individual continues to fall, the staff and physician will reevaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will reevaluate the continued relevance of current interventions. - Post Fall: the nurse will complete an incident report - Monitoring and Follow up: Residents who continue to fall with interventions in place will be assessed for changes in or additions to interventions. Resident #44 was admitted to the facility in May 2017 with diagnoses that included tremors, adult failure to thrive, and gait instability resulting in frequents fall and recent left distal fibula fracture (broken ankle). Review of the most recent Minimum Data Set (MDS) assessment, dated 5/11/21, indicated that Resident #44 had a Brief Interview for Mental Status (BIMS) score of 15 out of a total score of 15 which indicated that he/she was cognitively intact. The Resident had a Health Care Proxy in place that had not been activated. During an interview on 6/14/21 at 10:02 A.M., Resident #44 said he/she recently had a fall trying to use the vending machine in the solarium. The Resident said before my last fall I could walk around the building using my walker but now I have to use the wheelchair so I can't move around as much. Review of Resident 44's progress notes from April 2020 through June 2021 indicated he/she had a total of fourteen falls in the facility. The falls were as follows: - 4/22/20 2:00 A.M.: Unwitnessed fall out of bed reaching for remote control - no injury - 4/24/20 4:45 A.M.: Unwitnessed fall ambulating to bathroom - no injury - 5/12/20 5:30 A.M.: Unwitnessed fall ambulating to bathroom, nurse notified by roommate of fall - no injury - 7/25/20 11:25 P.M.: Unwitnessed fall ambulating to bathroom, nurse notified by roommate of fall - 1 cm (centimeter) by 1.5 cm induration on back of head and 3 cm by 2 cm bruise to left shoulder - 8/25/20 7:05 A.M.: Unwitnessed fall in bathroom - Back pain - 11/15/20 11:15 A.M.: Fall in front foyer of building - Friction burn from rug to left elbow - 12/1/20: Fall in solarium - no injury - 1/2/21 10:05 P.M.: Fall self-transferring in room, nurse notified by roommate - Sent to ER for back pain - 1/26/21: Unwitnessed fall in bathroom, nurse notified by roommate - no injury - 2/23/21: Found leaning against vending machine in solarium due to loss of balance. Lowered to chair by staff. - No injury (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- 5/6/21 9:30 P.M.: Unwitnessed fall in solarium attempting to use vending machine - no injury - 5/11/21 7:49 A.M.: Unwitnessed fall in room - No injury - 5/11/21 11:15 P.M.: Unwitnessed fall in solarium attempting to use vending machine - Sent to ER for left distal fibula fracture. Review of the medical record (MDS and nurse's notes) indicated that prior to 5/11/21, Resident #44 was able to ambulate with a rolling walker and supervision. Review of the Physician's progress note for Resident #44, dated 5/12/21 indicated that following the fall on 5/11/21 the Resident had sustained a left distal fibula fracture, required a splint and was non-weight bearing on the left lower extremity. Resident # 44 was to follow up with orthopedics within 3 days. Review of the Resident's care plan for falls (initiated 11/20/20), indicated that the Resident was at risk for falls related to weakness, tremors and the use of psychotropic medications. The goal was for no injuries related to falls. Previously resolved care plans for falls were unavailable for surveyor review. Interventions to prevent falls/injury included: - 2 quarter side rails to assist with bed mobility and transfers (4/17/21) - Continuous education on importance of using call light and keep reminding the Resident to ask for assistance when getting out of bed and walking and wait for assistance all the time (5/11/21) - Educate and remind the Resident to ask for assistance when getting out of bed and walking (11/20/20) - Electrical bed to assist with safe transfers (11/20/20) - Ensure items are within reach of resident (11/20/20) - Ensure proper foot wear on when ambulating: Nonskid socks or shoes (1/26/21) - Keep room well-lit and clutter free (11/20/20) - Monitor for changes in cognitive status, evidence of infection (11/20/20) - Monitor pain as ordered (11/20/20) - Monitor side effects of psychotropic medications (11/20/20) - Remind Resident if she wants a soda to ask for assistance (5/6/21) - Notify MD and NP as needed (11/20/20) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Orient to call light; keep within reach and encourage use (11/20/20) - Overnight checks for toileting (11/20/20) - Place TV remote within reach (11/20/20) - PT/OT as ordered (11/20/20) - Reeducation on importance of using call light and asking for help with all ADL's care and transfers when needed, and wait for staff to help (5/11/21) - Rehab referral regarding safe ambulation and walker (11/18/20) - Remind resident to ask for assistance with getting things from low areas (shelves, floor etc.) (5/6/21) - Ask Resident if they would like you to get something from the vending machine on 7-3 and 3-11 shifts (5/12/21, after injury occurred) Review of the Physician's progress note for Resident #44 dated 5/11/21, indicated that last night the Resident slid to the floor. He/She is noncompliant with nursing instructions and frequently attempts to transfer to the bathroom. Gait is unsteady and she/he is on fall precautions due to high risk of falls. During an interview on 6/14/21 at 11:58 A.M., Unit Manager #2 said Resident #44 is impulsive and would ambulate without asking for assistance. We have tried to educate the Resident and make sure she has her call light but she keeps falling. She said the Resident likes to go to the vending machine to buy sodas. We have encouraged her to use her call light and keep her things within reach. On 6/14/21 at 12:40 P.M., the surveyor observed Resident #44 in his/her room. The Resident was sitting in his/her wheelchair between his/her bed and the window. There was no call light available within reach of the Resident. The surveyor asked the Resident how he/she would call for help if needed. The Resident said he/she would probably scream for someone or just do things myself. On 6/14/21 at 12:44 P.M., the Infection Control Nurse (who was assigned to work this current shift as a staff nurse) and was caring for Resident #44) said she was unaware of the specific fall interventions in place for the Resident but would expect his/her call light to be within reach at all times. The surveyor and the Infection Control Nurse reentered the room and observed the call light out of reach to the Resident. During an interview on 6/14/21 at 2:02 P.M., the Director of Nurses (DON) and the surveyor attempted to review all incident reports (a total of 14) for Resident #44's falls between April 2020 and June 2021, as referenced in the nurse's notes. The Director of Nurses said she had only been in the building since April 2021 and could not find all incident reports because a lot of documentation had gone missing. She was able to locate seven falls investigation reports out of 14 reports for review. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	At 2:28 P.M. the DON also said, fall prevention interventions were reviewed for Resident #44 including call light use and the education provided to the Resident. The Director of Nurses said that education with the Resident was ineffective since she is so impulsive, but her expectation is that the call light is within the Residents reach.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10249 Based on observation, record review and interviews, the facility failed to ensure nutritional status was maintained for three Residents (#8, #1, and #35), out of a total sample of 33 residents. Specifically, the facility failed to: 1. Monitor the fluid restriction and provide adequate nutrition prior to attending hemodialysis for one Resident (#8); and 2. Maintain acceptable parameters of nutritional status which resulted in weight loss for two Residents (#1 and #35). Findings include: 1. Review of the Dialysis contract indicated: Preparation of ESRD Residents: The nursing home shall ensure that ESRD Residents are prepared to spend an extended length of time at the ESRD Dialysis Unit and have received proper nourishment and any medications prescribed as appropriate, before coming to the ESRD Dialysis Unit. Resident #8 was admitted to the facility in March of 2016 with a diagnosis of End Stage Renal Disease (ESRD) and received renal dialysis treatments four times a week. Review of the Minimum Data Set (MDS) assessment, dated 3/9/21, indicated the Resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. The MDS also indicated that the Resident was 68 inches tall, weighed 273 pounds and received dialysis. Review of the physician's order indicated that Resident #8 prescribed diet was: CCD (consistent carbohydrate diet), No added salt, large portion of protein with meals, no tomato sauce, no orange juice, no bananas, and a 1500 milliliter (ml) fluid restriction (240 ml per meal and nursing 780 ml). Review of a physician's order, dated 7/20/20, indicated Resident #8 attended dialysis treatments four times weekly on Monday, Wednesday, Thursday, and Friday and PRN (as needed) per request of the dialysis center. Review of Resident #8's care plans indicated: 1.) The Resident has renal failure and receives dialysis four times a week (initiated and revised 3/20/21). The interventions include: -dialysis scheduled at center -Fluid restriction as ordered, educate as needs, non-compliant at times, dialysis MD aware -monitor renal failure and dietary restrictions (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-nursing not to leave fluids at bedside, resident is non-compliant, educate frequently -non-compliant with meal choices continue with education and offer better choices 2.) Altered nutrient utilization-carbohydrate metabolism related to diabetes and ESRD, overweight/obesity, altered labs related to renal disease hyperkalemia (elevated potassium) and dialysis (initiated 3/14/19). The interventions include: -diet: CCD, NAS large protein portions at meals, 1.5 l fluid restriction (240 ml at each meal for dietary (beverage of choice) (revised 3/10/20 -observe/document as indicated: meal consumption, amount of assistance needed at meals and tolerance to diet/fluids (initiated 3/14/19) During an interview on 6/14/21 at 9:15 A.M., Resident #8 said that he/she goes to dialysis four times a week, and today was leaving at 11:00 am to go to the dialysis center. The Resident said he/she does not eat lunch on those days, nor receive any snacks or lunch from the facility to take to dialysis. Review of the annual nutrition assessment, dated 3/15/21, indicated that Resident #8 was 68 inches tall, weighed 275 pounds and required 2093 calories, 84-105 grams protein and 2093 ml of fluid per 24 hours to meet his/her nutritional needs. The Dietitian also documented that the resident was prescribed a no added salt, consistent carbohydrate diet, and had a 10 pound weight loss in six months (not significant), however there was no documentation that the resident was on a fluid restriction. There was no indication of an alternative plan in place to ensure that the Resident received 100% of his/her nutritional needs since he/she was out of the facility to attend dialysis during the noon meal four times each week. On 6/14/21 at 9:15 A.M., the surveyor observed Resident #8 finishing breakfast. The Resident consumed eight ounces of coffee and eight ounces of milk. Review of the meal ticket indicated that Resident #8 was on a No added salt, consistent carbohydrate diet, 1500 fluid restriction, allergy: tomato, banana, orange, mandarin orange, and tomato sauce. The meal ticket also indicated coffee (no amount) and 4 ounces of milk, with large portions of meat at all meals and no lunch Monday, Wednesday and Friday. The surveyor also observed a 16 ounce bottle of soda and a 16 ounce insulated cup, on the Resident's tray table, which the Resident said he/she drinks during the day On 6/15/21 at 12:25 P. M., the surveyor observed Resident #8 during mealtime and the Resident consumed eight ounces of coffee and four ounces of milk. On 6/16/21 at 8:30 A.M., the surveyor observed Resident #8 and he/she consumed 16 ounces of coffee from [NAME] Donuts. On 6/16/21 at 9:00 A.M., the surveyor observed Resident #8 had consumed an additional eight ounces of coffee. On the Resident's bureau was a 16 ounce insulted mug with liquid inside. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Treatment Administration Record (TAR) for June 2021 indicated 1500 cc fluid restriction indicating the three shifts were marked with a check only. No identified quantity of fluid consumed was documented to monitor that the Resident's fluid consumption did not exceed the 1500 cc fluid restriction order. During an interview on 6/16/21 at 9:55 A.M., Nurse #3 said she was aware that Resident #8 was on a fluid restriction, but could not speak to the quantity of fluid consumed daily by the Resident. During an interview on 6/21/21 at 11:00 A.M. (via telephone), the facility Dietitian said she was aware that the Resident was prescribed a fluid restriction but was not aware that the dietary staff were providing the incorrect amount on fluids on the Resident's tray. She also said that she was not aware that there was no plan in place for the 3-4 meals a week the Resident misses when he/she is at dialysis receiving treatment. 15218 2. Resident #35 was admitted to the facility in October 2019 with diagnoses that included advanced and worsening dementia. Review of the Minimum Data Set (MDS) assessment, dated 1/26/21, indicated Resident #35 had impaired short and long term memory and required supervision cueing and encouragement to complete each meal. The resident weighed 167 pounds and was 64 inches (5'4 tall). Review of the Comprehensive Nutrition Assessment, dated 1/31/21, indicated Resident #35 weighed 161 pounds and required assistance when he/she ate and drank. The assessment indicated both the resident's physical and mental conditions affected his/her nutritional status. At the time of the assessment, the dietitian indicated Resident #35's intake was variable, tolerating 25 - 75% of his/her meals, and weight changes were not clinically significant. No change was made to the plan of care. Review of the most recent MDS, dated [DATE], indicated a weight of 155 pounds, a loss of 12 pounds (7. 1%). Review of the Resident's monthly weights for May and June 2021 were as follows: - On 5/10/21 - the Resident's weight was 152.3 lbs., an additional 2.2 pound weight loss since 4/27/21, with overall weight loss of 23.7 lbs. since 1/26/21 - On 6/3/21 - the Resident's weight was 143 lbs., an additional 12 pound weight loss in less than a month and an overall weight loss of 24 pounds since 1/27/21. Review of the medical record indicated there was no intervention or change in the nutrition plan of care to address the weight loss. On 6/10/21, seven days after the facility staff obtained Resident #35's weight of 143 lbs., the nurse's note, indicated the Resident was referred to nutrition for consult due to weight loss. The note indicated Resident #35 had lost 10 pounds in one month and 20 pounds in six months. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Actual harm Residents Affected - Few	A nutritional assessment was completed on 6/10/21. The dietitian added Mighty shakes and Med pass, 120 ml, twice daily between meals for added calories. On 6/9/21 at 12:00 P.M., the surveyor observed Resident #35 during mealtime in the dining room. Resident #35 was provided a meal on tray, which was placed on the table. The staff did not cue or encourage him/her during the meal. The Resident looked disinterested in the meal. At the end of the meal, the staff asked if the Resident was done and took the meal away, the plate of food was barely touched. On 6/11/21 at 12:20 P.M., the surveyor observed Resident #35's during mealtime in the dining room. The Resident was observed occasionally picking at meal. At no time did staff assist, cue, or encourage Resident #35 to eat. During an interview on 6/11/21 at 2:00 P.M., Unit Manager #1 said the facility does not have nutrition risk meetings. She said that had notified the dietitian about Resident #35's weight loss once she had become aware on 6/10/21. During an interview on 6/15/21 at 1:45 P.M., the Dietitian said that she had just started working at the facility and was not aware of the weight loss until the unit manager had identified the loss on 6/10/21. The Dietitian said she has remote access to the medical record and could have identified the problem, but had not. She said Resident #35 weight loss was not planned and interventions for undesirable weight changes had not been put in place until she had been notified by the staff on 6/10/21. 3. Resident #1 was admitted to the facility in February 2021 with diagnosis that included chronic obstructed pulmonary disorder (lung disease that blocks airflow and makes it difficult to breathe) and depression. Review of the Nutrition Assessment, dated 2/25/21, indicated the resident required supervision with meals, weighed 136 pounds, had a pressure injury and was at risk for unintentional weight loss. The Dietician recommended Ensure for extra protein for wound healing. Review of the MDS assessment, dated 3/3/21, indicated the Resident scored 9 out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment and he/she was able to eat independently. Review of the medical record did not include a care plan for nutrition. Review of the June 2021 Physician's orders included documenting percentage of intake after each meal and obtaining monthly weights. Review of the monthly weights is as follows: -2/24/21: 136 lbs. -3/3/21: 134.4 lbs. -6/10/21: 125. 4 lbs. (loss of 10.6 lbs. or 7.7% in 4 months) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	There were no weights for April or May 2021 available for review. During an interview on 6/10/21 at 7:30 A.M., Resident #1 said that breakfast was not very good and had only eaten the oatmeal. The Resident said that no one has come and asked what he/she likes to eat. During an interview on 6/15/21 at 12:30 P.M., Resident #1 said he/she did not like the meal and was eating a peanut butter and jelly sandwich instead. During an interview on 6/15/21 at 1:45 P.M., the Dietitian said she knew nothing about Resident #1's weight loss or missing weights.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41065 Based on observations, interviews, and record review, the facility failed to ensure pain management consistent with professional standards and the resident's goals and preferences was provided to one Resident (#59), out of a total sample of 33 residents. Specifically, for Resident #59, the facility failed to: 1) administer medications timely and per facility policy; and 2) accommodate transportation to a scheduled pain clinic appointment. Findings include: 1. Resident #59 was admitted to the facility in November 2020 with diagnoses of chronic pain syndrome, osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy and interstitial pulmonary disease, and chronic respiratory failure with hypoxia (low oxygen). Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that he/she was cognitively intact. Review of the facility's policy titled Medication Administration, updated December 2019, indicated the following: - Medications shall be administered in a safe and timely manner, and as prescribed. - Medications should be administered in accordance with the physician orders, including any required time frame. - Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). During an interview on 6/16/21 at 8:40 A.M., the Staff Development Coordinator (SDC), who had just accepted responsibility for the medication cart on Unit B, said there was a scheduling conflict and she will be administering medications until the scheduled nurse arrives. On 6/16/21 at 9:19 A.M., the surveyor observed Resident #59 telling the SDC that he/she had a pain level of 8 out of 10 in his left hip (indicating the Resident had severe pain). On 6/16/21 at 9:33 A.M., the surveyor observed Resident #59 lying in bed and was grimacing. The Resident said he/she was all done eating breakfast but still had not received his/her insulin, had his/her blood sugar checked, or received pain medication for the pain reported in his/her left hip. Resident #59 said, the pain is constant. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/16/21 at 9:40 A.M., the SDC said she had not given out any medications and was late on everything. She said she would check Resident #59's blood sugar and planned to call the doctor. On 6/16/21 at 9:45 A.M. (26 minutes after requesting pain medication from the SDC for his left hip pain), the surveyor observed Resident #59 yelling out from the bed saying, Come on now will you, hurry up! The surveyor asked the Resident what was wrong and he/she said, I'm in pain and need something to help it! Review of the current physician's orders for Resident #59 indicated the following pain medications were overdue: - Prednisone 10 mg (Steroid used for pain) daily at 9:00 A.M. - Morphine Sulfate ER 15 mg (pain) give seven tablets (105 mg) two times per day at 9:00 A.M. and 9:00 P. M. - Acetaminophen 500 mg (pain) give two tablets (1000 mg) three times per day at 9:00 A.M., 1:00 P.M., and 5:00 P.M. Further review of the Resident's current physician orders indicated the following as needed medications and treatments were available for pain management: -Morphine Sulfate Tablet 30 mg-Give two tablets by mouth every six hours as needed for pain. -Acetaminophen Tablet 325 mg-Give two tablets by mouth every six hours as needed for pain -Apply hot pack to right thigh for pain/discomfort, every six hours as needed for pain -Biofreeze Gel 4% (Menthol topical analgesic)-apply right thigh topically every 12 hours as needed for pain -Capsaicin Cream 0.025% apply to body topically every eight hours as needed for arthritis -Lidocaine patch 4%-Apply to right hip topically every 12 hours as needed for pain -Tizanidine Tablet 2 mg-Give two mg by mouth every eight hours as needed for muscle cramps. On 6/16/21 at 10:00 A.M., the surveyor observed the SDC preparing and administering the following pain medications to Resident #59 (41 minutes after the Resident requested pain medication for hip pain): - Acetaminophen 1000 mg (approximately 1 hour late) - Prednisone 10 mg (approximately 1 hour late) - Morphine Sulfate ER 105 mg (approximately 1 hour late) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The surveyor observed no additional pain management medications or treatments provided to Resident #59. During an interview on 6/16/21 at 10:13 A.M., the SDC said she spoke with the physician who said to hold the 7:30 A.M. sliding scale Novolog insulin, but could administer the remaining medications. There was no discussion related to Resident #59's pain management. The surveyor was present at the nurse's station at the time of the telephone conversation between the SDC and the physician. On 06/16/21 at 10:25 A.M., the surveyor observed Resident #59 grimacing and yelling out in pain saying, I need pillows under my legs, it hurts, my god! The Resident said to the surveyor, When I don't get my pain medications on time, I get sharp shooting pains that don't go away. The medication helps take the edge off so it doesn't hurt so bad. 2. Review of Resident #59's physician's note, dated 5/3/21, indicated the following: Chronic pain disorder- Patient has a history of chronic pain and is on morphine sustained released 105 mg twice a day and morphine immediate release 60 mg every 6 hours as needed. -Resident also received Lyrica 200 mg three times a day for chronic peripheral neuropathy. -Resident is reported to have knowledge of when his/her next dose of as needed medication is able to be given. -Behaviors concerning with substance abuse and tolerance. -I recommend that he be referred to pain clinic and that his/her medications be considered for change including consideration of suboxone for pain management. Review of Unit B schedule book indicated the following: -Resident #59 had a scheduled appointment 5/19/21 at Pain management Clinic for chronic pain, severe bilateral osteoarthritis and neuropathy at 1:00 P.M. During an interview on 06/11/21 at 10:28 A.M., Resident #59 said the last two nights the pain has been really bad. Resident #59 said he had a scheduled appointment with the pain clinic in May, but the facility canceled the appointment because they could not provide transportation to the appointment. During an interview on 06/16/21 at 08:35 A.M., Resident #59 said he/she is still experiencing a lot of pain. Resident #59 said when he gets the pain, it is a sharp pain, and if it was a 10, it's now a 15 (scale 0-10). Resident #59 said he needs a hip replacement, but is unable to have the surgery due to his breathing difficulty. Resident #59 said physical therapy gave him a wheelchair with the best cushion, but because of the hip pain he/she can only sit up for one hour before he/she starts getting sharp hip pain. Resident #59 said he wanted to be seen in the pain clinic because they have helped him in past with pain relief by changing his/her medication doses or by receiving injections. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/16/21 at 08:40 A.M., the Director of Nurses (DON) said, at the time of the scheduled appointment on 5/19/21, the facility did not have a transportation contract for non-emergency appointments requiring medical supervision. During an interview on 06/16/21 01:35 P.M., with the DON and the Administrator, the DON said we could not provide Resident #59 with transportation to the pain clinic appointment. The Administrator confirmed they had no transportation contract to bring any residents to appointments in May 2021.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 10249 Based on record review and staff interview, the facility failed to ensure that dialysis care and treatment, including the communication of pertinent clinical assessment information between the Nursing Facility (NF) and the dialysis unit was documented in accordance with the Skilled Nursing Facility Outpatient Dialysis Services Agreement for one Resident (#8) receiving dialysis, from a total sample of 33 residents. Specifically, the facility failed to ensure that the communication book used to refer information between the facility and the dialysis unit was up-to-date and contained pertinent information including dialysis treatment outcomes. Findings include: Review of the Dialysis Contract, dated 5/1/21, between the nursing facility and the dialysis unit indicated: Mutual Obligations: -Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the nursing facility and ESRD [End Stage Renal Disease] Dialysis Unit. Documentation shall include, but not limited to, participation in care conferences, continual quality improvement programs, annual review of infection control policies and procedures, and the signature of team members from both parties on a short or long term plan. Team members shall include the physician, nurse, social worker, and dietitian from the ESRD Dialysis unit and a representative from the nursing facility. Resident #8 was admitted to the facility in March 2016 with a diagnosis ESRD, and received renal dialysis treatments four times a week. Review of the Minimum Data Set (MDS) assessment, dated 3/9/21, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident was cognitively intact; and received dialysis treatments. Review of the most recent physician's orders indicated Resident #8 received dialysis treatments four times weekly on Monday, Wednesday, Thursday, and Friday, and as needed at the request of the Dialysis physician. Review of Resident #8's most recent care plan indicated the Resident received renal dialysis four times a week with one intervention that included: -Check dialysis communication book after treatment and complete prior to dialysis appointment, send with resident to dialysis The NF and dialysis center used a Dialysis Communication Form to communicate pertinent clinical information about the Resident. The Dialysis Communication Form was sent with the Resident to dialysis by the NF in the communication book (a three ring binder) and completed by the nurse and/or technician at the dialysis center. Information required by the dialysis unit to provide to the NF included: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pre/Post weight -Pre/Post BP -Pre/Post Temp -Pre/Post Respiration -Pre/Post pulse Additional comments and signed by the dialysis nurse and technician. Review of Resident #8's dialysis communication book indicated limited documentation between the NF and dialysis unit including: *April 2021- the Resident was scheduled for 18 treatments and review of the communication book indicated only eight documented visits for the month. *May 2021- the Resident was scheduled for 17 dialysis treatments and the communication book indicated only three documented visits for the month. *Tracking My Numbers (document of the Resident's monthly labs) is issued monthly by the dialysis dietitian; however there was only two months available, March 2021 and May 2021. During an interview on 6/16/21 at 9:55 A.M., Nurse #3 said that she could not locate any dialysis communication forms other than what was currently in the Resident's communication book.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 41106 Based on observations, record review, and staff interviews, the facility failed to implement their side rail assessment and installed side rails on one Resident's (#33) bed when they were not indicated; and failed to assess the beds with side rails for entrapment and maintain the side rails in working order for two Resident's (#15 and #33), out of a total of 33 residents. Findings include: Review of the facility's policy for Side Rails, revised September 2019, indicated the following: -Each resident will be assessed for functional status on admission, readmission, and quarterly, for any significant change and as needed. Side rails will only be used by a resident to assist with his or her bed mobility. -Side rails will be analyzed for safety and prevention of entrapment. -On admission, readmission, and quarterly and with significant change in condition, the residents sleeping environment shall be assessed to include the need for side rails to assist with their bed mobility. -Maintenance Director will measure and review and maintain proficiency in the practice of side rail safety, utilizing the bed entrapment measuring tool. Inspection by maintenance staff of all beds and related equipment is part of facility's regular bed safety program to identify risks and problems including potential entrapment risks. -Documentation of Bed Assessment tool to Prevent Entrapment will be done on the attached assessment tool, confirmed with the administrator and kept on file for one year. -The maintenance department shall provide a copy of inspections to the administrator and report results to the Quality Assurance (QA) Committee for appropriate action. Copies of the inspection results and QA Committee recommendations shall be maintained by the Administrator and/or Safety Committee if applicable. 1. Resident #13 was admitted to the facility with diagnoses of coronary heart disease and heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/16/21, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident was cognitively intact. During an interview on 6/17/21 at 3:35 P.M., the Administrator said all residents on Unit A were moved to Unit B on 6/1/21 as part of the construction plan. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/16/21 at 1:15 P.M., Resident #13 said his/her left bed rail is broken (loose) and it is scary when I pull on it to turn in bed. Resident #13 said he/she has reported the loose bed rail to the nurses, but no one has fixed it; it keeps coming loose. During an interview on 6/16/21 at 4:35 P.M., Maintenance Worker #1 said he was not sure why Resident #13's mobility bar keeps coming loose; he just tightened it a few days ago. He said when he is walking around and he sees one hanging down, then he goes in and tightens the mobility bar. Maintenance Worker #1 said when Resident #13 moved to Unit B at the beginning of June he did not evaluate Resident #13's new bed for entrapment. 2. Resident #33 was admitted to the facility with diagnoses of seizure disorder and dementia. Review of Resident #33's Quarterly side rail assessment, dated 4/7/2021, indicated the following: -Reason for side rails: None -Recommendations for side rails: Side rails are NOT recommended at this time During an interview on 6/16/21 at 4:35 P.M., Maintenance worker #1 and the surveyor viewed Resident #33's bed and found the right mobility bar off the bed, lying on the spare bed. Maintenance Worker #1 said the new side rails loosen all the time, I just have to get a wrench and screw it back on. Maintenance Worker #1 said when Resident #33 moved over to Unit B at the beginning of June he did not evaluate Resident #33's bed for entrapment. During an interview on 6/24/21 at 9:30 A.M., the Staff Development Coordinator said Resident #33 is not supposed to be sleeping in the bed by the door; he/she should be in the bed by the window which does not have side rails. During an interview on 6/24/21 at 9:30 A.M., Certified Nursing Assistant (CNA) #5 said Resident #33 has always slept in the first bed by the door with the side rails.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 15214 Based on document review and staff interview, the facility failed to: 1) ensure that nursing staff were assessed to have the competencies and skill sets required to provide safe and effective nursing care to the residents of the facility; and 2) ensure that a glucose control test was conducted prior to testing a Resident's (#59) blood and prior to using a new bottle of test strips. Findings include: 1. During an interview on 6/16/21 at 2:19 P.M., the facility Staff Development Coordinator (SDC) said that she was newly-hired in May 2021 and was just starting to plan to assess nurses' competencies as she currently did not have any competencies for the licensed nurses who worked at the facility. The SDC explained that the facility had been without an SDC from 1/2021 to 5/23/21, and that many of the duties performed by the SDC were not completed, i.e. (orientation requisites, staff education, infection control surveillance, licensed and unlicensed staff clinical competencies, etc.). She said that there were few nursing competencies available for the Certified Nursing Assistants (CNAs) and nurses employed by the facility and there was minimal evidence available that nurses and CNAs had been assessed for competency to perform their duties. The surveyor reviewed the binders provided by the SDC on 6/17/21 at 8:34 A.M. The only competencies available were: -Medication prep-competency exam -Infection Control Line listing training -Change in Resident Condition -Proper Filing in Medical record -Nursing Competency (general) Exam-5/2021 -Neurological Fall Assessment-4/2021, 5/2021 -Emergency versus Non-Emergency Transfer-4/19/21 During an interview on 6/17/21 at 8:40 A.M., the SDC said there were no clinical nursing competencies or documented evidence for the following: -care for residents with intravenous infusions (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-care of a resident with a gastrostomy tube (feeding tube) -use of the glucometer/blood sugar testing -use of oxygen and oxygen saturation monitoring -training and verbalizing an understanding of the elopement process and Wanderguard system -revision of ineffective interventions following falls -providing appropriate transportation to and from routine appointments -infection control practices including PPE use and the care and treatment of catheters -resident safety and the need to ensure medication carts remain locked when not in use -assessment of bed rail safety and equipment -monitoring water temperatures for resident comfort and safety -monitoring the facility Water Management Program to reduce, and/or prevent, the risk of Legionella and other water-borne illness Additionally, review of staff education training binders indicated that there was no licensed nurse, or CNA training, documented for 9/2020, 10/2020, 11/2020, 12/2020, 5/2021, or 6/2021. The SDC said to the surveyor that she had not tried to reach out to the former SDC to determine whether competencies existed for the nurses and CNAs that were currently caring for the residents at the facility. During an interview on 6/24/21 at 3:45 P.M., the SDC said that there were no additional competencies to support that the facility had assessed the qualifications/skills of the nursing staff at the facility. 41065 2. Resident #59 was admitted to the facility in November 2020 with diagnoses that included diabetes mellitus and obesity. On 6/16/21 at 9:33 A.M., the surveyor observed Resident #59 lying in bed with an empty breakfast tray on the bedside table. The Resident said he/she was all done eating breakfast, but still had not received his/her insulin or had his/her morning blood sugar checked which is usually done by 7:30 A.M. each day. During an interview on 6/16/21 at 9:41 A.M., the SDC said she was caring for Resident #59 today and was very late with all medications and would be checking the Resident's blood sugar shortly. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/16/21 at 9:46 A.M., the surveyor observed the SDC gathering supplies which included Resident #59's patient specific Assure Prism glucometer (a meter used to check a person's blood glucose level), an alcohol prep pad (to clean the skin) and a lancet (a small, sharp needle used to prick skin to draw blood). The SDC was unable to locate glucometer test strips specific for Resident #59's glucometer. On 6/16/21 at 9:57 A.M., the surveyor observed the SDC take an opened bottle of Assure Prism tests strips from Nurse #3. These test strips were specific to another glucometer and was not tested with a control solution prior to obtaining Resident #59's blood sugar. On 6/16/21 at 9:59 A.M., the surveyor observed the SDC take all supplies, including the test strips, into Resident #59's room to obtain a blood sugar reading. The blood sugar level was 289 which Resident #59 said was high. During an interview on 6/16/21 at 10:01 A.M., the SDC said she did not have to perform the control solution test prior to the use of the new bottle of test strips because the lot numbers on each bottle were the same. Review of the Assure Prism Blood Glucose Monitoring User Manual indicated the following: -You should check your meter and test strips using Assure Prism Control Solutions (Level 1 and 2). Assure Prism Control Solutions contain known amounts of glucose and are used to check that the meter and test strips are working properly. -You should do a control test: - When you want to practice the test procedure using the control solution instead of blood - When using the meter for the first time - Whenever you open a new vial of test strips or open a new bottle of individually wrapped test strips - If the meter or test strips do not function properly - If your symptoms are inconsistent with the blood glucose test results and you feel that the meter or test strips are not working properly - If you drop or damage the meter. During a telephonic interview on 7/12/21 at 3:21 P.M., the Assure Prism Clinical Customer Service Member #1 said despite each bottle having the same lot number, anytime a different bottle of test strips is used with a glucometer, a control test must be completed to ensure the glucometer is functioning properly. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/16/21 at 2:18 P.M., the surveyor met with the Director of Nurses and the SDC. The surveyor requested to review competencies for the use of the Assure Prism Glucometers. The SDC said she only could find very few competencies for nurses, and was unable to locate any competencies for the nursing staff on the proper use of the Assure Prism Glucometer.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10249 Based on observations, record review, and interviews, the facility failed to ensure necessary services were provided for behavioral-emotional support related to mental health for one Resident (#48), out of a total sample of 33 residents. Specifically, for Resident #48, the facility failed to ensure, after a court appointed emergency transfer to the hospital, that a behavior treatment plan was implemented to address the Resident's behavior, including refusal of care, fecal smearing, and poor hygiene. Findings include: Resident #48 was admitted to the facility in August of 2018 with diagnoses that included Bipolar Disorder, anxiety disorder, and vascular dementia with behavioral disturbances. Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated Resident #48 was severely cognitively impaired. Resident #48 triggered for behaviors such as inattention, disorganized thinking, and short temper. Review of Resident #48's mood and behavior care plan (revised 2/9/21), indicated the facility identified the Resident as having behaviors that included physical aggression, refusal of care, smearing feces on floors, walls, including in common areas, yelling, and clogging toilet with multiple different items. Interventions included the following: -Administer psychotropic medications as ordered by the physician. Monitor for side effects and effectiveness every shift. -Assure that RN, social worker, MD, and family are aware of my behaviors -Reassure and redirect me when I am behavioral Review of the medical record indicated that Resident #48 was seen and evaluated by psychiatric consulting services on 2/19/21. Psychiatric note written by the Nurse Practitioner (NP) indicated the Resident was to be sent to the hospital for a psychiatric evaluation for psychosis associated agitation, smearing of feces on wall, bed, and furniture and possible ingestion. NP documented that the psychiatric service would follow up upon return to facility. Resident #48 returned to the facility on [DATE] at 12:00 A.M. in stable condition. The hospital discharge summary did not indicate any new orders. Review of a Social Service note, dated 3/5/21, indicated Resident continued with behaviors such as yelling, agitation, fecal smearing, and refusing care. Note does not address any new interventions or implementation of new plan to decrease behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated the psychiatric consulting service evaluated Resident #48 on 4/23/21, two months after his/her hospitalization , and documented that facility nursing reported more frequent episodes of smearing feces. The note also indicated that the Resident's behavior had not improved since last seen. He/she exhibits delusional behaviors relatively behaving in an obvious bizarre manner and unable to redirect. The following recommendations were: -Per PCP approval, start Depakote Sprinkles 750 mg twice a day for mood, then simultaneously start Zyprexa Zydis 5 mg twice a day for break through episodes of psychosis (smearing feces, delusions, and combative with care) -CBC,BMP next lab day and monthly for medication management -Depakote level next day -Continue to monitor every shift to help guide treatment plan Review of the nurse's progress notes, dated 2/20/21-5/31/21, indicated Resident #48 continued to exhibit behaviors, including fecal smearing and refusal of care, almost daily. On 6/14/21 at 9:54 A.M., the surveyor observed Resident #48 wearing soiled clothing. The Resident's shirt had a large stain and his/her pants had a dried brown substance on them. On 6/15/21 at 8:21 A.M., the surveyor observed Resident #48 seated in a chair, located in the hallway next to the wall, eating breakfast. Next to the Resident on the chair rail was a napkin with a large amount of feces on it. Staff was observed to walk by without noticing. Unit Manager #1 removed the napkin with feces after surveyor alerted her. During an interview on 6/15/21 at 11:32 A.M., Unit Manager #1 said she does not think that Resident #48 has any type of behavioral or treatment plan to help decrease his/her behaviors. She said she has not been educated on any specific plan for Resident #48. During an interview on 6/16/21 at 10:30 A.M., Nurse #2 said that Resident #48 had no treatment plan for behaviors other than to give him/her their medications. During an interview on 6/16/21 at 10:45 A.M., the Psychiatric NP said that the psychiatric consulting group develops their own treatment plan and includes it in their notes for the facility to review. The NP said that she provided the facility with a medication plan only and recommended to continue monitoring the Resident's behavior. Review of the medical record and interviews confirm that there was no documented evidence that the facility developed or implemented a behavioral treatment plan to help decrease behaviors, including smearing feces and refusal of care, exhibited by Resident #48 daily.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 15218 Based on observation, record review, and interview, the facility failed to ensure a plan of care was developed with individualized-person centered interventions for three Residents (#36, #37, and #35) with a dementia diagnosis, out of a total sample of 33 residents. Findings include: Review of the facility's policy titled Dementia, revised November 2016, indicated: *The facility's main focus in the care of the resident with dementia is on functioning, to understand the basic diagnosis and improve each resident's functioning. *The policy outlines the procedure and identifies what is offered a resident with dementia to maximize remaining function and quality of life. 1. Resident #36 was admitted to the facility in October 2019 with diagnoses that included dementia, depression, and anxiety. The Minimum Data Set (MDS) assessment, dated 4/27/21, indicated the Resident scored 7 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. Review of the physician's orders indicated an activated Health Care Proxy on 10/22/19. Review of Resident #36's care plan failed to indicate a plan of care for managing Resident #36's dementia. Further review of Resident #36's care plans, identified a plan of care for psychotropic medication: the plan of care identified depression and psychosis, takes antipsychotic and antidepressant medication and refuses to get out of bed (10/26/20). -The goal is to control symptoms with no side effects. -Interventions include administer medications, encourage out of bed activities, monitor resident in room, monitor effectiveness of medication, monitor mood, psych services as needed. There were no non-pharmacological interventions for managing Resident #36's symptoms of dementia. On 6/9/21 at 11:30 A.M., the surveyor observed Resident #36 in bed. The Resident did not engage easily and limited conversation with the surveyor. On 6/9/21 at 12:20 P.M., the surveyor observed Resident #36 in bed. The Resident did not recall the earlier visit with the surveyor (less than one hour prior). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/21 at 2:00 P.M., the surveyor observed Resident #36 in bed. The Resident engaged with surveyor easily, but had no recall of meeting the surveyor. 2. Resident #37 was admitted to the facility in May 2013 with diagnoses that included advanced dementia and anxiety. Review of Resident #37's MDS assessment, dated 4/27/21, indicated the Resident had significant short and long term memory loss, and required extensive assistance by two staff in all aspects of care. Review of Resident #37's medical record indicated the Health Care Proxy was invoked due to dementia. Review of the psychiatric consultant medication management progress note, dated 4/21/21, described Resident #37 as nonverbal and unaware of his/her surroundings. The psychiatric progress note recommended no non-pharmacological interventions for managing Resident #37's behaviors or symptoms of dementia, only medication; -Lexapro - anti depressant medication 10 milligrams (mg), daily; -Depakote 125 mg - mood stabilizer. On 6/9/21 from 11:38 A.M. until 12:45 P.M., on 6/10/21 at 10:17 A.M., on 6/11/21 at 9:20 A.M., on 6/15/21 at 12:20 P.M. and on 6/15/21 from 1:45 P.M. through 3:30 P.M., the surveyor observed Resident #37 either sitting in a Broda chair (positioning chair), in a reclined position in the hallway, or in bed. The resident did not engage in conversation and rarely provided eye contact and during most observations. Review of Resident #37's care plan indicated the facility failed to initiate a resident-centered care plan for Resident #37's treatment of dementia or specific individualized interventions or measurable goals. 3. Resident #35 was admitted to the facility in October 2019 with diagnoses that included advanced and worsening dementia. Review of Resident #35's MDS assessments indicated a progressive decline in functioning: -MDS assessment, dated 10/27/20, indicated Resident #35 had significant short and long term memory loss, cognitively was inattentive and thoughts were disorganized. The MDS indicated the resident could ambulate with supervision, and was minimal assistance of a set up with transfers, food set up and other aspects of care. -MDS assessments dated 1/26/21 and 4/27/21, both indicated Resident #35 had impaired short and long term memory. Resident #35's ability to walk, transfer, feed self and care for self, showed decline and the resident required both the physical assistance and extensive assistance of staff for care. Review of Resident #35's most recent care plan indicated: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility staff failed to initiate a resident-centered care plan for Resident #35's treatment of dementia or specific individualized interventions or measurable goals, other than pharmacological. -The physician had activated the health care proxy of Resident #35 on 11/21/19, due to worsening dementia. During an interview on 6/11/21 at 10:30 A.M., Unit Manager #1 said she had not implemented interventions into Residents' #36, #37, and #35, plans of care for managing behaviors or symptoms of dementia.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41065 Based on observations, interviews, and record review, the facility failed to ensure that two Residents (#59 and #55), out of a total sample of 33 residents, were free from significant medication errors. Findings include: Review of the facility's policy titled Medication Administration, revised 12/2019, indicated the following: - Medications shall be administered in a safe and timely manner, and as prescribed. - Medications should be administered in accordance with the physician orders, including any required time frame. - Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). During an interview on 6/16/21 at 8:40 A.M., the Staff Development Coordinator (SDC), who had just accepted responsibility for the medication cart on Unit B, said there was a scheduling conflict and she will be administering medications until the scheduled nurse arrives. The SDC was observed from 8:40 A.M. until approximately 9:15 A.M., assisting with breakfast meal pass and supervising the resident's eating in the day room. No medications were administered at this time. 1) Resident #59 was admitted to the facility in November 2020 with diagnoses of chronic pain syndrome, osteoarthritis, type 2 diabetes mellitus with diabetic neuropathy and interstitial pulmonary disease, chronic respiratory failure with hypoxia (low oxygen). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/16/21, indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that the Resident was cognitively intact. On 6/16/21 at 9:19 A.M., the surveyor observed Resident #59 telling the SDC that he/she had a pain level of 8 out of 10 (indicating the Resident had severe pain) in his/her left hip. During an interview on 6/16/21 at 9:33 A.M., the surveyor observed Resident #59 lying in bed grimacing. The Resident said he/she was all done eating breakfast, but still had not received his/her insulin, had his/her blood sugar checked, or received pain medication for the pain reported in his/her left hip. Resident #59 said the pain is constant. During an interview on 6/16/21 at 9:40 A.M., the SDC said she had not given out any medications and was late on everything. She said she would check Resident #59's blood sugar and planned to call the doctor. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/16/21 at 9:45 A.M. (26 minutes after requesting pain medication from the SDC for his left hip pain), the surveyor observed Resident #59 yelling out from the bed saying, Come on now, will you hurry up! The surveyor asked the Resident what was wrong and he/she said, I'm in pain and need something to help it! Review of the current physician's orders for Resident #59 indicated the following were due for administration: - Ferrous Sulfate 325 mg (Iron) daily at 9:00 A.M. - Furosemide 20 mg (diuretic) give two tablets daily at 8:00 A.M. - Lisinopril 5 mg (blood pressure) daily at 8:00 A.M. - Metformin 850 mg (diabetes) daily at 7:30 A.M. - Multivitamin (supplement) daily at 9:00 A.M. - Polyethylene Glycol (constipation) give 17 gm daily at 8:00 A.M. - Prednisone 10 mg (Steroid used for pain) daily at 9:00 A.M. - Colace 100 mg (constipation) give two tablets two times per day at 9:00 A.M. and 5:00 P.M. - Lantus 100 units/ml (diabetes) give 50 units two times per day at 9:00 A.M. and 5:00 P.M. - Morphine Sulfate 15 mg (pain) give seven tablets (105 mg) two times per day at 9:00 A.M. and 9:00 P.M. - Omeprazole 20 mg (acid reflux) give two tablets two times per day at 8:00 A.M. and 5:00 P.M. - Senna 8.6 mg (constipation) give two tablets two times per day at 9:00 A.M. and 9:00 P.M. - Acetaminophen 500 mg (pain) give two tablets (1000 mg) three times per day at 9:00 A.M., 1:00 P.M., and 5:00 P.M. - Novolog 100 unit/ml (diabetes) give 40 units scheduled three times per day at 9:00 A.M., 12:00 P.M., and 5:00 P.M. - Novolog 100 unit/ml (diabetes) give before meal per sliding scale at 7:30 A.M., 11:00 A.M., and 5:00 P.M. - Simethicone 80 mg (gas relief) give two tablets three times per day at 9:00 A.M., 1:00 P.M., and 5:00 P.M. On 6/16/21 at 10:00 A.M., the surveyor observed the SDC preparing and administering the following medications to Resident #59 (41 minutes after the Resident requested pain medication for hip pain): (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Acetaminophen 1000 mg (approximately 1 hour late) - Colace 200 mg (approximately 1 hour late) - Ferrous Sulfate 325 mg (approximately 1 hour late) - Multivitamin 1 tablet (approximately 1 hour late) - Prednisone 10 mg (approximately 1 hour late) - Morphine Sulfate 105 mg (approximately 1 hour late) - Senna 17.2 mg (approximately 1 hour late) The surveyor observed the SDC checking Resident #59's blood sugar which was 289. The Resident said that number was high, as he/she usually runs in the 130's in the morning. During an interview on 6/16/21 at 10:13 A.M., the SDC said she spoke with the physician who said to hold the 7:30 A.M. sliding scale Novolog insulin, but could administer remaining medications. There was no discussion related to Resident #59's pain management. On 6/16/21 at 10:17 A.M., the surveyor observed the SDC preparing and administering the following medications to Resident #59: - Metformin 850 mg (approximately 3 hours late) - Furosemide 40 mg (approximately 2 hours late) - Lisinopril 5 mg (approximately 2 hours late) - Omeprazole 20 mg (approximately 2 hours late) - Miralax 17 gm in 6 oz of water (approximately 2 hours late) - Lantus 100 unit/ml 50 unit (approximately 1.5 hours late) - Novolog 100 unit/ml 40 unit (approximately 1.5 hours late) On 6/16/21 at 10:25 A.M., the surveyor observed Resident #59 grimacing and yelling out in pain saying, I need pillows under my legs, it hurts, my god! The Resident said to the surveyor, When I don't get my pain medications on time, I get sharp shooting pains that don't go away. The medication helps take the edge off so it doesn't hurt so bad. 2) Resident #55 was admitted to the facility in February of 2021 with diagnoses that included hypertension (high blood pressure), tremors, thyroid disorder, atrial fibrillation, congestive heart failure, and anxiety. Review of Resident #55's physician's orders indicated the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Digoxin 125 mcg - Give one tablet one time per day at 9:00 A.M. for atrial fibrillation - Metolazone 2.5 mg - Give one tablet every Wednesday at 8:30 A.M., 30 minutes prior to Torsemide for congestive heart failure - Primidone 50 mg - Give one tablet two times per day at 9:00 A.M. and 9:00 P.M. for tremors - Propylthiouracil 50 mg - Give two tablets two times per day at 9:00 A.M. and 9:00 P.M. for thyroid disorder - Torsemide 20 mg - Give two tablets daily at 9:00 A.M. for congestive heart failure - Xanax 1 mg - Give one tablet two times per day at 9:00 A.M. and 9:00 P.M. for anxiety Review of the medication administration record (MAR) indicated that Resident #55 did not receive his/her medication until 1:27 P.M. (4.5-5 hours late). The MAR further indicated that the Metolazone and Torsemide had been signed off as given less than ten minutes apart. Metolazone is recommended to be taken in the morning due to its prolonged absorption and duration of action. In patients resistant to loop diuretics, Metolazone should be given at least 30 minutes before the regular morning dose of a loop diuretic (Torsemide). During an interview on 6/16/21 at 1:25 P.M., the MDS Nurse said she does not typically work on the unit and was late with her medications today.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41065 Based on observation and interview, the facility failed to 1) store all drugs and biologicals in locked compartments, and permit only authorized personnel to have access for 1 out of 1 treatment carts on Unit B; and 2) maintain clean and sanitary conditions in 1 out of 2 medication rooms on Unit C. Findings include: Review of the facility's policy titled Medication - Storage, revised 1/2019, indicated the following: - With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy. 1. On 6/9/21 at 9:40 A.M., the surveyor observed the treatment cart on Unit B was unsupervised and unlocked at the end of the hallway blocking a set of double doors leading to Unit A, near the nurse's station. There was no nurse present in the hallway or at the nurse's station at the time the observation was made. The treatment cart was observed to remain unlocked and unsupervised for greater than fifteen minutes. The surveyor was able to open the treatment cart draws and observed several prescription and over the counter creams, ointments, and powders labeled with resident information. On 6/14/21 at 8:46 A.M., the surveyor observed the Unit B treatment cart unlocked and unsupervised with no nurse present. The treatment cart was observed to the right of the nurse's station, against a wall. The surveyor was able to open the treatment cart draws and observed several prescription and over the counter creams, ointments, and powders labeled with resident information. During an interview on 06/14/21 at 08:50 A.M., Unit Manager (UM) #2 said all treatment and medication carts should be locked at all times when not in use. 15214 2. On 6/15/21 at 10:50 A.M., the surveyor and UM #1 inspected the medication room on Unit C and observed the following: -The unit medication refrigerator, that contained various medications and nutritional supplements, was dirty. -The bottom shelf was soiled with a large amount of yellowish, brown, sticky substance. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The door of the refrigerator had a moderate amount of dried yellow stains scattered throughout the door. -The medication room floor was dirty, especially the area directly below the refrigerator, where large amounts of dirt, black stains, debris, dust, and shreds of paper were observed. During an interview on 6/15/21 at 11:00 A.M., UM #1 said that the medication room refrigerator and floor needed to be cleaned.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 10249 Based on record review and staff interviews, the facility failed to: 1. Designate a person who met the minimum qualifications to serve as the Director of Food and Nutrition Services; and 2. Ensure that a Registered Dietitian was consistently employed at the facility to ensure the nutritional needs of the residents were being met. Findings include: 1. During an interview on 6/9/21 at 9:15 A.M., the Food Manager said that she was hired as a full time cook in December 2020. The Food Manager said that the prior Food Manager left on 5/11/21 and she was asked by the contract dining service if she would like to have the position, and they would provide management training and assist in registering her for needed classes. The Food Manager said that she does not have any certification or degrees in hospitality or food management, but does have a current food safety certificate. The food safety certification alone does not fulfill the minimum regulatory requirements. Review of personnel record indicated the Food Manager was hired as a first cook on 12/21/20 and transitioned to the Food Manager's position on 5/14/21. 2. During an interview on 6/10/21 at 2:00 P.M., the facility Dietitian said she started at the facility on 6/4/21 and works 8-10 hours per week and is not responsible for the Food and Nutrition Department. The Dietitian said that the previous dietitian left in April 2021, but was unaware of the date. During an interview on 6/24/2021 at 3:00 P.M., the Administrator provided a list of the last four dietitians who were employed at the facility since September 2019. Dates of employment were confirmed with the Human Resource Director on 6/30/21 and indicated the following: Dietitian #1 Date of Hire (DOH) 9/23/19 and terminated employment on 6/3/20 Dietitian #2 DOH 6/15/20 and terminated employment on 10/7/20 Dietitian #3 DOH 11/2/20 and terminated employment on 4/28/21 Current facility Dietitian DOH 6/4/21 Review of the employment dates indicated a gap of 26 days between Dietitian #2 and Dietitian #3, and 37 days between Dietitian #3 and the current facility Dietitian. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/10/21 at 4:00 P.M., the facility Dietitian said she contacted the previous dietitian who said her last day in the facility was 4/23/21, and not 4/28/21.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 10249 Based on observation, record review, and interviews, the facility failed to employ sufficient staff with the appropriate competencies and skills to carry out the function of the food and nutrition services. Specifically, the facility failed to ensure that: 1. Sufficient and competent support staff were available to provide timely, appetizing, palatable food and fluids, and honor the resident's preferences, to meet the resident's needs, based on resident assessment and plans of care; and 2. Sanitation of all food service areas met food service safety standards including the main kitchen and 2 out of 2 nourishment kitchenettes that were located on the nursing units. Findings include: 1. During an interview on 6/24/21 at 9:00 A.M., the Food Manager said that she frequently has to fill the morning cook position which interfered with completing her responsibility as the Food Manager including ordering and monitoring staff. The Food Manager said that the contract dining service took the part time cook to fill in at another facility owned by the company, and therefore she would be cooking whenever she was working. Menus were not consistently followed due to food supplies not ordered timely from the vendor and supportive staff not reading the tray cards to ensure accuracy of meals provided to the residents. Several residents who were on therapeutic diets received inaccurate meals, including Resident #29 on a gluten free diet. There was no supervisory oversight to ensure the food items for planned menus were available, prepared appropriately and served accurately. Refer to F 0803. Food served to the resident was unpalatable and not always served at the acceptable temperature for 2 of 2 meals observations and numerous resident complaints. Food temperature monitoring and documentation prior to meal service was inconsistently documented and there was no monitoring of meal service delivery and distribution of meals to the residents to ensure food palatability. During an interview on 6/9/21, the food manager said currently there are 2 diet aides and 1 cook, just had to let a diet aide go last week due to decline in census. On 6/15/21 at 4:30 P.M. the surveyor observed that one diet aide would leave the tray line during the meals service to go deliver the food trucks to the unit. The meal service would come to a very slow pace until the diet aide returned from delivery of the meal trucks. 2. Sanitation issues identified on 6/9/21 in the kitchen area and two nourishment kitchenettes were found to be in unsanitary condition. The dish machine was not properly monitored by staff to ensure the correct sanitizing temperature was attained to prevent the potential spread of foodborne pathogens. Refer to F812. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/16/21 at 9:30 A.M., the Food Manager and Regional Food Manager from the contracted dining service both said they were unable to find any documented evidence of training or competencies for dietary staff going back through 2020.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10249 Based on observation, record review, review of the facility's cycle menu, and interview, the facility failed to follow the planned cycle menu. Specifically, the facility failed to: 1. Follow the menu for one Resident (#29) prescribed a gluten free diet, out of a total sample of 33 residents; and 2. Ensure food supplies were ordered timely from the vendor to enable staff to consistently follow planned menus. Findings include: 1. Resident #29 was admitted to the facility in September 2020 with diagnoses that included Celiac Disease (long term autoimmune disorder that can damage the small intestine presenting with diarrhea, abdominal distention, malabsorption, and loss of appetite), Alzheimer's disease, and dysphagia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #29 was severely cognitively impaired and required assistance with meals. The MDS also indicated that the resident had difficulty or pain with swallowing, was 62 inches tall and weighed 89 pounds. Review of the physician's orders indicated Resident #29 was prescribed a Regular Diet, mechanical soft texture, thin consistency, gluten free diet for Celiac Disease. Review of the Comprehensive Nutrition Assessment, dated 1/6/21, indicated the Resident was on a gluten free diet; at nutritional risk related to underweight; cognitive function/dementia; and potential alteration in nutrition assimilation (absorption and digestion) and absorption of food. Review of Resident #29's care plan, dated 10/15/20, indicated that the Resident had Celiac Disease and indicated the following: - administer medications as tolerated - gluten free diet - monitor for signs and symptoms of Celiac Disease (diarrhea, fatigue, weight loss, bloating, abdominal pain, and anemia) Review of Resident #29's meal tray ticket indicated the following: - gluten free allergy - beverages for all three meals should be coffee, juices (2), and milk - add yogurt and banana at all meals (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- mechanical soft On 6/14/21 at 12:14 P.M., the surveyor observed Resident #29's lunch tray consisting of: plain chicken, mashed potato with gravy, a dinner roll, and sweet and sour red cabbage. The Resident did not receive the yogurt and banana as indicated on the meal tray ticket. Review of the facility lunch menu dated 6/14/21 for gluten free diet, indicated that the Resident should have received grilled chicken, mashed potato, sweet and sour red cabbage, gluten free bread, cinnamon apple slices and milk. On 6/15/21 at 9:07 A.M., the surveyor observed Resident #29 receive a breakfast tray that included a muffin, toast, and cream of wheat. The Resident did not receive yogurt or banana as indicated on meal tray ticket. Review of the breakfast menu, dated 6/15/21, for gluten free diet indicated that the Resident should have received cream of rice cereal, western omelet, gluten free toast and 8 ounces of milk, as well as the yogurt and banana as identified on the meal ticket. On 6/15/21 at 12:00 P.M., the surveyor observed Resident #29 receive a lunch tray consisting of ground meat with BBQ sauce and a chocolate eclair. The Resident did not receive yogurt or banana as indicated on meal tray ticket. Review of the noon menu, dated 6/15/21, indicated that the Resident should have received pork (omit BBQ sauce), green peas, gluten free bread, a gluten free dessert, and 8 ounces of milk as well as the yogurt and banana as indicated on the tray ticket. During an interview on 6/15/21 at 1:08 P.M., Unit Manager #1 said that Resident #29 is on a gluten free diet and that the kitchen usually sends the right diet and that the staff usually double check it before giving to the Resident. 2. The surveyor made the following observations while comparing the 5 week cycle menu to the actual food items served: On 6/9/21 during the noon meal, the residents were served chicken, cauliflower, mashed potato and pudding instead of the scheduled Italian blend vegetables, red bliss potato and pound cake. The other foods were served as planned. On 6/14/21 during the noon meal observation, the residents were not served a dinner roll, there was no substitution for the roll. On 6/15/21 during the noon meal service there were no peas or dinner roll available for service. On 6/15/21 during the supper meal the peaches were substituted with apricots. Review of the facility menu during meal service indicated that many food substitutions were required due to food supplies not ordered timely from the vendor. It was also observed there was no record via a substitution log to ensure that foods would be correctly ordered for the future weeks. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/14/21 at 3:15 P.M., the Food Manager said that she was getting used to the new ordering system through the contracted dining service and she did not have a substitute list to document menu changes.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 10249 Based on observation, record review, and interviews, the facility failed to ensure that staff served food that is palatable and at an appetizing temperature on 2 out of 2 units, for 2 out of 2 test trays conducted. Findings include: During an interview on 6/9/21 at 12:54 P.M., Resident #15 said they put gravy on everything. Review of the Resident's food ticket, located on his/her tray indicated they were to receive 1/2 cup hot water and coffee. The Resident said that was old and dietary had not changed it yet. During an interview on 6/9/21 at 02:51 P.M., Resident #34 said they ran out cranberry juice weeks ago and sometimes they run out of snacks. The Resident said when they do have snacks, they are lousy. During an interview on 6/9/21 at 3:01 P.M., Resident #44 said the food is always cold; and on 6/14/21 at 12:37 P.M., Resident #44 said he/she did not like the meal; I only ate the dessert and yogurt. During an interview on 6/9/21 at 3:11 P.M., Resident #59 said there are no diabetic snacks and you can never get a salad or fresh fruit. Resident #59 said if they do have snacks, its only graham crackers or peanut butter and jelly sandwiches, and How many of them can you eat? During a group meeting on 6/10/21 at 10:30 A.M., the surveyor met with nine residents who traditionally participate in Resident Council meetings. The residents said that the food is not good and usually cold in temperature. If staff reheats the meal, they overheat it, and the food becomes rubbery in texture. The residents said they never get evening snacks, nor are they offered or available. The residents do not have a selective menu and are not offered choices, and staff is not good about assisting them in getting foods if they don't like the meal. The residents said they get a lot of peanut butter and jelly sandwiches. During an interview on 6/11/21 at 12:20 P.M., Resident #13 said he/she was served baked crusted fish today for lunch that was hard and cold. Resident #13 said with his/her throat problem this meal was too hard to eat. During an interview on 6/15/21 at 11:23 A.M., Resident #51 said food was always cold and he/she doesn't like the taste of the food. The coffee is terrible. He/she avoids certain foods due to migraines including deli meat. Resident #51 also said that we get sandwiches on hot dog rolls. During an interview on 6/16/21 at 9:01 A.M., Resident #59 said he/she was just served breakfast and they never get it right and it is always cold. During an interview on 06/16/21 at 09:06 A.M., Resident #13 said breakfast is always cold, it doesn't matter what day of the week. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Resident Council Meeting minutes, dated 11/4/20, 3/21/21, and 5/18/21 indicated that the residents had complaints about receiving cold food. On 4/20/21 the response from the Food Manager, in reference to cold food served from the prior meeting (3/21/21), documented no plate warmer. There was no response as to how the Food Manager would address the cold food issue. On 11/4/20 and 5/18/21 the residents complained about limited fresh fruit and no variety for soup and sandwiches. During an interview on 6/9/21 at 12:10 P.M., the surveyor observed the noon meal tray service in the kitchen. The Food Manager said she did not take food temperatures prior to the start of service. The surveyor did not observe the Food Manager or any other dietary staff take food temperatures to ensure adequate food temperatures during service. The 2013 Food and Drug Administration Food Code indicates that temperatures should be monitored to ensure proper cooking and holding temperatures. The Food Code is a model for safeguarding public health and ensuring food is safe for consumption. On 6/14/21 at 11:40 A.M., the surveyor asked for a test tray to be placed in the last tray on the last truck for Unit B. The tray line finished at 12:06 P.M. and the food cart was delivered to Unit B and arrived on the unit at 12:08 P.M. The surveyor observed that the MDS nurse started serving trays from the second food cart before all the resident's trays were served from the first food cart. The test tray was conducted at 12:27 P.M. with the following results: -Crispy Ranch chicken registered 130 degrees Fahrenheit (F) and had good flavor, however tepid in temperature; -Mashed potato registered 127 degrees F and was very runny on the plate and tepid in temperature; -Cole slaw salad (hot) served from steam table registered 109 degrees F and was soggy in texture; -Coffee registered 118 degrees F and was lukewarm; -Apple juice registered 64 degrees F and was lukewarm; -Milk registered 62 degrees and was warm in temperature; -The blueberry cobbler did not have any crumb topping, just blueberries; All foods and fluids were not served at an appetizing temperature and were unpalatable. On 6/15/21 at 4:30 P.M., the surveyor observed the supper meal. Cook #2 said that she did not take temperatures, It's a cold meal. At 4:37 P.M. the surveyor requested a test tray to be sent on the second food cart to Unit C. The cart arrived on the unit at 4:43 P.M. The test tray was conducted at 5:01 P.M. with the following results: -Deli (bologna, salami and cheese) sandwich in a hot dog roll registered 69 degrees Fahrenheit (F) and was room temperature; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Milk registered 68 degrees F and was warm in temperature with a slight sour taste; -Cranberry juice registered 58 degrees F and was lukewarm in temperature; -Coffee registered 131 degrees F and was tepid in temperature and bitter in taste; and -The apricots registered 57 degrees F and were tepid. All foods and drinks for the meal were unappetizing and not palatable. During an interview on 6/16/21 at 9:30 A.M., the Regional Dining Manager and the Food Manager both said that there was no monitoring of the meal service, including test trays, to ensure palatable and appetizing food temperature of the food served to the residents.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106 Based on observations, staff interviews, and record review, the facility failed to ensure that staff accommodate food preferences and appealing options of similar nutritional value when a resident is initially served or who request a different meal choice for two Resident's (#53 and #23), out of a total sample of 33 residents. Specifically, 1. For Resident #53, the facility failed to offer foods that the Resident prefers, including pasta. 2. For Resident #23, the facility failed to ensure that the Resident received food preferences that align with Kosher law and meet nutritional needs based on substitutes offered. Findings include: Resident #53 was admitted to the facility in August 2018 with diagnoses of stroke with right sided hemiparesis (loss of function) and adult failure to thrive. Review of the Minimum Data Set (MDS) assessment, dated 05/25/21, indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 indicating severe cognitive impairment. The MDS also indicated Resident #53's preferred language is Italian and is rarely/never understood; family or significant other are not available to assist in communication. Review of Resident #53's meal ticket indicated the following: -Regular diet, mechanical soft, beverages-coffee and four ounces of milk -Dislikes- (left blank) -Likes- extra gravy/sauce and two ice creams. On 6/9/21 at 12:54 P.M., the surveyor observed Resident #53's lunch tray and Resident #53 did not eat any of the main meal and had a couple bites of ice cream. Resident #53 spoke limited English and when asked if he/she liked lunch (surveyor pointed to the food), Resident #53 waved the food away with his/her hand and head gesture. During an interview on 6/9/21 at 1:07 P.M., Unit Manager #2 said Resident #53 doesn't like the regular food served at the facility and prefers to eat pasta. She said Resident #53's family brings in containers of pasta with red sauce and donuts every week. Unit Manager #2 said when Resident #53 will not eat the main meal served, the staff will heat up a container of pasta for Resident #53. Unit Manager #2 and surveyor reviewed Resident #53's meal ticket and it did not indicate Resident #53 prefers pasta. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/21 at 12:20 P.M., the surveyor observed CNA #8 serve Resident #53 his/her lunch from the meal cart. Resident #53 was observed to wave the food away. CNA #8 returned to Resident #53's room and dumped a container of spaghetti with red sauce on top of what appeared to be French fries left on Resident #53's plate. Review of the facility menu indicated lunch served on 6/11/21 was Beer Battered fish with steak fries. On 6/15/21 at 5:51 P.M., the surveyor observed Resident #53's tray and he/she did not consume any of the facility prepared meal which consisted of the following: Italian sub sandwich served with chips, glass of milk and two containers of ice cream. There was a half-eaten peanut butter and jelly sandwich left on the tray. During an interview on 6/15/21 at 5:55 P.M., CNA #5 and #9 both said Resident #53 does not eat a lot of the main meals and he/she does not like ice cream or milk, only coffee and water. CNA #5 said if he/she doesn't eat the dinner, which is most of the time, we give him/her a peanut butter and jelly sandwich. CNA #5 said tonight, Resident #53 ate one and half peanut butter and jelly sandwiches for dinner and nothing else from the tray. During a phone interview on 7/6/2021 at 4:08 P.M., the Dietitian said she has only been working in the facility since the beginning of June 2021 and is not familiar with Resident #53 or his/her food preferences. The Dietitian said she obtains the percentage of meal eaten from the nursing staff documentation and the resident's dietary needs are based on the food served from the facility menus. She said the facility staff has not notified her that Resident #53 is not eating the facility prepared meals, and they are substituting the meals with pasta provided from the family and/or peanut butter and jelly sandwiches. The Dietitian said she has already identified there are communication issues between the nutrition services department and nursing that need to be addressed to assure resident's dietary needs are being met at the facility. 10249 2. Resident #23 was admitted to the facility in June 2017 with diagnoses that included cerebral palsy. Review of the Resident's MDS, dated [DATE], indicated that the Resident had a BIMS score of 15 out of 15, indicating the Resident was cognitively intact. The MDS also indicated that the Resident was totally dependent (two person assist) for bed mobility, transfer, bathing, and toileting, was dependent (one person assist) for dressing and personal hygiene, and extensive assist with eating. During an interview on 6/15/21 at 10:45 A.M., Resident #23 said he/she prefers Kosher meals and is aware that the facility did not uphold Kosher law; he/she selected foods that would fit into his/her preferences. However, the Resident's meals consisted of only peanut butter and jelly sandwiches for lunch and grilled cheese sandwiches for dinner daily. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nutrition assessment, dated 3/10/21, indicated that the Resident had food allergies of shellfish, fish and meat, which were not true allergies but foods requested by Resident #23 to avoid due to his/her preference of kosher like meals. There were no other preferences listed or documentation that the dietitian was aware of the Resident's limited variety of food and no offering of alternative food choices. During an interview on 6/21/21 at 11:00 A.M. (via telephone), the facility Dietitian said she was not aware of Resident #23 and that he/she was not offered choices or alternative foods of equal nutritional value.

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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** 10249 Based on observation, staff interview, and record review, the facility failed to ensure that staff stored, prepared, distributed, and served food in accordance with professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Findings include: On [DATE] at 8:30 A.M., the surveyor made the following observations in the main kitchen: -Seven pieces of essential kitchen equipment were identified as broken and non-functioning. (refer to F980) -There were obvious mouse droppings on both window sills. (refer to F925) -The juice machine, no longer used for resident meal service since ,d+[DATE], still had a container of syrup connected to the machine which was leaking on the floor. The floor was sticky. -The coffee machine was dirty. -Three boxes of frozen food were stored on the floor in the walk-in freezer. -The dish machine temperature gauge registered 110 degrees Fahrenheit (F) for the wash and rinse cycle. -The tile floor, throughout the main kitchen, was cracked with missing grout. The spaces allowed water to build up between the tiles, especially in the dish machine area, and posed a fall risk to employees. There was a buildup of a gunky substance on and between the tiles. During an interview on [DATE] at 9:00 A.M., the Food Manager said they were having trouble with the dish machine and that it was a high temperature machine (sanitize dishware with hot water greater than 180 degrees Fahrenheit). The Food Manager said the tiles around the floor drain, by the dish machine, were collapsing. The Food Manager said that the floor was to be washed every night by housekeeping, but she was not sure if that was occurring. During an interview on [DATE] at 9:20 A.M., the surveyor observed the dish machine. The temperature gauge was registering 125 degrees F for wash and 120 degrees F for rinse. Dietary Aide #1 said that it takes a few cycles to get it up to temperature. Review of the dish machine temperature log for [DATE] indicated that the rinse cycle never reached 180 degrees F. At 9:30 A.M., the surveyor asked that the machine be shut down until someone could evaluate the problem. On [DATE] at 9:35 A.M., the surveyor observed the following in the main kitchen: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The bottom of the reach-in refrigerator was dirty with a buildup of a brown substance. -The ice machine was dirty. -The hand washing sink lacked available paper towels. -The interior walls of the microwave were dirty with food splatters. During an interview on [DATE] at 10:00 A.M., the Food Manager said there is no master cleaning schedule or documentation as to when equipment is to be washed and sanitized. The Food Manager said the ice machine had not been cleaned since [DATE], and could not provide the surveyor with the manufacturer's recommendations on the frequency of cleaning and sanitizing the ice machine. On [DATE] at 10:29 A.M., the surveyor, accompanied by a corporate representative of the contracted food service company, observed the following in the kitchen: -The food prep sink was located next to a rack that held pots, pans, and serving utensils. Water was observed splashing onto the clean, dry pots and pans. -The walk-in refrigerator had a container of broth that was not labeled or dated, a jar of pickles that expired [DATE], and a jar of tomato sauce that was opened and undated. -The walk-in freezer had three frozen pizzas opened and undated. On [DATE] at 12:10 P.M., the surveyor observed the following in the kitchen: -All meal trays were badly scratched with missing material -The janitor's closet had mops on the floor (serve as a breeding ground for pests), plaster was coming off the wall, and the wall had visible mold. On [DATE] at 3:00 P.M., the surveyor observed the meat slicer blade was dirty. [DATE]at 10:35 A.M., the surveyor observed the following: -The top gauge on dish machine was leaking. -The vents were dusty in the dish room. -The mixer had food splatters and debris on the base and by the beater. -The slicer was dirty. On [DATE] at 12:35 P.M., the surveyor observed the following in the Unit B nourishment kitchenette: -The refrigerator registered 47 degrees F. -Two blocks of cheese in the freezer not labeled or dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two containers of Ben and Jerry's ice cream not labeled or dated. -Three containers of thickened lemon water (expired [DATE]). Review of the Unit B nourishment kitchenette temperature logs for [DATE] indicated they were incomplete with many dates left blank. On [DATE] at 12:45 P.M., the surveyor observed the following in the Unit C nourishment kitchenette: -Freezer unit contained: three bottles of frozen water, one yogurt container, one milk carton, and four containers of orange juice, all were not labeled or dated. -A thermometer could not be located in the freezer unit. -Four containers of lemon thickened water (expired on [DATE]). -The refrigerator gasket had a buildup of food. -The utensil holder had food debris at the bottom of each compartment. -The shelf above the refrigerator had a buildup of food. -The container for the prepackaged cookies was dirty. Review of the Unit C nourishment kitchenette temperature logs for [DATE] indicated they were incomplete with many dates left blank. On [DATE] at 11:40 A.M., the surveyor observed the following during the noon meal service: -the server had no hair restraint On [DATE] at 4:30 P.M., the surveyor observed the following during the dinner meal service: -Cook #2 serving potato chips with ungloved hands.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 10249 Based on observation and staff interview, the facility failed to ensure that trash, garbage and refuse were disposed of properly, including the surrounding area of the dumpster. Findings include: On 6/16/21 at 9:40 A.M., the surveyor observed the following at the outside dumpster/disposal area: -Debris, paper, used medical disposable gloves, small plastic bags, soda cans and bottles, disposable food containers, and garbage all spread throughout the wooded area to the left, right and back of the dumpster. -Two residents' bed headboards, several wood fence pieces, a small metal fence, a bed bolster, yellow wet floor cone, eight wood pallets, and an upholstered recliner chair. During an interview on 6/16/21 at 10:15 A.M., the Administrator acknowledged that the trash was not disposed of properly. During an interview on 6/16/21 at 10:30 A.M., Maintenance staff #1 acknowledged that the trash was not disposed of properly.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 15214 Based on review of the Facility Assessment and interviews, the facility failed to conduct and document a facility wide assessment that accurately reflected the resources necessary to care for its residents. Specifically, the facility failed to: 1) complete a Facility Assessment which accurately reflected the plan for renovations to the resident care units; 2) identify the multiple systems at the facility that were either inoperable, and/or, not consistently assessed or monitored such as the Wanderguard system, Water Management Plan, hot water system, and elevator, to determine their safe and effective functioning, and the effects their non-functioning had on the safety and welfare of the residents; 3) conduct competencies of nursing staff; and 4) provide services to appointments outside of the facility. Findings include: The Facility Assessment should be reviewed and updated whenever there is, or the facility plans for, any change that would require a substantial modification to any part of its assessment. Review of the Facility Assessment, dated 4/13/21, indicated that the facility had 113 licensed beds with an average daily census of 68-74 residents. The resident census on 6/9/21 was 59. 1. Review of the Facility Assessment failed to indicate that it had been updated to reflect the current renovations underway on Unit A, the recent renovation of Unit B, other renovation projects planned at the facility, and the impact the renovations would have on the residents' quality of life. During an interview on 6/15/21 at 10:34 A.M., the Administrator said he had not updated the Facility Assessment to reflect the renovations, or the resources necessary to maintain a clean, safe, and homelike environment for the residents at the facility. The Administrator said that he understood the importance of maintaining an up-to-date and accurate Facility Assessment. 2. The Facility Assessment listed the need for two full-time Maintenance Directors. However, on 6/9/21, the facility did not employ a Maintenance Director, only one maintenance worker. Maintenance Worker (MW) #1 was responsible for all the day to day repairs, monitoring, and maintenance duties required by the facility. The Facility Assessment Tool indicated that all equipment is checked for safety monthly by maintenance and as needed. Equipment replaced when needed. During an interview on 6/16/21 at 2:57 P.M., Life Safety Surveyor (LSS) #1 said that the facility Wanderguard system, tied into the elevator on Unit C, was not functioning. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview of 6/17/21 at 10:00 A.M., LSS#1 said that the elevator repair technician informed him that the elevator had been malfunctioning for over two years. On 6/17/21 at 10:28 A.M., the surveyor and LSS #1 observed the elevator control room door wedged open with a piece of wood. LSS#1 said that the door to the elevator control room should never be left unsecured. The Facility Assessment failed to be updated to reflect how the facility would monitor, assess, and inspect for ongoing functionality. In the elevator's present condition, staff, residents, and others, could become trapped in the elevator without anyone's knowledge. The Facility Assessment failed to indicate how the Wanderguard system would be monitored, assessed, and inspected for ongoing functionality. No safety checks were provided by the facility, which placed residents with Wanderguards at risk for elopement and potential injury. The facility's Facility Assessment failed to indicate the Water Management Plan (WMP) or monitoring of the facility's water system. 3. The Facility Assessment Tool failed to indicate that the facility conducted staff training/education and competencies that are necessary to provide the level and types of support and care needed for the resident population, including staff certification requirements as applicable. During an interview on 6/16/21 at 2:19 P.M., the Staff Development Coordinator (SDC) said she did not have any competencies for the licensed nurses who worked at the facility. During an interview on 6/17/21 at 8:40 A.M., the SDC said there were no clinical nursing competencies or documented evidence for the following: -training and verbalizing an understanding of the elopement process and Wanderguard system - infection control practices including PPE use and the care and treatment of catheters -care of residents with intravenous infusions -care of residents with a gastrostomy tube (feeding tube) -use of the glucometer/blood sugar testing -use of oxygen and oxygen saturation monitoring - revision of ineffective interventions following falls - providing appropriate transportation to and from routine appointments - resident safety and the need to ensure medication carts remain locked when not in use -assessment of bed rail safety and equipment (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-monitoring water temperatures for resident comfort and safety -monitoring the facility Water Management Program to reduce, and/or prevent, the risk of Legionella and other water-borne illness 4. The Facility Assessment indicated that Pain Management was one of the Services and Care We Offer Based on our Residents' Needs. According to the tool, The intent is to identify and reflect on resources needed to provide these types of care. For Resident #59, the facility did not provide Pain Management services in accordance with the services listed on the Facility Assessment Tool. During an interview on 6/11/21 at 10:28 A.M., Resident #59 said that at times her/his pain is excruciating and that the pain clinic can help with pain control and make adjustments to her/his medications, or she/he gets injections to treat the pain. The Resident further stated that she/he missed her/his appointment to the pain clinic because the facility could not provide a ride to the clinic by stretcher. During an interview on 6/16/21 at 8:40 A.M., the Director of Nursing (DON) said that the facility was not able to provide the Resident with a ride to the scheduled pain clinic appointment due to the facility not having a contract with a medical transportation service.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 10249 Based on staff interview, record review, and review of the Hospice agreement contract, the facility failed to ensure that two Residents (#29 and #4) were receiving appropriate Hospice services, out of a total of 33 residents. Specifically, 1) for Resident #29, the facility failed to ensure a collaborative Hospice care plan was implemented; and 2) for Resident #4, the facility failed to ensure that Prevalon Boots (used to prevent or treat pressure ulcers on the resident's heels) were available for the Resident as ordered by the physician. Findings include: 1. Resident #29 was admitted to the facility in September 2020, with diagnoses that included neoplasm of the bronchus and lung, dysphagia (trouble swallowing), Alzheimer's disease, and depression. Review of the Minimum Data Set (MDS) assessment, dated 4/6/21, indicated Resident #29 is severely cognitively impaired. Review of the physician's orders indicated that Hospice was ordered and Resident #29 was admitted to Hospice on 3/13/21. During an interview on 6/5/21 at 11:30 A.M., Unit Manager (UM) #1 said that the facility implements a hospice care plan. She said the care plan is documented in the care plan section in the electronic medical record (EMR). Review of the Hospice/Nursing Facility Agreement, section 5.2 under Facility Duties, Responsibilities, and Services, dated 3/16/21, indicated in the following: -Facility shall revise its plan of care to coordinate the facility plan of care with Hospice Plan of Care -Facility agrees that the Facility Plan of Care will be consistent with Hospice Plan of Care. Review of the care plans on 6/15/21 indicated that there was no documented evidence of a collaborative Hospice care plan in Resident #29's medical record. 2. Resident #4 was admitted to the facility with diagnoses that included dementia with behavior disorders, coronary artery disease, PTSD, and muscle weakness. Review of the most recent MDS assessment, completed March 2021, indicated Resident #4 is dependent on staff for Activity of Daily Living (ADLs), dependent with bed mobility, and is dependent with transfers. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated Resident #4 was admitted to Hospice on 3/13/21. Review of the medical record indicated a physician order, dated 5/17/21, to apply Prevalon Boots while in bed to keep feet off-loaded (distribute the load to other areas which are not susceptible to pressure) as tolerated. On 6/15/21 at 7:30 A.M. the surveyor observed Resident #4 lying in bed not wearing Prevalon Boots. The Resident's feet were not off-loaded. During an interview on 6/15/21 at 2:15 P.M., Nurse #1 said that Prevalon Boots have not been available. During an interview on 6/15/21 at 3:00 P.M., Unit Manager (UM) #1 said that the Hospice nurse is responsible for ordering the Prevalon Boots and the boots have not arrived yet. On 6/16/21 at 7:25 A.M., the surveyor observed Resident #4 lying in bed not wearing Prevalon Boots. The Resident's feet were not off-loaded. During an interview on 6/16/21 at 7:30 A.M., Nurse #2 said the Prevalon Boots had not been delivered yet. Nurse #2 said the Hospice nurse was responsible for ordering the Prevalon Boots. Review of Hospice documentation, dated 5/17/21, indicated the wound physician recommended that Resident #4 should have Prevalon Boots while in bed to prevent heel pressure. Documentation indicated that Prevalon Boots were ordered by Hospice and were pending delivery. Review of Hospice documentation, dated 5/26/21, indicated that Prevalon Boots ordered were still not in place and delivery was unable to be tracked. During an interview on 6/16/21 at 10:30 A.M., Nurse #2 said that she spoke to the Hospice nurse and that the Hospice nurse said she had to re-order the Prevalon Boots that day from a new vendor because the current vendor did not supply them anymore. Nurse #2 said she did not have a date when the boots would arrive. Review of the Hospice and Nursing Facility Services Agreement under section IV titled Hospice Service and Responsibilities states in section 4.1, Hospice shall provide or arrange for all supplies, medications and durable medical equipment that are reasonable and necessary for the palliation and management of the terminal illness. Section 4.6 titled Medical Equipment and Medical Supplies states: If an eligible resident's Hospice plan of care specifies the need for medical equipment and medical supplies related to the Residential Hospice patient's terminal illness, which aren't ordinarily provided by the facility to its residents and not included in the basic room and board charge, Hospice shall provide such medical equipment and medical supplies.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41065 Based on record review and interviews, the facility failed to define, implement, and maintain a comprehensive quality assurance and performance improvement (QAPI) plan to address the full range of care and services provided by the facility, including infection control practices during the COVID-19 pandemic. Findings include: Review of the facility's policy titled Quality Assurance Plan, dated March 2020, indicated the facility shall develop, implement, and maintain an ongoing facility-wide Quality Assurance and Performance Improvement (QAPI) Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. On 6/17/21 at 3:35 P.M., Surveyor #1 and Surveyor #2 met with the Administrator and the Director of Nurses (DON) to discuss the facility's QAPI program. The surveyors requested documentation of the facility's QAPI meeting sign-in forms for 2020 and 2021. The DON and Administrator were unable to provide sign-in sheets for QAPI meetings prior to April 2021. During an interview on 6/17/21 at 3:40 P.M., the DON said she had been working in the building since April of 2021 and prior to her start date the previous leadership team had not been conducting quarterly QAPI meetings. The Administrator and DON could provide no documentation that infection control practices such as the use of personal protective equipment (PPE), outbreak management, testing requirements, visitation or any changes to state and federal guidance had been discussed and reviewed in the facility's QAPI program meetings throughout the COVID-19 pandemic.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15214 Based on document review, record review, interview and observation, the facility 1.) Failed to maintain/implement its Water Management Program (WMP), to prevent the development and spread of Legionella and other water borne diseases in the facility water system; 2.) Failed to maintain an effective infection control program that ensured staff applied Personal Protective Equipment (PPE); and 3.) Failed to ensure effective infection control practices were implemented, for one Resident (#23) with a suprapubic catheter, of a total sample of 33, in accordance with the facility's Infection Control Program. Findings include: 1.) Review of the Water Management Plan, dated [DATE], indicated that a Program Team be identified-persons responsible for program development and implementation. The Program Team listed on the WMP, included a Building Manager/Administrator, Director of Maintenance, and Risk and Quality Management Staff, all of whom were no longer employed by the facility. Further review of the plan indicated that the Water Management Plan expired on [DATE]. There was no evidence that the facility had revised its WMP since it expired on [DATE]. Further review of the WMP indicated that the water heater in the sprinkler room was to be checked for flow and return temperatures at the hot water heater monthly. There was no evidence to support that this was being done. Additional review of the WMP indicated that the supply temperature should be checked at the outlet of the hot water heater and should not be lower than 140 degrees Fahrenheit. The return temperature should also be checked monthly and should not be lower than 122 degrees Fahrenheit. There was no evidence to support that the temperature was being checked. On [DATE] at 11:00 A.M., the surveyor observed the water temperature for one out of two shower rooms located on Unit B. The surveyor allowed the water to run for greater than two minutes. The thermometer used read 90.1 degrees Fahrenheit and felt lukewarm to the touch. On [DATE] at 11:00 A.M., a second surveyor simultaneously checked the water temperature in bathroom of room [ROOM NUMBER] on Unit B. The room was located on the far end of the hallway, away from the shower room. The surveyor allowed the water to run for greater than two minutes. The thermometer used read 97 degrees Fahrenheit and felt lukewarm to the touch. During an interview on [DATE], immediately after the observations, the surveyor reviewed the WMP with Maintenance Worker (MW) #1 to determine whether the facility monitored water temperatures, or implemented the expired WMP, as written. MW#1 said that he could not provide evidence that the facility WMP was being implemented. MW#1 said he did not have logs of weekly water temperature monitoring in resident areas, weekly flushing of stagnant flow areas, suitable for Legionella growth, or flushing in other areas of the water system, with the potential to harbor the growth of Legionella. (continued on next page)

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	225208	A. Building B. Wing	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlwell House Health and Rehabilitation	305 Walpole Street Norwood, MA 02062

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 1:15 P.M., the Administrator said that he did not have any water temperatures or information to demonstrate compliance with the WMP. He indicated that, failing to implement the facility's WMP could pose a risk of infection, such as Legionella, to residents at the facility. 2.) During an interview on [DATE] at 8:26 A.M., the Infection Control Nurse said the expectation is all staff will be wearing eye protection and face masks while they are on the unit. On [DATE] at 9:41 A.M., the surveyor observed Social Worker (SW) #1 entering Unit C without any eye protection on. Nurse #1 noticed that the SW #1 did not have any eye protection on and told SW #1 that she needs to wear eye protection when in resident areas. SW #1 said that she was not told that she needed to wear them and that she didn't have any to wear. Nurse #1 called management and alerted them that SW #1 needed eye protection. SW #1 proceeded to stay on Unit C without any eye protection. On [DATE] at 9:08 A.M., the surveyor observed Unit Manager (UM) #1 not perform hand hygiene prior to administering medications to Resident's #6, #21, and #45. On [DATE] at 11:59 A.M., the surveyor observed Certified Nurse's Aide (CNA) #1 walking in the hallway on Unit C with eye protection on top of her head. During an interview on [DATE] at 12:00 P.M., UM #1 said that CNA #1 should be properly wearing her eye protection while on the unit and that she would speak to the CNA. On [DATE] at 12:13 P.M., the surveyor observed CNA #1 feeding a resident with her eye protection on top of her head. On [DATE] at 3:51 P.M., the surveyor observed the Administrator standing in the hall outside the kitchen door and had his face mask below his mouth. On [DATE] at 6:05 A.M., the surveyor observed Housekeeper #2 exiting the elevator on Unit C. The Housekeeper was pushing a laundry cart onto the unit and was observed to only be wearing a face mask and no eye protection. During an interview on [DATE] at 6:06 A.M., Housekeeper #2 said she forgot to put on her eye protection before entering the unit. During an interview on [DATE] at 7:03 A.M., the Infection Control Nurse said the facility has been in outbreak mode for COVID-19 since a positive case had been identified on [DATE]. She said the expectation is that all staff should be wearing a N95 respirator mask, and eye protection at all times, on the units, and a gown and gloves worn for high contact care. 3.) For Resident #23, the facility failed to ensure effective infection control practices were implemented for a suprapubic catheter Resident #23 was admitted to the facility in June of 2017 with diagnoses including suprapubic catheter due to neurogenic bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Resident's Minimum Data Set (MDS), completed on [DATE], indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating that the Resident was cognitively intact. The MDS also indicated that the Resident was totally dependent (with 2 person assist) for bed mobility, transfer, dressing and toileting and had an indwelling catheter. Review of the medical record indicated that the Resident had the following Physician's Order: -change suprapubic tube every 4 weeks with 20 French silicone catheter with 10 cc balloon every 30 days or as needed; -change drainage bag every night shift on Friday; -monitor suprapubic tube for patency every shift -irrigate suprapubic tube with 30 ml normal saline daily, every night shift every other day On [DATE] at 12:03 P.M., the surveyor observed the Resident lying in a recliner chair and the catheter tubing was touching the floor under the chair. The urine appeared dark in color. On [DATE] at 12:30 P.M., the surveyor observed that the catheter tubing still remained on the floor. On [DATE] at 3:40 P.M., the surveyor observed the Resident lying in bed and approximately 12 inches of the catheter tubing as observed lying on the floor under the Resident's bed. On [DATE] at 11:55 A.M., the surveyor observed the Resident lying in bed and the catheter tubing was observed touching the floor. On [DATE] at 12:30 P.M., the surveyor observed the Resident eating in bed, assisted by a CNA. The surveyor observed the catheter tubing was touching the floor During an interview on [DATE] at 12:35 P.M., the MDS Nurse said the Resident's catheter tubing should not be touching the floor and immediately entered the Resident's room to elevate the catheter tubing off the floor. Review of the nursing progress notes, dated [DATE], indicated that at 7:45 A.M., a nurse entered Resident #23's room and observed the resident alert, but vomiting large undigested food, skin flush, sweating and the Resident complained of lower abdominal pain. The nurse documented that the Resident's temperature was 101.2 degrees Fahrenheit, and the Resident's suprapubic catheter was intact, but draining amber urine. The nurse called 911 and the Resident was taken to the hospital. The nurse documented that the Physician and family were both notified and the Resident was admitted with a urinary tract infection (UTI) and urosepsis per the charge nurse at the hospital.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10249 Based on observation, staff interviews and record review, the facility failed to ensure staff implemented a system to ensure that all mechanical and electrical equipment was maintained in safe operating condition for three areas: 1.) Essential kitchen equipment, 2.) Wanderguard system and the 3.) Facility hot water system. Findings include: 1.) During the initial tour of the kitchen, the surveyor observed the following essential kitchen equipment: - One of two ovens was broken - Fryolator broken - The convection oven door did not close or stay shut; therefore unable to safely operate - Food steamer was new, however was never installed - Plate warmer was broken. The Food Manager said it has been broken since her arrival in December 2020. - Ice machine had not been serviced or cleaned since the Food Manager started in December 2020. The Food Manger was unable to provide manufacture instructions or recommendations to maintain or sanitize. - The juice machine had not been used since December 2020, however the machine still had a used juice syrup container, the hand held spray was operating and there was water in the tray. The Food Manager said it is not used for residents; staff uses it for water for themselves. - The coffee machine is working, but the Food Manager said it has not been serviced or cleaned since December 2020. - The reach-in refrigerator gasket, located on the right hand door, was broken and did not allow the door to close tightly. -In the emergency food supply closet there were two ceiling lights burnout. During an interview on 6/10/21 at 10:10 A.M., the Assistant Maintenance Director said he was aware of the broken equipment in the kitchen, but unable to call in outside contractors unless facility administration paid first. He said that the convection oven door and the plate warmer have been broken since March of 2020. The Assistant Maintenance Director also said the previous Administrator bought the food steamer, but never arranged for it to be installed since it required a plumber and an electrician. He also said that he has never maintained or cleaned the ice machine and was not able to locate the manufacturer's instructions. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/16/21 at 9:30 A.M., the Regional Food Manager said he identified all broken equipment to the Maintenance Department upon his arrival to the facility in May of 2021 with no success. 2.) During an interview on 6/16/21 at 2:57 P.M., the Life Safety Surveyor #1 (LSS#1) said that the facility Wanderguard system, tied into the elevator on Unit C, was not functioning. Ten residents diagnosed with dementia resided on Unit C and were identified as being at risk for elopement. Nursing staff on Unit C were not aware that the Wanderguard system was inoperable and did not know which residents on the unit wore Wanderguard bracelets. During an interview on 6/16/21, LSS#1 said that the Administrator and Maintenance Supervisor (MS) #1 were both aware that the Wanderguard system was not working. He said that the facility had no plan to repair it. Maintenance Worker (MW) #1 told LSS#1 that he did not know how long the Wanderguard system had been inoperable for. The Wanderguard system remained inoperable during the course of the standard survey and during the two on-site revisits on 6/24/21 and 6/30/21. During an interview on the 6/30/21 revisit at 6:30 A.M., the Administrator said that the elevator company would need to be contacted so that the installation of the Wanderguard system could be coordinated between the Wanderguard technician and the elevator service company. 41065 3.) During Resident group meeting held on 6/10/21 at 10:30 A.M., the residents said that they do not get regular showers for several reasons, one being the cold water temperatures. The resident's said, if the water is too cold then we just don't get our shower that day. During an interview on 6/14/21 at 12:38 P.M., Resident #44 said he/she likes to have showers twice per week, but last Thursday (6/10/21) he/she did not receive one. The Resident told the surveyor the water was too cold to take the shower and was hoping to have his/her second shower today. During a subsequent interview on 6/15/21 at 10:46 A.M., Resident #44 told the surveyor she never received his/her Monday shower (6/14/21). The Resident said the staff told her the water was not warm enough to take a shower and could only provide a bed bath. The Resident said I would have loved my shower last night, even more so because I never received one last week. During an interview on 06/16/21 at 01:15 P.M., Resident #13 said he/she gets a shower every five days; the only problem is the water is always cold. During an interview on 6/15/21 at 11:34 A.M., Unit Manager #2 said Resident #44 did not receive her shower last evening because there was an issue with the water temperatures. She further said maintenance was trying to fix the problem, but it has taken a long time to fix. During an interview on 6/16/21 at 2:57 P.M., the Life Safety Surveyor said the facility had an inoperable return pump, as it was burnt-out. The non-functioning return pump did not allow the facility's hot water to constantly circulate and therefore, does not get distributed quickly enough to the far end of the building. This would cause sinks and showers to have low water temperatures. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/15/21 at 11:00 A.M., the surveyor observed the water temperature for one out of two shower rooms located on Unit B. The surveyor allowed the water to run for greater than two minutes. The thermometer used read 90.1 degrees Fahrenheit and felt lukewarm to the touch. On 6/15/21 at 11:00 A.M., a second surveyor simultaneously observed the water temperature in bathroom of room [ROOM NUMBER] on Unit B. The room was located on the far end of the hallway, away from the shower room. The surveyor allowed the water to run for greater than two minutes. The thermometer used read 97 degrees Fahrenheit and felt lukewarm to the touch. During an interview on 6/15/21 at 1:29 P.M., the surveyor requested to review the water temperature logs for the facility to determine whether the facility monitored water temperatures. Maintenance Worker #1 said he did not have logs of weekly water temperature monitoring in resident areas. During an interview on 06/15/21 at 01:15 P.M., the Administrator said he had looked everywhere for a record of weekly water temperatures being taken, but was unable to locate them.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 41106 Based on observations and staff interviews, the facility failed to provide documentation that regular bed inspections and entrapment assessments were being performed for all facility's beds. Findings include: During an interview on 6/16/21 at 4:35 P.M., Maintenance Worker #1 said there is no system or documentation for regular inspections of the facility beds, mattresses, bed frames or for entrapment. He said when the facility bought all new beds last year, there were no assessments performed for entrapment on the new beds or when they had admissions. Maintenance Worker #1 said when all the beds were replaced, they came with mobility bars that always seem to come loose. He said when he is walking around and he sees one hanging down, then he goes in and tightens the mobility bar. Maintenance Worker #1 was unable to provide the surveyor with any documentation of regular bed inspections or entrapment assessments. During an interview on 6/16/21 at 3:24 P.M., the Administrator said he would provide the surveyor with whatever he had regarding the side rail safety assessments. During an interview on 7/6/21 at 9:30 A.M., the Administrator had not provided the surveyor with any additional documentation of bed side rail safety assessments or regular maintenance records of the facility beds.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106 Based on observations and interview, the facility failed to provide full privacy curtains for two Residents (#55 and #33), from a total sample of 33 residents. Findings include: On 06/10/21 at 10:59 A.M., the surveyor observed Unit B and made the following observations: -room [ROOM NUMBER] B: Resident #55's bed did not have a privacy curtain. There were two residents assigned to the room. -room [ROOM NUMBER] B: Resident #33's bed did not have a privacy curtain. There were two residents assigned to the room. During an interview on 6/17/21 at 3:35 P.M., the Administrator said all residents on the Unit A were moved to the Unit B on 6/1/21 as part of the construction plan. During an interview on 6/24/2021 at 8:30 A.M., the Director of Nurses and Staff Developer both said the renovations on Unit B have been completed and they both checked all the rooms before residents were moved from Unit A to Unit B. They both said they were not aware rooms on Unit B were missing privacy curtains.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41106 Based on observation and staff interview, the facility failed to ensure a glass exit door was replaced after significant damage presenting a safety risk to residents. Findings include: On 6/10/21 at 10:59 A.M., the surveyor observed Unit B and observed a full glass pane exit door at the end of the hallway to have multiple large horizontal cracks. On 06/11/21 at 12:20 P.M., the surveyor, Administrator and Director of Nurses (DON) observed the full glass pane exit door on Unit B to have multiple full width horizontal cracks. The Director of Nurses said she was not aware the glass door cracked; she thought they were scratches in the glass. The surveyor applied a light pressure to the glass door and could feel the glass move with an audible cracking sound. The Administrator said he does not know how long the glass window has been cracked; he will have to check work orders. On 06/11/21 at 03:12 P.M., Maintenance Worker #1 said the glass door on Unit B cracked a couple of months ago when they were moving new beds into the facility. Maintenance Worker #1 said he told the old Maintenance Director not to use the door because it was old and when he tried to pull the door the closed the glass cracked. Maintenance Worker #1 said when the painters were painting Unit B a few weeks ago, they used the door and made the cracks bigger. Maintenance worker #1 said the old Administrator had two different glass companies come in and measure the door and give price quotes in March, but the door was never fixed. During an interview on 06/11/21 at 03:30 P.M., the Administrator said he could not find a work order or price quotes to have the cracked glass door on Unit B replaced.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 10249 Based on observation, record review, and staff interview, the facility failed to maintain an effective pest control program ensuring that the facility, including the main kitchen, is free from pests including mice. Findings include: During the initial tour on 6/9/21 at 8:30 A.M. and the follow up tour on 6/9/21 at 9:15 A.M. of the main kitchen, the surveyor observed mice dropping on two large windows sill in the main kitchen. The Food Manger said that they had seen a mouse in the past. There were also several large mouse traps located under utility tables and under the bay sink in the kitchen. Review of the contract pest control service reports indicated dead mice were located in the traps in May 2021. The surveyor attempted to contact the Pest control Service technician twice, with no reply.