STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30889 Based on observation, interview and record review, facility staff failed to ensure that residents received care and treatment in a manner that promoted dignity and enhanced their quality of life by failing to 1) provide hair grooming services for 1 Resident (#10), 2). provide a dignified dining experience for one Resident (#40), and 3). failing to remove facial hair for 3 Residents (#10, #22 and #40) out of a total sample of 37 residents. Findings include: 1. For Resident #10, the facility failed to ensure the Resident's hair was cared for in a dignified manner and was free of snarls and matting in the back of his/her head. Resident #10 was admitted to the facility in May, 2013 with diagnoses which included diabetes, anemia, and renal insufficiency. Review of the Resident's most recent quarterly Minimum Data Set (MDS) assessment, dated 5/18/21, indicated that the Resident was cognitively intact, required extensive assist of 2 staff for bed mobility. Resident #10 required extensive assistance of one staff for grooming/hygiene. On 8/31/21 at 9:29 A.M., the surveyor observed Resident #10, lying in bed. Resident #10's hair was long, full of snarls and matted on the back of his/her head. During an interview on 8/31/21 at 9:30 A.M., Resident #10 said that he/she has always worn his/her hair short. Resident #10 said it is very long and it's so matted now that he/she can't let the staff comb it because it hurts too much. Resident #10 said he/she hasn't had a haircut since Covid started and that he/she really would like and needs a haircut. During an interview on 9/2/21 at 10:00 A.M., Activity Assistant #1 said that the facility hasn't had a hairdresser since Covid and that they finally got one who was supposed to start last week, but she didn't show up. During an interview on 9/7/21 at 12:39 P.M., Administrator #1 said that the original hairdresser left at the start of Covid in March 2020 and that she had been working on getting a hairdresser but had not been successful. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #40, the facility failed to ensure he/she was assisted with feeding by staff in a dignified manner. Resident #40 was admitted to the facility in July 2017 with diagnoses which included dementia and depression. Review of the Resident's most current quarterly MDS assessment, dated 6/22/21, indicated Resident #40 was severely cognitively impaired and required extensive assistance with feeding from one staff. On 8/31/21 at 1:46 P.M., the surveyor observed the following during the lunch dining experience on the 2nd floor unit; Resident #40 was being fed by staff. Resident #40 was fed the entire meal by Certified Nursing Assistant (CNA) #10 while standing next to Resident #40. CNA #10 did not verbally interact or engage in any way with Resident #40. On 9/1/21 at 12:31 P.M., surveyor observation of the lunch dining experience on the 2nd floor unit, revealed Resident #40 as he/she was being fed by Nurse #11. Nurse #11 was standing while feeding Resident #40. At 9/1/21 at 12:32 P.M., Nurse #11 fed Resident #40 a bite of food, left the Resident and began cutting another resident's food. Nurse #11 returned to Resident #40 and gave him/her another bite of food. On 9/1/21 at 12:34 P.M., Nurse #11 left Resident #40 again to prevent another resident from touching another resident's food. Nurse #11 returned to Resident #40 and gave the Resident another bite of food. Nurse #11 left and returned to Resident #40 seven more times during the lunch meal to assist other residents. During an interview on 9/1/21 at 3:10 P.M., Nurse #11 said that there is a lot going on in that dining space and there aren't enough people assisting in the dining room (2 staff for 17 residents during the lunch meal). She said she doesn't have time to sit with the residents while she is feeding because she must watch the room and go to other parts of the dining room to cue other residents. Nurse #11 said they could really use more help in the dining room. Nurse #11 said the Staff Development Nurse did say she should sit when feeding residents. Nurse #11 said she couldn't sit because there wasn't enough staff in the dining room to spend all that time with one resident. 37565 3. For Resident #22, the facility failed to remove unwanted facial hair. Resident #22 was admitted to the facility in 9/2020 with diagnoses including a blood clot of the right leg, cellulitis (infection) of the left leg, dementia and schizophrenia. Review of the Resident's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident was moderately cognitively impaired and scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS. The MDS further indicated the Resident required an extensive assist with 1 person physical assist for personal hygiene. Review of the Resident's current care plan indicated Resident #22 required extensive assistance of 1 staff for personal hygiene including to observe facial hair daily. Interventions included offer to trim, pluck or shave daily as needed. If the Resident refuses, honor the choice and notify the nurse for documentation. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/31/2021 at 9:35 A.M. Resident #22 was sitting in a chair beside his/her bed. Resident #22 was alert and appeared well groomed except for hair on the upper lip and several long gray hairs hanging down from his/her chin. The Resident was aware of the long hairs and said they have been bothersome for years and I always removed them timely. The Resident expressed the dislike for them and had explained to staff the hairs must be plucked, not shaved because the return growth increases. Review of the Resident's nurses' notes had no evidence that Resident #22 refused removal of facial hair. During an observation on 9/1/2021 at 11:16 A.M., Resident #22 continued to have the same facial hair present. During an interview on 9/1/2021 at 12:05 P.M., Certified Nursing Assistant (CNA) #5 said Resident #22 was on her assignment and that she did not notice any facial hair when she provided care in the morning. CNA #5 added if she had noticed, she would have asked the Resident if he/she wanted the hair removed and would have if requested. Review of care provided by CNAs for Resident #22 indicated that on 8/21/2021, 8/24/2021, 8/25/2021, 8/27/2021 and 8/30/2021 the Resident had facial hair trimmed or shaved. Resident #22 continued to have the same upper lip hair and several long gray hairs hanging from the chin on 9/8/2021 and 9/28/2021.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on observation, record review and interview the facility failed to ensure 1 Resident (#73) was able to choose the size of his/her meal portions out of a total sample of 37 residents. Findings include: The facility policy titled Quality of Life-Self Determination and Participation, dated 2017, indicated: * Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facts of his or life. Resident #73 was admitted to the facility in August 2020, and had diagnoses that included morbid obesity and diabetes. Review of the Resident's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that on the Brief Interview for Mental Status (BIMS) exam Resident #73 scored a 15 out of a possible 15, indicating intact cognition. During an interview on 9/01/21 at 10:54 A.M., Resident #73 complained that staff made decisions for him/her. Review of Resident #73's medical indicated: * A Nutrition note, dated 7/27/21, Resident #73's current diet was regular, double portions. The note further indicated that the plan for Resident #73 was to continue receiving double portions with lunch and dinner. * A Nurse Practitioner (NP) progress note, dated 8/24/21, Resident #73 had been advised on risks and dangers of obesity, but refused to change his/her diet. During an interview on 9/15/21 at 12:16 P.M., Resident #73's Certified Nursing Assistant (CNA) #16 said that she did not know what to do anymore, because Resident #73 had requested double portions with meals and every day Resident #73 complained that he/she did not receive double portions. CNA#16 said that on that day, just as she did each day, she called the kitchen and asked to speak with the Food Service Director (FSD) who refused to send double portions. CNA#16 showed the surveyor the meal ticket that indicated that Resident #73 was supposed to get double portions with meals. During an interview with Resident #73's Nurse (#1) on 9/15/21 at 12:20 P.M., she said she had just spoken to the FSD and the FSD told her Resident #73 could not have double portions because he/she was a diabetic. Nurse #1 said that she called Resident #73's Nurse Practitioner who was already aware Resident #73 preferred double portions and the NP gave another order for double portions. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Food Service Director (FSD) on 09/15/21 at 12:43 P.M., she said that she has been fighting with various staff regarding this for 10 months and that she won't send double portions because Resident #73 was a diabetic. The FSD was aware that the meal ticket, generated in the kitchen said double portions, and said resident choice doesn't matter. The FSD acknowledged that the staff had given her a physician's order for double portions but she thought it was fake because they got it too easily.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 40928 Based on interview, policy and record review, the facility failed to ensure the resident's legal representative was notified of medical changes for 1 Resident (#13), out of a total sample of 37 residents. Findings include: Review of the facility's policy Change in a Resident's Condition or Status and Notification dated April 2020, indicated the following: *Our facility shall promptly notify the resident, his or her Attending Physician, and representative (consistent with his or her authority) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Resident #13 was admitted to the facility in July of 2020 with diagnoses including Schizophrenia, Psychotic disorder, Manic depression, Anxiety disorder, Diabetes Mellitus. Review of the medical record indicated Resident #13 has a court appointed guardian. On 9/1/ 21 at 11:14 A.M., review of the Resident #13's Quarterly Nutritional Assessment completed on 8/25/21 indicated that Resident # 13's Percutaneous endoscopic gastronomy (PEG) tube (a tube used to provide nutrition through the stomach) is still in place, it has been scheduled to be removed but the Resident refused. The Quarterly Assessment further indicated the PEG tube is not being used for any nutrient delivery. During an interview on 9/2/21 at 12:08 P.M., Nurse Practitioner (NP #2) said she wrote a progress note on 7/21/21 stating Resident #13 still has the PEG tube, he/she went to the surgeon for removal, and he/she refused the removal. During an interview on 9/3/21 at 11:10 A.M., NP #2 said Resident #13's Legal Guardian should have been notified of the attempt to remove the PEG tube and Resident #13's refusal of the PEG tube removal. During a telephone interview on 9/10/21 at 12:33 P.M., Resident #13's Legal Guardian said the facility did not notify her that Resident #13 had an appointment with a surgeon for removal of the PEG tube and that Resident #13 had refused the procedure.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, record review and interview, the facility failed to protect residents from neglect by 1) failing to ensure there was clinical staff present to provide nursing services and assure residents safety on 1 of 3 occupied resident units, 2) failing to ensure there was adequate staff to provide 1:1 supervision as ordered by the physician to maintain safety, resulting in a fall with injury for 1 Resident (#44) and 3) failing to provide, for 1 Resident (#74) out of a total sample of 37 residents, Activities of Daily Living (ADL) including incontinence care and assistance with feeding from 7:00 A.M. until approximately 1:45 P.M., due to limited staff assigned to the unit, Findings include: 1) The facility failed to protect residents from neglect by failing to ensure there was clinical staff present to provide nursing services and assure resident safety on 1 of 3 occupied resident care units. Findings include: Review of facility policy titled 'Staffing', revised April 2007, indicated the following: *Policy Statement: -Our facility provides adequate staffing to meet needed care and services for our resident population. *Policy Interpretation and Implementation: - Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. - Certified Nursing Assistants (CNAs) are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan On 9/7/21 at 6:55 A.M., the surveyor arrived onto the 1st floor unit. The surveyor was unable to locate a staff person. Observation of the 1st floor unit revealed two residents residing in two different rooms. The surveyor observed the staffing coordinator (who does not have a clinical background) sitting in the back of the nurses station, using a desktop computer. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/7/21 at 6:55 A.M., the staffing coordinator said that the 11:00 P.M.-7:00 A.M. shift nurse (#6) was also covering the 2nd floor unit. The staffing coordinator said she comes in at 6:00 A.M., but did not see the nurse on the 1st floor unit. She said there was a CNA (#3) covering the 1st floor unit but she left at 6:50 A.M. because of childcare. The staffing coordinator said there is a nurse scheduled to cover the 1st floor unit for the 7:00 A.M.- 3:00 P.M. shift but she hadn't arrived yet. The surveyor asked what would happen if the residents on the 1st floor unit needed assistance. The staffing coordinator said she would probably call someone on the second floor. The staffing coordinator said she was not a clinical staff and was just on the unit to use the computer. The staffing coordinator could not say how residents would have been able to get assistance if she had not come to the desk to use the computer. On 9/7/21 at 7:05 A.M., the surveyor observed CNA #11 standing at the 1st floor nurses station. During an interview on 9/7/21 at 7:05 A.M., CNA #11 said she is working on the second floor and they sent her down to the first floor until the nurse arrives. During an interview on 9/7/21 at 7:07 A.M., the staffing coordinator said she called for assistance after she spoke with the surveyor. On 9/7/21 at 7:20 A.M., the surveyor observed as Nurse #15 (scheduled to work on the unit for the 7-3 shift) arrived onto the 1st floor unit. On 9/7/21 at 7:10 A.M., the surveyor reviewed the Medication Administration Record (MAR) for Resident #27 (a resident residing on the 1st floor unit). The review indicated that Resident #27 should have received the following medications at 6:00 A.M.: cholecalciferol (vitamin D3) 800 units, colace 100 milligrams (mg) one by mouth and Levothyroxine (thyroid medication) 50 micrograms(mcg) by mouth every day. The MAR was not initialed by the 11-7 nurse as given. During an interview on 9/7/21 at 11:10 AM, Nurse #6 (who had been assigned to the 2nd floor unit on the 11-7 shift) said that she did not give Resident #27 his/her 6:00 A.M. medications. Nurse #6 said that she usually will give them on her way out of the building, after she finished her work on the 2nd floor unit, but she ran out of time and needed to leave the facility. Nurse #6 said she covers the 2nd floor unit and 1st floor unit about once a week and will come down if a resident requests an 'as needed' medication, if not, she said she stays on the 2nd floor because she has 40 residents upstairs and can't be down on the first floor. Nurse #6 said it isn't safe to leave the 2nd floor. Nurse #6 said she instructs the CNA assigned to check the residents every two hours and to call her if there is a problem, other than that she would not go downstairs. The surveyor asked if she performed needed assessments or observed Resident #27 or Resident #139, whom resided on the first floor unit, at all during the 11-7 shift. Nurse #6 said she did not see either of them at all the entire shift. Nurse #6 said she did not go to the 1st floor unit at all during the 11:00 P.M.- 7:00 A.M. shift on 9/6/21-9/7/21. 2) The facility failed to protect Resident #44 from neglect, by failing to ensure there was adequate staff to provide 1:1 supervision as ordered by the physician to maintain safety, resulting in a fall with injury. Resident #44 was admitted to the facility in March 2021 with diagnoses including traumatic brain injury, dementia, multiple falls, anxiety and bipolar disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #44's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had moderate cognitive impairment and scored a 10 out of 15 on the Brief Interview Status (BIMS). Further review of Resident #44's MDS indicated the Resident required assistance with all care activities and that the Resident had falls with injury since the previous assessment. Review of Resident #44's medical record indicated a physician's order, dated 9/3/21, for 1:1 sitter for safety, every shift. Review of Resident #44's care plans indicated he/she was a high risk for falls related to incontinence, poor safety awareness, restlessness and agitation, use of psychotropic medication, anxiety, akathisia (a movement disorder characterized by inner restlessness), attempts to self transfer, recent fall history and indicated an intervention, dated 9/3/21, for Resident #44 to be 1:1 in arms reach to prevent falls. On 9/3/21 at 8:08 A.M., Resident #44 was observed in a wheelchair in front of the nurses station. Resident #44 appeared visibly restless and agitated and had a healing laceration over his/her left eyebrow, bruising to his/her left peri orbital area (area around the eye) and old bruises to the right and left sides of his/her forehead. Nurse #3 said that Resident #44 fell twice last night after returning from the hospital for a previous fall and said the Resident fell again this morning and pulled a chair on top of himself/herself. Nurse #3 said the Nurse Practitioner (NP) had ordered a 1:1 for the Resident. On 9/3/21 at 8:18 A.M., Nurse #3 said the medical records clerk was going to stay with the Resident for a brief period of time until a 1:1 could be arranged. Nurse #3 said a 1:1 will be used for a resident with multiple falls but there is not enough staff to have one and further said staffing is challenging. On 9/03/21 at 8:23 A.M., Nurse #3 said the floor staff, assigned to give care to all of the other residents on the unit, would alternate shifts in 30 minute increments to provide 1:1 supervision for the Resident. Review of Resident #44's Adult Protective Services Intake Report dated 9/5/21 indicated the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-EMS (Emergency Medical Services) responded to the facility for a reported fall with arm injury and when they arrived to the unit that Resident #44 resided on, there was no staff at the nurse's station. EMS located a staff member at the end of one hall. EMS reported the staff member said she was a nurse on one side of the unit but was unaware that EMS had been called and was unsure where the nurse for the other side of the unit was. The report further indicated that EMS began a room to room search and located Resident #44 in his/her room laying on his/her back on the floor of his/her room with no one around the Resident. The report indicated that EMS assessed Resident #44 to have diminished mental status and that another staff member walked by the Resident's room and said that this was his/her normal mental status and that they were unsure of why EMS had been called or when Resident #44 had fallen. Further, the staff member reported that Resident #44 had initially been found on the floor of the hallway and then was moved back into his/her room. The report indicated that Resident #44 was noted to have multiple bruises across his/her head and arms in all different stages of healing and multiple skin tears in all different stages of healing. The report further indicated that Resident #44's room was noted to have multiple soiled adult diapers on the floor and the Resident smelled of urine and his/her pants were noted to be wet. During a record review of Resident #44's medical record on 9/7/21 at 8:00 A.M., the following was indicated: - Skin Only Evaluation dated 9/5/21 at 5:43 P.M.: Patient 1:1 supervision with 2 aides on entire floor. Patient fell in hallway when an aide was looking for assistance. Order to send to ER. Unwitnessed. Small skin tear noted. Will go to hospital. -Nurses Note dated 9/5/21 at 6:43 P.M. : Patient 1:1 supervision with 2 aides on entire floor. Unwitnessed fall. Patient combative and aggressive. Assist up to wheelchair. Small skin tear noted. Order to send to hospital to evaluate and treat. Review of Resident #44's Emergency Department document dated 9/5/21 indicated the following: - Patient presents to the emergency room for evaluation after an unwitnessed fall at nursing home. Apparently, the patient crawled out into the the hallway of the nursing home when staff found him/her. Patient states he/she fell out of bed. According to EMS (Emergency Medical Services) they could not find any staff that was aware of the patient, there was no staff on his/her floor at all, and they filed elder neglect paperwork. During an interview on 9/7/21 at 9:40 A.M., the Interim Director of Nursing said she was familiar with Resident #44 and that the Resident had multiple falls and was impulsive. The Interim Director of Nursing said that the expectation regarding the order and care plan intervention for 1:1 supervision for this Resident is that it should have been followed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During telephone interviews throughout the day on 9/7/21 and 9/16/21, Nurse #4 said she was working on 9/5/21 when Resident #44 fell . Nurse #4 said she was only notified that the Resident fell on ce during her shift and that the multiple notes written about his/her fall were related to the same fall. Nurse #4 said staff did their best to watch him/her during the shift but due to low staffing it was difficult. Nurse #4 said that there were only 2 Certified Nursing Assistants (CNAs) working on the unit (unit census was 41 residents) when Resident #44's fall happened and it was difficult to maintain the 1:1 for the Resident as ordered. Nurse #4 said that a CNA left the Resident alone in the hallway to ask for help and that's when the Resident fell . Nurse #4 said staff assisted him/her to a wheelchair and she observed a skin tear to the Resident but was unsure of the location. Nurse #4 said another nurse dressed the skin tear and then brought the Resident back to his/her room. Nurse #4 was unable to say if the Resident remained supervised as ordered after the fall and could not say why the Resident was found alone on the floor of his/her room by EMS. Nurse #4 said she had called Administrator #1 on 9/5/21 to say that there was not enough staff to provide a 1:1 for Resident #44 and ensure his/her safety and asked if Administrator #1 would come in to act as the 1:1. Nurse #4 said Administrator #1 told her she lived too far away and would not come in. Nurse #4 said that Resident #44 fell after she had contacted Administrator #1 asking her to come in to be the Resident's 1:1. Nurse #4 said she didn't think the staffing level was safe on the unit. Nurse #4 said she thought the Resident sustained a skin tear but she was unsure of the location. Nurse #4 said nursing staff had notified administration multiple times that they felt Resident #44 was unsafe in the facility and that they couldn't safely care for him/her. During an interview on 9/8/21 at 9:09 A.M., Administrator #1 said she was familiar with Resident #44. Administrator #1 said he/she has fallen more than any resident she has ever worked with. Administrator #1 said on 9/3/21 they talked about having staff with Resident #44 at all times as a 1:1. Administrator #1 said a nurse called her on 9/5/21 in the afternoon and asked her to come in to be the 1:1. Administrator #1 said she told the nurse no and that she would not come in because she lived too far away. Administrator #1 said the nurse then told her that the staff couldn't provide the 1:1 for Resident #44. Administrator #1 said she did not ask how many staff were on the unit and that she was unsure how many staff was present. Administrator #1 said she called the scheduler about an hour after receiving the call from nursing staff that they couldn't provide the 1:1 for Resident #44. Administrator #1 said she did not follow up with the nursing staff or the scheduler regarding the request from the nurse for a 1:1 for Resident #44. Administrator #1 was unsure as to when she was notified about Resident #44's fall and being sent to the hospital. During an interview on 9/8/21 at 11:06 A.M., The Staffing Coordinator said that there was a staffing issue on 9/5/21 during the 3-11 shift on the 3rd floor. The Staffing Coordinator said Administrator #1 asked her if she could come in to be Resident #44's 1:1 and she was unable to do it. The Staffing Coordinator said she reached out to staff to try to find someone but no one responded. The Staffing Coordinator was unable to say if she notified Administrator #1 or nursing staff that she was unable to find someone to act as a 1:1. See tag F689 and F835 41105 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) The facility failed to protect Resident #74 from neglect by failing to provide Activities of Daily Living (ADL) care, including turning and repositioning in bed, incontinence care and assistance with feeding from 7:00 A.M. , until approximately 1:45 P.M., due to limited staff assigned to the unit. Resident #74 was admitted to the facility in August 2019, and had diagnoses that included dementia and chronic obstructive pulmonary disease (COPD). Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #74 was assessed by staff to have had severely impaired cognition. The MDS further indicated Resident #74 required total assist of two staff for all aspects of his/her Activities of Daily Living (ADL's). During a record review on 8/31/21 at 11:15 A.M., the record for Resident #74 indicated the following: * A current ADL care plan which indicated Resident #74 was dependent on staff for care. During an observation on 9/03/21 at 1:03 P.M., Resident #74 was observed alone in his/her room in bed sleeping, with a pudding container in his/her hand and an untouched lunch tray on the tray table directly in front of him/her. During an interview with the facility's Consulting Nurse (CN) #1 on 9/03/21 at 1:14 P.M., she said she was unable to locate a CNA or a nurse on Resident #74's end of the unit. CN#1 said she would leave the unit and see if she could find the staff elsewhere in the building. During an interview with Certified Nursing Assistant (CNA) #6 on 9/03/21 at 1:26 P.M., she said that she was the CNA responsible for Resident #74 but that on that date she hadn't seen or cared for Resident #74 since providing incontinence care at 7:00 A.M. CNA#6 said that Resident #74 was totally dependent on her for all ADL care including incontinence care and feeding, and that she had not had a chance that day to assist her with eating breakfast or lunch or to clean her because there were not enough staff on the unit and she was still providing morning care to other residents. CNA #6 said that it was impossible to provide the residents on the unit with the amount of care they needed due to the limited numbers of CNA's assigned. During an interview with Administrator #1 and CN#1 on 9/03/21 at 1:49 P.M., CN #1 said that she overheard CNA #6 had not cared for Resident #74 since the start of her shift nearly 7 hours prior and that they had initiated an investigation to determine if any other staff had provided the needed care. Administrator #1 and CN#1 said it was the expectation, because Resident #74 was totally dependent on staff for care, that he/she be turned and repositioned in bed every two hours, be checked for incontinence care needs every two hours and be fed his/her meals. Review of the state's Health Care Facility Reporting System (HCFRS) data base indicated that on 9/3/21 the facility had reported the incident regarding Resident #74's lack of care as neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow-up interview with Administrator #1 on 9/07/21 at 9:09 A.M., she said that she had interviewed all facility staff and the hospice aide and hospice nurse assigned to Resident #74 and concluded that Resident #74 had not received any care from 7:00 A.M., until approximately 1:45 P.M., when the surveyor brought it to staff's attention. She indicated that the expectation was that staff provide dependent residents with care every two hours and that in this case that did not happen. Administrator #1 provided the surveyor with her investigative file which included a statement from CNA #6 that she had not provided Resident #74 with the required care due to low staffing. See F725 and F835

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41063 Based on observation, record review, interviews and facility policy review the facility failed to complete a restraint assessment for 1 Resident (#26) out of a total sample of 34 residents. Findings include: Review of the facility policy titled Use of Restraints with a revision date of 2007, indicated the following: *The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. *Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls. *Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. *Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, bean bag chair, concave mattress, recliner chairs, wheelchair safety bars, geri-chairs, and lap cushions, hand mitts, trays, etc. that the resident cannot remove. *Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptoms and to determine if there are less restrictive interventions that may improve the symptoms. *Restrained individuals should be reviewed regularly (at least quarterly) to determine whether they are a candidate for restraint reduction, less restrictive methods of restraints, or total restraint elimination. Resident #26 was admitted in September 2017 with diagnoses including Dementia with Lewy Bodies. Review of the most current Minimum Data Set, dated dated dated [DATE], indicated that Resident #26 scored a zero out of 15 on the Brief Interview for Mental Status (BIMS) indicating a severe cognitive deficit. Further review of the MDS indicated that Resident #26 did not walk, required extensive assistance with bed mobility, transfers, toilet use, personal hygiene, locomotion on the unit, and dressing, required limited assistance with eating and was totally dependent with bathing. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/10/21, at 7:05 A.M. the surveyor observed Resident #26 lying in bed on a raised perimeter mattress with his/her head raised and the footboard all the way down to the floor, positioning Resident #26 at a slant in the bed. During an interview on 11/10/21, at 2:06 P.M., CNA #1 said Resident #26's head of the bed was raised and the foot of the bed was all the way down to the floor when she went to get him/her up , CNA#1 said that the 11-7 shift must have positioned the bed like that, CNA#1 further said that she thought maybe they forgot to clear the bed to level it out. During an interview on 11/10/21, at 2:17 P.M., Unit Manager (UM) #1 said that in order to place a raised perimeter mattress on a resident's bed, the staff would have to complete a restraint assessment for a specialized mattress. U.M. #1 said Resident #26 did not have a restraint assessment. UM #1 further said that staff should not be positioning residents in bed with the footboard all the way down and the head raised.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40928 Based on observation, interview and record review, the facility failed to report potential allegations of abuse and/or neglect to the state agency as required for 5 residents (#4, #29, #49, #64 and #86) out of a total sample of 37 residents. Findings include: Review of facility policy titled 'Accidents and Incidents- Investigating and Reporting', revised 2017 indicated the following: *Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. *Policy Interpretation and Implementation: 1. The Nurse Supervisor/ Charge Nurse and/ or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/ Accident form: a. The date and time the accident or incident took place; b. The nature of the injury/ illness (e.g. bruise, fall, nausea, etc.); c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, included his/ her vital signs; j. The disposition of the injured (i.e. transferred to hospital, put to bed, sent home, returned to work, etc.); k. Any corrective action taken; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l. Follow up information; m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report. 1. For Resident #86, the facility failed to report a bruise of unknown origin. Resident #86 was admitted to the facility in March, 2018 with diagnoses including chronic kidney disease and anxiety disorder. Review of Resident #86's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident was cognitively intact and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS). Review of Resident #86's medical record indicated the following: - A Nurses note dated 6/30/21: Dialysis called this afternoon to report that they found a bruise on Resident # 86's right breast. Bruise measures approximately 5.5 cm (centimeters) by 3.5 cm yellow in color with small area purple in color. No c/o pain to site. - A Social Services noted dated 6/30/21: Had a voicemail from Social Worker at dialysis that Resident # 86 had a bruise on his/her left breast when he/she was at dialysis yesterday. Social Worker informed Assistant Director of Nursing of this and she will follow up. Also, Assistant Director of Nursing will reach out to Social Worker at dialysis to inform her. - A care plan dated 7/1/21: Alteration in skin integrity r/t Bruise L breast. Interventions: encourage to wear a bra to dialysis; please do weekly skin checks as ordered by MD/ NP; monitor healing process and contact MD/ NP for treatment changes as needed. On 9/02/21, review of the Health Care Facility Reporting System (HCFRS) failed to indicate the bruise of unknown origin to Resident #86's breast had been reported by the facility. During an interview on 9/02/21 at 3:48 P.M., Administrator #1 said that any bruise of unknown origin should be investigated and reported. The Administrator further said that nursing should perform an assessment and if the cause is unknown then an investigation should be completed. 30889 2. For Resident #4, the facility failed to report a bruise of unknown etiology to the state agency as required. Resident #4 was admitted to the facility in 9/2019 with diagnoses which included delusional disorders, dementia and anxiety. Review of the most recent annual Minimum Data Set Assessment, dated 8/10/21, indicated that the Resident was severely cognitively impaired and there were no behaviors noted. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/21 at 2:10 P.M., review of the clinical record indicated a nurses note documented on 9/14/21 at 2:30 P.M., which indicated Resident #4 had a light blue bruise under his/her left eye. There was no further documentation regarding size or etiology of the bruise. On 9/15/21 at 2:45 P.M., the surveyor, with Nurse #10, observed Resident #4 while sitting in the activity room with a bruise under his/her left eye approximately 3- 4 centimeters (cm) long by 1.5 cm wide. The color was dark blue surrounded by a faint yellow. Also noted was a dark blue bruise located below the resident's lower lip that was approximately 0.5 cm in diameter. During an interview on 9/15/21 at 2:53 P.M., Nurse #10 said that she was told by one of the Certified Nursing Assistant (CNA)'s that the Resident had a bruise under his/her eye. Nurse #10 said she hadn't noticed it earlier, but the Resident's left side wasn't facing her, so she could have missed it. Nurse #10 said she began interviewing staff and then notified the Resident's spouse, and the Nurse Practitioner immediately after observing the bruise herself. Nurse #10 said that on 9/14/21 at 2:30 P.M., she reported the bruise to Consultant Nurse #3. Nurse #10 said she doesn't know how the bruise got there and she didn't notice the bruise under Resident #4's lower lip. Review of the Medication Administration Record dated 9/14/21, Behavior Monitoring: Combative with care; hits, indicated that no behaviors were exhibited by Resident #4 during the previous 24-hour period prior to identifying the bruise of unknown etiology. Review of the Certified Nursing Assistant Behavior Symptoms form for 9/14/21 indicated that no behavioral symptoms were present by Resident #4 the previous 24 hours prior to identifying the bruise of unknown etiology. During an interview on 9/15/21 at 3:25 P.M., Consultant Nurse #3 said that she was told the Resident had been combative with care during the 11:00 P.M.-7:00 A.M. shift. Consultant Nurse #3 said she thought it must have happened during the night therefore she didn't report it. Consultant Nurse #3 said that maybe the facility concluded without fully investigating and she could see that it should have been reported to the Department of Public Health. 41105 3.) For Resident #29 the facility failed to report an allegation of sexual abuse to the State Agency within the required two hour time frame. Resident #29 was admitted to the facility in July 2021, and had diagnoses that included cerebral infarction and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that on the Brief Interview for Mental Status (BIMS) exam Resident #29 scored a 12 out of a possible 15 indicating moderately impaired cognition. During an interview on 8/31/21 at 1:20 P.M., the Administrator #1 notified the surveyors that the facility had just received an allegation of sexual abuse from Resident #29 towards Resident #64 and that they were investigating and reporting this allegation to the Department of Public Health (DPH). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review on 8/31/21 at 1:40 P.M., a clinical progress note, dated 8/27/21, indicated that administration came to speak to (Resident #29) in regards to the accusations from (Resident #64). During an interview with the Administrator #1 and facility's Corporate Nurse (CN) #1 on 9/1/21 at 1:24 P.M., Administrator #1 said that the facility had actually known about this allegation a week ago, not today as she had previously told the surveyor. Administrator #1 said that about a week ago it was reported to her that Resident #29 told Resident #64 words to the effect that he/she wanted to suck your breasts. Administrator #1 said that she considered this to be a grievance not an allegation of sexual abuse. Administrator #1 said in hindsight she should have investigated/reported this as an allegation of abuse. Review of the Health Care Facility Reporting System (HCFRS) indicated that the 8/26/21 incident was not reported until 9/1/21, 7 days after it was initially reported. 4.) For Resident #64 the facility failed to report an allegation of sexual abuse to the State Agency within the required two hour frame. Resident #64 was admitted to the facility in July 2021, and had diagnoses that included Major Depressive Disorder and suicidal ideations. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that on the Brief Interview for Mental Status (BIMS) exam Resident #64 scored a 15 out of a possible 15 indicating intact cognition. The MDS further indicated Resident #64 had no behaviors. During an interview on 8/31/21 at 1:20 P.M., Administrator #1 notified the surveyors that the facility had just received an allegation of sexual abuse regarding Resident #64 and that they were investigating and reporting this allegation to the Department of Public Health (DPH). During a record review on 8/31/21 1:28 P.M., a clinical progress note, dated 8/26/21, indicated that Resident #64 had reported to 2 staff nurses that a male resident had sexually harassed him/her at 3 PM and during supper time. Resident #64 stated that the resident said words to the effect that he/she wants to suck his/her breast. The note further indicated Resident #64 was offered a room on a different floor and incident was reported to the administrator. During an interview with Resident #64 on 9/1/21 10:37 A.M., he/she said that a few weeks ago Resident #29 had told him/her that he/she had a nice set of breasts and asked if he/she could see more. Then the following night Resident #29 approached Resident #64 and asked can I suck on your breasts, or words to that effect. Resident #64 said that he/she reported the incidents to staff that were working and that they reported it to Administrator #1. Resident #64 said that he/she was told by Administrator #1 the next day that Resident #29 denied the allegation and that Resident #64 would need to move to a different unit if he/she did not want to be near Resident #29. Resident #64 moved units and said that the situation has never been addressed by staff again. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Administrator #1 and facility's Corporate Nurse (CN) #1 on 9/1/21 at 1:24 P.M., Administrator #1 said that the facility had actually known about this allegation a week ago, not just today as she had previously told the surveyor. Administrator #1 said that about a week ago it was reported to her that Resident #64 reported Resident #29 had told him/her words to the effect that he/she wanted to suck your breasts. Administrator #1 said that she considered this to be a grievance not an allegation of sexual abuse. Administrator #1 said in hindsight she should have reported this as an allegation of abuse. Review of the Health Care Facility Reporting System (HCFRS) indicated that the 8/26/21 incident was not reported until 9/1/21, 7 days after it was initially reported. 5. For Resident #49, the facility failed to report an allegation of emotional and verbal abuse. Resident #49 was admitted to the facility in November 2019 with diagnoses that included hemiplegia and cerebrovascular accident (CVA). Review of the Minimum Data Set (MDS) dated on 7/13/21 indicated Resident # 49 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #49 is cognitively intact. During an interview on 8/31/21 at 12:24 P.M., Resident #49 reported an allegation of abuse to the surveyor. Resident #49 said staff are disrespectful, non-responsive and rude to him/her. Resident #49 said he/she has tried to reach the Social Worker (SW #1) by phone to report the abuse allegations, but he/she has had no response from SW #1. During an interview on 9/1/21 at 1:16 P.M., the surveyor informed SW#1 of Resident #49's allegation of staff being disrespectful, non-responsive and rude to him/her. During an interview on 9/2/21 at 9:01 A.M., Resident #49 said SW #1 has not followed up with him regarding his/her allegations of staff being disrespectful, non-responsive and rude. During an interview on 9/2/21 at 10:49 A.M., Administrator #1 said SW#1 did not report any abuse allegations made by Resident #49 to her. Administrator #1 said she will follow up on the abuse allegations. On 9/3/21, review of Health Care Facility Reporting (HCFRS) failed to indicate that the facility reported the abuse allegation to the Department of Public Health (DPH) as required. See F610 and F835

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, interview and record review, the facility failed to thoroughly investigate incidents of potential abuse for 5 residents (#29, #49, #64, #79 and #86) out of a total sample of 37 residents. Findings include: Review of facility policy titled 'Accidents and Incidents- Investigating and Reporting', revised 2017 indicated the following: *Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. *Policy Interpretation and Implementation: 1. The Nurse Supervisor/ Charge Nurse and/ or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/ Accident form: a. The date and time the accident or incident took place; b. The nature of the injury/ illness (e.g. bruise, fall, nausea, etc.); c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, included his/ her vital signs; j. The disposition of the injured (i.e. transferred to hospital, put to bed, sent home, returned to work, etc.); k. Any corrective action taken; l. Follow up information; (continued on next page)

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Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report. Review of facility policy titled 'Abuse Investigations', revised 2017, indicated the following: *Policy statement: All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. *Policy Interpretation and Implementation: 1. Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator or his/her designee will appoint a member of management to investigate the alleged incident. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors; i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident. 1. For Resident #86, the facility failed to thoroughly investigate a bruise of unknown origin. Resident #86 was admitted to the facility in 3/2018 with diagnoses including chronic kidney disease and anxiety disorder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #86's Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident was cognitively intact and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of Resident #86's MDS indicated that the resident required assistance with care activities and that the resident required dialysis (a procedure to remove waste products and excess fluid from the body when kidneys stop working properly). During interviews throughout the day on 9/1/21, Resident #86 said he/she attends dialysis three times per week and that she gets there using a private companion in the companion's vehicle. Review of Resident #86's medical record indicated the following: - A Nurses note dated 6/30/21: Dialysis called this afternoon to report that they found a bruise on Resident # 86's right breast. Bruise measures approximately 5.5 centimeters (cm) by 3.5 cm yellow in color with small area purple in color. No c/o pain to site. - A Social Services noted dated 6/30/21: Had a voicemail from Social Worker at dialysis that Resident # 86 had a bruise on his/her left breast when he/she was at dialysis yesterday. Social Worker informed Assistant Director of Nursing of this and she will follow up. Also, Assistant Director of Nursing will reach out to Social Worker at dialysis to inform her. - A care plan dated 7/1/21: Alteration in skin integrity r/t Bruise L breast. Interventions: encourage to wear a bra to dialysis; please do weekly skin checks as ordered by MD/ NP; monitor healing process and contact MD/ NP for treatment changes as needed. On 9/02/21 at 12:00 P.M., the surveyor asked for any incident reports or investigations for Resident #86. Review of the incident reports and investigations provided to the surveyor failed to indicate any investigation was completed for the bruise of unknown origin on Resident #86's breast. During an interview on 9/02/21 at 3:48 P.M., Administrator #1 said that any bruise of unknown origin should be investigated and reported. Administrator #1 further said that nursing should perform an assessment and if the cause is unknown then an investigation should be completed. On 9/02/21 at 4:08 P.M., Corporate Nurse #1 provided the surveyor with a soft file regarding the bruise to Resident #86's breast. Corporate Nurse #1 said that she had just located the file after the surveyor discussed the bruise of unknown origin with the Administrator. Corporate Nurse #1 was unable to say why the incident was not reported or investigated thoroughly or why she was unable to locate file when surveyor had previously asked. Corporate Nurse #1 said the facility had determined the resident got the bruise from a transport chair car seatbelt, but was unable to say how this was determined. Review of the soft file for Resident #86's breast bruise of unknown origin included the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*An undated, unsigned typed document written by the former ADON which indicated that during morning meeting on 6/30 it was reported that dialysis had called the prior afternoon and reported noticing bruises to the Resident's breast during dialysis. The document further indicated a skin check was completed, and findings were bruises (did not specify which breast and did not specify how many bruises) and no other skin integrity issues. Resident unable to state if anything happened. The document further indicated that the former ADON spoke to Certified Nursing Assistants (CNAs) and nurses regarding the origin of bruising and that no one had noted bruising prior to leaving for dialysis. CNAs assisted with dressing the Resident and no bruises were noted during morning care and no record of the Resident falling or banging into anything. * A document dated 6/30/21 which indicated: Final Conclusion: After examination and location of the bruising, it was determined that the positioning of the straps in the transport car was the cause of bruising. No other bruising noted on his/her skin checks. Patient has no complaints at this time. This document had no signature and no name to identify who wrote it. Review of the soft file provided to the surveyor and Resident #86's medical record failed to indicate any skin check was completed when the bruise of unknown origin was reported to the facility, contradicting the unsigned document. During an interview on 9/02/21 at 4:44 P.M., Corporate Nurse #1 acknowledged the file did not include any signed witness statements, skin assessments, or interviews and acknowledged that the investigation did not identify which of Resident #86's breasts had the bruise. Corporate Nurse #1 further said that she was incorrect when she previously told the surveyor that the Resident had gotten the bruise from riding in a transport chair car to get to dialysis and that Resident #86 was using a private passenger car and hadn't gone in chair car since 5/30/21. During an interview on 9/03/21 at 12:23 P.M., the former Assistant Director of Nursing (ADON) said she worked at the facility for about a month from June-July. The former ADON said generally she was responsible for any investigations but that some administrators like to do their own investigations. The former ADON said that any injury of unknown origin should be investigated. The former ADON said for bruises of unknown origin, she would perform a complete skin check to document what the findings are, interview care providers, interview the resident if able and review notes. The former ADON said Administrator #1 usually does all of the investigations. The former ADON said dialysis discovered the bruise on the Resident's breast. The former ADON was unsure of which breast had the bruise. The former ADON said that a thorough investigation should have been done. 41105 2.) For Resident #29 the facility failed to investigate an allegation of sexual abuse. Resident #29 was admitted to the facility in July 2021, and had diagnoses that included cerebral infarction and major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that on the Brief Interview for Mental Status (BIMS) exam Resident #29 scored a 12 out of a possible 15 indicating moderately impaired cognition. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/31/21 at 1:20 P.M., Administrator #1 notified the surveyors that the facility had just received an allegation of sexual abuse from Resident #29 toward another Resident (#64) and that they were initiating an investigation into the allegation. During a record review on 8/31/21 1:40 P.M., a clinical progress note, dated 8/27/21, indicated that administration came to speak to (Resident #29) in regards to the accusations from (Resident #64). During an interview with Administrator #1 and facility's Corporate Nurse (CN) #1 on 9/1/21 at 1:24 P.M., Administrator #1 said that she had actually known about this allegation a week ago, and had not just been notified today as previously reported to the surveyor. Administrator #1 said that about a week ago it was reported to her that Resident #29 told Resident #64 words to the effect that he/she wanted to suck your breasts. Administrator #1 said that she considered this to be a grievance not an allegation of sexual abuse and that she had not conducted an investigation. Administrator #1 said in hindsight she should have investigated this as an allegation of abuse. 3.) For Resident #64 the facility failed to investigate an allegation of sexual abuse. Resident #64 was admitted to the facility in July 2021, and had diagnoses that included Major Depressive Disorder and suicidal ideations. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that on the Brief Interview for Mental Status (BIMS) exam Resident #64 scored a 15 out of a possible 15 indicating intact cognition. The MDS further indicated Resident #64 had no behaviors. During an interview on 8/31/21 at 1:20 P.M., the Administrator #1 notified the surveyors that the facility had just received an allegation of sexual abuse from one resident toward another resident and that they were initiating an investigation into the allegation. During a record review on 8/31/21 1:28 P.M., a clinical progress note, dated 8/26/21, indicated that Resident #64 had reported to 2 staff nurses that a male resident had sexually harassed him/her at 3 PM and during supper time. Resident #64 stated that the male/female resident said words to the effect that he/she wants to suck his/her breast. The note further indicated Resident #64 was offered a room on a different floor and incident was reported to the administrator. During an interview with Resident #64 on 9/1/21 10:37 A.M., he/she said that a few weeks ago Resident #29 had told him/her that he/she had a nice set of breasts and asked if he/she could see more. Then the following night Resident #29 approached Resident #64 and asked can I suck on your breasts, or words to that effect. Resident #64 said that he/she reported the incidents to staff that were working and that they reported it to Administrator #1. Resident #64 said that he/she was told by Administrator #1 the next day that Resident #29 denied the allegation and that Resident #64 would need to move to a different unit if he/she did not want to be near Resident #29. Resident #64 moved units and said that the situation has never been addressed by staff again. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Administrator #1 and facility's Corporate Nurse (CN) #1 on 9/1/21 at 1:24 P.M., Administrator #1 said that they had actually known about this allegation a week ago, not today. Administrator #1 said that about a week ago it was reported to her Resident #64 reported that another resident said words to the effect that he/she wanted to suck your breasts. Administrator #1 said that she considered this to be a grievance not an allegation of sexual abuse and that she had not conducted an investigation. Administrator #1 said in hindsight she should have investigated this as an allegation of abuse. 4.) For Resident #49, the facility failed to thoroughly investigate an allegation of verbal and emotional abuse. Resident #49 was admitted to the facility in November 2019 with diagnoses that included hemiplegia, cerebrovascular accident (CVA). Review of the Minimum Data Set (MDS) dated [DATE] indicated Resident # 49 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #49 is cognitively intact. During an interview on 8/31/21 at 12:24 P.M., Resident #49 reported an allegation of abuse to the surveyor. Resident #49 said staff are disrespectful, non-responsive and rude to him/her. Resident #49 said he/she has tried to reach Social Worker (SW #1) by phone to report the abuse allegations, but he/she has had no response from SW #1. During an interview on 9/1/21 at 1:16 P.M., SW #1 said Resident # 49 has never reported disrespect, rude and non-responsive staff behavior to her. During an interview on 9/2/21 at 9:01 A.M., Resident #49, the Surveyor informed SW#1 of Resident #49's allegations of staff being disrespectful, non-responsive and rude to him/her. During an interview on 9/2/21 at 10:49 A.M., Administrator #1 said SW#1 did not report any abuse allegations made by Resident #49. The facility Administrator said she would follow up on the abuse allegations. During an interview on 9/3/21 at 1:39 P.M., Administrator #1 said she was still working on the abuse allegation investigation. During an interview on 9/7/21 at 9:20 A.M., Administrator #1 said she was still working on the investigation and was unable to provide the surveyor with any documents or records related to the investigation. 43807 43882 5.) For Resident #79 the facility failed to thoroughly investigate an allegation of abuse per facility policy. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #79 was admitted to the facility in May 2021 with diagnoses including, Type II Diabetes, anxiety disorder, pulmonary embolism (blood clot of the lung), and cerebral infarction (tissue death). Review of Resident #79's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that he/she is cognitively intact with a score of 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) assessment. During an interview on 08/31/21 at 09:15 A.M., Resident #79 reported an allegation of abuse to the surveyor. Administration was notified by the surveyor of the allegation. During an interview on 09/07/21 at 9:10 A.M. Administrator #1 said the abuse investigation for Resident #79 was still being completed. On 9/08/21 Administrator #1 was asked for Resident #79's abuse investigation. On 9/8/21 at 8:02 A.M., Administrator #1 provided the surveyor with the completed abuse investigation. Review of the completed abuse investigation indicated an interview with Resident #79 was completed as well as an interview with the nurse involved. Further review of the investigation failed to indicate interviews with witnesses, staff members who have had contact with the resident and other residents whom the accused employee provided care to had not been completed. See F835

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37565 Based on observation, record review and interview, the facility failed to identify and complete a significant change in condition assessment for 1 Resident (#80) from a total sample of 37 residents. Findings include: Resident #80 was admitted to the facility in May of 2021 with diagnoses including alcohol and psychoactive substance abuse, chronic chest pain related to coronary artery disease, hemiplegia (paralysis of one side of the body) related to cerebrovascular accident and atrial fibrillation (abnormal heart rhythm). During observation 8/31/21 at 11:54 A.M., Resident #80 was lying in bed unshaven with only an adult brief on. Both arms and legs were pulled up into a fetal position. The Resident was speaking in repetitive phrases and said my legs hurt. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had a Brief Interview for Mental Status exam score of 12 out of a possible 15 which indicated he/she had moderate cognitive impairment. Resident #80 required extensive assistance of 2 staff for moving in bed, transfers in and out of bed and supervision of 1 staff for walking and with eating. The Resident exhibited verbal behaviors and did not reject care. He/she was frequently incontinent of urine and bowel, weighed 178 pounds and had no wounds. Review of the most recent MDS dated [DATE] indicated the Resident had a Brief Interview for Mental Status exam score of 10 out of a possible 15 which indicated he/she had further moderate cognitive impairment. Resident #80 required extensive assistance of 2 staff for moving in bed, transfers in and out of bed and supervision of 1 staff for walking and with eating. The Resident exhibited physical behavioral symptoms not directed towards others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste or verbal/vocal symptoms like screaming, disruptive sounds. The Resident did not reject care. He/she was always incontinent of urine and bowel, weighed 149 pounds and had developed a Stage 1 (intact skin with nonblanchable redness of a localized area) pressure area. Review of the specialty wound physician's initial wound evaluation and management summary for Resident #80, dated 8/9/21 indicated the following: - Appetite as good. - Appearance as cachectic (physical wasting with weight loss) and contracted (arms and legs shortened, unable to straighten). - Site 1-Stage 2 (partial thickness loss of the middle layer of skin) pressure wound of the left foot with a duration of over 10 days. - Site 2-Stage 2 pressure wound of the left first toe with a duration of over 10 days. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Site 3-Wound to left buttock with a duration of over 14 days. - Site 4-Wound to the right buttock with a duration of over 14 days. - Site 5-Wound to the right flank with a duration of over 14 days. - A treatment plan was put into place for each wound. The wound physician's documentation dates indicated the wounds assessed on 8/9/21 should have been present on the 8/3/21 quarterly MDS assessment. Review of the specialty wound physician's wound evaluation and management summary dated 8/30/21 indicated the following: - Appetite as good. - Appearance as contracted. - Site 1-has deteriorated to unstageable (due to necrosis) of the left foot with a duration of over 29 days. - Site 2-has deteriorated to unstageable of the left first toe with a duration of over 29 days. - Site 3-of the left buttock has continued with a duration of over 33 days. - Site 4-of the right buttock has continued with a duration of over 33 days. - Site 5-of the right hip has deteriorated to unstageable with a duration of over 33 days. - Site 6-new Stage 2 of the left shin with a duration of over 14 days. - Site 7-new Stage 2 of the right thigh with a duration of over 14 days. - Site 8-new unstageable deep tissue injury to right foot with a duration of over 5 days. - Site 9-new Stage 2 of the left elbow with a duration of over 5 days. - A treatment plan was put into place for each wound. Resident #80 had experienced a major decline in several areas determined by he/she no longer got out of bed, did not ambulate due to limb contractures, had 8 new and deteriorating wounds, could not feed self and had significant weight loss of 29 pounds in 3 months. Review of the physical therapy progress and plan of care dated 6/22/21 to 7/19/21 indicated that Resident #80 was contracted had not ambulated since 6/22/21. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 9/7/21 at 12:12 P.M., Occupational Therapist (OT) #1 said Resident #80 was being treated with a focus on feeding. OT #1 said this is a very sad case, the Resident's treatment plan success is complicated by behaviors and refusals. The Resident no longer ambulates or gets out of bed at all. During an interview 9/7/21 at 3:41 P.M., the Corporate MDS Nurse said the facility MDS position is currently vacant. She added that MDS nurses are very difficult to hire right now. The facility does have a per diem MDS nurse that completes the resident assessments remotely. The Corporate MDS Nurse said she would reach out to the MDS nurse regarding the significant change in condition for Resident #80. The surveyor did not get a return call regarding the significant change in condition for Resident #80.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37565 Based on observation, interview and record review the facility failed to accurately assess and document a Minimum Data Set Assessment for 1 Resident (#80) from a total sample of 37 residents. Resident #80 was admitted to the facility in May of 2021 with diagnoses including alcohol and psychoactive substance abuse, chronic chest pain related to coronary artery disease, hemiplegia (paralysis of one side of the body) related to cerebrovascular accident and atrial fibrillation (abnormal heart rhythm). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident had a Brief Interview for Mental Status (BIMS) exam score of 12 out of a possible 15, indicating moderately impaired cognition. Resident #80 required extensive assistance of 2 staff for moving in bed, transfers in and out of bed and supervision of 1 staff for walking and with eating. The MDS further indicated Resident #80 was frequently incontinent of urine and bowel, weighed 178 pounds and had no wounds. Review of the most recent MDS dated [DATE] indicated Resident #80 had a Brief Interview for Mental Status assessment (BIMS) score of 10 out of a possible 15 which indicated he/she had moderate cognitive impairment. The MDS further indicated Resident #80 ambulated and fed self with the supervision of 1 staff, was always incontinent of urine and bowel, weighed 149 pounds and had developed a Stage 1 (intact skin with nonblanchable redness of a localized area) pressure area. During an observation 8/31/21 at 11:54 A.M., Resident #80 was lying in bed, unshaven, wearing only an adult brief. Both of Resident #80's arms and legs were pulled up into a fetal position. The Resident was speaking in repetitive phrases saying my legs hurt. Review of the specialty wound physician's initial wound evaluation and management summary for Resident #80, dated 8/9/21 indicated the following: - Appearance as cachectic (physical wasting with weight loss) and contracted (arms and legs shortened, unable to straighten). - Site 1-Stage 2 (partial thickness loss of the middle layer of skin) pressure wound of the left foot with a duration of over 10 days. - Site 2-Stage 2 pressure wound of the left first toe with a duration of over 10 days. - Site 3-Wound to left buttock with a duration of over 14 days. - Site 4-Wound to the right buttock with a duration of over 14 days. - Site 5-Wound to the right flank with a duration of over 14 days. - A treatment plan was put into place for each wound. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound physician's documentation dates indicated the wounds assessed on 8/9/21 would have been present on 8/3/21 when the quarterly MDS assessment was done. There was no indication these wounds were identified on the 8/3/21 MDS assessment. The wound physician had observed the Resident as cachectic and contracted on 8/9/21. There was no evidence to indicate this was documented in the 8/3/21 quarterly MDS assessment. Review of the quarterly MDS assessment dated [DATE] indicated Resident #80 was ambulatory with the supervision of 1. Review of the physical therapy progress and plan of care dated 6/22/21 to 7/19/21 indicated Resident #80 had not ambulated since 6/22/21. During an interview 9/7/21 at 12:12 P.M., Occupational Therapist (OT) #1 said Resident #80 was being treated with a focus on feeding and that Resident #80 no longer ambulated or got out of bed. Based upon interview with the OT and the wound physician's documentation the quarterly MDS, dated [DATE], was not assessed accurately for Activities of Daily Living, ambulation or wounds.

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Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30889 Based on observation, interview and record review, the facility failed to implement the plan of care for 8 Residents (#3, #10, #27, #73, #74,#83, #86 and #290) out of a total sample of 37 residents. 1. For Resident #27, the facility failed to administer medications per the physician orders. Resident #27 was admitted to the facility in June 2021 with diagnoses which included major depression, hypothyroidism and schizoaffective disorder. Review of the Resident's Minimum Data Set assessment (MDS), dated [DATE], indicated the Resident scored an 8 out of 15 on the Brief Interview for Mental Status exam, which indicated the Resident's cognition was moderately impaired. On 9/7/21 at 7:10 A.M., review of the Medication Administration Record, dated 9/7/21, indicated that cholecalciferol capsule, give 800 units by mouth one time a day at 6:00 A.M. was not initialed by the 11:00 P.M.- 7:00 A.M. shift nurse as given, Colace capsule 100 milligrams, give one capsule by mouth in the morning for constipation at 6:00 A.M. was not initialed by the 11:00 P.M.- 7:00 A.M. shift nurse as given and Levothyroxine 50 microgram(mcg) tablet, give 50 mcg by mouth one time a day for hypothyroidism at 6:30 A.M. was not initialed by the 11:00 P.M.- 7:00 A.M. shift nurse as given. During an interview on 9/7/21 at 11:10 AM, Nurse #6 said that she did not give the medications to Resident #27. She said she would normally give the 6 A.M. meds on her way out the door. She said she did not this morning. She said that she covers the 2nd and 1st floor about once a week and will come down if a resident needs an as needed (PRN) medication, if not, she said she stays on the 2nd floor because she has 40 residents upstairs and can't be down on the first floor. She said she instructs the Certified Nursing Assistant (CNA) assigned to check the residents every two hours and to call her if there is a problem, other than that she would not go downstairs. 2. For Resident #83, the facility failed to ensure staff implemented the plan of care to ensure safe feeding. Resident #83 was admitted to the facility in August 2020 with diagnoses which include dementia with behavioral disturbances and traumatic brain injury. Review of the most recent quarterly MDS assessment indicated the Resident's cognition was severely impaired and she/he required physical assist of one staff for eating. Review of the clinical record indicated that Resident #83 was hospitalized on [DATE] and 3/22/21 due to esophageal impaction (when food becomes stuck in the esophagus, occurs when the esophagus doesn't function properly or if a person doesn't chew food completely). Review of the Speech Therapy Plan of Care, dated 3/22/21, indicated that the Speech Language Pathologist suspects impaired esophageal clearance, resulting in backflow into pharynx, eventually spilling into laryngeal vestibule (food getting stuck in throat). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #83's Plan of Care, swallowing problem related to esophageal impaction, dated 7/20/21, included the following: * Alternate small bites and sips. * Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. * Resident to eat only with supervision. * Keep head of bed elevated at least 30 degrees during meals and thirty minutes after. On 9/2/21 at 8:33 A.M., during an observation of the breakfast meal, in the 2nd floor unit dining room, revealed 11 residents at various levels of feeding abilities and Nurse #11 feeding a resident. Resident #83 was sitting in the back of the dining room, behind Nurse #11 out of the Nurse's point of vision. Resident #83 was feeding him/herself pureed bread with a spoon, one bite after another, without taking sips of liquid in between each bite of food per the plan of care. Nurse #11 was not supervising or cueing Resident #83 per the plan of care. Once Resident #83 finished eating his/her breakfast, the Resident slouched down into the recliner, lying in the recliner. Resident #83 was not sitting upright per the plan of care. On 9/7/21 at 8:50 A.M., during observation of the breakfast meal on the 2nd floor unit, revealed Resident #83 sitting upright in a recliner feeding him/herself pureed breakfast of bread, eggs and cereal. Resident #83 ate bite after bite of the pureed food without taking sips of liquids. CNA #10 was sitting next to the Resident during this meal and did not provide verbal cueing to ensure the Resident would alternate with sips of fluid to decrease the possibility of esophageal impaction. 3. For Resident #10, the facility failed to ensure the air mattress used for pressure reduction and prevention for developing pressure injury, was set per the physician's order. Resident #10 was admitted to the facility 5/2013 with diagnoses which included diabetes, anemia, and renal insufficiency. Review of the most recent quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated that Resident #10 was cognitively intact, required extensive assist of 2 staff for bed mobility. Further review of the MDS indicated Resident #10 was at risk of developing pressure ulcers and utilized a pressure reduction device for the bed. On 8/31/21 at 9:31 A.M., surveyor observation revealed Resident #10 lying in his/her bed. The air mattress was set at an inflation rate of 300. On 9/1/21 at 11:30 A.M., surveyor observation revealed Resident #10 lying in his/her bed. The air mattress was set at an inflation rate of 300. Review of the physician's order, dated 8/4/21, indicated; Air mattress set at 200 every shift for skin breakdown check function shiftly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/2/21 at 12:30 P.M., Nurse #20 said that staff look at the air mattress. She said that she will look at the mattress and if I think there's a problem, she'll let maintenance know. Nurse #20 said she doesn't look at the controls to see what its supposed to be set at. 40928 4. For Resident #86, the facility failed to administer a treatment according to physician orders. Resident #86 was admitted to the facility in 3/2018 with diagnoses including chronic kidney disease and anxiety disorder. Review of Resident #86's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the resident was cognitively intact and scored a 15 out of 15 on the Brief Interview for Mental Status Exam. Further review of Resident #86's MDS indicated that the resident required assistance with care activities and that the resident required dialysis. Review of Resident #86's medical record indicated the following: -a progress note dated 5/4/21: Resident will be starting dialysis tomorrow. Will be going Mon, Wed and Fri. -a progress note dated 5/6/21: Change in Resident's dialysis schedule: Will be going Tue, Thu and Sat. -A physician's order dated 5/6/21 for dialysis Tue, Thu, Sat -A physician's order dated 5/5/21: Lidocaine-prilocaine 2.5-2.5% (a topical numbing cream). Apply to right arm fistula (a connection between an artery and a vein used for dialysis) topically one time each day every Mon- Wed- Fri apply 1 hour before going to dialysis. Review of Resident #86's August 2021 Medication Administration Record (MAR) indicated the Resident received Lidocaine-prilocaine 2.5-2.5% every Monday, Wednesday and Friday in the month. During an interview on 9/01/21 at 4:39 P.M., Resident #86 said he/she attends dialysis on Tue, Thu and Sat. Resident #86 said he/she does not get any cream applied to his/her right arm fistula prior to dialysis. During an interview on 9/02/21 at 10:49 A.M., Nurse #1 said she has been Resident #86's nurse many times and knows him/her well. Nurse #1 said the Resident gets Ativan (an anti anxiety medication) prior to dialysis. Nurse #1 said that there are no topical creams that are applied to the Resident. Nurse #1 said the Resident usually gets picked up around 11:15 A.M. and comes back to the facility in the afternoon. On 9/02/21 at 11:10 A.M., Resident #86 said she was waiting to be picked up for dialysis. Resident #86 showed the surveyor his/her arms. No cream had been applied to the fistula site. During an interview on 9/02/21 at 1:27 P.M., Nurse #1 said the lidocaine-prilocaine is not something that is administered in the facility. Nurse #1 said the Resident has not gotten that cream. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/02/21 at 3:06 P.M., Nurse #2 she has provided care for the Resident. Nurse #2 said she had not administered the cream to Resident #86 even though she had documented that she had given it. Nurse #2 acknowledged that the Resident did not attend dialysis on the dates listed on the order and would not require a topical numbing cream on non-dialysis days. 5. For Resident #290, the facility failed to administer medications and implement monitoring according to physician orders. Resident #290 was admitted to the facility in August, 2021 with diagnoses including alcohol abuse, major depressive disorder and suicidal ideations, Review of Resident #290's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident was cognitively intact and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) and had no behaviors, hallucinations or delusions. Resident #290's MDS further indicated that he/she had little interest or pleasure in doing things 7-11 days; was feeling down, depressed or hopeless 12-14 days; had trouble falling/staying asleep or sleeping too much 7-11 days; poor appetite or overeating 7-11 days; thoughts that he/she would be better off dead or hurting self in some way 2-6 days. Review of Resident #290's medical record indicated the following physician orders: - Remeron (an anti depressant) give 7.5 milligrams (mg) at bedtime: not given 8/15 and 8/29. -Sertraline (an antidepressant) 50 mg at A.M. daily: not given 8/11, 8/14, 8/16, 8/26, 8/28, 8/30, 8/31. -An order dated 8/13/21 for Seizure precautions four times a day not done on 8/14. -An order dated 8/16/21 for Seizure precautions every shift not done on the following shifts: 8/16 night shift, 8/19 day shift, 8/22 night shift , 8/28 evening and night shifts, 8/29 night shift, 8/30 day and evening shifts. During an interview on 9/03/21 at 11:07 A.M., Nurse Practitioner #1 said Resident #290 was started on Remeron to help get his/her appetite back. Nurse Practitioner #1 said she ordered seizure precautions as a result of Resident #290's previous diagnosis of alcohol abuse and that since he/she had detoxed in the hospital, the Resident should be monitored for seizures for 30 days Nurse Practitioner #1 said seizure precautions involve monitoring for a change in mental status, tremors. Nurse Practitioner #1 said she would have expected to be notified for any missed doses and that she hadn't been notified that the Resident didn't receive the medications as ordered. Nurse Practitioner #1 said the expectation is that the staff will administer the medications and treatments as ordered. 37565 6. For Resident #3 the facility failed to ensure side rails were assessed according to the plan of care. Resident #3 was admitted to the facility in September of 2019 with an anxiety disorder, depression, psychotic disorder, obsessive compulsive disorder, alcohol abuse and pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation 8/31/21 at 8:35 A.M., Resident #3 was sitting on the side of the bed with both upper half side rails in the upright position. Review of the care plan initiated 9/13/19 indicated a focus for side rails and that the resident preferred side rails on the bed. Interventions included a consent signed by the resident for the use of side rails and that the resident would be assessed at least yearly for continued need/want of side rails. Record review 9/1/21 indicated no evidence to support an updated signed consent or a completed side rail assessment after 9/12/19. There was no physician order for the use of side rails. During an interview 9/7/21 at 2:45 P.M., Corporate Nurse #1 said side rail assessments are to be completed annually. Side rails were further observed in the upright position on 9/1/21, 9/2/21, 9/7/21 and 9/8/21. 41105 7. For Resident #74 the facility failed to provide assistance with meals as needed. The facility policy titled Activities of Daily Living (ADL) support, dated 2017, indicated the following: * Resident will perform selfcare with ADLs at the level on the Certified Nursing Assistant (CNA) care plan or care card or assigned tasks. * Assure adequate intake at each meal by encouraging =, cueing, prompting and or feeding as needed. * Toilet resident as per the scheduled program. Resident #74 was admitted to the facility in August 2019, and had diagnoses that included dementia with behavioral disturbance and Chronic Obstructive Pulmonary Disease (CHF), Dysphagia and dementia. On the most recent Minimum Data Set (MDS) assessment dated [DATE], Resident #74 was assessed by staff to have had severely impaired cognition. The MDS further indicated Resident #74 required supervision and 1 person physical assist with eating. During an observation on 8/31/21 at 8:45 A.M., Resident #74 was observed in bed, in the room alone attempting to feed him/herself cheerios. Resident #74 was not responsive to verbal questions and stared straight ahead. During a record review on 8/31/21 at 11:15 A.M., the Resident's record indicated the following: * An Activities of Daily Living (ADL) care plan, revised 9/14/21, indicated Resident #74 required continual supervision /limited assistance of 1 with increased fatigue/weakness with eating. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* An incontinence care plan, with an intervention to check and change resident every 2 hours and as needed for incontinent episodes. * A potential skin care plan, with an intervention to turn and reposition every 2 hours and as needed * The Certified Nursing Assistant care card indicated Resident #74 required supervision and one person physical assist with eating. During an observation on 9/02/21 at 7:57 A.M., Resident #74 was observed alone in his/her room. A nurse delivered a tray of breakfast to the room, set up the tray and then walked out. Between 8:00 A.M., and 8:25 A.M., Resident #74 was alone in his/her room, no staff entered the room or offered assistance. At 8:25 A.M., the surveyor observed Resident #74 in bed attempting to feed him/herself, however he/she was struggling to keep items on the spoon. During an observation on 9/02/21 at 12:16 P.M., Resident #74 was observed alone in his/her room attempting to feed him/herself the lunch tray left with him/her. During an observation on 9/03/21 at 1:03 P.M., Resident #74 was observed alone in his/her room in bed sleeping, with a pudding container in his/her hand and an untouched lunch tray on the tray table directly in front of him/her. During an observation on 9/07/21 at 8:53 A.M., Resident #74 was observed alone in his/her room attempting to feed self breakfast. During an observation on 9/15/21 at 8:14 A.M., Resident #74 was observed alone in his/her room asleep in bed, holding a fork, with his/her breakfast tray directly in front of him/her. During an interview with Resident #74's Certified Nursing Assistant (CNA) #6 on 9/03/21 at 1:26 P.M., she said that Resident #74 was dependent on staff for all care, including eating but that the facility did not have enough staff for the amount of care the residents need. During an interview with the Nursing Home Administrator (NHA) and Consulting Nurse (CN) #2 on 9/03/21 at 1:49 P.M., they said that they were aware that Resident #74 was dependent on staff for all care, including feeding, turning and repositioning and incontinence care, and that for Resident #74 the staff had not followed the plan of care that was detailed in the Resident's care card. 43882 8. For Resident #73, the facility failed to provide wound care as ordered. The facility failed to change Resident #73's dressings as ordered by the Physician. Review of the facility policy titled Charting and Documentation dated 2017 indicated: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #73 was admitted to the facility in August 2020 with diagnoses including morbid obesity, type 2 diabetes mellitus, chronic obstructive pulmonary disorder, and peripheral vascular disease. Review of Resident #73's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident was cognitively intact and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS). During an interview on 8/31/21 at 8:35 A.M., Resident #73 said dressing changes were not being completed as ordered and said that his/her wound care had not been completed on 8/28/21 and 8/29/21 Review of Resident #73's medical record indicated physician orders dated 8/24/21 for daily dressing changes to venous wound of left anterior, superior shin, inferior shin, wound of left lower abdomen, lower abdominal wound, and right anterior medial shin ulcer. Review of Resident #73's August 2021 Treatment Administration Record (TAR) failed to indicate that wound care was provided as ordered to Resident #73 on 8/28/21 and 8/29/21. During an interview on 9/7/21 at 10:57 A.M., Nurse #6 said Resident #73 was alert, a good historian and rarely refused care. Nurse #6 said she was caring for Resident #73 on 8/28/21 and 8/29/21 during the 7 A.M. to 3 P.M. shift. Nurse #6 was unable to say why the Resident's wound care had not been completed as ordered and confirmed Nursing staff was responsible for administering medications and treatments as ordered. See F677, F689, F725

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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. 37565 Based on record review and interview, the facility failed to provide pain medications according to acceptable standards of clinical practice, resulting in prolonged use of a substitute medication (morphine) and an incorrect dose of another medication (suboxone) for 2 Residents (#3 and #80) from a total sample of 37 residents. Findings include: 1. Resident #3 was admitted to the facility in September of 2019 with diagnoses including anxiety disorder, depression and psychotic disorder. During record review 9/1/2021 at 8:44 A.M., the nursing progress notes indicated that Resident #3 had experienced a fall resulting in a wrist fracture. Review of a physician's order dated 8/14/2021 indicated tramadol HCL (opioid medication to treat moderate to severe pain) tablet 50 milligrams (mg), give 25 mg by mouth every 8 hours as needed for pain. Discontinue the morphine (narcotic medication to treat moderate to severe pain) when the tramadol is available. Review of Resident #3's Medication Administration Record (MAR) indicated that he/she received morphine for pain relief August 14th, 15th, 16th and 19th. Review of Resident #3's medical record indicated that Tramadol tablets were received from the pharmacy on 8/21/2021. Resident #3 received the 1st dose of tramadol on 8/21/2021. The facility has a Cubex electronic box system to provide an interim supply of medications for use in emergency and non-emergency dosing for nursing facility residents until the provider pharmacy can provide a regular supply of medication to the resident. Review of the facility Cubex inventory on 9/1/2021 at 10:02 A.M., revealed that 6 tramadol 50 mg tablets were available for usage 8/14, 8/15, 8/16 and 8/19. During an interview 9/2/21021 at 4:25 P.M., Nurse #9 and Nurse #11 said that accessing the Cubex is a problem on the off shifts because most nurses are agency staff and agency nurses do not have access to the Cubex. Nurse#9 and Nurse #11 said they do their best to get any needed medications before the day shift nurses leave for the day. Both Nurse #9 and Nurse #11 are agency nurses and do not have access to the Cubex. During an interview 9/7/2021 at 2:48 P.M., the Interim Director of Nursing said the facility does have a Cubex medication system to assist with emergency and non-emergency interim medication use. She also said that agency nurses do not have access to the Cubex system and on occasion the system cannot be accessed due to no facility staff working at the time of need. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #80 was admitted to the facility in May of 2021 with diagnoses including alcohol and psychoactive substance abuse, chronic chest pain related to coronary artery disease, hemiplegia (paralysis of one side of the body) related to cerebrovascular accident and atrial fibrillation (abnormal heart rhythm). Review of Resident #80's Physician orders on 09/02/21 at 03:52 PM indicated a Nurse Practitioner (NP#1) order for Suboxone film 2-0.5 mg give 2 films sublingually (under the tongue) 2 times a day (8:00 A.M. and 2:00 P.M.) for pain related to opioid dependence for a total of 4 mg dated 8/14/21 and an order for Suboxone film 2-0.5 mg give 4 films sublingually 1 time a day (6:00 P.M.) for pain related to opioid dependence for a total of 8 mg dated 8/14/2021. Review of a nursing progress note on 9/7/2021 at 11:42 A.M. indicated Resident #80 did not receive the full dose of Suboxone on 9/5/2021 as ordered by the prescribing NP#1. The progress note indicated only 2 Suboxone 2-0.5 mg films were administered, not 4 films at 6:00 P.M. The total dose was not available at the time of administration. During an interview 9/7/2021 at 12:06 P.M., NP #1 said she was not notified that Resident #80 did not receive his/her full dose of Suboxone at 6:00 P.M. on 9/5/2021 and that it was her expectation to be notified for such circumstances. During an interview 9/7/2021 at 2:35 P.M., Nurse #12 said there was not enough Suboxone to administer the total dose ordered on 9/5/21 at 6:00 P.M. Nurse #12 said only 2 Suboxone films were available and Suboxone is not available in the Cubex system. Review of the medication administration record for Resident #80 indicated that Nurse #12 administered Suboxone film 2-0.5 mg, give 4 films sublingually at 6:00 P.M. when she stated only 2 films had been administered. During an interview 9/7/2021 at 2:45 P.M., Corporate nurse #1 said the facility could only receive the medication every 3 days for insurance reasons. Review of the medical record 9/28/2021 indicated that Resident #80 again did not receive a morning dose of Suboxone on 9/27/2021. A nurses' note indicated Suboxone was not given this morning related to not being available. Pharmacy was called and stated the medication would be delivered on the morning run. Nurse Practitioner #1 was notified that the Resident did not receive the morning Suboxone dose. See F726

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on observation, interview and record review the facility failed to provide Activities of Living (ADL) care for 2 Residents (#73 and #74) out of a total sample of 37 residents. Findings include: The facility policy titled Activities of Daily Living (ADL) support, dated 2017, indicated the following: * Resident will perform selfcare with ADLs at the level on the CNA care plan or care card or assigned tasks. * Assure adequate intake at each meal by encouraging, cueing, prompting and/ or feeding as needed. * Toilet resident as per the scheduled program. 1.) For Resident #74 the facility failed to provide assistance with meals, turning and repositioning and incontinence care. Resident #74 was admitted to the facility in August 2019, and had diagnoses that included dementia with behavioral disturbance and Chronic Obstructive Pulmonary Disease (CHF), Dysphagia and dementia. On the most recent Minimum Data Set (MDS) assessment dated [DATE], Resident #74 was assessed by staff to have had severely impaired cognition. The MDS further indicated Resident #74 required supervision and 1 person physical assist with eating. During an observation on 8/31/21 at 8:45 A.M., Resident #74 was observed in bed, in the room alone attempting to feed him/herself cheerios. Resident #74 was not responsive to verbal questions and stared straight ahead. During a record review on 8/31/21 at 11:15 A.M., the record indicated the following: * An Activities of Daily Living (ADL) care plan, revised 9/14/21, indicated Resident #74 required continual supervision /limited assistance of 1 with increased fatigue/weakness with eating, extensive to dependent assistance with bed mobility * An incontinence care plan, with an intervention to check and change resident every 2 hours and as needed for incontinent episodes. * A potential skin care plan, with an intervention to turn and reposition every 2 hours and as needed * The Certified Nursing Assistant care card indicated Resident #74 required supervision and one person physical assist with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* The hospice care plan indicated Resident #74 required assistance with eating During an observation on 9/02/21 at 7:57 A.M., Resident #74 was observed alone in his/her room. Between 8:00 A.M., and 8:25 A.M., Resident #74 was alone in his/her room, no staff entered the room or offered assistance. At 8:25 A.M., the surveyor observed Resident #74 in bed attempting to feed him/herself, however he/she was struggling to keep items on the spoon. During an observation on 9/02/21 at 12:16 P.M., Resident #74 was observed alone in his/her room attempting to feed him/herself the lunch tray left with him/her. During an observation on 9/07/21 at 8:53 A.M., Resident #74 was observed alone in his/her room attempting to feed self breakfast. No staff were present to cue or assist. During an observation on 9/15/21 at 8:14 A.M., Resident #74 was observed alone in his/her room asleep in bed, holding a fork, with his/her breakfast tray directly in front of him/her. No staff were present to cue or assist. During an interview with Resident #74's Certified Nursing Assistant (CNA) #6 on 9/03/21 at 1:26 P.M., she said that Resident #74 was dependent on staff for all care, including eating, incontinence care and turning and repositioning. She said that she was the CNA for Resident #74 that day but had not provided any care since 7:00 A.M., when she provided incontinence care to the Resident. She said she had not returned back to the Resident since that time, had not assisted with breakfast or lunch feeding, had not turned and repositioned him/her and had not provided incontinence care again, on that day because they were short staffed and she was still trying to care for other residents. During an interview with the Administrator #1 and Consulting Nurse (CN) #2 on 9/03/21 at 1:49 P.M., they said that they were aware that Resident #74 was dependent on staff for all care, including feeding, turning and repositioning and incontinence care, and that for Resident #74 this had not been provided on that day. Administrator #1 said it was the expectation that all residents that were dependent on staff for care receive that care. 43882 2. For Resident #73 the facility failed to ensure that showers were provided to maintain good personal grooming. Review of the facility policy titled Activities of Daily Living (ADL) Support, dated 2017 indicated: -Resident will perform selfcare with ADL's at the level on the Certified Nursing Assistant (CNA) care plan or care card or assigned tasks. If the resident shows a change in ADL function the nurse will be notified. - Encourage the resident to make choices related to their daily living- clothing, time to get up, time and type of bath. - Document ADL support and performance as per the facility's policy. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notify nurse of any change in mental status or change in residents' usual behavior. Resident #73 was admitted to the facility in August 2020 with diagnoses including morbid obesity, chronic pain syndrome, and peripheral vascular disease. Review of Resident #73's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that he/she is cognitively intact with a score of 15 out of possible 15 on the Brief Interview for Mental Status (BIMS). The MDS also indicated Resident #73 required extensive assistance for personal hygiene and that it was very important for him/her to be able to choose between a shower, bed bath and sponge bath. During an interview on 8/31/21 at 8:35 A.M., Resident #73 said that he/she had not had a shower in months and would like one. Resident #73 also said he/she was told he/she could not use the shower due to a leak that occurred whenever he/she was showered. During an interview on 9/1/21 at 10:57 A.M., Certified Nursing Assistant (CNA) #16 said showers are scheduled twice a week. CNA #16 said she was unsure when Resident #73 last had a shower, and the normal care was giving the Resident a full bed bath. During an interview on 9/1/21 at 11:08 A.M., CNA #17 said she was told water from the shower traveled into the wall into an electrical panel and was told Resident #73 could not shower in it. CNA #17 also said Maintenance was aware of the problem. During interviews throughout the day on 9/1/21, Maintenance Staff #1 said he was told the shower on the unit had overflowed one time but said that it was functional and had no problems that would limits a resident's ability to shower. Maintenance Staff #1 further said he had not been notified of any other issues with the shower and that the shower was fully functional and able to be used by residents. See F725

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37565 Based on observation, record review and interview, the facility failed to (1) promote the prevention of skin injury, (2) promote the healing of skin injury and (3) prevent further development of new skin injury for 1 Resident (#80) from a total sample of 37 residents. Findings include: Resident #80 was admitted to the facility in May 2021 with diagnoses including alcohol and psychoactive substance abuse, chronic chest pain related to coronary artery disease, hemiplegia (paralysis of one side of the body) related to cerebrovascular accident and atrial fibrillation (abnormal heart rhythm). During an observation on 8/31/21 at 7:45 A.M., Resident #80 was lying in bed on a low air loss mattress in a fetal position. He/she appeared emaciated with visible muscle wasting. The Resident had no clothes on other than an adult brief, was unshaven and had long fingernails with brown caked material under each nail. A gauze wrapped dressing was seen on the left foot with bloody drainage and a dressing was in place to the left shin. The Resident's right hip had an exposed open wound approximately 3 x 1.5 inches with a dark brown center and very pink edges. Review of the Resident's Minimum Data Set (MDS) dated [DATE] indicated the Resident was cognitively intact with a BIMS score of 12 out of 15. The MDS further indicated that Resident #80 required assistance to reposition in bed and to get out of bed. He/she ambulated with a cane under supervision due to an unsteady gait. Resident #80's skin was intact and had no wounds. Review of the attending physician's admission history and physical dated 5/11/21, indicated that Resident #80 was alert, forgetful and cooperative during the exam with an irritable affect. The physician note further indicated the Resident was well developed, well nourished and in no acute distress. He/she had decreased strength in the left arm and leg. The Resident was having difficulty with ambulation up and down the hall due to the left sided weakness. Review of the clinical record indicated Resident #80 suffered a significant weight loss identified 6/7/21 and this weight change was considered severe by facility policy. Further record review 9/1/2021 indicated no evidence of the Resident's physician or dietitian notification of the significant weight change identified 6/7/21 with a 24 hour response required by facility policy. A nutritional intervention did not occur until 6/25/2021 (18 days after Resident #80's significant weight loss was documented). Resident #80 developed denuded (damaged skin from prolonged moisture and friction) skin to the coccyx area on 6/25/21. The following interventions were ordered on 6/25/21: - air mattress - multivitamins with minerals 1 tablet by mouth once daily (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- vitamin C 500 milligrams 1 capsule by mouth once daily - ensure plus liquid (nutritional supplement) 1 unit by mouth once daily - nutritional consult The denuded skin on the coccyx area deteriorated to an open pressure wound on 7/5/21. The Resident continued to lose weight and the nutritional consult ordered by the physician did not occur until 8/13/21. The dietician assessed the resident to have protein and calorie malnutrition related to poor appetite and nourishment. Review of the MDS dated [DATE] indicated Resident #80 had a Stage 1 wound. The skin was intact with redness present. During an interview 9/1/21 at 8:20 A.M., Nurse #10 said the Resident must be fed and usually eats 25% or less of his/her meal. She also said that the Resident will take liquids when offered. Review of the Resident #80's care plan, dated 8/17/21, identified the potential for pressure ulcer development related to decreased mobility, incontinence, hypertension, diabetes and pain. The goal of the care plan was the Resident would have intact skin, free of redness, blisters or discoloration through the next review date. Interventions to achieve the goal were to follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor nutritional status, serve diet as ordered, monitor intake and record. The Resident needs moisturizer barrier applied every shift and as needed to skin. The Resident needs assistance to turn/reposition at least every 2 hours, more often as needed. Review of Resident #80's medical record indicated no evidence of sufficient monitoring or interventions regarding the Resident's nutritional status. There was no evidence of the Resident's intake and output documentation. The Wound Physician evaluated the Resident 8/9/21 at the request of the attending physician. The evaluation was as follows: - Site 1, Stage 2 pressure wound of the left, distal, medial foot. The wound is over 10 days duration, presents as a fluid filled blister that measured 2.5 x 4 centimeters (cm). Treatment plan was to off-load the wound. - Site 2, Stage 2 pressure wound of the left, medial, first toe. The wound is over 10 days duration, presents as a fluid filled blister measured 2.4 x 1.5 cm. Treatment plan was to off-load the wound. - Site 3, moisture associated skin damage of the left buttock. The wound is over 14 days duration, measured 2 x 1 cm. Treatment plan was nystatin powder twice daily, off-load the wound and reposition per facility protocol. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Site 4, moisture associated skin damage of the right buttock. The wound is over 14 days duration, measured 2 x 1 cm. Treatment plan was nystatin powder twice daily, off-load the wound and reposition per facility protocol. - Site 5, wound of the right flank. The wound is over 14 days duration, measured 2 x 3 cm. Treatment plan was xeroform sterile gauze with a gauze island dressing with a border and off-load the wound. The Wound Physician re-evaluated the Resident 8/30/21 at the request of the attending physician. The evaluation was as follows: - Site 1, Unstageable (due to necrosis) wound of the left, distal, medial foot with full thickness, measured 5x4 cm. No wound progress. Surgical debridement (cleaned the wound and removed any infected and dead tissue) was performed. Treatment plan was apply santyl (debridement ointment) once daily, alginate calcium (absorbs drainage) once daily and cover with gauze roll and secure with paper tape. Off-load the wound. - Site 2, Unstageable (due to necrosis) of the left, medial, first toe with full thickness, measured 4x2 cm. No wound progress. Surgical debridement was performed. Treatment plan was apply santyl once daily, alginate calcium once daily, cover with gauze roll and secure with paper tape. Off-load the wound. - Site 3, moisture associated skin damage of the left buttock with partial thickness, measured 2x1 cm. No wound progress. Treatment plan was nystatin powder twice daily, off-load the wound and reposition per facility protocol. - Site 4, moisture associated skin damage of the right buttock with partial thickness, measured 2x1 cm. No wound progress. Treatment plan was nystatin powder twice daily, off-load the wound and reposition per facility protocol. - Site 5, Unstageable deep tissue injury of the right, lateral hip with full thickness, measured 2x3 cm. No wound progress. Surgical debridement was performed. Treatment plan was santyl once daily with alginate calcium, gauze island dressing with a border and off-load the wound. - Site 6, Stage 2 wound of the left, medial shin with partial thickness. The wound is over 14 days duration, measured 3 x 1 x 0.1 cm. Wound has improved. Treatment plan was gauze island dressing with a border once daily and off-load the wound. - Site 7, Stage 2 pressure wound of the right, medial, thigh with partial thickness. The wound is over 10 days duration, measured 2 x 1.5 x 0.1 cm. No wound progress. Treatment plan was gauze island dressing with a border once daily and off-load the wound. - Site 8, Unstageable deep tissue injury of the right, distal, lateral foot with partial thickness. The wound is over 14 days duration, measured 2 x 2 cm. The treatment plan was skin prep once daily and off-load the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Site 9, Stage 2 pressure wound of the left elbow with partial thickness. The wound is over 5 days duration. Presents as a fluid filled blister that measured 3 x 2 cm. Treatment plan is off-load the wound. The Wound Physician evaluated the Resident 9/27/21 at the request of the attending physician. The evaluation was as follows: - Site 1, Stage 4 pressure wound of the left, distal, medial foot with full thickness. The wound is over 55 days duration, measured 3 x 2 cm. No wound progress. Surgical debridement was performed. Treatment plan was santyl and alginate calcium once daily with gauze roll secured by paper tape. Off-load the wound. - Site 2, Unstageable (due to necrosis) of the left, medial, first toe with full thickness. The wound is over 55 days duration, measured 4 x 2.5 cm. No wound progress. Surgical debridement was performed. Treatment plan was santyl and alginate calcium once daily with gauze roll secured with paper tape. Off-load the wound. - Site 5, Unstageable deep tissue injury of the right, lateral hip with full thickness. The wound is over 59 days duration, measured 1 x 2 cm. Wound has improved. Treatment plan was alginate calcium covered with a gauze island dressing with a border once daily. Off-load the wound. - Site 6, Stage 2 pressure wound of the left, medial shin with partial thickness. The wound is over 40 days duration, measured 2 x 1 x 0.1. Wound has improved. Treatment plan was a gauze island dressing with a border once a day. Off-load the wound. - Site 7, Stage 2 pressure wound of the right, medial thigh was resolved. - Site 8, Unstageable deep tissue injury of the right, distal, lateral foot with partial thickness. The wound is over 31 days duration, measured 2 x 2 cm. No wound progress. Treatment plan was skin prep once daily and off-load the wound. - Site 10, moisture associated skin damage of the upper buttock with partial thickness. The wound is over 13 days duration, measured 1x1.5x0.2 cm. No wound progress. Treatment plan was xeroform sterile gauze, an ABD pad once daily and nystatin powder to the peri-wound once daily. Resident #80 continued to lose weight, became contracted and had multiple deteriorated wounds. See F692 and F725

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, interview and record review, the facility failed to ensure that 1) interventions were implemented to prevent falls, resulting in a fall with injury and 2) interventions to prevent elopement were implemented for 1 Resident (#44), 3) an entrapment and a fall were investigated for 1 Resident (#50) and 4) fall interventions were added to the plan of care after a fall for 1 Resident (#51) out of a total sample of 37 residents. Findings include: 1) The facility failed to ensure interventions were implemented to prevent falls, resulting in a fall with injury. Resident #44 was admitted to the facility in March 2021 with diagnoses including traumatic brain injury, dementia, multiple falls, anxiety and bipolar disorder. Review of Resident #44's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had moderate cognitive impairment and scored a 10 out of 15 on the Brief Interview Status (BIMS). Further review of Resident #44's MDS indicated the Resident required assistance with all care activities and that the Resident had falls with injury since the previous assessment. Review of Resident #44's care plans indicated he/she was a high risk for falls related to incontinence, poor safety awareness, restlessness and agitation, use of psychotropic medication, anxiety, akathisia (a movement disorder characterized by inner restlessness), attempts to self transfer, recent fall history and indicated an intervention, dated 9/3/21, for Resident #44 to be 1:1 in arms reach to prevent falls. Review of Resident #44's medical record indicated the Resident had 42 falls reports between 3/26/21 and 9/3/21 Review of Resident #44's medical record indicated a physician's order, dated 9/3/21, for 1:1 sitter for safety, every shift. On 9/3/21 at 8:08 A.M., Resident #44 was observed in a wheelchair in front of the nurses station. Resident #44 appeared visibly restless and agitated and had a healing laceration over his/her left eyebrow, bruising to his/her left peri orbital area (area around the eye) and old bruises to the right and left sides of his/her forehead. Nurse #3 said that Resident #44 fell twice last night after returning from the hospital for a previous fall and said the Resident fell again this morning and pulled a chair on top of himself/herself. Nurse #3 said the Nurse Practitioner (NP) had ordered a 1:1 for the Resident. On 9/3/21 at 8:18 A.M., Nurse #3 said the medical records clerk was going to stay with the Resident for a brief period of time until a 1:1 could be arranged. Nurse #3 said a 1:1 will be used for a resident with multiple falls but there is not enough staff to have one and further said staffing is challenging. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 9/03/21 at 8:23 A.M., Nurse #3 said the floor staff, assigned to give care to all of the other residents on the unit, would alternate shifts in 30 minute increments to provide 1:1 supervision for the Resident. On 9/04/21, Resident #44 was observed alone in his/her room from 11:27 A.M. to 11:34 A.M. Review of Resident #44's Adult Protective Services Intake Report dated 9/5/21 indicated the following: -EMS (Emergency Medical Services) responded to the facility for a reported fall with arm injury and when they arrived to the unit that Resident #44 resided on, there was no staff at the nurse's station. EMS located a staff member at the end of one hall. EMS reported the staff member said she was a nurse on one side of the unit but was unaware that EMS had been called and was unsure where the nurse for the other side of the unit was. The report further indicated that EMS began a room to room search and located Resident #44 in his/her room laying on his/her back on the floor of his/her room with no one around the Resident. The report indicated that EMS assessed Resident #44 to have diminished mental status and that another staff member walked by the Resident's room and said that this was his/her normal mental status and that they were unsure of why EMS had been called or when Resident #44 had fallen. Further, the staff member reported that Resident #44 had initially been found on the floor of the hallway and then was moved back into his/her room. The report indicated that Resident #44 was noted to have multiple bruises across his/her head and arms in all different stages of healing and multiple skin tears in all different stages of healing. The report further indicated that Resident #44's room was noted to have multiple soiled adult diapers on the floor and the Resident smelled of urine and his/her pants were noted to be wet. During a record review of Resident #44's medical record on 9/7/21 at 8:00 A.M., the following was indicated: - Skin Only Evaluation dated 9/5/21 at 5:43 P.M.: Patient 1:1 supervision with 2 aides on entire floor. Patient fell in hallway when an aide was looking for assistance. Order to send to ER. Unwitnessed. Small skin tear noted. Will go to hospital. -Nurses Note dated 9/5/21 at 6:43 P.M. : Patient 1:1 supervision with 2 aides on entire floor. Unwitnessed fall. Patient combative and aggressive. Assist up to wheelchair. Small skin tear noted. Order to send to hospital to evaluate and treat. Review of Resident #44's Emergency Department document dated 9/5/21 indicated the following: - Patient presents to the emergency room for evaluation after an unwitnessed fall at nursing home. Apparently, the patient crawled out into the the hallway of the nursing home when staff found him/her. Patient states he/she fell out of bed. According to EMS (Emergency Medical Services) they could not find any staff that was aware of the patient, there was no staff on his/her floor at all, and they filed elder neglect paperwork. During an interview on 9/7/21 at 9:40 A.M., the Interim Director of Nursing said she was familiar with Resident #44 and that the Resident had multiple falls and was impulsive. The Interim Director of Nursing said that the expectation regarding the order and care plan intervention for 1:1 supervision for this Resident is that it should have been followed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During telephone interviews throughout the day on 9/7/21 and 9/16/21, Nurse #4 said she was working on 9/5/21 when Resident #44 fell . Nurse #4 said she was only notified that the Resident fell on ce during her shift and that the multiple notes written about his/her fall were related to the same fall. Nurse #4 said staff did their best to watch him/her during the shift but due to low staffing it was difficult. Nurse #4 said that there were only 2 Certified Nursing Assistants (CNAs) working on the unit (unit census was 41 residents) when Resident #44's fall happened and it was difficult to maintain the 1:1 for the Resident as ordered. Nurse #4 said that a CNA left the Resident alone in the hallway to ask for help and that's when the Resident fell . Nurse #4 said staff assisted him/her to a wheelchair and she observed a skin tear to the Resident but was unsure of the location. Nurse #4 said another nurse dressed the skin tear and then brought the Resident back to his/her room. Nurse #4 was unable to say if the Resident remained supervised as ordered after the fall and could not say why the Resident was found alone on the floor of his/her room by EMS. Nurse #4 said she had called the Administrator #1 on 9/5/21 to say that there was not enough staff to provide a 1:1 for Resident #44 and ensure his/her safety and asked if the Administrator #1 would come in to act as the 1:1. Nurse #4 said the Administrator #1 told her she lived too far away and would not come in. Nurse #4 said that Resident #44 fell after she had contacted the Administrator #1 asking her to come in to be the Resident's 1:1. Nurse #4 said she didn't think the staffing level was safe on the unit. Nurse #4 said she thought the Resident sustained a skin tear but she was unsure of the location. Nurse #4 said nursing staff had notified administration multiple times that they felt Resident #44 was unsafe in the facility and that they couldn't safely care for him/her. During an interview on 9/8/21 at 9:09 A.M., Administrator #1 said she was familiar with Resident #44. Administrator #1 said he/she has fallen more than any resident she has ever worked with. Administrator #1 said on 9/3/21 they talked about having staff with Resident #44 at all times as a 1:1. Administrator #1 said a nurse called her on 9/5/21 in the afternoon and asked her to come in to be the 1:1. Administrator #1 said she told the nurse no and that she would not come in because she lived too far away. Administrator #1 said the nurse then told her that the staff couldn't provide the 1:1 for Resident #44. Administrator #1 said she did not ask how many staff were on the unit and that she was unsure how many staff was present. Administrator #1 said she called the scheduler about an hour after receiving the call from nursing staff that they couldn't provide the 1:1 for Resident #44. Administrator #1 said she did not follow up with the nursing staff or the scheduler regarding the request from the nurse for a 1:1 for Resident #44. Administrator #1 was unsure as to when she was notified about Resident #44's fall and being sent to the hospital. During an interview on 9/8/21 at 11:06 A.M., The Staffing Coordinator said that there was a staffing issue on 9/5/21 during the 3-11 shift on the 3rd floor. The Staffing Coordinator said Administrator #1 asked her if she could come in to be Resident #44's 1:1 and she was unable to do it. The Staffing Coordinator said she reached out to staff to try to find someone but no one responded. The Staffing Coordinator was unable to say if she notified Administrator #1 or nursing staff that she was unable to find someone to act as a 1:1. 2) The facility failed to ensure elopement interventions were implemented. Resident #44 was admitted to the facility in March 2021 with diagnoses including traumatic brain injury, dementia, multiple falls, anxiety and bipolar disorder. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #44's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had moderate cognitive impairment and scored a 10 out of 15 on the Brief Interview Status (BIMS). Further review of Resident #44's MDS indicated the Resident required assistance with all care activities and that the Resident had falls with injury since the previous assessment. Review of Resident #44's medical record indicated the following: - The Resident's Health Care Proxy was invoked effective 3/23/21 - A care plan initiated 7/16/21: *Focus- It is unsafe for the Resident to leave this facility, however he/she may attempt to do so related to decreased cognition, poor safety awareness, history of elopement, poor adjustment, dementia, history of wandering * Interventions- Please monitor the Resident's whereabouts frequently and re-direct him/her away from doors; initiated 7/16/21 - A physician's order dated 7/16/21 for a wander guard (a device used to prevent elopement) in place to the Resident's left ankle - A nurses note dated 7/16/21: Healthcare Proxy approved to place wander guard on the Resident -A nurses note dated 8/23/21 at 8:00 A.M.: Resident #44 was confused, restless, agitated at times, non compliant within baseline most of the 11-7 shift. Around 6 A.M., another Certified Nursing Assistant (CNA) from a lower floor reported that she needed help to stop the Resident from exiting this facility. Immediately, the Resident was persuaded to return to his/her room. The nurses note failed to indicate if the Resident's wander guard was in place at the time of the elopement. Review of the facility incident report indicated the following: - An incident report form dated 8/30/21: The Resident was found at approximately 6:30 A.M. in his/her wheelchair on the front patio by a staff member (contradicting the nurse's note). - An undated statement signed by the Scheduling Coordinator: On Monday 8/23 around 6:30 A.M., the Scheduling Coordinator was coming in to the building when she saw Resident #44 on the front patio. He/she was out of his/her wheelchair and was starting to walk. The Scheduling Coordinator ran to get on to the patio but was too late, the Resident had already fallen onto the ground. - A statement dated 8/23/21 and signed by the Interim Director of Nursing that she had interviewed Nurse #5 concerning Resident #44 being found on the patio by the Staffing Coordinator. The statement indicated that Nurse #5 told the Interim Director of Nursing that he saw the Resident with a CNA but he was never told that the CNA went downstairs to bring the Resident back to the unit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 9/07/21 at 1:02 P.M., the Scheduling Coordinator said she saw the Resident on the front patio while she was walking into the building on her way in to work. The Scheduling Coordinator said Resident #44's wheelchair was by the door to the facility and that the Resident was on the ground. The Scheduling Coordinator said the Resident was alone. The Scheduling Coordinator said she entered the building from the same door the Resident had exited the facility from and told the CNA on the first floor to call for a nurse. The Scheduling Coordinator said a CNA from the 3rd floor came down to bring the Resident back up. During an interview on 9/07/21 at 1:59 P.M., the Interim Director of Nursing said that if a resident is found outside of the building, and has an activated Health Care Proxy, then it would be considered an elopement. The Interim Director of Nursing said she learned that the Resident had cut his/her wander guard off using a butter knife. The Interim Director of Nursing said staff was aware that the Resident was able to remove the wander guard but still continued to keep it as an elopement intervention. The Interim Director of Nursing said the wander guard was kept in the medication cart on the unit, and not on the Resident, so it wouldn't get lost. The Interim Director of Nursing was unable to say how long the wander guard was off of Resident #44 prior to his/her elopement. The Interim Director of Nursing said she interviewed Nurse #5 but did not have him complete a statement. The Interim Director of Nursing said the investigation was still ongoing and acknowledged this incident occurred on 8/23/21 (15 days prior to the interview). Attempts to interview Nurse #5 by telephone were unsuccessful. 37565 3) For Resident #50, the facility failed to investigate an entrapment and a fall. Review of the facility policy Accidents and Incidents-Investigating and Reporting dated 2017 on 9/7/2021 at 1:51 P.M. indicated all accidents or incidents involving residents, employees, vendors etc., occurring on our premises shall be investigated and reported to the Administrator. Review of the nursing progress notes for Resident #50 indicated the Resident was yelling out for help on 5/4/2020 at 1:46 A.M. The Resident was found caught between the bed mattress and the bed side rails. The facility staff assisted the Resident back to the middle of the bed and observed scrapes under the breast and groin. These injuries were treated with cleansing and bacitracin. Resident #50 was admitted to the facility in March 2015 with diagnoses including anemia, renal insufficiency and multiple sclerosis. Resident #50 was cognitively intact, did not ambulate and required the assistance of 2 staff for most care needs. Review of the accident/incident file indicated no report or investigation into the entrapment. During an interview 9/7/2021, the Interim Director of Nursing said she could not find a file of the incident that occurred 5/4/2020 at 1:46 A.M. The Interim Director of Nursing also said that she did not work at the facility at that time. Further review of the nursing progress notes for Resident #50 indicated the Resident took a fall while sleeping, yelled out for help and was found on the floor 6/14/2020 at 9:18 A.M. The Resident complained of discomfort to the right side of his/her head after the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The incident file contained a completed incident report. No resident or staff interviews were included in the file. No investigation had been completed per facility policy. During an interview 9/7/2021, the Interim Director of Nursing said only the report was in the file, no interviews or investigation were included. The Interim Director of Nursing also said that she did not work at the facility at that time. 43882 4) For Resident #51, the facility failed evaluate and implement interventions to prevent falls. Review of facility policy titled, Assessing Falls and Their Causes dated, 2017 indicated: When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found 2. Assessment data, including vital signs and any obvious injuries 3. Notification of the physician and family, as indicated. 4. Completion of a falls risk assessment 5. Appropriate interventions taken to prevent future falls Resident #51 was admitted to the facility in August 2020 with diagnoses including, acute kidney failure, osteoarthritis, scoliosis, and adult failure to thrive Review of Resident #51's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that he/she is cognitively intact with a score of 13 out of possible 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS indicated extensive assistance for bed mobility, transfers, and toileting. Review of Resident #51's medical record indicated the resident had a fall in July 2021. Nursing progress notes dated 7/15/21 and 7/16/21 indicated Resident #51 was status post a fall. A hospice note dated 7/20/21 indicated Resident #51 had a fall on 7/15/21 and was found on the floor in his/her room in between the two beds. Further review of Resident 51's medical record indicated no further nursing notes regarding incidents of falls or interventions put into place. Further review of Resident #51's medical record indicated a Physicians order dated 8/28/21 to send resident to the hospital for an evaluation due to a fall with a head strike. Review of incident reports for Resident #51 dated 7/12/21 and 7/14/21 indicated Resident #51 had fallen on both days. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 09/07/21 at 9:37 A.M. the Interim Director of Nursing said expectations for Nursing Staff following a fall include putting an immediate intervention in place which will be assessed the following morning in morning meeting. See F835

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37565 Based on observation, record review and interview, the facility 1) failed to follow their Weight Assessment and Intervention policy to identify a significant weight loss for 1 Resident (#80) and 2) failed to ensure weights were obtained in accordance with physician's orders and facility policy for 1 Resident (#49) from a total sample of 37 residents. Findings include: Review of the facility Weight Assessment and Intervention policy dated 2017 with a revision date of 2019, indicated the following: Nursing staff will measure resident weights on admission, the next day and weekly for 2 weeks or as recommended or ordered thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss = (usual weight-actual weight) / (usual weight x 100): a. 1 month-5% weight loss is significant; greater than 5% is severe. b. 3 months-7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months-10% weight loss is significant; greater than 10% is severe. 1) Resident #80 was admitted to the facility in May of 2021 with diagnoses including alcohol and psychoactive substance abuse, chronic chest pain related to coronary artery disease, hemiplegia (paralysis of one side of the body) related to cerebrovascular accident and atrial fibrillation (abnormal heart rhythm). During an observation 8/31/21 at 7:45 A.M., Resident #80 was lying in bed in a fetal position. He/she appeared emaciated with visible muscle wasting. Review of the clinical record indicated Resident #80 weighed 178.4 pounds on admission in May 2021. He/she weighed 159.0 pounds in June 2021, which indicated a significant loss of 10.87% in 1 month and weighed 149.0 pounds in August 2021 which indicated a significant loss of 16.48 pounds in 3 months. These weight changes were considered severe by facility policy. Resident #80's recorded weights were: 5/8/21-178.4 standing. 5/8/21-178.4 standing. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	5/9/21-no weight completed as required per policy. 5/17/21-no weight completed as required per policy. 5/24/21-no weight completed as required per policy. 6/7/21-159.0 by lift-10.87% significant weight loss in 1 month. 8/5/21-148.8 by lift-16.59% significant weight loss in 3 months. 8/9/21-149.0 by chair-16.48% significant weight loss in 3 months. Review of the Weight Assessment and Intervention policy indicated once a 3 pounds weight change has been confirmed, nursing will immediately notify the physician and the dietician. The physician and the dietician are expected to respond within 24 hours of the Resident's weight change. Further record review 9/1/2021 indicated no evidence the Resident's physician or dietician were notified of a significant weight change identified 6/7/21 with a 24 hour response. A nutritional intervention did not occur until 6/25/2021 (18 days after Resident #80's significant weight loss was documented). During an interview 9/1/21 at 8:20 A.M., Nurse #10 said the Resident must be fed and usually eats 25% or less of his/her meal. She also said that the Resident will take liquids when offered. During an interview 9/1/21 at 12:53 P.M., CNA #4 was attempting to feed Resident #80 and requested assistance from Nurse #10. The Resident consumed 25% of the meal and 3-6 ounce glasses of juice. CNA #4 said the Resident's appetite is not very good. Review of Resident #80's medical record indicated Ensure Plus (nutritional supplement) 1 unit daily by mouth and a nutritional consult were ordered on 6/25/2021. Record review indicated no evidence of the nutritional consult until 8/13/2021. During an interview on 9/2/2021 at 11:28 A.M., Dietician #1 said that she is in the facility 2 days weekly and further said to her knowledge the dietician position had been vacant for months. Dietician #1 said she did visit Resident #80 on the unit but did not document in the record other than the Minimum Data Set Assessment (MDS). Dietician #1 also said the Resident's quarterly nutritional assessment was completed 8/13/2021 which revealed severe chronic protein and calorie malnutrition related to poor oral intake secondary to the Resident's refusal of meals and that the Resident had a significant weight loss since admission. The Dietician said the Resident's wounds present were related to pressure injuries and inactivity. Dietician #1 said the nursing staff would offer an alternate meal when meals are refused and offer snacks throughout the day. Dietician #1 said she does not attend resident risk meetings but will bring any concerns to nursing staff and further said when resident weights are missing she does bring it to the nurses attention at morning meetings. 2) For Resident #49, the facility failed to ensure weights were obtained according to physician orders and failed to ensure a reweigh was performed in accordance with facility policy. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	a. Resident #49 was admitted to the facility in November 2019 with diagnoses including Hemiplegia and Cerebrovascular Accident (CVA). Review of the Minimum Data Set (MDS) completed on 7/13/21 indicated Resident # 49 was cognitively intact and scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicates Resident #49 is cognitively intact. Review of Resident #49's medical record indicated that Resident #49 was not weighed for a period of 8 months between 12/14/20-8/4/21. Review of Physician's orders dated 4/12/2021 indicated that the Resident needed to be weighed weekly for four weeks then monthly thereafter. Review of Dietician #1 record review on 7/18/21 indicated she identified no recorded weights for Resident #49 from 12/14/20 to 8/4/21. During an interview on 9/2/2021 at 11:24 A.M., Dietician #1 said the Resident was not weighed for a period of 8 months. Dietician #1 said weights should be completed at admission, weekly, then monthly after. The Dietician #1 said staff should document if the resident refuses to be weighed. Review of the progress notes indicated that Resident #49 refused to be weighed only on 3/19/21 and 5/12/21. There was no indication that Resident #49 refused to be weighed at any other time. b.) Review of the facility policy titled Weight Assessment and Intervention, revised in 2019, indicated: *The facility may elect to treat any unplanned, undesired weight change of three (3) pounds or more from the previously recorded weight as a potential undesired weight change. Any (3) pound weight change will result in a reweigh within 24 hours. Once these three (3) pounds weight change have been confirmed, nursing will immediately notify the Physician and Dietitian of the weight change. Documentation of this notification shall be entered in the resident's medical records. Resident #49 was admitted to the facility in November 2019 with diagnoses including Hemiplegia, Cerebrovascular Accident (CVA). Review of the Minimum Data Set (MDS) completed on 7/13/21 indicated Resident # 49 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicates Resident #49 is cognitively intact. Review of Resident #49's medical record indicated the following: *On 5/25/20, Resident #49 weighed 195.6 lbs. (on a chair scale). *On 6/4/20, Resident #49 weighed 163.3 lbs (a 32.3 lb weight difference in 11 days that was not identified and addressed). During an interview on 9/3/2021 at 1:14 P.M., Certified Nursing Assistant (CNA) # 10 said if weights are suspected to be incorrect, reweighs are prompted by the nurse on the unit. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interviews throughout the day on 9/7/21, Dietitian #1 said reweighs in the facility should be done for any weight change of 3 pounds, and a reweigh should be done within 24 hours. Dietician #1 said she had worked at the facility for 2 months and she was told when she was hired that it was the expectation that the dietitian, unit managers and Director of Nursing would have risk meetings (meetings to discuss weight loss) but that no risk meetings had been done as of yet because there were no unit managers in the facility. During an interview on 9/8/21 at 11:59 A.M., the Interim Director of Nursing said the expectation would be that for any weight loss of 2 pounds or more, residents would be reweighed within 24 hours by a nurse and an aide to validate the accuracy of the weight loss and that the residents would be tracked in risk meetings. 43807

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 30889 Based on observation, interview and policy review, the facility failed to ensure oxygen tubing was changed weekly to minimize the risk of spread of infection for 4 of 4 residents using oxygen (#10, #46, #56, #79), observed out of a total sample of 37 residents. Findings include: Review of the facility policy, entitled, Oxygen Therapy, dated 2017, indicated that oxygen masks, cannulas and tubing are replaced with new equipment every 7 days, items are dated and initialed. A. For Resident #10, the facility failed to ensure oxygen tubing attached to his/her nebulizer was changed weekly per the facility policy. On 8/31/21 at 9:33 A.M., observation revealed oxygen tubing attached to a nebulizer machine on the Resident #10's bedside table. A piece of tape attached to the oxygen tubing was dated 8/5/21. Based on the facility policy, the tubing should have been changed weekly on 8/12/21, 8/19/21 and 8/26/21. During an interview on 8/31/21 at 9:35 A.M., Resident #10 said that staff do not tend to get to changing the tubing very often. B. For Resident #56, the facility failed to ensure oxygen tubing attached to his/her oxygen concentrator was changed weekly per the facility policy. On 8/31/21 at 12:25 P.M., observation revealed oxygen tubing attached to a Resident #56's oxygen concentrator located next to the Resident's bed. A piece of tape attached to the oxygen tubing was dated 8/5/21. Based on the facility policy, the tubing should have been changed weekly on 8/12/21, 8/19/21 and 8/26/21. During an interview on 8/31/21 at 12:26 P.M., Resident #56 said he/she wished that staff would change the oxygen tubing. Resident #56 said it's been a while and he/she uses it every day. C. For Resident #46, the facility failed to ensure oxygen tubing attached to his/her oxygen concentrator was changed weekly per the facility policy. On 8/31/21 at 1:00 P.M., observation revealed oxygen tubing attached to Resident #46's oxygen concentrator located next to the Resident's bed. A piece of tape attached to the oxygen tubing was dated 8/5/21. Based on the facility policy, the tubing should have been changed weekly on 8/12/21, 8/19/21 and 8/26/21, 9/2/21 and 9/9/21. On 9/15/21 at 8:35 A.M., surveyor observation revealed that the oxygen tubing was still dated as changed on 8/5/21. 43882 D. For Resident #79, the facility failed to date and label oxygen tubing according to policy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #79 was admitted to the facility in May 2021 with diagnoses including, Type II Diabetes, anxiety disorder, pulmonary embolism (blood clot of the lung), and cerebral infarction (tissue death). An observation on 08/31/21 at 09:15 A.M. Resident #79 was observed lying in bed with a nasal cannula (tubing that delivers oxygen through nose) being used for supplemental oxygen. The nasal cannula was noted to be unlabeled with a date or initials. Further observations of undated oxygen tubing were observed on 9/1/21 at 8:45 A.M. and 9/8/21 at 8:09 A.M. During an interview on 09/08/21 at 08:09 A.M. Resident #79 said oxygen was supposed to be changed weekly, but the tubing had not been changed in a while. During an interview on 09/08/21 at 9:42 A.M. the Director of Nursing said the expectation of oxygen tubing is to be changed weekly and dated.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40928 Based on observation, interview and schedule review, the facility failed to 1) ensure there was clinical staff present to provide nursing services and assure resident safety on 1 of 3 resident care units and 2) ensure there was sufficient staff available to provide safe and adequate care required to meet residents' needs. Findings include: Review of facility policy titled 'Staffing', revised April 2007, indicated the following: *Policy Statement: -Our facility provides adequate staffing to meet needed care and services for our resident population. *Policy Interpretation and Implementation: - Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. - Certified Nursing Assistants (CNAs) are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan 1a. On 9/7/21 at 6:55 A.M., the surveyor arrived onto the 1st floor unit. The surveyor was unable to locate a staff person. Observation of the 1st floor unit revealed two residents residing in two different rooms. The surveyor observed the staffing coordinator (who does not have a clinical background) sitting in the back of the nurses station, using a desktop computer. During an interview on 9/7/21 at 6:55 A.M., the staffing coordinator said that the 11:00 P.M.-7:00 A.M. shift nurse (#6) was also covering the 2nd floor unit. The staffing coordinator said she comes in at 6:00 A.M., but did not see the nurse on the 1st floor unit. She said there was a CNA (#3) covering the 1st floor unit but she left at 6:50 A.M. because of childcare. The staffing coordinator said there is a nurse scheduled to cover the 1st floor unit for the 7:00 A.M.- 3:00 P.M. shift but she hadn't arrived yet. The surveyor asked what would happen if the residents on the 1st floor unit needed assistance. The staffing coordinator said she would probably call someone on the second floor. The staffing coordinator said she was not a clinical staff and was just on the unit to use the computer. The staffing coordinator could not say how residents would have been able to get assistance if she had not come to the desk to use the computer. On 9/7/21 at 7:05 A.M., the surveyor observed CNA #11 standing at the 1st floor nurses station. During an interview on 9/7/21 at 7:05 A.M., CNA #11 said she is working on the second floor and they sent her down to the first floor until the nurse arrives. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/7/21 at 7:07 A.M., the staffing coordinator said she called for assistance after she spoke with the surveyor. On 9/7/21 at 7:20 A.M., the surveyor observed as Nurse #15 arrived onto the 1st floor unit. During an interview on 9/7/21 at 7:21 A.M., Nurse #15 said that Nurse #6 was covering the 1st floor unit but was still working upstairs on the 2nd floor unit. Nurse #15 said she got the medication keys from Nurse #6 and came downstairs. On 9/8/21 at 8:05 A.M., the surveyor observed Nurse #6 as she exited the elevator and walked to the 1st floor unit nurses station. Nurse #6 spoke to Nurse #15 for approximately 1 minute and then began to walk off the unit to leave the building. During an interview on 9/8/21 at 8:07 A.M., the surveyor asked Nurse #6 if she conducted change of shift narcotic count with Nurse #15, Nurse #6 said she told Nurse #15 when she came up to the 2nd floor unit how many narcotics were left in the locked drawer, but no they did not conduct narcotic count as they were expected to. Nurse #6 said she was too busy on the second floor and there were only two controlled medication cards in the locked drawer. During interview on 9/8/21 at 8:08 A.M., Nurse #15 said that Nurse #6 should have come to the 1st floor unit to do narcotic count and Nurse #15 said she should not have just taken the medication/narcotic drawer keys from Nurse #6 but she needed to get started as she was late already and Nurse #6 could not come to the 1st floor because she was too busy on the 2nd floor unit. On 9/7/21 at 7:10 A.M., the surveyor reviewed the Medication Administration Record (MAR) for Resident #27 (a resident residing on the 1st floor unit). The review indicated that Resident #27 should have received the following medications at 6:00 A.M.: cholecalciferol (vitamin D3) 800 units, colace 100 milligrams (mg) one by mouth and levothyroxine (thyroid medication) 50 micrograms(mcg) by mouth every day. The MAR was not initialed by the 11-7 nurse as given. During an interview on 9/7/21 at 11:10 AM, Nurse #6 said that she did not give Resident #27 his/her 6:00 A. M. medications. Nurse #6 said that she usually will give them on her way out of the building, after she finished her work on the 2nd floor unit, but she ran out of time and needed to leave the facility. Nurse #6 said she covers the 2nd floor unit and 1st floor unit about once a week and will come down if a resident requests an 'as needed' medication, if not, she said she stays on the 2nd floor because she has 40 residents upstairs and can't be down on the first floor. Nurse #6 said it isn't safe to leave the 2nd floor. Nurse #6 said she instructs the CNA assigned to check the residents every two hours and to call her if there is a problem, other than that she would not go downstairs. The surveyor asked if she performed needed assessments or observed Resident #27 or Resident #139, whom resided on the first floor unit, at all during the 11-7 shift. Nurse #6 said she did not see either of them at all the entire shift. Nurse #6 said she did not go to the 1st floor unit at all during the 11:00 P.M.- 7:00 A.M. shift on 9/6/21-9/7/21. 1b. During a record review, the staffing for the 1st floor unit from 8/7/21 through 9/7/21 was reviewed. For those 31 days, the floor was occupied by residents and the following was indicated: * For 3 of 31 days there was no nurse or Certified Nursing Assistant assigned to the unit on the 7-3 shift: 8/9, 8/20, 8/26 (CNA was listed as being at an appointment from 10:00 am on) (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* For 1 of 31 days there was no nurse or Certified Nursing Assistant (CNA) assigned to the unit on the 3-11 shift: 8/15 * For 1 of 31 days there was no nurse or Certified Nursing Assistant (CNA) assigned to the unit on the 11-7 shift: 8/15 * For 14 of 31 days no nurse was assigned to the unit on the 7-3 shift: 8/7, 8/11, 8/12, 8/14, 8/15, 8/16, 8/19, 8/20, 8/24, 8/26, 8/28, 8/29, 8/30, 8/31 * For 8 of 31 days no nurse was assigned to the unit on the 3-11 shift: 8/12, 8/14, 8/15, 8/22, 8/27, 8/28, 8/29, 8/30 * For 13 of 31 days no nurse was assigned to the unit on the 11-7 shift: 8/12, 8/14, 8/15, 8/16, 8/17, 8/22, 8/24, 8/27, 8/28, 8/29, 9/1, 9/5, 9/6 * For 15 of 31 days no Certified Nursing Assistant (CNA) was assigned to the unit on the 7-3 shift: 8/8, 8/9, 8/10, 8/13, 8/17, 8/20, 8/22, 8/26 (CNA was listed as being at an appointment from 10:00 A.M. on), 8/27, 9/1, 9/2, 9/3, 9/4, 9/5, 9/7 * For 23 of 31 days no Certified Nursing Assistant (CNA) was assigned to the unit on the 3-11 shift: 8/7, 8/8, 8/9, 8/10, 8/13, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20, 8/22, 8/23, 8/24, 8/25, 8/31, 9/1, 9/2, 9/3, 9/4, 9/5, 9/6, 9/7 * For 15 of 31 days no Certified Nursing Assistant (CNA) was assigned to the unit on the 11-7 shift: 8/7, 8/9, 8/10, 8/11, 8/13, 8/15, 8/18, 8/19, 8/23, 8/25, 8/26, 8/30, 8/31, 9/2, 9/7 1c. Additionally, the records of the residents that occupied the 1st floor unit between 8/7/21- 9/7/21 were reviewed and the following was indicated: Resident #27 was admitted to the facility in 6/2021 with diagnoses including acute kidney failure, Schizoaffective Disorder and Major Depressive Disorder. Resident #27 resided on the first floor resident unit 31 out of 31 days reviewed. Review of Resident #27's medical record indicated the following physician orders: -Levothyroxine Sodium Capsule 25 mcg (micrograms) daily at 6 A.M. not given 8/13, 8/15, 8/16. There was no nurse scheduled at the time the dose should have been administered. -Levothyroxine Sodium Capsule 50 mcg daily at 6 A.M. not given 8/17, 8/29, 8/30 . There was no nurse scheduled at the time the dose should have been administered. -Vital signs daily at 9 A.M. not done 8/7, 8/9, 8/14, 8/16, 8/19 . There was no nurse scheduled for the 7-3 shift on these dates. Resident #139 was admitted to the facility in 8/2021 with diagnoses including abnormalities of gait and mobility. Resident #139 resided on the first floor resident unit 7 out of 31 days reviewed. Review of Resident #139's medical record indicated the following physician orders: (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-COVID 19 evaluation every shift not done 9/1 night shift and 9/5 night shift. There was no 11-7 nurse scheduled for these shifts. Resident #290 was admitted to the facility in 8/2021 with diagnoses including alcohol abuse, major depressive disorder and suicidal ideations. Resident #290 resided on the 1st floor unit 23 out of 31 days reviewed. Review of Resident #290's medical record indicated the following physician orders: - Remeron (an anti depressant) give 7.5 milligrams (mg) at bedtime: not given 8/15 and 8/29. There was no 3-11 nurse scheduled on these dates. -Sertraline (an antidepressant) 50mg at 8A.M. daily: not given 8/11, 8/14, 8/16, 8/26, 8/28, 8/30, 8/31. There was no 7-3 nurse scheduled on these dates. -An order dated 8/13/21 for Seizure precautions four times a day not done on 8/14. There was no nurse scheduled for all 3 shifts on this day. -An order dated 8/16/21 for Seizure precautions every shift not done on the following shifts: 8/16 night shift (there was no 11-7 nurse), 8/19 day shift (there was no 7-3 nurse), 8/22 night shift (there was no 11-7 nurse), 8/28 evening and night shifts (there was no nurse for either shift), 8/29 night shift (there was no 11-7 nurse), 8/30 day and evening shifts (there was no nurse for either shift). During an interview on 9/8/22 at 9:22 A.M., Administrator #1 said that there should always be a clinical staff member on each unit if there are residents on that unit. Administrator #1 further said the expectation would be that nursing staff would administer medications and treatments and monitoring such as seizure precautions and Covid monitoring according to orders. 2. On 9/2/21 at 8:36 A.M. through 9:15 A.M., observation of the 2nd floor dining room revealed a total 12 residents eating breakfast. There was one staff member (Nurse #11) present to provide supervision, cueing and feeding. One of the Residents (#83) required 1:1 supervision due to a history of esophageal impaction. Nurse #11 spent the entire time feeding another resident and cueing a second resident, with her back to Resident #83. During an interview on 9/2/21 at 9:30 A.M., Nurse #11 said she knows that Resident #83 needs constant supervision but she was the only one in the dining room and another resident needed to be fed. Nurse #11 said they don't have enough staff to be able to staff the dining room and get the residents that eat in their rooms fed. During a record review on 9/07/21 at 1:00 P.M., the care needs of all residents at the facility (Certified Nursing Assistant -CNA care cards) were reviewed and the following was indicated: 1st floor unit=census is 2; 1 of 2 residents required physical assist with eating; 2nd floor unit= census is 42; 16 of 42 required physical assistance with eating, 23 of 42 require 2 person assist with bed mobility/transfers, 18 of 42 required 2 person assist for toileting; (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3rd floor unit = census is 41; 18 of 41 required physical assistance with eating, 25 of 41 required 2 person assist with bed mobility/transfers, 12 of 41 required 2 person assist for toileting. During an interview with 3rd floor unit Nurse #14 on 9/8/21 at 5:04 A.M., she said that she was the only nurse on the floor with two Certified Nursing Assistants (CNA #12 and #15) and that the unit census was 40. During an observation on the facility's 3rd floor unit on 9/8/21 at 5:18 A.M., CNA #12 was observed alone in a room with a resident. CNA#12 was attempting to pull a brief off of the resident and at the same time roll the resident on to his/her side. During an interview with CNA #12 on 9/8/21 at 5:24 A.M., she said that the resident that she had been caring for required 2 staff to provide total care but because there were only 2 CNA's on the unit and most of the residents required two person care, they had no choice but to provide the care alone in order to get the care done for the residents. During an interview with CNA #15 on 9/8/21 at 5:42 A.M., she said that they used to have 3 CNA'S to ensure they could safely provide care to all the residents but that that had changed months ago and they had no other option than to provide care alone to residents that need two caregivers. During an observation on the 3rd floor unit on 9/15/21 at 8:05 A.M., the surveyor observed the breakfast truck delivered to the unit. The following observations were made: -At 8:14 A.M., a tray was delivered to Resident #74. It was placed on a tray table directly in front of Resident #74 and the staff person exited the room. At 8:17 A.M., the surveyor observed Resident #74 asleep, holding a fork. Review of the care card for Resident #74 indicated he/she required supervision and 1 person physical assistance with eating. -At 8:18 A.M., Resident #35 was observed alone in his/her room sleeping. An untouched breakfast tray was on the tray table directly in front of him/her. Review of the care card for Resident #35 indicated he/she required supervision and assist with eating. - At 8:22 A.M., Resident #33 was observed in the unit's main dining room, fiddling with the food on his/her tray. No staff were present in the dining room. Review of the care card for Resident #33 indicated he/she required supervision with eating. - At 8:25 A.M., Resident #67 was observed alone in his/her room with a breakfast tray directly in front of him/her. Review of the care card for Resident #67 indicated he/she required one person physical assist with eating. - At 8:27 A.M., Resident #69 was observed alone in his/her room. A nurse placed a breakfast tray directly in front of him/her and exited the room. Review of the care card for Resident #69 indicated he/she required extensive one person assist with eating. - At 8:34 A.M., Resident #62 was observed alone in his/her room with breakfast directly in front of him/her. Review of the care card for Resident #62 indicated he/she required one person physical assist with eating. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At 8:36 A.M., Resident #37 was observed in the unit's main dining room with breakfast placed on the table directly in front of him/her. No staff were present in the dining room. Review of the care card for Resident #37 indicated he/she required one person physical assist with eating. See tag F835 41105

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 30889 Based on observations, staff interviews and records reviewed, the facility 1) failed to ensure agency nurses received orientation to the facility, including knowing which nurse is in charge of the facility on off shifts, management of a crisis, emergency or disaster and how to reach the Administrator and Director of Nursing, 2) failed to ensure that 2 of 2 licensed nurses observed were trained and competent to properly open a cylinder of oxygen which is located on the code cart and used for medical emergencies, and 3) failed to ensure agency nurses were able to access the electronic medication dispensing system (Cubex), which contains medications used in emergency situations. Therefore, a resident experiencing an acute change in condition with the need for supplemental oxygen, a medical crisis with the need to initiate a Code Blue, the need to access and dispense medication related to an acute change, or in the event of a facility disaster such as a fire, the potential for severe adverse outcomes for multiple residents exists. Findings include: 1) On 9/15/21 at 5:02 A.M., on the 3rd floor unit, Nurse #19 was behind the nurse's station sitting with his head down and wearing headphones (ear buds). During an interview at that time, Nurse #19 said he was an agency nurse and that he had not gotten any orientation to the facility and said he was unsure of who was in charge of the building. Nurse #19 said he thought it was the nurse on duty on the 2nd floor unit (the only other nurse in the facility at that time). During an interview with Nurse #18 on the 2nd floor unit on 9/15/21 at 5:12 A.M., Nurse #18 said she was an agency nurse and had not received any orientation to the facility. She said that she was unsure who was in charge of the building at that time. During an interview on 9/15/21 at 11:55 A.M., the Interim Director of Nursing said that there is a packet for agency nurses that should be reviewed with them at the start of the shift. The Interim Director of Nursing said that the Staff Development Coordinator was supposed to be doing this but since she was absent, the Scheduling Coordinator was filling in. The Interim Director of Nursing said that the expectation would be that any agency nurse would receive orientation at the start of their shift, while also acknowledging the Scheduling Coordinator was not in the facility when the 11-7 shift worked. During interviews throughout the day on 9/15/21, the Scheduling Coordinator said the facility Staff Development Coordinator was out of work and that now she was responsible for ensuring agency nurses were given an orientation to the facility at the start of their shift. The Scheduling Coordinator said that the orientation involved going through a packet with the agency nurse and giving them a tour. The Scheduling Coordinator said she kept a binder with all of the completed forms related to orientation. The Scheduling Coordinator said she was not a clinical staff member, so if there were any clinical questions she would refer them to nursing. The Scheduling Coordinator said she had not provided orientation to Nurse #18 or #19 prior to their 11-7 shift and said she had not provided orientation to Nurse #14 prior to her shift on 9/12/21. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility document titled 'Vero Agency Staff Facility Orientation', revised 2/26/21 indicated that agency staff should have been oriented and had an opportunity to ask questions on items which include: -Abuse prevention and who to report to -Fire Safety, Fire Drill procedure and use/ location of fire extinguisher reviewed (RACE/PASS) -How to reach the Administrator and Director of Nursing Services 2) On 9/7/21 at 9:55 A.M., during review of the code cart contents on the 2nd floor, the surveyor asked Nurse #8 if she would open the emergency oxygen cylinder. The surveyor observed as Nurse #8 made several attempts to open the cylinder of oxygen. Nurse #8 was unable to open the emergency oxygen cylinder. After 5 minutes Nurse #8 called Nurse #7 over and asked Nurse #7 to open the emergency oxygen cylinder. After several attempts, Nurse #7 was unable to open the emergency oxygen cylinder. During an interview on 9/7/21 at 10:10 A.M., the surveyor asked what Nurse #8 would do in an emergency situation if the resident needed oxygen. Nurse #8 said she did not know what she would do in that case. Nurse #8 said she worked for an agency and had not received any orientation in regard to the emergency equipment. Review of the resident care cards, provided by the facility, indicated that 53 of 85 residents residing in the facility on 9/7/21 were listed as being Full Code and therefore may require oxygen to be administered in a medical emergency. Facility staff competencies were requested for Nurse #7, hired in June 2021, and Nurse #8, temporary agency staff. The facility was unable to provide competencies for Nurse #7 or Nurse #8. During interviews throughout the day on 9/8/21, Administrator #1 said that she could not find any competencies for Nurse #7 and did not have anything for Nurse #8, who worked for the temporary staffing agency. Administrator #1 said there were no competencies on file for any of the nursing staff for 2020 or 2021. 40928 3) The facility failed to ensure agency nurses were provided with access to the medication dispensing system (Cubex) which has an interim supply of medications for use in emergency and non-emergency dosing for nursing facility residents until the provider pharmacy can provide a regular supply of medication to the resident, resulting in 1 Resident (#3) receiving an unnecessary pain medication. Resident #3 was admitted to the facility in September of 2019 with diagnoses including anxiety disorder, depression and psychotic disorder. During record review 9/1/2021 at 8:44 A.M., the nursing progress notes indicated that Resident #3 had experienced a fall resulting in a wrist fracture. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a physician's order dated 8/14/2021 indicated Tramadol HCL (opioid medication to treat moderate to severe pain) tablet 50 milligrams (mg), give 25 mg by mouth every 8 hours as needed for pain. Discontinue the morphine (narcotic medication to treat moderate to severe pain) when the Tramadol is available. Review of Resident #3's Medication Administration Record (MAR) indicated that he/she received morphine for pain relief August 14th, 15th, 16th and 19th. Review of Resident #3's medical record indicated that Tramadol tablets were received from the pharmacy on 8/21/2021. Resident #3 received the 1st dose of Tramadol on 8/21/2021. The facility has a Cubex electronic medication dispensing system (Cubex) to provide an interim supply of medications for use in emergency and non-emergency administration for nursing facility residents until the provider pharmacy can provide a regular supply of medication to the resident. Review of the facility Cubex inventory on 9/1/2021 at 10:02 A.M., revealed that 6 Tramadol 50 mg tablets were available for administration on 8/14, 8/15, 8/16 and 8/19. During an interview 9/2/21021 at 4:25 P.M., Nurse #9 and Nurse #11 said that accessing the Cubex is a problem on the off shifts because most nurses are agency staff and agency nurses do not have access to the Cubex. Nurse #9 and Nurse #11 said they do their best to get any needed medications before the day shift nurses leave for the day. Both Nurse #9 and Nurse #11 are agency nurses and do not have access to the Cubex. During an interview 9/7/2021 at 2:48 P.M., the Interim Director of Nursing said the facility does have a Cubex medication system to assist with emergency and non-emergency interim medication use. She also said that agency nurses do not have access to the Cubex system and on occasion the system cannot be accessed due to no facility staff working at the time of need. 41105

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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** 40928 Based on interview and record review, the facility failed to ensure behavioral health services were obtained as requested for 1 Resident (#289) out of a total sample of 37 residents. Findings include: Resident #289 was admitted to the facility in 7/2021 with diagnoses including traumatic subdural hemorrhage, alcohol abuse and anxiety. Review of Resident #289's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident was cognitively intact and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of Resident #289's MDS indicated that the Resident had experienced moving or speaking so slowly that other people could have noticed or been so fidgety or restless that he/she has been moving around more than usual for 12-14 days. During an interview on 8/31/21 at 8:34 A.M., Resident # 289 said there were not enough mental health services in the building. Resident #289 further said he/she would benefit from checking in with someone. During an interview on 9/7/21 at 11:44 A.M., Resident #289 said he/she had signed a consent form for therapy shortly after he/she came to the facility but had not heard anything about it, and had not seen anyone. Review of Resident #289's medical record indicated the following: -A signed consent form for Integrative Counseling Services, dated 7/14/21 -A care plan initiated 7/15/21: I have a current Alcohol Abuse problem with an intervention to provide the Resident with psych services as needed. -A care plan initiated 7/15/21: the Resident has a potential mood problem related anxiety and new admission with an intervention to provide behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc.) Further review of Resident #289's medical record failed to indicate the Resident had been seen by any therapist. During an interview on 9/07/21 at 11:58 A.M., Nurse #16 said she had not heard of this therapy service and said that the facility is responsible for ensuring consultant visits are scheduled if a resident signs a consent form. During an interview on 9/07/21 at 12:38 P.M., Social Worker #1 said the Integrative Counseling Service works with the facility but that she was unsure of the process for this service and if Resident #289 had ever been seen. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/07/21 at 12:47 P.M., the Interim Director of Nursing said the Integrative Counseling Service is for residents who have Substance Use Disorder and indicated they would like to see the counselor. The Interim Director of Nursing said that the counselor comes in on an as needed basis and that she would have to look into if Resident #289 was seen. During an interview on 9/07/21 at 1:53 P.M., the Interim Director of Nursing said that Resident #289 had not been seen by the counselor and that if the Resident signed the consent form then the facility should have called and arranged for the Resident to be seen.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 30889 Based on observation, review of the facility control substances book and staff interview, the facility failed to ensure staff (Nurse #15 and Nurse #6) reconciled controlled substances at the end and beginning of each shift. Findings include: Review of the facility policy, entitled, Controlled Substance Storage, not dated, included the following: * If a key system is used, the medication nurse on duty maintains possession of the key to the controlled substance storage areas. * At each shift change, or when keys are transferred, a physical inventory of all control substances, including refrigerated items is conducted by two licensed personnel and is documented. On 9/7/21 at 7:20 A.M. through 8:05 A.M., observation on the 1st floor unit revealed Nurse #15 arrive to the unit. There was not an 11:00 P.M. to 7:00 A.M. nurse present on the unit when Nurse #15 arrived. The surveyor asked Nurse #15 if she could open the medication cart for inspection. Nurse #15 took the keys to the medication cart (which also included keys for the locked controlled substances drawer located in the medication cart) out of her pocket and the surveyor inspected the cart. At 8:05 A.M., Nurse #6 (who was covering the 1st floor and 2nd floor units for the 11:00 P.M.- 7:00 A.M. shift) came down from the 2nd floor unit and spoke to Nurse #15 for 1 minute and then began to exit the facility. The surveyor did not see the reconciliation (narcotic count) of the controlled substances drawer take place between the oncoming Nurse #15 and the off going Nurse #6. During an interview on 9/7/21 at 8:05 A.M., Nurse #6 said she was too busy on the 2nd floor to come down to do count. Nurse #6 said Nurse #15 came to the 2nd floor unit and she gave Nurse #15 the keys to the medication cart without doing narcotic count. Nurse #6 said she is supposed to do the count with the nurse that is coming in for the 7:00 A.M.-3:00 P.M. shift. During an interview on 9/7/21 at 8:10 A.M., Nurse #15 said that she knows she should have done the narcotic count with Nurse #6, but that didn't happen this morning. Nurse #15 said she shouldn't have taken the keys from Nurse #6 until they did narcotic count.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37565 Based on record review and interview, the facility failed to act upon pharmacy recommendations following the Monthly Medication Regime (MRR) review for 3 Residents (#50, #70 and #80) from a total sample of 37 Residents. Findings include: Review of the facility Policy titled Drug Regimen Review-Monthly indicated: * Upon completion of the drug review, provide written documentation of all recommendations and submit monthly to the facility for attending prescriber or designee to review and respond. * The written documentation and prescriber response shall be considered a permanent part of each resident's medical record. a.) Resident #50 was admitted to the facility in March 2015 with diagnoses including anemia, renal insufficiency and multiple sclerosis. During a record review on 9/8/21 at 12:20 P.M., Resident #50's record indicated an MRR review by the pharmacist, dated 8/30/21, was completed with recommendations made to the physician. Further review of the record failed to indicate a response from the physician in the medical record or the electronic medical record. b.) Resident #70 was admitted to the facility in August 2018 with diagnoses including dementia, anxiety, depression and psychotic disorder. During a record review on 9/8/21 at 12:30 P.M., Resident #70's medical record indicated the following MRR reviews by the pharmacist: * MRR dated 5/26/21, was completed with recommendations made to the physician. Further review of the record failed to indicate a response from the physician in the medical record or the electronic medical record. * MRR dated 8/30/21, was completed with recommendations made to the physician. Further review of the record failed to indicate a response from the physician in the medical record or the electronic medical record. c.) Resident #80 was admitted to the facility in May of 2021 with diagnoses including chronic chest pain related to coronary artery disease. During a record review on 9/8/21 at 12:40 P.M., Resident #80's record indicated the following MRR reviews by the pharmacist: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* MRR dated 5/24/21, was completed with recommendations made to the physician. Further review of the record failed to indicate a response from the physician in the medical record or the electronic medical record. * MRR dated 6/28/21, was completed with recommendations made to the physician. Further review of the record failed to indicate a response from the physician in the medical record or the electronic medical record. * MRR dated 7/28/21, was completed with recommendations made to the physician. Further review of the record failed to indicate a response from the physician in the medical record or the electronic medical record. During multiple interviews on 9/7/21 - 9/8/21 the surveyor requested the interim Director of Nursing (DON) provide the completed pharmacy recommendations and the physician responses for Resident's #50, #70 and #80. On 9/8/21 at 3:40 P.M., the Interim DON said she could not figure out the previous DON's process or any evidence of physician responses to the MRR's.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30889 Based on observation, interview and record review the facility failed to ensure that it was free of a medication error rate of 5 percent or greater. Three of 6 licensed nurses (Nurse #7, Nurse #9 and Nurse #10) observed, made errors while administering medications on 2 of 3 units. Three medication errors were observed out of 31 opportunities, resulting in a medication error rate of 9.68%. This affected three Residents (#3, #23 and #79) out of a total of six residents observed. Findings include: 1. For Resident #3, the facility failed to administer Creon (pancreatic enzyme which requires food to be activated) 12,000 units (u), per the physician order. During observation of a medication pass on [DATE] at 4:15 P.M., on the 2nd floor unit, Nurse #9 prepared several medications, which included 1 capsule of Creon 12,000 u. Nurse #9 entered Resident #3's room and administered the Creon medication. On [DATE] at 4:35 P.M., during reconciliation of Resident #3's medications, indicated a physician's order, dated [DATE], which included an order for Creon capsule delayed release particles, 12,000 u give 1 capsule with meals. During an interview on [DATE] at 8:05 A.M., Nurse #9 said the dinner trays come to the unit around 5:15 P. M. Nurse #9 said she didn't realize the Creon needed to be given with food. Nurse #9 said she should have waited for the dinner trays to get to the Resident, then administer the Creon. On [DATE] at 5:30 P.M., observation revealed that Resident #3 still had not receive his/her dinner meal tray. 2. For Resident #23, the facility failed to ensure staff ensured the proper dose of docusate sodium (stool softener) was administered. During observation of a medication pass on [DATE] at 7:49 A.M., on the 2nd floor unit, Nurse #10 prepared 1 tablet of docusate 100 milligrams (mg). Nurse #10 entered Resident #23's room and administered the 1 tablet of docusate 100 mg by mouth to Resident #23. On [DATE] at 7:55 A.M., during reconciliation of Resident #23's medications, indicated a physician's order, dated [DATE], which included an order for docusate sodium tablet by mouth two times a day. The physician's order did not indicate the milligram dosage. During an interview on [DATE] at 8:00 A.M., Nurse #10 said that she didn't even realize the docusate order was incomplete. She said she should have clarified the dosage with the doctor first. 3. For Resident #79, the facility failed to ensure that staff (Nurse #7) did not administer insulin that was not labeled properly and at risk for expiration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation of a medication pass on [DATE] at 8:05 A.M., on the 3rd floor unit, Nurse #7 was observed preparing Resident #79's morning medications which included Lispro insulin. Without checking the expiration date, Nurse #7 drew up a total 15 units of the Lispro insulin and was prepared to administer this medication. The surveyor examined the multidose vial of the Lispro insulin and saw that the vial was not labeled with the date the multidose vial was opened or labeled with the expiration date. The surveyor stopped the nurse from administering the potentially expired Lispro insulin. During an interview on [DATE] at 8:30 A.M., Nurse #7 said she thought the expiration date for opened vials of insulin was 29 days. She said she did not look at the vial to determine when it was opened and due to expire.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30889 Based on observation and interview the facility failed to properly label and store medications on 2 of 3 units. Findings include: 1. On 9/7/21 at 10:21 A.M., during inspection of the medication cart on the East side of the 3rd floor unit with Nurse #17, revealed the following: * A bottle of Trazodone suspension in the top drawer of the med cart. The bottle was clearly labeled must be refrigerated. * An opened multidose vial of Novolog insulin not labeled with date or time it was opened or labeled with a resident's name. * an opened multidose vial of Lantus insulin, not labeled with the date opened or expiration date. During an interview on 9/7/21 at 10: 30 A.M. Nurse #17 said that the Trazodone solution is given at night so its been in the cart since last evening, but should have been refrigerated after use. Nurse #17 also said that all insulins, once opened expire in 28 days and should be discarded. 41105 2.) During an observation on the 3rd floor unit on 9/15/21 at 5:02 A.M., both medication carts were observed to be unlocked. No staff were present and the surveyor was able to open/access both medication carts. During an interview with Nurse #22 on 9/15/21 at 5:10 A.M., he said that he was the only nurse on the unit and responsible for both medication carts. Nurse #22 said that they were supposed to be locked at all times when unattended. During an interview with the Director of Nursing (DON), facility Administrator and facility Corporate Nurse (CN) #1 on 9/15/21 at 1:30 P.M., the DON said that it was the policy and expectation that the medication carts be locked at all times. 3.) For Resident #52 the facility failed to keep his/her inhaler securely locked in a medication cart. Resident #52 was admitted to the facility in October 2018, and had diagnoses that included Chronic Pulmonary Embolism. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that on the Brief Interview for Mental Status (BIMS) exam Resident #52 scored 7 out of a possible 15, indicating moderately impaired cognition. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on the 3rd floor unit on 9/03/21 at 1:12 P.M., the surveyor observed an unattended box containing a Flovent Inhaler on the nursing station countertop labeled with Resident #52's name. During an interview on 9/3/21 at 1:13 P.M., Nurse #3 said I have been looking for that medication everywhere and couldn't find it. Resident #52 really needs it and I didn't have it today. I must've left it there and forgot. Nurse #3 said that medication was supposed to always be locked in the medication cart and that Resident #52 did not independently administer his/her own medication. Nurse #3 then went to Resident #52 and administered the medication. A facility corporate nurse was present at the time of the interview but did not interject.

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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. 41105 Based on observation and interview, the facility failed to ensure residents were served meals that were palatable and at appropriate temperatures on 3 of 3 resident units. Findings include: During initial screening on 8/31/21, multiple residents on 2 of 3 resident care units reported issues with food taste and temperature. During a resident group meeting on 9/01/21 at 2:06 P.M., 9 of 14 residents reported that the food at the facility was cold. During an observation on the first floor unit on 9/1/21 at 11:45 A.M., revealed the following: * 9/1/21 at 11:45 A.M., Three lunch trays were delivered to the floor on an open cart. * 9/1/21 at 12:00 P.M., Nurse #17 moved the open cart containing the residents' lunch trays, to the door outside the kitchen. * 9/1/21 at 12:02 P.M., Nurse #17 began delivery of the trays to each resident's room. * 9/1/21 at 12:06 P.M., Nurse #17 finished delivery to each resident's room. *9/1/21 at 12:06 P.M. a test tray was conducted and revealed the following: - Egg/cheese/meat casserole was 125 degrees and lukewarm, not palatable. - 1 stuffed shell was 120 degrees and lukewarm, not palatable. -Peas were 118 degrees and cool, not palatable. -Coffee was 134 degrees and warm. - Pureed meat was 104 degrees and was lukewarm, bland in taste , not able to identify what meat it was, not palatable. -Pureed peas were 118 degrees cool, not palatable. - Mashed potatoes were 122 degrees and lukewarm, not palatable. - Cranberry juice was 64 degrees and cool. - Milk was 50 degrees and cool. - Vanilla ice cream was 22 degrees and beginning to get soupy in texture. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/1/21 at 12:13 P.M., Nurse #17 said he didn't realize that the open cart contained the lunch trays for this shift. He said he should have checked and delivered the meals right away to be sure food did not get cold. During an observation on the third floor unit on 9/2/21 at 8:18 A.M., a test tray was conducted: -The coffee was 119 degrees and tasted lukewarm; -The eggs were 100 degrees and tasted warm and rubbery; -The puree food was 99 degrees and tasted lukewarm. It was unidentifiable by taste and staff said that they did not know what it was; -The milk was 65 degrees and tasted cool; -The juice was 61 degrees and tasted cool; -The oatmeal was 99 degrees and tasted lukewarm and bland; -The toast was 61 degrees and tasted cool. There was no condiment to put on the toast. During an observation on the second floor unit on 9/2/21 at 12:36 P.M., a test tray was conducted: - The coffee was 132 degrees and tasted diluted by water; - The milk was 64 degrees and tasted cool; - The cranberry juice was 60 degrees and tasted cool; - The vanilla ice cream was 38 degrees and was soft/not frozen; - The stuffed cheese shell was 110 degrees; - The pureed green beans were 98 degrees; - The pureed beef quiche was 100 degrees; - The mashed potatoes were 112 degrees.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, interview and record review, the facility staff failed to ensure for one Resident (#70) out of a sample of 37 Residents that beverages with meals were provided in accordance with the physician's order. Findings include: According to the policy titled Therapeutic Diets, revised November 2015, indicated the following: *Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered therapeutic diets. Examples of therapeutic diets include, altered consistency diet. *A therapeutic diet must be prescribed by the resident's Attending Physician; the Physician's diet order should match the terminology used by Food Services. *Routine menus are planned by the Food Services Manager and approved by a Registered Dietician for nutritional adequacy. The Food Services Manager will establish and use a tray identification system to ensure that each resident receives his/her diet as ordered. Resident #70 was admitted to the facility in August of 2018 with diagnoses that included dementia, psychotic disorder, anxiety, and depression. Review of Resident # 70's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident scored a 99 on the Brief Interview for Mental Status (BIMS) and had severe cognitive impairment and that the Resident is rarely or never understood. Resident #70's medical record indicated a Physician's order for Puree texture with Nectar Thick liquids. Review of Resident # 70's care plan initiated in 8/11/18 indicated he/she has chewing and swallowing difficulties with an intervention to provide diet as ordered. During an observation on 9/3/21 at 1:03 P.M., Resident #70 was in the dining room having lunch. Certified Nursing Assistant (CNA) #4 was seated next to the Resident #70 assisting him/her to drink coffee. Resident #70 started coughing, the Surveyor observed Resident #70's coffee was not thickened. Nurse #11 immediately checked Resident #70's drink and told CNA#4 his/her coffee was not Nectar thick. CNA # 4 told Nurse #11 she had no idea Resident #70's drinks should be Nectar thick during meals. During an observation on 9/7/21 at 12:20 P.M., Resident #70's lunch tray was delivered by Nurse #7, the slip on the lunch tray indicated all liquids should be Nectar thick. Nurse #7 proceeded to give Resident #70 a sip of cranberry juice without thickener, the surveyor interrupted Nurse #7 and asked if she had read Resident #70's slip on the lunch tray. During an interview on 9/7/21 at 12:25 P.M., Nurse #7 reviewed the slip on the Resident's lunch tray and said all of Resident's drinks should be Nectar thick. Nurse #7 acknowledged that the drink was not Nectar thick as ordered. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43807

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41105 Based on observation and interview, the facility failed to ensure staff handled cups in accordance with professional standards for food service safety, putting Residents at risk. Findings include: During an observation on the 2nd floor unit on 11/10/21 at 12:07 P.M., the surveyor observed the lunch tray pass and the following was observed: * At 12:10 P.M., a Certified Nursing Assistant (CNA), without performing hand hygiene, picked up a cup by the lip, contaminating the lip of the cup, filled it with a beverage and then served it to a resident. * At 12:13 P.M., a CNA, without performing hand hygiene, picked up a cup by the lip, contaminating the lip of the cup, filled it with a beverage and served it to a resident. * At 12:17 P.M., a CNA, without performing hand hygiene, picked up a cup by the lip, contaminating the lip of the cup, filled it with a beverage and served it to a resident. * At 12:18 P.M., a CNA, without performing hand hygiene, picked up a cup by the lip, contaminating the lip of the cup, filled it with a beverage and served it to a resident. * At 12:20 P.M., a CNA, without performing hand hygiene, picked up a cup by the lip, contaminating the lip of the cup, filled it with a beverage and served it to a resident. * At 12:21 P.M., a CNA, repositioned a resident's legs on wheelchair leg rests. Then, without performing hand hygiene, picked up a cup by the lip, contaminating the lip of the cup, and handed it to the resident, who drank the beverage. * At 12:23 P.M., a CNA, without performing hand hygiene, picked up a cup by the lip, contaminating the lip of the cup, filled it with a beverage and served it to a resident. During an interview with the Director of Nursing on 11/10/21 at 2:19 P.M., the observations made at lunch were shared with her. She stated that handling the cups in that manner would contaminate the cups and that education would need to be provided top the staff.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41105 Based on observations and interviews, the facility failed to ensure it was administered in a manner that enabled the facility to use its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to (1.) Safely and adequately staff the facility (2.) Conduct COVID-19 outbreak testing in the middle of a COVID-19 outbreak (3.) Maintain an accurate facility assessment identifying resources needed to care for residents. Findings include: 1.) On 8/31/21 through 9/8/21 the survey team identified that the facility was not sufficiently or competently staffed resulting in neglect. During interviews throughout the day on 9/8/21, Administrator #1 said there were no competencies on file for any of the nursing staff for 2020 or 2021. 2.) The facility did not have a facility assessment to determine appropriate staffing levels. They were unable to provide the survey team with a plan to resolve these issues. 3.) On 9/15/21 the survey team returned to the facility and it was determined that the facility was in the middle of a COVID-19 outbreak, and failed to launch outbreak testing as required. Despite Administrator #1 and corporate nursing staff voicing knowledge of the facility-wide concerns, the facility's administrative team and governing body did not provide the services necessary to meet the needs of residents. See F838, F843, F868, F880, F881, F886, F887

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F 0838 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 40928 Based on document review and interview, the facility failed to maintain a complete and accurate Facility Assessment to reflect resident needs and staffing patterns and required competencies. Findings include: Review of facility document titled 'Facility Assessment Portfolio' dated August 2021 indicated the following: * Staffing plan- See attached Further review of the Facility Assessment failed to include any attachments or a staffing plan. * Staff Competency- Part 3 of the Facility Assessment indicated Facility resources needed to provide competent support and care for the resident population everyday and during emergencies and included facility staff members health care professionals and medical practitioners. The competency section did not include temporary nursing agency staff and did not provide what areas of nursing care they were required to be competent in. During an interview on 9/7/21 at 1:50 P.M., Administrator #1 said that there is no staffing assessment or plan for the facility. Administrator #1 was unable to provide the surveyor with a staffing assessment or plan or a contingency staffing plan. Administrator #1 was unable to say how they determine adequate staffing for the facility based on residents needs. During an interview on 9/15/21 at 7:36 A.M., Administrator #1 said that there had been no updates to the facility assessment or staffing plan that she was aware of. Administrator #1 said that she was working off a hand written formula to determine staffing. Administrator #1 was unable to answer how the facility determines average staffing ratios based on population and census and said that she had not gotten any assistance in determining this. 41105

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37565 Based on record review and interview, the facility failed to maintain accurate medical records for 4 Residents (#3, #51, #73 and #86) from a total of 37 residents. Findings include: 1. Resident #3 was admitted to the facility in 9/2019 with an anxiety disorder, depression, psychotic disorder, obsessive compulsive disorder, alcohol abuse and pain. Review of the medical record indicated a MOLST (Massachusetts Medical Orders for Life-Sustaining Treatment) dated 1/4/21 and was signed by Resident #3 and Nurse Practitioner #2. The document indicated in the event of a cardiac or respiratory arrest, attempt resuscitation, intubate and ventilate, use non-invasive ventilation and transfer to the hospital. Review of the current care plan for Resident #3 indicated a focus: in the event my heart stops, I do not wish to be resuscitated. I would like no extraordinary measures to be taken. Date initiated: 10/1/19. The goal of the focus was the Resident's wishes would be honored as documented in the medical record. Date initiated 10/1/19. Target Date: 8/24/21. The interventions were to be sure there is a Physician's order in the medical record to verify and honor these wishes. Honor my MOLST Form, it is present in my medical record. My medical record is marked per facility policy to honor my wishes. My wishes will be reviewed quarterly at my interdisciplinary care conference. I have been educated that I may change my wishes at any time. At my request please contact clergy for me. Date initiated: 10/1/19. The current Physician orders for MOLST is Full Code, dated 7/29/21. During an interview 9/8/21 at 12:15 P.M. Nurse Practitioner #2 said she was not aware of the discrepancy in the plan of care and would address it with nursing. 40928 2. Resident #86 was admitted to the facility in 3/2018 with diagnoses including chronic kidney disease and anxiety disorder. Review of Resident #86's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident was cognitively intact and scored a 15 out of 15 on the Brief Interview for Mental Status Exam. Further review of Resident #86's MDS indicated that the Resident required assistance with care activities and that the Resident required dialysis (a procedure to remove waste products and excess fluid from the body when kidneys stop working properly). Review of Resident #86's medical record indicated the following: -a progress note dated 5/6/21: Change in Resident's dialysis schedule: Will be going Tue, Thu and Sat. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A physician's order dated 5/6/21 for dialysis Tue, Thu, Sat -A physician's order dated 5/5/21: Lidocaine-prilocaine 2.5-2.5% (a topical numbing cream). Apply to right arm fistula (a connection between an artery and a vein used for dialysis) topically one time each day every Mon- Wed- Fri apply 1 hour before going to dialysis. Review of Resident #86's August 2021 Medication Administration Record (MAR) indicated the Resident received Lidocaine-prilocaine 2.5-2.5% every Monday, Wednesday and Friday in the month. During an interview on 9/01/21 at 4:39 P.M., Resident #86 said he/she attends dialysis on Tuesday, Thursday and Saturday. Resident #86 said he/she does not get any cream applied to his/her right arm fistula prior to dialysis. During an interview on 9/02/21 at 10:49 A.M., Nurse #1 said she has been Resident #86's nurse many times and knows him/her well. Nurse #1 said the Resident gets Ativan (an anti anxiety medication) prior to dialysis but there are no other orders for medications or treatments prior to dialysis. Nurse #1 said the Resident attends dialysis on Tuesday, Thursday and Saturday. Nurse #1 said that there are no topical creams that are applied to the Resident. Nurse #1 said the Resident usually gets picked up around 11:15 A.M. and comes back to the facility in the afternoon. On 9/02/21 at 11:10 A.M., Resident #86 said she was waiting to be picked up for dialysis. Resident #86 showed the surveyor his/her arms. No cream had been applied to the fistula site. During an interview on 9/02/21 at 1:27 P.M., Nurse #1 said the lidocaine-prilocaine is not something that is administered in the facility. Nurse #1 said the Resident has not gotten that cream. Nurse #1 said that it shouldn't be signed off on the MAR if it's not given. During an interview on 9/02/21 at 3:06 P.M., Nurse #2 said she has provided care for the Resident. Nurse #2 said she had not administered the cream to Resident #86 even though she had documented that she had given it. Nurse #2 acknowledged that the Resident did not attend dialysis on the dates listed on the order and would not require a topical numbing cream on non-dialysis days. Nurse #2 said that she had documented that she had given the cream but had actually not administered it. 43882 3. For Resident #73 The facility failed to accurately document Activities of Daily Living Records (ADL's). Review of the facility policy titled, Charting and Documentation, dated 2017, indicated: -All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. -Review of the facility policy titled, Charting errors and/or omissions, dated 2017, indicated: -Accurate medical records shall be maintained by this facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #73 was admitted to the facility in August 2020 with diagnoses including morbid obesity, chronic pain syndrome, and peripheral vascular disease. Review of Resident #73's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that he/she is cognitively intact with a score of 15 out of possible 15 on the Brief Interview for Mental Status (BIMS). The MDS also indicated Resident #73 required extensive assistance for personal hygiene and that it was very important for him/her to be able to choose between a shower, bed bath and sponge bath. During an interview on 08/31/21 at 8:35 A.M., Resident #73 said he/she has not had a shower in months. Review of Resident #73's medical record, indicated that showers were documented as being given on 8/13/21, 8/17/21, 8/20/21, 8/27/21, and 8/31/21. During an interview on 9/1/21 at 10:57 A.M., with Certified Nursing Assistant (CNA) #16 said she had provided care for Resident #73 and said showers are scheduled twice a week. CNA #16 also said if residents refuse a shower, she will reapproach the resident to try again, make the nurse aware and document the refusal. CNA #16 said Resident #73 had not had a a shower as documented and that she was unsure when Resident #73 last had a shower. CNA #16 also said showers were documented under the shower task. 4. For Resident #51 the facility failed to document per policy following a fall. Review of the facility policy titled, Charting and Documentation, dated 2017, indicated: -All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. Review of the facility policy titled, Charting errors and/or omissions, dated 2017, indicated: -Accurate medical records shall be maintained by this facility. -If it is necessary to change or add information in the resident's medical record, it shall be completed by means of an addendum and signed and dated by the person making such change or addition. -Late entries in the medical record shall be dated at the time of entry and noted as a late entry for _____ the date the entry should have been entered. Resident #51 was admitted to the facility in August 2020 with diagnoses including, acute kidney failure, osteoarthritis, scoliosis, and adult failure to thrive Review of Resident #51's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that he/she is cognitively intact with a score of 13 out of possible 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS indicated extensive assistance for bed mobility, transfers, and toileting. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's progress notes dated 9/8/21, indicated that Resident #51 had a fall and was transferred to the hospital. On further review it was indicated this progress note was an inaccurate late entry from an incident on 8/28/21. During an interview on 9/8/21 at 9:38 A.M., the Interim Director of Nursing said the expectation for nursing documentation is any intervention should be documented and addendums should be expected to be documented within 24 hours.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 41105 Based on record review and interview the facility failed to maintain in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid program. Findings include: Between 8/31/21 and 9/8/21 the surveyor, multiple times, requested documentation of a transfer agreement with a hospital from Administrator #1 and the Corporate Nurse (CN) #1, however they were unable to provide one. During an interview on 9/8/21 at 11:30 A.M., Administrator #1 said that she was unable to find a hospital transfer agreement

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40928 Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee consisted of the required members. Review of facility document titled 'Quality Assurance and Performance Improvement (QAPI) Process and Plan Description', revised 2019 indicated the following: *QAPI Framework: All department managers, the administrator, the director of nursing, infection control preventionist, Medical Director, consulting pharmacist, resident and/or family representatives (if appropriate) and three additional staff members will provide QAPI leadership by serving on the QAA committee. Review of the facility's QAA Meeting Attendance Signature Sheets indicated the following: -An attendance signature sheet dated January 2021 failed to indicate the Director of Nursing or designee attended. -An undated attendance signature sheet (filed under the April 2021 section of the QAA binder) failed to indicate the Administrator attended. During an interview on 9/8/21 at 1:02 P.M., Administrator #1 acknowledged the attendance signature sheets were missing signatures from some of the required members and that she believed the undated signature sheet was from the April 2021 quarterly meeting.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, interview and document review, the facility failed to 1) ensure staff wore appropriate Personal Protective Equipment (PPE), during a COVID-19 outbreak, while providing care to decrease the risk of spread of infection related to the Covid-19 virus, 2) implement Transmission Based Precautions (TBP) for 1 of 1 applicable unvaccinated new admission (#139) from a hospital setting, 3) ensure staff performed Binax (rapid testing for Covid-19 virus) in a private setting to reduce the potential spread of infection, 4) ensure laundry staff properly donned appropriate PPE when handling soiled linen and properly performed hand hygiene after handling soiled linens to decrease the risk of spread of infection, 5) ensure there was an active Infection Control Committee (ICC) in place and failed to ensure infection control policies were signed and dated on an annual basis, and 6) ensure that 2 of 6 nurses (Nurse #7 and Nurse #16) performed hand hygiene properly during medication administration. Findings include: 1) The facility failed to ensure staff wore appropriate PPE, during a COVID-19 outbreak, while providing care. Review of facility document titled 'COVID-19 Outbreak Checklist', undated, indicated that if the facility identifies one new resident or staff case then the facility should take the following steps to mitigate any further transmission: * Personal Protective Equipment (PPE) and Hand Hygiene: - Use gowns and gloves for high contact care activities in addition to facemasks and eye protection for COVID-19 negative residents - Post precaution signs immediately outside of resident rooms indicating appropriate infection control and prevention precautions. Review of the facility PPE Guide Card, dated 10/27/20, indicated that if there are COVID-19 cases in the facility in the last 14 days, gowns and gloves are also recommended for any high contact care. During an interview with Administrator #1 and the Interim Director of Nursing on 9/15/21 at 6:55 A.M., the Interim Director of Nursing said that the facility was currently experiencing an outbreak of COVID-19. She said that a staff member Certified Nursing Assistant (CNA) #1 who worked on the 2nd floor unit had been tested on [DATE] as part of surveillance testing and the facility was notified of the positive COVID-19 result on 9/11/21. During an observation on the 2nd floor unit (the unit on which the positive staff member had worked) on 9/15/21 at 5:15 A.M., CNA #19 was observed bringing a bag full of soiled sheets out of a resident room. CNA #19 was only wearing a mask. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/15/21 at 5:17 A.M., CNA #19 said he just changed a resident. He said the resident had been incontinent. CNA #19 said he thought that because he was vaccinated, he only had to wear a mask. On 9/15/21 at 5:16 A.M., CNA #18 was observed in a resident's room, gathering soiled linens. CNA #18 was wearing a mask, goggles and gloves. CNA #18 was not wearing a precaution gown. During an observation on the 3rd floor unit on 9/15/21 at 5:02 A.M. the following observations were made: -Nurse #19 and 2 Certified Nursing Assistants (CNAs) (#12 and #15) were on the unit. None of the staff members were wearing eye protection of any type. -There was no signage on the unit to indicate that there had been a positive COVID-19 case in the facility in the past 14 days. -CNA#15 was wearing a mask under her nose and no eye protection while going in and out of occupied resident rooms. -At 5:20 A.M., CNA #12 and CNA#15 were observed providing direct care to residents in separate resident rooms not wearing eye protection or gowns. During an interview on 9/15/21 at 5:10 A.M., Nurse #19 said he was not aware of any COVID-19 positive cases in the facility. During an observation on 9/15/21 at 6:50 A.M., Nurse #19 was observed providing G-Tube care to a resident and Nurse #19 was not wearing a gown. On 9/15/21 at 8:26 A.M., an observation on the 2nd floor unit, revealed that staff had not posted the proper transmission-based precautions that indicates the proper PPE requirements during a COVID-19 outbreak on any of the resident rooms. There were not precaution carts set up on the unit to ensure staff would be able to access the proper PPE. During an interview on 9/15/21 at 8:40 A.M., Certified Nursing Assistant (CNA) #11 said they don't have any precaution gowns on the floor. CNA #11 said they used to keep at least one big precaution cart at the elevator, but that's been gone for a while now. During an interview on 9/15/21 at 9:00 A.M., Nurse #11 said that there is a new staff case of COVID-19 within the last few days. Nurse #11 thought she only had to wear just the mask and goggles for all care. She said she didn't know the requirements changed. During an interview on 9/15/21 at 9:15 A.M. Consultant Nurse #3 said they posted signage over the weekend and staff should be wearing a gown with high contact care. During an observation on 9/15/21 at 9:30 A.M., on the 2nd floor unit, with Consultant Nurse #3, revealed that there were no posted signs to indicate that the facility was in a COVID-19 outbreak on any resident room and there were no precaution carts set up to ensure staff had the appropriate PPE they needed to provide care. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Administrator #1, the Interim Director of Nursing and Corporate Nurse #1 on 9/15/21 at 11:31 A.M., the Interim Director of Nursing said that staff should be wearing full PPE during any direct care they are providing. The Interim Director of Nursing said full PPE would include a mask, eye protection, a gown and gloves. The Interim Director of Nursing said there should be signs on the unit indicating the facility was experiencing an outbreak of COVID-19. The Interim Director of Nursing further said the facility had enough PPE and had a large supply of disposable gowns. See tag F886 30889 2) The facility failed to implement Transmission Based Precautions (TBP) for 1 of 1 applicable unvaccinated new admissions (Resident #139). Review of the [NAME] Summary of Centers for Disease Control (CDC) Personal Protective (PPE) Guidance, dated 10/27/20, indicated that new admissions should be quarantined, and staff should don full PPE (face mask, gowns, face shield, eye protection and gloves) when caring for these residents. On 8/31/21 at 10:15 A.M., during observation on the 2nd floor unit revealed Resident #139, a new admission from a hospital, who also had not received a vaccine for Covid -19, lying in his/her bed. There was no signage on his/her bedroom door to indicate he/she should be on TBPs or any cart setup with PPE supplies. On 8/31/21 at 10:20 A.M., Nurse #15 said that Resident #139 was a new admission and should be on precautions. She said she wasn't sure why he/she was not because she doesn't always work on this unit. On 8/31/21 at 4:15 P.M., during observation on the 2nd floor unit, revealed that there was no precaution cart set up or TBP signage outside of Resident #139's room. On 9/1/21 at 8:15 A.M., during observation on the 2nd floor unit, revealed that there was no precaution cart set up or TBP signage outside of Resident #139's room. During an interview on 9/1/21 at 3:05 P.M., Certified Nursing Assistant (CNA) #2 said she worked on the East side of the 2nd floor unit and there are no residents on precautions on this side of the unit as far as she knew. During an interview on 9/1/21 at 3:15 P.M., Nurse #11 said there isn't anyone on precautions. When the surveyor asked about Resident #139, Nurse #11 said that he/she is in with another resident so he/she can't be on precautions. Nurse #11 said anyone on precautions is in a private room. During an interview on 9/1/21 at 3:35 P.M., the Staff Development Nurse/Infection Preventionist (SDC/IP) said that any new admission should be in a room alone and quarantined. She said that staff should don full PPE when entering the residents room. The surveyor asked why Resident #139 was admitted to a room with a roommate. The SDC/IP said she did not know why. During an interview on 9/1/21 at 3:40 P.M., the Corporate Nurse said that a new admission, unvaccinated from the hospital, should have been monitored and in a room alone. (continued on next page)

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Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) The facility failed to ensure staff performed Binax testing (rapid testing for Covid-19 virus) in a private setting to reduce the potential spread of infection. Findings include: On 9/7/21 at 8:42 A.M., during observation of the lobby area of the facility, revealed Housekeeper #1 performing Binax testing in the lobby corridor in the presence of another staff member. The surveyor observed as she pulled her mask down, inserted the Binax swab into her nostril and performed the test. Once she finished swabbing her nostrils, she held the swab in the air before placing it into the Binax card. Simultaneously, Housekeeper #2, who was approximately 2 feet from Housekeeper #1, pulled down her mask, inserted the Binax swab into her nose and once she finished swabbing her nostrils, with the swab exposed to the air, she placed it into the Binax card. During an interview on 9/7/21 at 8:45 A.M., Housekeeper #1 said that this is how they always do it. She said there are no private places to go. Housekeeper #1 said she couldn't go into the offices across from the lobby because they were not allowed. During an interview on 9/7/21 at 8:50 A.M., Receptionist #1 said that staff can go into the offices. Receptionist #1 said staff know they are supposed to conduct the testing in private. On 9/15/21 at 4:10 P.M., the surveyor observed an unidentified staff member in the lobby, self-performing Covid-19 Binax testing. Several staff members passed through as this staff member pulled down her mask, performed nasal swabbing and held the Binax swab in her hand, open to air, then she placed the swab in the Binax card to await results. During an interview on 9/15/21 at 4:15 P.M., the surveyor asked the Interim Director of Nursing (IDON), if she saw the unidentified staff member perform Binax testing in the lobby. The IDON said that she did, and staff need to be in a private space. The IDON said she thought she had curtailed that practice, but obviously did not. 4) The facility failed to ensure laundry staff properly donned appropriate PPE when handling soiled linen and properly performed hand hygiene after handling soiled linens to decrease the risk of spread of infection. On 9/8/21 at 11:13 A.M., during observation of the laundry area, revealed Laundry Worker (LW) #1 wearing a sleeveless T-shirt, shorts, gloves, mask and goggles. LW #1 lifted dirty blankets and sheets out of a soiled bin and carried them to the washing machine. The soiled linen touched his T-shirt - therefore contaminating his T-shirt. LW #1 then removed his gloves, and without performing hand hygiene, began folding clean johnnies. The [NAME] was pressed up against his contaminated T-shirt. When the surveyor asked him about the process of hand hygiene, he went into the soiled linen room and began washing his hands in a sink that was filled with soiled laundry, touching his hands with the contaminated linens. During an interview on 9/8/21 at 11:35 A.M., LW #1 said that he should have put on a gown before picking up the soiled linen. He said its very busy and sometimes he forgets. LW #1 said he tries to keep the soiled linens separate and because the area is small, he keeps the soiled johnnies in the handwashing sink. 5) The facility failed to ensure there was an active Infection Control Committee (ICC) in place and failed to ensure infection control policies were signed and dated on an annual basis. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/8/21 at 12:07 P.M., during review of the Infection Control book (given to the surveyor by the Interim Director of Nursing), lacked identification of the Infection Control Committee members, ICC meeting minutes or comprehensive policies related to infection prevention. The last date noted on the policies that were in the book was 2017. There was no indicator that an ICC signed and approved any infection control policies within the last 12 months. During an interview on 9/8/21 at 12:07 P.M., the Interim Director of Nursing said that the facility does not have a designated Infection Control Committee. She said that there has been changeover in the nurse management staff over the last several months. She said that approximately 3 weeks ago the SDC/IP from a sister facility came to this facility but has done little thus far in the way of infection control. 6) The facility failed to ensure that 2 of 6 nurses (Nurse #7 and Nurse #16) performed hand hygiene properly during medication administration. Review of the facility policy, entitled Injectable Medication Administration, not dated, indicated that staff must wash hands prior to preparation of medication. A. On 9/1/21 at 8:05 A.M., during observation of the medication pass on the 3rd floor unit, revealed Nurse #7 as she was preparing medications for administration to a resident. Nurse #7 finished preparing medications for a resident that contained an inhaler, insulin for injection and several by mouth medications. Nurse #7 had all the medications in her hand and realized she needed to change the insulin for injection. Nurse #7 discarded the original syringe of insulin and began searching through the medication cart for another vial of insulin. Once she found the correct insulin vial, she placed it on the med cart and without performing hand hygiene, she prepared a new syringe of insulin to inject the resident. Nurse #7 was called away to assist another resident. Nurse #7 placed all the medications in the medication cart and went to the resident. Nurse #7 returned to the medication cart, and without performing hand hygiene, she took the by mouth medications, the inhaler and the insulin filled syringe and proceeded to another resident's room to administer the medications. During an interview on 8:40 A.M., Nurse #7 said it was just so busy, she forgot to use the hand sanitizer after handling medications and then preparing new medications. B. On 9/1/21 at 9:18 A.M., during observation of the medication pass on the 3rd floor, revealed Nurse #16 as she was preparing medications for administration to a resident. Nurse #16 took the prepared medications (all by mouth medications) and entered the resident's room. Nurse #16 adjusted the resident's bed linen and questioned the resident in regard to another medication. Nurse #16 left the resident's room with medications in hand, placed them on the medication cart and without performing hand hygiene, opened the medication cart and prepared another medication for the resident. During an interview on 9/1/21 at 9:22 A.M., Nurse #16 said that she should have washed her hands before preparing the next medication.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 30889 Based on interview and infection control documentation review, the facility failed to ensure that a facility-wide antibiotic stewardship program was established to monitor the appropriate use of antibiotics. The facility failed to demonstrate staff accountability for oversight of educating and training staff about antibiotic stewardship. Findings include: During an interview on 9/8/21 at 12:07 P.M., the Interim Director of Nursing (IDON) said that the Infection Preventionist (IP) was not available for interview as she was not in the facility. The IDON said that she would assume education was conducted regarding antibiotic stewardship, but she couldn't locate it. The IDON said that because they don't have a formal Infection Control Committee (ICC), they have not met to discuss antibiotic stewardship. She was unable to locate any meeting minutes relative to antibiotic stewardship or any staff education regarding antibiotic stewardship. The IDON provided the surveyor with a list of antibiotics dispensed to the facility from 6/2021- 7/2021 which included the following: June 2021: Antibiotic Stewardship Compliance Rate: 78.57% July 2021: Antibiotic Stewardship Compliance Rate: 50.00% During an interview on 9/8/21 at 12:25 P.M., the surveyor asked if the decrease in Antibiotic Stewardship Compliance from 6/2021 to 7/2021 was reviewed. The IDON said that they had not met as the ICC therefore have not discussed Antibiotic Stewardship. The IDON said there was an Assistant Director of Nursing (ADON) who tracked all these things, but she was burnt out from covering shifts and left a few months ago. The IDON said the former Director of Nursing left after 3 weeks and as far as the IP, she wasn't sure when she started, but the IP hadn't submitted any reports related to infection control yet. The IDON also said that there had been no Infection Control topics discussed at Quality Assurance Performance Improvement (QAPI) except for discussion about Covid-19.

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on interview and document review, the facility failed to ensure staff were tested for Covid-19 as indicated, in response to a Covid-19 outbreak in the facility. Findings include: 1) Review of facility policy titled 'Long Term Care Surveillance Testing', dated 9/15/21, indicated the following: * Surveillance Testing Program: If the staff testing results indicate a positive COVID-19 staff member, then the provider must conduct outbreak testing of all residents and staff, including those who are fully vaccinated and those who are not, to ensure there are no resident cases and to assist in proper cohorting of residents. Testing must take place as soon as possible and within 48 hours. Review of facility document titled 'COVID-19 Outbreak Checklist', undated, indicated that if the facility identifies one new resident or staff case then the facility should take the following steps to mitigate any further transmission: *Testing: Once a new case is identified, the facility should initiate outbreak testing. Outbreak testing should include: -Testing all staff and residents as soon as possible and no later than 48 hours after identification of the positive. This testing should include a molecular test (i.e., PCR) for affected units. During an interview with Administrator #1 and Interim Director of Nursing on 9/15/21 at 6:55 A.M., the Interim Director of Nursing said that the facility was currently experiencing an outbreak of Covid-19. She said that Certified Nursing Assistant #1 had been tested on [DATE] as part of surveillance testing and that the facility was notified of the positive Covid-19 result on 9/11/21, 4 days after the test was conducted. During an interview on 9/15/21 at 11:31 A.M., Administrator #1 said the following: -She was notified of a positive case of Covid-19 in CNA#1 on Sat. [DATE]th in the evening. Administrator #1 said CNA#1 had been tested on [DATE], as a part of routine surveillance testing, and the facility received the positive Covid-19 results on 9/11/21. -Administrator #1 said that the facility initiated outbreak testing for residents on 9/11/21 and for employees on 9/12/21. Administrator #1 said that as of the 11:31 A.M. interview, some employee PCR tests had been obtained and others were still being collected. None of the collected employee tests had been sent out to the lab for processing. -Administrator #1 was unable to say how many staff still needed to be tested . (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Administrator #1 said she doesn't have a way to send out mass notifications to staff to inform them of a positive Covid-19 test in the facility and to notify them to come to the facility for testing. She said she tries to capture staff when they arrive for work. Administrator #1 further said that since receiving the positive result on 9/11/21, not all staff had been tested . -Administrator #1 acknowledged that it was Day 4 of the Covid-19 outbreak and that the facility had not yet tested all staff or sent any employee tests out to the lab for processing. During interviews throughout the day on 9/15/21, the Interim Director of Nursing acknowledged the facility had the ability to do Binax testing (a rapid Covid-19 test that shows results within 15 minutes) but that they had chosen to do PCR testing for outbreak testing. The Interim Director of Nursing further said the following: -The facility had chosen to do Covid-19 testing, and not contact tracing, in response to the outbreak and that she was unable to say how many staff members had been tested and how many still needed to be tested . -The facility's Infection Control Nurse was out of work currently and that she would be covering until they could get a replacement. -That she had spoken with the Department of Public Health (DPH) Epidemiologist on Tuesday (9/14/21) in the late afternoon but could not recall what the conversation was. She couldn't recall if she told the Epidemiologist that the employee test specimens were still in the facility and that not all staff had been tested . The Interim Director of Nursing couldn't recall if the Epidemiologist asked her if staff had been tested . The Interim Director of Nursing said she still needed to review the Epidemiologist's email from the previous day that outlined what they had discussed regarding Covid-19 outbreak management. 41105 30889

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F 0887 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30889 Based on interview and record review, the facility failed to ensure that 1.) 4 sampled residents (#27, #29, #31 and #80) out of a total sample of 37 residents and 4 additional residents (#18, #33, #54 and #71) received education and were offered the Covid-19 vaccine and 2.) Two additional residents (#35 and #68) received their second Covid-19 vaccine. Findings include: During an interview with Administrator #1 and Interim Director of Nursing on 9/15/21 at 6:55 A.M., the Interim Director of Nursing said that the facility was currently experiencing an outbreak of Covid-19. She said that a staff member (CNA #1) had been tested on [DATE] as part of surveillance testing and the facility was notified of the positive COVID-19 result on 9/11/21. During an interview on 9/8/21 at 12:30 P.M., the Interim Director of Nursing said that there are 11 residents that have not been vaccinated for COVID-19. She said she is not aware why they have not been vaccinated, but that she would look into it. The Interim Director of Nursing said that she also had 2 residents that had only received one of the two required Covid-19 vaccinations. The Interim Director of Nursing said she did not know why but was in the process of communicating with the Medical Director as to what should be done for those two residents. During an interview on 9/15/21 at 4:00 P.M., Corporate Nurse #1 said that 3 of the 11 residents that the Interim Director of Nursing said were not vaccinated, were in fact vaccinated leaving 8 residents (#27, #29, #31 #80, #18, #33, #54 and #71) without any vaccine and 2 residents (#35 and #68) that had received one dose. During an interview on 9/15/21 at 4:05 P.M., the Interim Director of Nursing said that the 8 remaining residents that have not been vaccinated have not received any education or signed an informed consent form. The Interim Director of Nursing said she gave that to the Infection Control Nurse to complete but does not know where the Infection Control Nurse is at with this process. The Interim Director of Nursing further said she was notified that day that the Infection Control Nurse will be out of work until December 2021. The Interim Director of Nursing said she would need to find someone to fill that slot. Review of facility documents indicated the facility had 8 residents who were unvaccinated for COVID-19 and 2 residents who had received one dose of the COVID-19 vaccine. Review of resident medical records indicated the following residents had received one dose of the COVID-19 vaccine: - Residents #35 and #68 Review of medical records failed to indicate the following residents were provided education or informed consent and had not received the COVID-19 vaccine: (continued on next page)

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F 0887 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Residents #27, #29, #31, #80, #18, #33, #54, #71. 40928