STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225523	A. Building B. Wing	05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Glen Ridge	120 Murray Street Medford, MA 02155

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 41019 Based on observation and interview, the facility failed to provide a reasonable accommodation regarding call light accessibility for 1 resident (Resident #42) out of a total sample of 28 residents. Findings include: Resident #42 was admitted to the facility in 01/2016 with diagnoses including contractures of the right elbow, left elbow, right wrist, right hand, left hand, and left wrist. Resident #42 requires the use of a chin touchpad to alert staff. Review of the current care plan indicates the following: * Resident #42 needs a safe environment with a working and reachable call light. * Be sure Resident #42's call light is within reach and encourage to use it for assistance as needed. * Resident #42 is dependent with eating, toileting, incontinence care, and repositioning in bed. Resident #42 needs a total assist of one with personal care. On 5/20/2021 at 9:48 A.M., Resident #42 did not have his/her chinpad in reach. During an interview on 5/20/2021 at 12:04 P.M., Resident #42 said that it is very difficult to get staff attention and that he/she often has to yell out, sometimes for hours, before someone comes to help. On 5/21/2021 at 8:48 A.M., Resident #42 did not have his/her chinpad in reach. On 5/21/2021 at 12:30 P.M., Resident #42 did not have his/her chinpad in reach.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation and interview the facility failed to ensure residents can file a grievance anonymously on 2 out of 4 units. Findings include: During the resident group meeting on 5/20/21, at 11:00 A.M. 4 of 12 residents said that they did not have access to the grievance forms. They said that they were not comfortable voicing grievances because they were afraid of retaliation. They also said that they would be a lot more comfortable voicing their concerns if they could do it anonymously. 1. On 5/20/21, at 1:24 P.M., the surveyor was not able to locate grievance forms accessible to residents without having to ask for the form on the [NAME] unit. During an interview on 5/20/21 at 1:24 P.M., Nurse #4 said that the residents were not allowed to have the grievance forms. She said that if the residents need to voice a grievance, they tell the nurse, and the nurse will write it on the grievance forms. Nurse #4 was not able to locate a grievance form on the [NAME] unit. 40928 2. On 5/20/21 at 12:47 P.M. on the Oak Grove Unit, the Grievance Form binder was observed at the nurse's station desk. The Grievance Form binder was inaccessible to residents During an interview on 5/20/21 at 12:58 P.M., Nurse #6 said if a resident has a concern with care or missing property, the resident will tell a staff member and the staff member will then complete a grievance form and/or notify the social worker. Nurse #6 said that if a resident wants to report something anonymously they can contact the ombudsman. Nurse #6 said that grievance forms are filled out by staff, not residents, and if a resident has concerns and doesn't want staff to know they can notify Ombudsman. During an interview on 5/24/21 at 11:38 A.M., the Executive Director said residents should have access to the grievance forms. The Executive Director said the forms used to be on bulletin boards on the units. Review of facility policy titled 'Grievance Concern' revised 7/01/19 indicated a description of the procedure for voicing grievances/ concerns will be on each unit in a prominent location and must include: - The right to file grievances orally (meaning spoken) or in writing, the right to file grievances anonymously

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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** 36876 Based on observation, record review and interview, the facility failed to identify and assess the use of pillows under fitted sheets as a potential restraint for 2 residents (#37 and #422), out of a total of 28 sampled residents. Findings include: Review of the facility's Restraints Policy, dated 11/1/19 indicated the following: Physical Restraint is defined as any manual method, physical or mechanical device, equipment or material that meets all of the following criteria: *is attached or adjacent to the patient's body *cannot be removed easily by the patient *restricts the patients freedom of movement or normal access to his/her body Patients will be evaluated for the use of restraints or protective devices during the nursing assessment processes. If it is determined that a protective device is being used an an enabler, no further assessment is needed. If the device cannot be easily removed by the patient and/or restricts freedom of movement or normal access to his/her body, the Restraint Evaluation/reduction will be completed. There must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint. A practitioner's order alone (without supporting clinical documentation) is not sufficient to warrant the use of the restraint. Consent must be obtained prior to the application of the restraint. 1. Resident #422 was admitted to the facility in March 2021 with diagnoses including [NAME]-Korsokoff syndrome (a memory disorder), generalized muscle weakness and seizure disorder. Review of Resident #422's Minimum Data Set Assessment (MDS) dated [DATE] indicated that he/she is severely cognitively impaired and required assistance with bathing, dressing and eating and is non-ambulatory. Review of Resident #422's clinical record indicated he/she sustained 4 falls from April 2021 through May 18, 2021. On 5/19/21 at 9:47 A.M., the surveyor observed Resident #422 resting in bed. There were three bed pillows under the fitted bedsheet on either side of Resident #422's body. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/21 at 8:53 A.M., the surveyor observed Resident #422 resting in bed. There were three bed pillows under the fitted bedsheet on either side of Resident #422's body. Review of Resident #422's clinical record failed to indicate that the use of pillows had been assessed for positioning or as a potential restraint for Resident #422. During an interview with Certified Nursing Assistant (CNA) #1 on 5/20/21 at 9:10 A.M., she said that the overnight shift puts the pillows like that for Resident #422. CNA #1 said that they're not supposed to do that unless they have an order for it. CNA #1 said that she wasn't sure, but maybe Resident #422 had fallen. Review of Resident #422's care plans failed to include the use of pillows as a means to prevent falls. During an interview with Unit Manger #1 on 5/21/21 at 7:00 A.M., she said she was not aware that pillows were being put under Resident #422's sheets. Unit Manager #1 said she they should not be put there. 40928 2. Resident #37 was admitted to the facility in December 2020 with diagnoses including dementia and agitation. Review of Resident #37's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had severe cognitive impairment and scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of Resident #37's MDS indicated the resident required assistance with care activities. During observations throughout the day on 5/19/21, Resident #37 was observed lying in bed with pillows under the sheets on both sides of the resident. On 5/20/21 at 8:50 A.M., Resident #37 was observed lying in bed with pillows under the sheets on both sides of the resident. Resident #37 said he/she was uncomfortable and didn't know why there were pillows under the sheets. During an interview on 5/21/21 at 9:54 A.M., Nurse #4 said Resident #37 was care planned to have the pillows on either side of the bed and the pillows are placed under the sheets to make it difficult to remove them. Nurse #4 said that Resident #37 has a tendency to roll out of bed and she thinks that is why the intervention is in place. During an interview on 5/24/21 at 10:54 A.M., the Director of Nursing said she was unsure why there would be pillows under sheets. The Director of Nursing said sometimes body pillows will be placed under sheets as a fall prevention intervention because the pillows will slow residents down. The Director of Nursing acknowledged there was no assessment done of Resident #37's pillows under the sheets to see if the pillows impede movement and there should be an assessment done for any intervention that might impede movement.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on record review and interview, the facility failed to report an allegation of abuse for 1 Resident (#10) out of a total sample of 28 residents. Findings include: Review of the facility policy titled 'Abuse Prohibition' revised 4/09/21, indicated the Center will implement an abuse prohibition program through the following: -Reporting of incidents, investigations, and Center response to the results of their investigations. Resident #10 was admitted to the facility in May 2015 with diagnoses including depression, diabetes mellitus and psychotic disorder Review of Resident #10's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident was cognitively intact and scored a 15 out of a possible 15 on the Brief Interview for Mental Status Exam. Further review of Resident #10's MDS indicated the resident did not have any hallucinations or delusions. Review of Resident #10's nursing progress note dated 1/29/21 indicated the following: -At approximately 4:30 A.M. the Certified Nursing Assistant (CNA) assigned to the resident overheard a loud noise and reported to the nurse that the resident was on the floor in front of the bathroom floor. The nurse asked Resident #10 what happened and Resident #10 said someone pushed him/her and gave him/her electricity into his/her back. The nurse assessed the resident and the resident insisted on calling the police for the guy that pushed him/her to the floor to make a report or have that person arrested. Review of the Massachusetts Health Care Facility Reporting System (HCFRS) failed to indicate that the incident had been reported. During an interview on 5/20/21 at 9:31 A.M., the Director of Nursing said that any accusation of abuse by a resident should be investigated and reported, regardless of any history of hallucinations. During an interview on 5/20/21 at 3:25 P.M., the Director of Nursing said that the incident wasn't reported. The Director of Nursing said that generally any allegation by a resident should be investigated and reported.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 1 Resident (#10) out of a total sample of 28 residents. Findings include: Review of facility policy titled 'Abuse Prohibition' revised 4/09/21, indicated the Center will implement an abuse prohibition program through the following: -Investigation of incidents and allegations Resident #10 was admitted to the facility in May 2015 with diagnoses including depression, diabetes mellitus and psychotic disorder with hallucinations. Review of Resident #10's Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident was cognitively intact and scored a 15 out of a possible 15 on the Brief Interview for Mental Status Exam. Further review of Resident #10's MDS indicated the resident did not have any hallucinations or delusions. Review of Resident #10's nursing progress note dated 1/29/21 indicated the following: -At approximately 4:30 A.M. the Certified Nursing Assistant (CNA) assigned to the resident overheard a loud noise and reported to the nurse that the resident was on the floor in front of the bathroom floor. The nurse asked Resident #10 what happened and Resident #10 said someone pushed him/her and gave him/her electricity into his/her back. The nurse assessed the resident and the resident insisted on calling the police for the guy that pushed him/her to the floor to make a report or have that person arrested. Review of Resident #10's Event Summary Report dated 1/29/21 indicated that the incident was investigated as a fall and failed to indicate a thorough investigation had been done into Resident #10's report of being pushed to the ground by a man. During an interview on 5/20/21 at 9:31 A.M., the Director of Nursing said that any accusation of abuse by a resident should be investigated and reported, regardless of any history of hallucinations. During an interview on 5/20/21 at 3:25 P.M., the Director of Nursing said there was not documentation of any investigation into Resident #10's allegation of being pushed by a man. The Director of Nursing said she discussed it with staff but was unable to provide any documentation. The Director of Nursing said that generally any allegation by a resident should be investigated and reported.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38141 41019 Based on observation, interview, and record review the facility failed to follow the plan of care and apply an elbow splint for 1 Resident (#42) out of a total sample of 28 residents. Findings include: For Resident # 42, the facility failed to follow the plan of care and apply an elbow splint. Resident #42 was admitted in 01/2016 with diagnoses including contractures of the right elbow, left elbow, right writst, right hand, left hand, and left wrist. Review of the most recent Occupational Therapy note, dated 12/2/2020, indicated that Resident #42 had bilateral upper extremity splints, right [NAME] roll, and left wrist splint. The Occupational Therapist noted that Resident #42 requires splints to manage contractures. Review of Resident #42's current physician orders for May 2021 indicated an order for a soft elbow splint to left arm at all times. Review of the current care plan indicated the following: * Soft elbow splint to left arm. Every shift. Remove and replace for care. On 5/21/2021 at 12:30 P.M., Resident #42 did not have any splints on either arm. On 5/20/2021 at 9:48 A.M., Resident #42 did not have any splints on either arm. On 5/21/2021 at 8:48 A.M., Resident #42 did not have splints on either arm. During an interview on 5/22/2021 at 12:22 A.M., the Occupational Therapist said that the Certified Nursing Aides are responsible for donning the splints and would notify the nurse if a resident was not tolerating them or they did not fit appropriately. The Occupational Therapist was not made aware that Resident #42 did not have the splints on and no changes with Resident #42 were brought to her attention.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on record review and interview, the facility failed to ensure that discharge planning was performed in accordance with the wishes of 1 Resident (#79) out of a total sample of 28 residents. Findings include: Resident #79 was admitted to the facility in June 2019 with diagnoses including heart failure, anxiety disorder and depression. Review of Resident #79's Minimum Data Set Assessment (MDS) dated [DATE] indicated that the resident was cognitively intact and scored 15 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). During an interview on 5/19/21 at 9:40 A.M., Resident #79 said that he/she would like to be on their own in an apartment. Resident #79 said he/she has talked to the social worker about it multiple times and nothing has happened yet. Resident #79 said he/she didn't know when he/she last had a follow up with the social worker about this. Review of Resident #79's Social Services note dated 11/6/20 indicated that the Social Worker filled out an application for the MFP waiver program (program that helps people who have been in a nursing home move back into the community with services) and sent it to the resident's Health Care Proxy (HCP) to sign. Review of Resident #79's Care Plan meeting dated 11/12/20 indicated that Resident #79 has been working with Social Services to obtain housing in the community. Review of Resident #79's Social Services Progress note dated 1/20/21 indicated the resident plan remains to return to the community when housing becomes available for him/her. Review of Resident #79's Quarterly Social Services Assessment and Documentation dated 4/19/21 indicated that the resident planned to be discharged home alone from the facility with support and was awaiting housing. The assessment further indicated that Resident #79 verbalized much frustration with the discharge planning process and that the resident is his/her own decision maker. During an interview on 5/21/21 at 11:39 A.M., Social Worker #1 said that Resident #79 has an activated Health Care Proxy and that the resident's Health Care Proxy doesn't want the resident to be discharged from the facility. Social Worker #1 said that Resident #79's Health Care Proxy would not sign the consent for the MFP waiver. Social Worker #1 said she had informed Resident #79 about this decision but had not documented it. Social Worker #1 further said she did not have any documentation regarding her conversations with Resident #79's Health Care Proxy. Social Worker #1 said that if a resident has an activated Health Care Proxy, the proxy will make decisions regarding the waiver. Social Worker #1 further said that if a resident doesn't have an activated Health Care Proxy, he or she would make their own decisions and the social worker would assist the resident. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #79's medical record failed to indicate that his/her Health Care Proxy had ever been activated. During an interview on 5/21/21 at 1:38 P.M., Resident #79 said he/she has expressed desire to go back to the community to staff at the facility. Resident #79 further said that he/she makes his/her own decisions regarding care. During a follow up interview on 5/21/21 at 2:11 P.M., Social Worker #1 said she only sent the MFP application to Resident #79's Health Care Proxy and did not discuss it with the resident. Social Worker #1 acknowledged that Resident #79 never had his/her Health Care Proxy activated and had expressed a desire to be discharged to the community which is why the waiver process was initially started. The Social Worker acknowledged that there was no follow up with the resident regarding his/her desire to be discharged and no further discharge plans were made even though Resident #79 had expressed this desire and did not have an activated proxy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36797 Based on observation, record review and interview, the facility failed to provide residents who are unable to carry out Activities of Daily Living (ADL's) the necessary services to maintain good grooming and personal hygiene for 4 residents (#19, #29, #104 and #13) out of a total of 28 sampled residents. Findings include: 1. Resident #19 was admitted to the facility in 5/2012 with diagnoses including Parkinson's disease, rheumatoid arthritis, and vascular dementia. Review of the Minimum Data Set (MDS) dated [DATE], Resident #19 scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicative of moderate cognitive impairment. Further review indicated that Resident #19 required an extensive assist for completing personal hygiene including nail care. Review of Resident #19's care plan dated 3/4/21, indicated to trim fingernails making sure they are clean and smooth. Further review failed to indicate that the Resident refused care. Review of the nurse's notes dated for the months of 4/2021 and 5/2021 failed to indicate that Resident #19 refused care. On 5/19/21, at 8:49 A.M., the surveyor observed Resident #19 with long and jagged fingernails. During an interview on 5/19/21, at 8:49 A.M., Resident #19 said that his/her fingernails were too long and wants them cut. On 5/19/21, at 4:02 P.M., and 5/20/21, at 10:43 A.M., the surveyor observed Resident #19's fingernails to be without change. 2. Resident #29 was admitted to the facility in 9/2020 with diagnosis including chronic obstructive pulmonary disease, depression and dementia. Review of the Minimum Data Set, dated dated dated [DATE], indicated Resident #29 had moderate cognitive impairment and scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS). Further review indicated that Resident #29 required an extensive assist for completing personal hygiene including nail care. Review of the care plan dated 3/3/21 indicated Resident #29 required an assist with grooming. Further review failed to indicate that Resident #29 refused care. On 5/19/21, at 8:50 A.M., the surveyor observed Resident #29's fingernails to be long and jagged. During an interview on 5/19/21, at 8:50 A.M., Resident #29 said that he/she would like his/her nails cut and didn't like them this way. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/21, at 4:03 P.M., and 5/20/21, at 10:43 A.M., the surveyor observed Resident #29's without change. Review of the nurse's noted dated for the months of 4/2021 and 5/2021 failed to indicate that Resident #29 refused care. During an interview on 5/20/21, at 10:45 A.M., Certified Nurse's Aid (CNA) #4 said that CNA's are responsible for cutting a resident's fingernails at least weekly on shower day. 3. Resident #104 was admitted to the facility in 1/2021 with diagnoses including heart failure, above the knee amputation and generalized weakness. Review of the Minimum Data Set, dated dated dated [DATE], indicated that Resident #104 required an extensive assist for activities of daily living (ADL's). Further review indicated that Resident #104 was cognitively intact and scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam. Review of the care plan dated 1/16/21, indicated that Resident #104 requires an extensive assist for ADL's. Further review failed to indicate that Resident #104 refuses showers. During an interview on 5/19/21, at 10:49 A.M., Resident #104 said that she/he doesn't get showers and she/he feels that the Certified Nurse's Aides (CNA's) can't clean her very well with just a bed bath. Resident #104 said she/he hasn't been showered for months. Review of the nurse's notes dated for the months of 4/2021 and 5/2021 failed to indicate that Resident #104 refused showers. Review of the facility documents titled Documentation Survey Report v2 for the months of 3/2021, 4/2021 and 5/2021 indicated that Resident #104 received a shower only on 4/14/2021 and 4/15/2021. Further review failed to indicate that Resident #104 refused care. During an interview on 5/20/21, at 10:45 A.M., CNA #4 said that the CNA's are responsible for giving residents showers and the daily assignment sheets are where the information for who gets a shower on what days is located. CNA #4 then said that after looking at the assignment sheets she couldn't tell when Resident #104 was supposed to get a shower. During an interview on 5/20/21, at 11:48 A.M., CNA #5 said that we give Resident #104 a shower in bed, we don't take Resident #104 to the shower room. CNA #5 then said that Resident #104 has a shower every Tuesday and Thursday but was not able to say how she was aware of that shower schedule. CNA #5 then said that although Resident #104 was on her assignment, she did not give Resident #104 a shower today, Thursday. Review of the facility documents titled CNA Assignment for 3 and CNA Assignment for 4 CNA and dated daily for the month of 5/2021 indicated a list of residents on the unit with the days and shift they are to be showered. Further review failed to indicate which day and/or shift Resident #104 was to be showered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Activities of Daily Living (ADLs) and dated revised 11/30/20, indicated that the purpose is to ensure that ADLs are provided in accordance with accepted standards of practice, the care plan, and the patient's choices and preferences. Further review indicated that a patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming and personal and oral hygiene. 38141 4. For Resident #13, the facility failed to provide good hygiene and grooming. Resident #13 was admitted to the facility in 11/2020 with diagnoses including dementia. Review of Resident #13's Minimum Data Set (MDS) dated [DATE] indicated that he/she is cognitively impaired and needed extensive assistance with daily care. Review of Resident #13's care plan indicates that he/she is dependent with bathing, grooming, dressing related to dementia. On 5/19/21 at 8:38 A.M., the surveyor observed Resident #13 in the hallway with disheveled/greasy hair. The surveyor also observed small, dry/crusty food in the Resident's hair. On 5/19/21 at 11:52 A.M., the surveyor observed Resident #13 sitting across from the nurse station with disheveled/greasy hair and small dry/crusty food on his/her hair. On 5/19/21 at 1:49 P.M., the surveyor observed Resident #13 wandering in the hallway with disheveled/greasy hair and small dry/crusty food in his/her hair. On 5/20/21 at 8:51 A.M., the surveyor observed Resident #13 sitting across from the nurse station with disheveled/greasy hair and small dry/crusty food in his/her hair. Resident #13 was also wearing the same clothes from the previous day. On 5/20/21 at 10:45 A.M., the surveyor observed Resident #13 wearing the same clothes, with disheveled/greasy hair and small dry/crusty food on his/her hair. On 5/20/21 at 1:20 P.M., the surveyor observed Resident #13 wearing the same clothes, with disheveled/greasy hair and small dry/crusty food on his/her hair. During an interview on 5/20/21 at 1:28 P.M., Certified Nursing Assistant (CNA) #6 told the surveyor that Resident #13 was not on her assignment. CNA #6 said that Resident #13 has a history of refusing care. CNA #6 acknowledged that Resident #13 was wearing the same clothes from the previous day and had disheveled/greasy hair and small dry/crusty food on it. CNA #6 told the surveyor she will try to approach Resident #13 to help him/her change and clean his/her hair.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 36797 Based on record review and interview, the facility failed to ensure 1 Resident (#423), out of a sample of 28 residents, received the necessary treatment to promote the healing of a pressure ulcer and prevent infection, resulting in hospitalization s for surgical debridement of the wound and osteomyelitis (bone infection) requiring antibiotic treatment. Findings include: Resident #423 was admitted to the facility in 3/2021 with diagnosis including Stage 2 pressure ulcer, Cerebral infarction due to blood clot, and chronic kidney disease. Review of the nurse's notes dated 3/6/21, indicated a skin check was completed upon admission and included a finding of a healing pressure ulcer 2.5 x 3.5 centimeters (cm) on Resident #423's buttocks. Review of the facility document titled Skin Check -V4 and dated, 3/6/21, indicated that Resident #423 had a pressure area on the buttocks measuring 3.5 x 2.5 cm. Review of the facility document titled Skin Integrity Report and dated 3/6/21, indicated resident #423 had a pressure ulcer on his/her buttocks measuring 3.5 cm L x 2.5 cm W., no drainage and the wound edges were healthy. Further review indicated that the tissue surrounding the wound was not evaluated, there was no evaluation of the depth of the wound or if there was tunneling or undermining of the wound. Review of the facility document titled Skin Integrity Report and dated 3/13/21, indicated resident #423 had a pressure ulcer on his/her buttocks measuring 3.5 cm L x 2.5 cm W., no drainage and the wound edges were now macerated. Further review indicated that the tissue surrounding the wound was not evaluated, there was no evaluation of the depth of the wound or if there was tunneling or undermining of the wound. Review of the doctor's orders dated 3/6/21 through 3/13/21 failed to indicate a treatment for the healing pressure ulcer on Resident #423's buttocks. Review of the facility treatment record dated for the month 3/2021 indicated that no treatment to the pressure ulcer was initiated until 3/13/21. Review of the nurse's notes 3/6/21 through 3/13/21, failed to indicate a treatment to the pressure ulcer was initiated. Further review failed to indicate that the pressure area on Resident #423's buttocks was monitored for changes. Review of the doctor's orders dated 3/16/21, indicated to send Resident #423 to Massachusetts General Hospital (MGH). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the document titled MGH wound Clinic and dated 5/3/21, indicated that on 3/16/21, Resident #423 presented to the hospital with a sacral wound of enlarged size and development of devitalized tissue since discharge on 3/6/21. Further review indicated that Resident #423 required sharp excisional debridement of the wound to a size of 5 cm. x 5 cm. and down to bone, in the operating room (OR) on 4/9/21, was placed on VAC therapy (negative pressure wound therapy) and was discharged back to the facility on [DATE] with a clean, granulating wound. Review of the facility treatment record dated for the month 4/2021 failed to indicate the facility was monitoring the wound and the tissue surrounding the wound for signs and symptoms of infection. Review of the doctor's orders dated for 4/13/21 through 4/23/21, failed to indicate an order to monitor the wound for signs and symptoms of infection. Review of the document titled MGH wound service and dated 5/3/21, indicated that Resident #423 then presented to MGH wound clinic on 4/23/21, without a dressing to the sacral wound and with the wound covered by a towel. Further review indicated that Resident #423 had a temperature and a markedly deteriorated sacral wound (6.5 x 6.5 x 2.7 cm. with circumferential undermining) malodorous, enlarged, now with necrotic tissue and was subsequently admitted to the hospital with sepsis from the sacral wound. The document then indicated that Resident #423 had debridement of the wound on 4/24/21 and 4/26/21 in the OR with a bone biopsy which resulted in the diagnoses of acute Osteomyelitis (infection of the bone). Review of the nurse's notes dated 4/23/21 failed to indicate the VAC dressing had been removed or became dislodged prior to sending to MGH wound clinic. Review of the facility policy titled Skin Integrity Management and dated revised 1/31/20, indicated to perform daily monitoring of wounds or dressings for presence of complications or declines and document. Further review indicated that for wounds that did not require a daily dressing change monitor status of tissue surrounding the dressing (free of new redness or swelling). Review of the facility policy titled Skin/Wound Management dated 2005, indicated that the plan of care for all patients who have wounds will include routine evaluations and daily monitoring of the wound site (covered or uncovered). Further review indicated that daily monitoring for a dressing site not scheduled to be changed includes the evaluation of: status of dressing (intact, not leaking); status of tissue surrounding dressing (no new redness or swelling). Review of the medical record failed to indicate that the wound VAC dressing was monitored for the presence of wound decline or the status of the tissue surrounding the dressing (free of new redness or swelling). During an interview on 5/24/21, at 9:45 A.M., the Director of Nursing said that she had not seen the wound. She said that the unit managers usually call her to come and see the wounds when they change the dressings but she didn't have the chance until Resident #423's last re-admission to the facility on [DATE]. During an interview of 5/24/20, at 11:35 A.M., Unit Manager #1 said that there was no documentation of the wound having been monitored daily.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure that falls care plans were implemented and followed to prevent falls for 1 resident, (#422), out of a total of 28 sampled residents. Findings include: Review of the facility's Accidents/Incidents policy, dated 5/2/18, indicated the following: Policy: The facility staff will use the Risk Management System (RMS) to report, review and investigate all accidents/incidents which occurred, or allegedly occurred on center property and involved, or allegedly involved, a patient who is receiving services. An accident is defined as any unexpected or unintentional incident which may result in injury or illness to a patient/resident. The licensed nurse will utilize RMS to report accidents/incidents and assist with the completion of a timely investigation to determine root cause. Purpose: *To define causative/contributing factors and institute preventive measures to avoid further occurrences as part of the Quality Assurance Performance Improvement Process. Resident #422 was admitted to the facility in March 2021 with diagnoses including [NAME]-Korsokoff syndrome (a memory disorder). Review of Resident #422's Minimum Data Set Assessment (MDS) dated [DATE] indicated that he/she is severely cognitively impaired. Review of Resident #422's Fall Care Plan dated 3/31/21 indicated the following: Focus: Resident is at risk for falls: cognitive loss, lack of safety awareness, impaired mobility Interventions: Bed alarm while in bed, monitor for placement and functioning every shift, 4/1/21. Educated staff to provide resident with close supervision at all times, 4/12/21. Floor mat right side of bed, 4/7/21. Scoop mattress, 3/31/21. Place call light within reach while in bed or close proximity to the bed, 3/31/21. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/21 at 9:47 A.M., and on 5/20/21 at 8:53 A M., the surveyor observed Resident #422 resting in bed. Resident #422 was on a regular mattress, not a scoop mattress and there was no bed alarm in place. On both occasions Resident #422's call light was on the floor, out of reach and his/her door was shut, so staff was unable to provide supervision per his/her care plan. Review of Resident #422's RMS report dated 5/18/21 indicated that Resident #422 rolled off the bed onto the floor at 12:40 P.M. The portion labeled Corrective Action indicated that staff would implement the use of a scoop mattress to prevent further falls. Per Resident #422's care plan, a scoop mattress was to be implemented as of 3/31/21. During an interview with Unit Manager #1 on 5/21/21 at 8:27 A.M., she said that she wasn't sure when the bed alarm was implemented for Resident #422. Unit Manager #1 said that she did not know that Resident #422 was supposed to have either of those intervention in place prior to his/her fall on 5/18/21.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to address a significant weight loss in a timely manner leading to the continued loss of a significant weight loss of 8.31% in 2 weeks and 19.77% in 2 months for for 1 Resident (#422) out of a total of 27 sampled residents. Findings include: Review of the facility policy titled Weights and Heights, dated 1/31/20, indicated the following: -Policy: Patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Additional weights may be obtained at the discretion of the interdisciplinary team. -Purpose: To obtain baseline weight and identify significant weight change, to determine possible causes of significant weight change. -Significant Weight Change Management: Significant changes will be reviewed by the licensed nurse for assessment. Significant weight changes are defined as: 5% in one month, 10% in six months. -The licensed nurse will: notify the physician and Dietitian of significant weight changes, document notification of the physician and dietitian in the [clinical record]. -The interdisciplinary care plan will be updated to reflect individualized goals and approaches for managing the weight change. Resident #422 was admitted to the facility in March 2021 with diagnoses including dysphagia, and [NAME]-Korsokoff syndrome (a memory disorder). Review of Resident #422's Minimum Data Set Assessment (MDS) dated [DATE] indicated that he/she is severely cognitively impaired and totally dependent on staff for eating. On 5/19/21 at 9:47 A.M., and on 5/20/21 at 8:53 A M., the surveyor observed Resident #422 resting in bed. Resident #422 was thin and frail. Review of Resident #422's Dietitian assessment dated [DATE] indicated the following: Current weight is considered underweight. Observed during lunch today. Resident had eaten 100% and staff assisted him/her with feeding. Recommend large portions with all meals, which was implemented per physicians orders on 3/31/21. Review of Resident #422 physician's orders indicated an order for his/her weight to be obtained every Monday for 4 weeks, written 4/1/21. Review of Resident #422's weights indicated the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/31/21: 130 lbs (pounds) 4/8/21: 130.12 lbs 4/12/21: 119.12 lbs 4/12/21: 119.2 lbs (a re-weigh to confirm his/her weight loss) From 3/31/21 through 4/12/21 Resident #422 had a significant weight loss of 8.31% of his/her total body weight in 2 weeks. Review of Resident #422's physicians orders failed to indicate any medications that could contribute to a significant weight loss. Review of the Dietitian's notes dated 4/12/21 indicated recommendations for Resident #422 to receive a daily frozen nutritional supplement twice a day. Review of the physicians orders indicated this was implemented on 4/13/21. Resident #422's monthly weights indicated that his/her weight was not obtained as ordered on 4/19/21. Additional review of Resident #422's clinical record indicated that he/she was hospitalized with aspiration pneumonia and shunt infection from 4/21/21 through 5/10/21. Resident #422's weight was documented on 5/11/21 at 111.9 lbs. (a total weight loss of 11.9% of his/her total body weight since 3/31/21). Review of his/her meal percentage intakes from 5/10/21 though 5/17/21 indicated that staff documented Resident #422 ate between 75-100% for 11 out of 20 documented meals. There were no documented intakes for 8 meals during that time period. Review of the Dietitian's assessments indicated that Resident #422 was assessed by the Dietitian on 5/17/21; 7 days after his/her return from the hospital. The assessment indicated the following: Comment: meeting estimated needs with recorded consumption of ordered nourishments and meals with large portions. Evaluation/Nutrition Plan: Resident #422 is at nutrition risk underweight body mass index with recent significant weight loss. Continue large portions with meals on regular/liberalized diet as his/her intake seems to be improving. Continue frozen nutrition treat twice a day as ordered to supplement intake at meals. Continue to monitor trends weekly. Despite having had a significant weight loss prior to and during his/her hospitalization , the Dietitian did not implement or identify new interventions to address Resident #422's continued weight loss. On 5/20/21 Resident #422's weight was obtained at 104.3 lbs, a total loss of 19.77% of his/her total body weight since 3/31/21. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Unit Manager #1 on 5/21/21 at 7:15 A.M., she said that she left the Dietitian a message on 5/20/21 regarding Resident #422's new weight. During an interview with the Dietitian on 5/21/21 at 9:57 A.M., she said that she was in the building on 5/20/21 but left early and was not notified that Resident #422 had lost more weight. The Dietitian said that she did not implement new interventions after Resident #422 was readmitted to the facility after having lost more weight because she assumed he/she had eaten well in the 3 days prior to her assessment on 5/17/21 and thought that the increased intakes with large portions would meet his/her nutritional needs.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to provide appropriate care (dressing changes, external catheter length and arm circumference per the physician's order) for a peripherally inserted central catheter [PICC] for 1 resident (#423) out of a total of 27 sampled residents. Findings include: Resident #423 was initially admitted to the facility in 3/2021 with diagnoses including sepsis. Review of his/her Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she was severely cognitively impaired. During an interview with Resident #423 on 5/19/21 at 9:05 A.M., the surveyor observed a Peripherally Inserted Central Catheter (PICC) line dressing on his/her right arm. The dressing was visibly soiled and peeling away from his/her arm. The dressing was dated for April 2021, but the day was illegible. Due to Resident #423's cognition, he/she could not say when his/her dressing was last changed. Review of the Facility's Central Vascular Access Device (CVAD) Dressing Change Policy, dated 5/1/16, indicated the following Considerations: 1. CVAD access devices include: (PICC) Guidance: 1. Sterile dressing change using transparent dressings is performed: 1.1. 24 hours post-insertion or upon admission 1.2. At least weekly 1.3. If the integrity of the dressing has been compromised (wet, lose or soiled) On 5/20/21 at 7:03 A.M., the surveyor observed the dressing again with Nurse #1. The dressing was still visibly soiled and had the same illegible date written on it. Nurse #1 could not make out the date and could not say when the dressing was last changed. On 5/20/21 at 7:13 A.M., Unit Manager #1 joined the surveyor and also observed Resident #423's dressing. Unit Manager #1 said that the dressing was soiled and should have been changed by nursing as soon as it became compromised. Unit Manager #1 was also unable to read the date of the dressing and acknowledged it was dated for sometime in April 2021. Review of Resident #423's physicians orders indicated the following: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change catheter site transparent dressing. Indicate external catheter change and upper arm circumference 10 CM above antecubital. Notify practitioner if external length has changed since last measurement, upon admission. dated 5/4/21: Additional review of the physician's orders indicated the following: Change catheter site transparent dressing. Indicate external catheter length and upper arm circumference (10 cm above antecubital.) Notify practitioner if external length has changed since last measurement every day shift every Tuesday Start date 5/11/21. Review of the Treatment Administration Record (TAR) indicated that the dressing was changed as ordered on 5/11/21, despite the observations made by the surveyor and the facility staff indicating that the dressing had not been changed since an unknown date in April 2021. The TAR also indicated that the dressing was not changed on 5/18/21. During a follow up interview on 5/20/21 at 9:03 A.M. with Unit Manager #1, she said that Resident #423's PICC was inserted while he/she was hospitalized in April 2021. Unit Manger #1 said that Resident #423's dressing was not changed as ordered and was not changed at the facility despite it being documented as being completed on 5/11/21.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on observation, interview and record review, the facility failed to ensure that oxygen was administered according to physician orders for 1 Resident (#106) out of a total sample of 28 residents. Findings include: Resident #106 was admitted to the facility in July 2019 with diagnoses including congestive heart failure, anxiety, chronic respiratory failure and obstructive sleep apnea. Review of Resident #106's Minimum Data Set assessment dated [DATE] indicated the Resident was cognitively intact and scored a 13 out of 15 on the Brief Interview for Mental Status Exam (BIMS). Further review of Resident #106's MDS indicated the Resident needed assistance with care activities. Review of Resident #106's May 2021 physician orders indicated the following order: -Oxygen at 2 L (liters) via nasal cannula (a thin flexible tube used to deliver oxygen through the nostrils) Review of Resident #106's medical record indicated a care plan for Risk of Respiratory failure related to obstructive sleep apnea and chronic respiratory failure with interventions for Oxygen at 2 liters via nasal cannula as ordered. On 5/20/21 at 9:32 A.M., Resident #106 was observed wearing his/her oxygen at 3 liters via nasal cannula. On 5/21/21 at 8:47 A.M., Resident #106 was observed wearing his/her oxygen at 3 liters via nasal cannula. On 5/21/21 at 12:59 P.M., Resident #106 was observed wearing his/her oxygen at 3 liters via nasal cannula. During an interview on 5/20/21 at 11:35 A.M., Resident #106 said he/she does not change the settings for his/her oxygen and that nursing manages his/her oxygen. During an interview on 5/21/21 at 8:20 A.M., the Director of Nursing and Executive Director said there was no facility policy related to oxygen administration. During an interview on 5/21/21 at 1:01 P.M., Nurse #5 said that the nursing staff manages Resident #106's oxygen and that the Resident doesn't change the flow. Nurse #5 acknowledged that Resident #106's oxygen was at 3 liters instead of 2 liters as ordered by the physician. Nurse #5 said that Resident #106 should be receiving oxygen as ordered.

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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 observation, interview and record review, the facility failed to ensure that physician orders for a psychiatric services consult were followed for 1 Resident (#37) out of a total sample of 28 residents. Findings include: Resident #37 was admitted to the facility in December 2020 with diagnoses including depression, anxiety disorder, dementia and agitation. Review of Resident #37's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had severe cognitive impairment and scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of Resident #37's MDS indicated the Resident had verbal behavioral symptoms and rejection of care daily. On 5/20/21 at 11:00 A.M., Resident #37 reported having no appetite and no desire to engage in activities. Resident #37 appeared depressed and had a flat affect. Review of Resident #37's medical record indicated a physician's order dated 2/3/21 for a psych consult due to agitation, physical escalation, refusal of Activities of Daily Living care and refusal of medications. Further review of Resident #37's medical record failed to indicate the psych consult was completed as ordered. During an interview on 5/20/21 at 1:46 P.M., Unit Manager #3 said she had no knowledge of Resident #37 having had a psych consult. Unit Manager #3 said any consults would be in Resident #37's chart and if it wasn't in the chart then it wasn't completed. Unit Manager #3 said there was no documentation that Resident #37 had refused the psych consult., During an interview on 5/24/21 at 10:51 A.M., the Director of Nursing said that if an order for psych services is written, it will be written in a log on the nursing unit or told to the psych services provider verbally. The Director of Nursing said that if the physician had ordered a psych consult for Resident #37 the Resident should have been seen.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40928 Based on record review and interview, the facility failed to ensure pharmacist recommendations were shared with the physician in a timely manner for 1 Resident (#10) out of a total sample of 28 residents. Findings include: Resident #10 was admitted to the facility in May 2015 with diagnoses including depression, diabetes mellitus and psychotic disorder Review of Resident #10's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident was cognitively intact and scored a 15 out of a possible 15 on the Brief Interview for Mental Status Exam. Further review of Resident #10's MDS indicated the resident did not have any hallucinations or delusions. Review of Resident #10's medical record indicated the following pharmacist recommendations: -A pharmacist recommendation dated 8/11/20 which indicated that Resident #10 frequently required insulin (an injectable medication used to manage blood sugar) per sliding scale and to optimize the Resident's current therapy due to frequent coverage needed. This recommendation was not addressed by the physician until 5/20/21 (9 months after the recommendation was made). -A pharmacist recommendation dated 8/11/20 to discontinue 2 medications: Claritin (an allergy medication) and Ondansetron (a medication used to treat nausea). This recommendation was not addressed by the physician until 5/20/21 (9 months after the recommendation was made). -A repeat pharmacist recommendation dated 1/14/21 to discontinue Claritin and Zofran (the brand name for Ondansetron). This recommendation was not addressed by the physician until 5/20/21 (4 months after the repeat recommendation was made). -A pharmacist recommendation dated 1/14/21 to discontinue sliding scale insulin three times daily and decrease to two times daily. This recommendation was not addressed by the physician until 5/20/21 (4 months after the recommendation was made). -A pharmacist recommendation dated 4/15/21 to discontinue Mupirocin (a topical antibiotic medication). If the therapy cannot be discontinued, please document a stop date. The recommendation was not addressed by the physician until 5/20/21 (1 month after the recommendation was made). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/21 at 10:10 A.M., the Director of Nursing said that a monthly report from the pharmacy goes to all unit managers and the Director of Nursing. The Director of Nursing said the policy is to give the physician or Nurse Practitioner the pharmacy reports when they come in and said the expectation is that the reports will be shared within one week. The Director of Nursing further said that no one had identified the pharmacy recommendations until the surveyor asked about them and acknowledged that there were recommendations made as long as 9 months ago that were not shared with the physician.

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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** 38141 Based on observations and interviews, the facility 1) failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the expiration date, when applicable, in three out of four medication carts inspected and 2) failed to ensure that prescription medications were secured for 1 Resident (#2) out of a total sample of 28 residents. Findings include: Review of the facility policy titled Storage and expiration dating of medication, biologicals with revision dated on 10/31/16 indicated the following: *Once any medication or biological packaged is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medication. *Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 1. During observations on 5/21/21 at 11:39 A.M., of the [NAME] Unit medication cart #2, the surveyor observed the following: - one bottle of fluticasone propionate (a medication used to treat nasal congestion) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instructions indicate once opened; they are good for 120 sprays. -two combivent spirmat inhaler (a medication used to treat and prevent shortness of breath) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instruction indicated they are good for 3 months after assembly of device. -two QVAR redihaler (a medication used to treat wheezing and shortness of breath) opened and undated. During an interview on 5/21/21 at 11:39 A.M., Nurse #2 acknowledged that the nasal spray and inhalers were opened and not dated. 2. During observations on 5/21/21 at 01:02 P.M., of the [NAME] Unit medication cart #1, the surveyor observed the following: -two sodium chloride eye solution (a medication used to draw water in cornea that can cause poor vision) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instructions indicate once opened; they are good for 3 months. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one brimonide ophthalmic solution (a medication used to treat high pressure in the eyes) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instruction indicates discard contents 4 weeks after opening the bottle. -one rhopressa ophthalmic solution (a medication used to treat high pressure in the eyes) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instruction indicates once opened; it is good for up to six weeks. -two bottle of fluticasone propionate (a medication used to treat nasal congestion) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instructions indicate once opened; they are good for 120 sprays. -one Flovent HFA (a medication used to treat asthma) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instructions indicate once opened; they are good for six weeks. During an interview on 5/21/21 at 01:15 P.M., Nurse #3 acknowledged that the eye drops, nasal spray and inhalers were opened and not dated. 3. During observations on 5/21/21 at 01:20 P.M., of the Oakgrove Unit medication cart #1, the surveyor observed the following: -four albuterol sulfate inhalation solution (a medication used to treat and prevent shortness of breath) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instruction indicates most albuterol inhalers expires one year after being issued. -three bottles fluticasone propionate (a medication used to treat nasal congestion) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instructions indicate once opened; they are good for 120 sprays. -one Flovent HFA (a medication used to treat asthma) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instructions indicate once opened; they are good for six weeks. -one combivent spirmat inhaler (a medication used to treat and prevent shortness of breath) opened and undated, therefore an expiration date cannot be determined. Manufacturer's instruction indicated they are good for 3 months after assembly of device. During an interview with Nurse #4 on 5/21/21 at 1:35 P.M., Nurse #4 acknowledged that the nasal spray and inhalers were opened and not dated. She said that it should have been dated to determine when to discard it. 40928 4. For Resident #2, the facility failed to ensure a prescription medication was not kept at the bedside, unsecured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled 'Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles' revised 10/31/16 indicated the following: - Facility should ensure that all medications and biologicals, including treatment items, are securely stocked in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Resident #2 was admitted to the facility in January 2021 with diagnoses including high blood pressure, chronic kidney disease and urinary retention. Review of Resident #2's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had moderate cognitive impairment and scored an 11 out of 15 on the Brief Interview for Mental Status Exam (BIMS). Further review of Resident #2's MDS indicated the Resident required extensive assistance with physical assistance for care activities. On 5/21/21 at 9:10 A.M., the surveyor observed a container of Triamcinolone Acetonide Cream 0.1% (a topical prescription cream to relieve skin inflammation, itching, dryness, and redness) next to the Resident's bedside. Resident #2 said he/she uses the cream. Review of Resident #2's medical records failed to indicate an order for the Triamcinolone cream. During an interview on 5/21/21 at 9:54 A.M., Nurse #4 said that if a resident wants to keep a medication or prescription cream in their room, then an order and an assessment must be done. Nurse #4 said she was unable to locate an order for Resident #2's Triamcinolone cream and further said it should not be kept at the bedside.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36876 Based on record review and interview, the facility failed to maintain accurate medical records for 1 Resident (#423) out of a total of 28 sampled residents. Findings include: Resident #423 was admitted to the facility in 3/2021 with diagnoses including sepsis, stroke and dysphagia. On 5/19/21 at 9:05 A.M., the surveyor observed a Peripherally Inserted Central Catheter (PICC) line dressing on Resident #423's arm. The dressing was observed to be dated for April 2021, but the day was illegible. On 5/20/21 at 7:13 A.M., Unit Manager #1 joined the surveyor and also observed Resident #423's PICC line dressing. Unit Manager #1 was also unable to read the date of the dressing and acknowledged it was dated for sometime in April 2021. Review of Resident #423's physicians orders indicated the following: Change catheter site transparent dressing. Indicate external catheter length and upper arm circumference (10 cm above antecubital.) Notify practitioner if external length has changed since last measurement every day shift every Tuesday Start date 5/11/21. Review of Resident #423's Treatment Administration Record (TAR) indicated that the dressing was changed as ordered on 5/11/21, despite the observations made by the surveyor and the facility staff indicating that the dressing had not been changed since an unknown date in April 2021. During a follow up interview on 5/20/21 at 9:03 A.M. with Unit Manager #1, she said that Resident #423's PICC was inserted while he/she was hospitalized in April 2021. Unit Manger #1 said that Resident #423's dressing was not changed as ordered and was not changed at the facility despite it being documented as being completed on 5/11/21.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38141 Based on observation, facility policy review and interview the facility failed to implement infection control practices to prevent the possible transmission of infectious diseases, including Covid-19 (a virus causing respiratory illnesses) when staff 1). failed to doff (remove) and dispose of Personal Protective Equipment (PPE) appropriately and failed to perform hand hygiene prior to donning (put on) and after doffing PPE on 2 of 4 resident care units, 2). failed to transport linens so as to prevent the spread of infection on 1 out of 4 units and 3). failed to ensure that infection control practices related to catheter management were followed for 1 Resident (#2) out of a total sample of 28 residents Findings include: Review of the CDC guidance titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 2/23/21, indicated the following: *Gowns -Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Reusable (i.e., washable or cloth) gowns should be laundered after each use. *Hand Hygiene -HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. -HCP should perform hand hygiene by using Alcohol Based Hand Sanitizer (ABHS) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to alcohol-based hand sanitizer. Review of the facility policy titled Hand Hygiene with a revision date of 11/15/20, indicated the following: *Perform hand hygiene: -before patient care -before an aseptic procedure -after any contact with blood or other body fluids, even if gloves are worn -after patients care -after contact with the patient's environment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/21 at 7:40 A.M., the Infection Control Nurse told the surveyors that the facility does not have Covid-19 positive cases for either residents or staff. She said that all staff members still wear gowns on all the units when providing close contact care to the residents and doff the gowns before exiting a resident's room. 1. On 5/19/21 at 8:30 A.M., the surveyor made the following observations on the first floor [NAME] unit: *At 8:35 A.M., Certified Nursing Assistant (CNA) #2 was observed exiting a resident's room wearing gown and gloves carrying a laundry bag to the soiled utility room. CNA #2 then exited the soiled utility room wearing the same gown and gloves. CNA #2 doffed her gown and gloves in the hallway and placed it in the dirty linen cart for gowns. CNA #2 did not perform hand hygiene after removing her soiled PPE. *At 8:48 A.M., CNA #2 was observed exiting a resident room wearing a gown and gloves. CNA #2 doffed her gown and gloves in the hallway and placed it in the dirty linen cart for gowns. CNA #2 did not perform hand hygiene after removing her soiled PPE. *At 9:06 A.M., CNA #2 was observed exiting a resident room wearing a gown and gloves. CNA #2 doffed her gown and gloves in the hallway and placed it in the dirty linen cart for gowns. CNA #2 did not perform hand hygiene after removing her soiled PPE. During an interview with CNA #2 on 5/19/21 at 9:10 A.M., she acknowledged walking in the hallway wearing gown and gloves and not performing hand hygiene after doffing off gown and gloves. *At 9:14 A.M., CNA #3 was observed walking in the hallway wearing a gown and gloves and carrying a laundry bag to the soiled utility room. CNA #3 then exited the soiled utility room wearing the same gown and gloves. She doffed off her gown and gloves in the hallway and placed it in the dirty linen cart for gowns. CNA #3 did not perform hand hygiene after removing her soiled PPE. With her contaminated hand, CNA #3 accompanied a resident that was wandering in the hallway to the activity room. *At 11:59 A.M., CNA #3 was observed exiting the activity room wearing a gown and gloves. CNA #3 entered a resident's room to answer a call light wearing the same gown and gloves. CNA #3 exited the resident's room wearing a gown and gloves. CNA #3 doffed her gown and gloves in the hallway and placed it in the dirty linen cart for gowns. CNA #3 did not perform hand hygiene after removing her soiled PPE. During an interview with CNA #3 on 5/19/21 at 12:05 P.M., she acknowledged not changing gown and gloves and not performing hand hygiene. During an interview with the Regional Nurse on 5/24/21 at 10:30 A.M., she told the surveyor that the expectations are before exiting resident room, staff should remove and bag PPE and perform hand hygiene. 36797 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 5/20/21, at 11:48 A.M., the surveyor observed Certified Nurse's Aide (CNA) #5 exit a resident's room with gloves on both hands, carrying a bag of soiled laundry and a bag of trash. CNA #5 then walked down the hall to the dirty utility room and opened the door with her contaminated hand therefore contaminating the door handle. CNA #5 then exited the dirty utility room without gloves, touched the door handle contaminating her hands. During an interview on 5/20/21, at 11:48 A.M., CNA #5 said she had gloves on in the hallway because she was taking out the trash. 40928 3. For Resident #2 the Facility failed to implement standard infection control practices for catheter care to prevent infections. Review of the Facility's Policy Titled, Catheter: Indwelling Urinary- Care of revised date 11/01/2019 indicated: -Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor. Review of the Facility's Policy Titled, Infection Prevention and Control Program Description dated, 11/15/2020 indicated: - Implementation of Control Measures and Precautions which includes basics such as hand hygiene, standard and transmission based precautions, cleaning disinfecting equipment and measures to protect persons from communicable diseases or infections. Resident #2 was admitted to the facility in January 2021 with diagnoses including atrial fibrillation, chronic renal failure, anemia, and urinary retention. Review of Resident #2's Minimum Data Set Assessment (MDS) dated [DATE] indicated the Resident had moderate cognitive impairment and scored an 11 out of 15 on the Brief Interview for Mental Status Exam (BIMS). Further review of Resident #2's MDS indicated he resident required extensive assistance with physical assistance for care activities. Resident #2's MDS data also indicated an indwelling catheter (including suprapubic catheter and nephrostomy catheter) and extensive assistance in toileting. On 05/20/21 at 8:57 A.M., the surveyor observed Resident #2 laying on his/her bed with his/her suprapubic catheter (a hollow flexible tube used to drain urine from the bladder) bag on the floor with the privacy cover off. On 5/21/21 at 9:11 A.M., the surveyor observed Resident #2 eating breakfast in bed with his/her catheter bag on the floor. On 5/21/21 at 9:49 A.M., Resident #2 was observed after his/her breakfast tray had been removed and the catheter bag was on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/21 at .9:54 AM., Nurse #4 said the expectation for foley/suprapubic catheter care was to keep the catheter bag below the bladder and off the floor as an infection control practice.