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	12/16/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 36876 Based on observation, record review and interview, the facility failed to provide a dignified environment during activities and meals on the [NAME] Unit and failed to maintain the dignity of 1 Resident (#124) by placing his/her catheter in a privacy bag out of a total sample of 38 Residents. Findings include: 1.) On 12/8/22 at 11:59 A.M., the surveyor observed the following in the [NAME] Unit (a secured unit which houses Residents with dementia): *The lights were turned off and a movie was playing in the dining room where approximately 15 Residents were sitting. The activity schedule indicated that the scheduled activity was board games. Multiple residents were yelling at one another, You're a bitch, Get the [expletive] out, You're a [derogatory term for a gay person]. *A CNA and an Activity Assistant were seated in the common room with the Residents, not engaging with the Residents or intervening as Residents were screaming and cursing. *The Activity Assistant saw the surveyor and promptly stood up, put the lights on and began cleaning up items off of the tables in front of the residents. Residents continued to scream, curse and yell at one another and no staff intervened. *At 12:12 P.M., the surveyor observed Residents continue to curse at one another. The CNA and Activities staff in the room continued to not engage with, redirect or communicate with any Resident in the room. During an interview with the Activities Director on 12/12/22 at 8:27 A.M., she said that if staff have to change an activity that was scheduled on the calendar, they alert her. She said that she was not alerted of any changes to Activities scheduled on the [NAME] Unit last week. The Activities Director said that she would expect that if staff observed Residents cursing at one another, or in any sort of distress, that they would address the behavior, intervene or alert nursing to become involved. During observations of the breakfast meal on 12/9/22, the surveyor observed the following on the [NAME] Unit: (continued on next page)

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	At 9:19 A.M., there were 24 Residents seated in the dining room. No staff were present in the room engaging with the Residents or supervising the Residents. At 12/09/22 9:28 A.M., staff began serving Residents their meals at different tables. Several Residents were watching their tablemates eat. Resident #92 was repeatedly trying to take food off of another person's plate and staff had to continuously ask him/her not to. Eventually, staff removed the Resident who had been served his/her meal away from Resident #92 as he/she continuously reached at the plate. Staff then served another Resident at Resident #92's table and the same behavior was repeated. Resident's were observed at other tables pulling their meals closer to themselves as their tablemates were reaching (less aggressively) to take food off of the plates of others. Once all Resident's had been served their meals, 3 staff members were observed standing while feeding Residents. One CNA was standing and attempting to feed a Resident who was asleep. During an interview with Director of Nursing #1, Director of Nursing #2 and Corporate Nurse #1 on 12/12/22 at 8:41 A.M., the surveyor informed them of the observations made during the breakfast meal on the [NAME] Unit. They acknowledged the concerns regarding the surveyors observations. 44095 2.) For Resident #124, the facility failed to ensure they provided a dignified existence when his/her urinary catheter bag was not in a catheter privacy bag and visible to his/her roommate. Resident #124 was admitted to the facility in October 2022 with diagnosis including hemiplegia (paralysis on one side of the body) following cerebral infraction (stroke) affecting the right dominant side, left humerus (bone in the upper arm) fracture and urinary retention. Review of Resident #124's Admission Minimum Data Set (MDS), dated [DATE] indicated that he/she could make self understood and that he/she understands others. The MDS indicated her/she required an indwelling urinary catheter. During an observation on 12/8/22 at 8:10 A.M., the surveyor observed his/her urinary catheter drainage bag without a privacy bag in view of his/her roommate. During an observation on 12/9/22 at 6:38 A.M., the surveyor observed his/her urinary catheter drainage bag without a privacy bag and in view of his/her roommate. During an interview on 12/14/22 10:55 A.M., Certified Nurse Aide #6 said that Resident #124's urinary drainage bag should be in a privacy bag. During an interview on 12/14/22 at 8:11 A.M., Director of Nursing #2 said that Resident #124's urinary drainage bag should be in a privacy bag.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on interview and record review, the facility failed to send invitational letters to Resident Representatives for participation in quarterly care plan meetings for 4 (#76, 11, 30, 55) out of 38 sampled Residents. Findings include: 1. During an interview on 12/8/22 at 10:34 A.M., Resident Representative #1 and Resident Representative #2 (for Resident #76) said they had not received a letter or other notification from the facility to participate in a scheduled care plan meeting for approximately 6 months. Resident Representatives #1 and #2 said the facility previously sent them letters of invitation every quarter and they would attend. Resident Representatives #1 and #2 said Resident #76 had advanced dementia and was unable to participate in care planning. Review of Resident #76's quarterly Minimum Data Set ((MDS) assessment, dated 11/4/22, indicated admission to the facility in October 2017, and a Brief Interview of Mental Status Score of 2, indicating severe cognitive impairment. The MDS indicated Resident #76 had a diagnosis of dementia. The medical record indicated Resident Representative #1 was the assigned responsible person for Resident #76. Review of Resident #76's care planning invitation letters, addressed to Resident Representative #1, indicated these were mailed on 7/9/21, 9/28/21,12/21/21 and 3/8/22. Care plan invitations were not sent to Resident Representative #1 in June 2022 or September 2022. 2. Review of Resident #11's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated admission to the facility in July 2019, and a Brief Interview of Mental Status Score of 11, indicating moderate cognitive impairment. The MDS indicated Resident #11 had a diagnosis of dementia and psychotic disturbance. The medical record indicated Resident Representative #3 was the assigned responsible person for Resident #11. Review of Resident #11's care planning invitation letters, addressed to Resident Representative #3, indicated these were mailed on 5/26/21, 6/10/21, 9/7/21, and 11/3/21. Care plan invitations were not sent to Resident Representative #3 in February, May, August, or November 2022. 3. Review of Resident #30's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated admission in June 2021, and a Brief Interview of Mental Status Score of 1, indicating severe cognitive impairment. The MDS indicated Resident #30 had a diagnosis of neurocognitive disorder with dementia of Lewy-bodies. The medical record indicated Resident Representative #4 was the assigned responsible person for Resident #30. Review of Resident #30's care planning invitation letters, addressed to Resident Representative #4, indicated these were mailed on 11/24/21, 2/15/22, 5/11/22, 8/19/22 and 8/20/22. Care plan invitations were not sent to Resident Representative #4 (Daughter) in November 2022. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #55's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated admission to the facility in February 2022, and a Brief Interview of Mental Status Score of 2, indicating severe cognitive impairment. The MDS indicated Resident #55 had a diagnosis of Alzheimer's dementia. The medical record indicated Resident Representative #5 was the assigned responsible person for Resident #55. Review of Resident #55's care planning invitation letter, addressed to Resident Representative #5, indicated it was mailed on 3/8/22. Care plan invitations were not sent to Resident Representative #5 in June 2022 or September 2022. During an interview with the Director of Medical Records on 12/14/22 at 10:46 A.M., he described the process for generating and storing the care plan invitation letters. The Director of Medical Records said the Receptionist completes the care planning letter, makes a copy, and then mails these to the Resident Representatives. The Director of Medical Records said the Receptionist then gives him a copy of the letters and he places them in the medical record. During an interview with the Receptionist at on 12/14/22 at 10:50 A.M., she said she provided copies of all mailed care planning letters to the Director of Medical Records.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to ensure 1 Resident's (#231) significant change in condition was reported to the nurse on duty out of a total of 38 sampled Residents. While providing care to Resident #231, Certified Nurses Aide (CNA) #2 and CNA #4 observed Resident #231 to have a change in condition evidenced by vomiting and difficulty breathing. CNA #2 and CNA #4 continued to provide care for Resident #231 and then left the Resident alone without alerting Unit Manager #2. Resident #231 was found deceased approximately one hour later. Findings include: Review of the Facility's Change in Condition policy, revised [DATE] indicated: *The center must immediately inform the resident/patient, consult with the patient's physician notify consistent with his/her authority, the patient's health care decision maker wherein there is: *a significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health mental or psychosocial status in either life threatening conditions or clinical complications) Review of the Facility's CNA Job Description, revised [DATE] indicated: Responsibilities/Accountabilities: -Reports changes in patient's condition, patient/family concerns or complaints to charge nurse and/or supervisor. Resident #231 was admitted to the facility in [DATE] with diagnoses including type 1 diabetes, ketoacidosis (a serious diabetic reaction where there is not enough insulin in the body), upper gastrointestinal (GI) bleed and kidney failure. Review of the hospital discharge paperwork, dated [DATE] indicated that Resident #231 had a previous hospital admission due to diabetic ketoacidosis and was found unresponsive in his/her home with coffee ground emesis. Review of Resident #231's Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) dated [DATE], indicated he/she was a Do Not Resuscitate (DNR), and wished to be transferred to the hospital in an urgent event. Review of CNA #2's employee record included an education sheet dated [DATE] which indicated: -It is the primary duty of a CNA to report any change in condition of a patient/resident to the nurse in charge. CNA's should never make Resident assessments on their own. It's not in a CNA scope of practice to assess. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of CNA #2's hand written witness statement signed and dated [DATE] indicated that on [DATE] Resident #231 was assigned to CNA #4. CNA #2 was asked by CNA #4 to help change Resident #231. When CNA #2 arrived in the room, Resident #231 had vomited, the bed was soiled and Resident #231 was gasping for air (originally written as help but was crossed out and written to air.) The statement indicated: I stated the Resident is dying, lets do this quick before [he]/she dies on me. I did my best to finish and set up everything and I left. It was around 6:30 A.M. I check on the resident before the new shift started and I found him/her dead. During an interview with CNA #2 on [DATE] at 8:29 A.M., he said that on [DATE] CNA #4 asked for help changing Resident #231. CNA #2 said that when he got into the room he was surprised because Resident #231 had vomited a brownish color, he/she was gasping for air and looked like he/she was dying. CNA #2 said he told CNA #4 that Resident #231 was dying and we needed to clean him/her quick. CNA #2 said they positioned Resident #231 on his/her back with the head of the bed propped up. CNA #2 said that when they left Resident #231's room, his/her mouth was open and he/she was still gasping for air. CNA #2 said he thought that because Resident #231 was assigned to CNA #4 that she would alert the nurse on duty (Unit Manager #2). CNA #2 said around 7:15 A.M., he went to check on Resident #231. CNA #2 said that Resident #231 was dead and went to tell Unit Manager #2. However, the written statement from CNA #2 indicated he found Resident #231 dead at 6:30 A.M. Review of CNA #4's statement dated [DATE] indicated that Resident #231 was assigned to CNA #2 on [DATE]. The statement indicated she assisted CNA #2 in changing Resident #231 and did not include any details of Resident #231's status. Review of Resident #231's Activities of Daily Living (ADL) sheets indicated that CNA #4 had provided care for Resident #231 on [DATE]. During an interview with CNA #4 on [DATE] at 1:27 P.M., she said that she was doing her rounds and saw Resident #231 vomiting. CNA #4 said she made CNA #2 aware that Resident #231 needed assistance and she provided him clean linen for Resident #231. CNA #4 said she did not provide care for Resident #231 on [DATE]. However, CNA #4's interview does not support her written and signed witness statement from [DATE] and clinical documentation in Resident #231's medical record. Review of the facility investigation indicated Unit Manager #2's typed and signed witness statement dated [DATE], indicated that she observed Resident #231 in bed after 6:00 A.M. Unit Manager #2 walked by Resident #231's room around 6:15 A.M. and heard CNA #2 and CNA #4 providing Resident #231 care and overheard CNA #2 and CNA #4 discussing who Resident #231 was assigned to. The statement indicated that on [DATE] at 7:15 A.M., CNA #2 informed Unit Manager #2 that Resident #231 was dead. The statement indicated that CNA #2 made Unit Manager #2 aware at 7:15 A.M., that while he was providing care to Resident #231 there was vomit around his/her mouth and chest and he realized that he/she was dying at that time. Unit Manager #2's statement indicated that she was shocked and went to assess Resident #231 who was found to have no vital signs and he/she had some coffee ground vomit around his/her mouth, he/she was laying flat in the bed. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Unit Manager #2 on [DATE] at 8:53 A.M., she said that on [DATE] Resident #231 was assigned to CNA #4. She said that sometime after 6:00 A.M., she had observed Resident #231 and he/she was ok. Unit Manager #2 said sometime after that she observed CNA #4 in Resident #231's room and CNA #2 in the hallway discussing who was assigned to the resident, and then they both went into Resident #231's room. Unit Manager #2 said sometime after that, CNA #2 came to her and said that Resident #231 was dead. Unit Manager #2 said she then ran to the room and found the resident without vitals and had vomit on his/her chest. Unit Manager #2 said that she then notified the provider to obtain a death pronouncement order. Unit Manager #2 said that Unit Manager #1 performed the pronouncement. Unit Manager #2 said that she told CNA #2 and CNA #4 that if they are taking care of a Resident, they need to leave right away and are required to report a change in condition to the nurse. Unit Manager #2 said I was beside myself, I was crying. Unit Manager #2 said both CNA #2 and CNA #4 had the responsibility to notify her of Resident #231's change in condition. Unit Manager #2 said that had she been made aware, she would have been able call 911 and maybe [Resident #231] would not have died here in the building. I did not have a chance to do anything to prevent it. Unit Manager #2 said that Resident #231's death was not expected. Review of CNA #4's employee record included an education sheet dated [DATE] which indicated: -It is the primary duty of a CNA to report any change in condition of a patient/Resident to the nurse in charge. CNA's should never make Resident assessments on their own. It's not in a CNA scope of practice to assess. During an interview with Director of Nursing (DON) #2 on [DATE] at 10:03 A.M., she said that both CNA #2 and CNA #4 had the responsibility to notify Unit Manager #2 of Resident #231's change in condition, regardless of who was assigned to the Resident. DON #2 said she could not say if Resident #231's death was expected or if it was reported to the medical examiner and she would have to review the record. During an interview with Resident #231's physician on [DATE] at 11:50 A.M., she said that she was not aware of a change in Resident #231's medical status prior to being found deceased . During an interview with Nurse Practitioner #1 on [DATE] at 10:46 A.M., she said that when she is called by facilities looking for RN pronouncement orders, they usually do not give details surrounding the Resident deaths. She said that she was not informed by the facility that Resident #231 had had a change in condition which was not reported to the nurse prior to being found deceased . Nurse Practitioner #1 said that if she had, she would have recommended the case to the office of the medical examiner. The facility failed to ensure CNA #2 and CNA #4 notified Unit Manager #2 of a significant change in condition in Resident #231's status when he/she had vomited (deterioration of health). Unit Manager #2 was unable to immediately inform his/her physician or implement his/her treatment plan. On [DATE] at 3:00 P.M., the Administrator was provided with the Immediate Jeopardy Template. On [DATE], the facility submitted, and the Department accepted, a Removal Plan and allegation of removal of the Immediate Jeopardy effective [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], it was determined that the Immediate Jeopardy was removed by the facility providing education to all staff regarding the change of patient/resident condition policies and procedures. The Immediate Jeopardy for F580 was removed effective [DATE].

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation and interviews, the facility failed to provide a homelike environment on the 1 of 4 Resident Units. Findings include: During observations of the [NAME] Unit (a unit which houses Residents with dementia) on 12/12/22 11:45 A. M., the following was observed: 155: The two shadow boxes outside of the door were empty and did not have any personal identifiers. There were no closet doors and there was permanent marker writing on the wall of the closet to indicate which side of the closet belonged to which bed. The wall, floors and furniture had several scuff marks. 156: One of the shadow boxes outside the room was empty of personal identifiers. There were no closet doors and there was permanent marker writing on the wall of the closet to indicate which side of the closet belonged to which bed. 157: The two shadow boxes outside of the door were empty and did not have any personal identifiers. There were missing knobs on dresser and bedside table. 158: There was one empty shadow box that did not have any personal identifiers. There were no closet doors and there was permanent marker writing on the wall of the closet to indicate which side of the closet belonged to which bed. There were handles missing from a dresser and scruff marks behind A bed. 159: There was no shadow box on the wall outside the door. There were areas of missing paint on the wall of the room and portions of the rubber baseboard molding was peeling away from the wall. 162: There were no shadow boxes outside of the doors. There were no closet doors and there was permanent marker writing on the wall of the closet indicate which side of the closet belonged to which bed. The night stands were scratched up and the linoleum flooring by the bathroom was peeling. 163: There was only one shadow box outside of the door which. There were areas of paint missing on the walls of the bathroom and the walls was scuffed. 165: There were stained ceiling tiles in the bathroom. 166: There was no bathroom mirror. The surveyor then spoke with the Maintence Director who said he found a broken mirror a couple weeks ago in the common area, but did not know which room it had come from. The surveyor then alerted him of the lack of mirror in room [ROOM NUMBER]. There were also stained ceiling tiles by the window. 167: There were no closet doors and there was chipped paint on the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	168: There was no closet door and stained ceiling tiles in the bathroom. 169: There were stained on the ceiling tile of the bathroom and there was a missing closet door. 170: The bathroom ceiling tiles were stained and one was buckling. 171: There was were no closet doors. 176: There was only one shadow box outside of the door without personal identifiers. There were no closet doors and there was permanent marker writing on the wall of the closet to indicate which side of the closet belonged to which bed and stained ceiling tiles. 177: The two shadow boxes outside of the door were empty and did not have any personal identifiers. There was only one closet door and a used brief on an overbed table by the foot of A bed. There was a strong odor of feces coming from the bathroom. 175: There was one shadow box outside of the door and did not have any personal identifiers. The walls and door frames were scuffed. The window blinds were broken. There were no closet doors and there was permanent marker writing on the wall of the closet to indicate which side of the closet belonged to which bed. There was a plastic bag tied from the inside of the closet to the interior door handle to keep the door open. During additional observations of the [NAME] Unit on 12/13/22 at 5:27 A.M., the following was observed: Activity room: There were scuffs marks on the walls, blankets on chairs and and staff personal effects on tables and on top of the TV cabinet. There was plaster exposed on the walls and a visibly torn chair. Dining room: There were scuffs marks on the wall, and a stain of an unknown substance on wall. Shower room: The overhead light in shower stall not working. There was clothing hanging off of shower rack and stains on the ceiling. There was a stuffed cat in a tub. The bathroom had a stained mirror scuffs on the wall and exposed plaster in the bathroom. During an interview with the Maintenance Director on 12/12/22 at 12:22 P.M., he said he was aware that a Resident bathroom on the [NAME] Unit was missing a mirror because approximately two weeks ago he found a broken mirror in a common area on the unit. The Maintenance Director said he did not know which room the mirror had come from. The surveyor then showed the Maintenance Director the bathroom in room [ROOM NUMBER]. The Maintenance Director said there was a mirror in inventory, and he would install it soon. During an interview with Director of Nursing #1 on 12/12/22 at 12:50 P.M., the surveyor informed her of the environmental observations on the [NAME] Unit. Director of Nursing #1 said she was unaware of the missing mirror, and that she did not know why closet doors were missing. 15016

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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** 36876 Based on observation, record review and interview, the facility 1.) failed to ensure Resident #231 was not left alone and neglected in bed by Certified Nurses Aide (CNA) #2 and CNA #4 after experiencing a significant change in condition, 2.) failed to ensure CNA #1 was immediately removed from the facility after allegations of abuse/neglect were alleged (and substantiated) for Resident #4 and Resident #88 and 3.) failed to ensure CNA #4 was immediately removed from the facility after allegations of abuse and neglect were alleged for Resident #82 out of a total of 38 sampled Residents. Findings include: Review of the facility's Abuse Prohibition Policy, updated [DATE] indicated: *Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, injury, or mental anguish. *Neglect is defined as the failure, indifference, or disregard of the Center, its employees or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish or emotional distress. *The employee alleged to have committed the act of abuse will be immediately removed from duty pending investigation. 1. CNA #2 and CNA #4 neglected to ensure Resident #231 was assessed by Unit Manager #2 after experiencing a significant change in condition evidenced by vomiting and difficulty breathing during care and was left alone in bed. Resident #231 was found deceased approximately 1 hour later. Resident #231 was admitted to the facility in [DATE] with diagnoses including type 1 diabetes, ketoacidosis (a serious diabetic reaction where there is not enough insulin in the body), upper gastrointestinal (GI) bleed and kidney failure. Review of Resident #231's Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) dated [DATE], indicated he/she was a Do Not Resuscitate (DNR), and wished to be transferred to the hospital in an urgent event. Review of CNA #2's hand written witness statement signed and dated [DATE] indicated that on [DATE] Resident #231 was assigned to CNA #4. CNA #2 was asked by CNA #4 to help change Resident #231. When CNA #2 arrived in the room, Resident #231 had vomited, the bed was soiled and Resident #231 was gasping for air (originally written as help but was crossed out and written to air.) The statement indicated: I stated the Resident is dying, lets do this quick before she dies on me. I did my best to finish and set up everything and I left. It was around 6:30 A.M. I check on the resident before the new shift started and I found him/her dead. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview with CNA #2 on [DATE] at 8:29 A.M., he said that on [DATE] CNA #4 asked for help changing Resident #231. CNA #2 said that when he got into the room he was surprised because Resident #231 had vomited a brownish color, he/she was gasping for air and looked like he/she was dying. CNA #2 said he told CNA #4 that Resident #231 was dying and we needed to clean him/her quick. CNA #2 said they positioned Resident #231 on his/her back with the head of the bed propped up. CNA #2 said that when they left Resident #231's room, his/her mouth was open and he/she was still gasping for air. CNA #2 said he thought that because Resident #231 was assigned to CNA #4, she would alert the nurse on duty (Unit Manager #2). CNA #2 said around 7:15 A.M., he went to check on Resident #231. CNA #2 said that Resident #231 was dead and went to tell Unit Manager #2. Review of CNA #4's statement dated [DATE] indicated that Resident #231 was assigned to CNA #2 on [DATE]. The statement indicated she assisted CNA #2 in changing Resident #231 and did not include any details of Resident #231's status. Review of Resident #231's Activities of Daily Living (ADL) sheets indicated that CNA #4 had provided care for Resident #231 on [DATE]. During an interview with CNA #4 on [DATE] at 1:27 P.M., she said that she was doing her rounds and saw Resident #231 vomiting. CNA #4 said she made CNA #2 aware that Resident #231 needed assistance and she provided him clean linen for Resident #231. CNA #4 said she did not provide care for Resident #231 on [DATE]. However, CNA #4's interview does not support her written and signed witness statement from [DATE] and clinical documentation in Resident #231's medical record. Review of Unit Manager #2's typed and signed witness statement dated [DATE], indicated that she observed Resident #231 in bed after 6:00 A.M. Unit Manager #2 walked by Resident #231's room around 6:15 A.M. and heard CNA #2 and CNA #4 providing Resident #231's care and overheard CNA #2 and CNA #4 discussing who Resident #231 was assigned to. The statement indicated that on [DATE] at 7:15 A.M., CNA #2 informed Unit Manager #2 that Resident #231 was dead. The statement indicated that CNA #2 made Unit Manager #2 aware at 7:15 A.M., that while he was providing care to Resident #231 there was vomit around his/her mouth and chest and he realized that he/she was dying at that time. Unit Manager #2's statement indicated that she was shocked and went to assess Resident #231 who was found to have no vital signs and he/she had some coffee ground vomit around his/her mouth and he/she was laying flat in the bed. During an interview with Unit Manager #2 on [DATE] at 8:53 A.M., she said that on [DATE] Resident #231 was assigned to CNA #4. She said that sometime after 6:00 A.M., she had observed Resident #231 and he/she was ok. Unit Manager #2 said sometime after that she observed CNA #4 in Resident #231's room and CNA #2 in the hallway discussing who was assigned to the resident, and then they both went into Resident #231's room. Unit Manager #2 said sometime after that, CNA #2 came to her and said that Resident #231 was dead. Unit Manager #2 said she then ran to the room and found the resident without vitals and had vomit on his/her chest. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Unit Manager #2 said that she told CNA #2 and CNA #4 that if they are taking care of a Resident they need to leave right away and are required to report a change in condition to the nurse. Unit Manager #2 said I was beside myself, I was crying. Unit Manager #2 said that had she been made aware, she would have been able call 911 and maybe [Resident #231] would not have died here in the building. I did not have a chance to do anything to prevent it. Unit Manager #2 said that Resident #231's death was not expected. 2. A. Resident #4 was admitted to the facility in February 2019 with diagnoses including chronic obstructive pulmonary disease, heart failure and diabetes. Review of Resident #4's most recent Minimum Data Set assessment dated [DATE] indicated he/she is cognitively intact and required assistance with bathing, dressing and toileting. During an interview with Resident #4 on [DATE] at 1:43 P.M., he/she said that CNA #1 refused to provide care after he/she had soiled himself/herself and that he/she sat in his/her own feces for hours. Resident #4 said he/she was so upset and ended up calling the police. Review of the facility's investigation dated [DATE] included witness statements from nurses indicating that between 8:00 P.M. and 8:30 P.M., CNA #1 was asked by nursing staff to assist Resident #4 with care after he/she had soiled himself/herself in bed. Both witness statements indicated that CNA #1 initially said that she would provide care after she finished her documentation, then when approached again said she was on break. One of the witness statements indicated that CNA #1 told the nurse she had already changed Resident #4 (when she had not) and to leave her alone. During an interview with Nurse #1 on [DATE] at 9:10 A.M , she said that on [DATE] Resident #4 had put on his/her call light and needed to be changed. Nurse #1 said she went to find CNA #1 who was in the TV room and she asked CNA #1 to change Resident #4. Nurse #1 said CNA #1 replied that she was doing her documentation and she would change Resident #4 after. Nurse #1 said that she went a few minutes later to ask CNA #1 again and CNA #1 then said she was on break. Nurse #1 said that the other nurse on that night had also asked CNA #1 to assist in changing Resident #4 but she was not sure how many times. Nurse #1 said that they had to call the nurse supervisor to intervene. CNA #1 had then assisted Resident #4. Nurse #1 said CNA #1 worked the rest of her shift that night. Nurse #1 said she was not sure how long Resident #4 was waiting but it was a long time and Resident #4 was continuously putting on his/her call light while waiting. During an interview with DON #2 on [DATE] at 12:31 P.M., she said that she was not informed of the incident until the day after on [DATE]. During an interview with DON #1, Administrator #1 and Corporate Nurse #1 on [DATE] 11:34 A.M., Corporate Nurse #1 said that the refusal to provide care to is neglectful. B. Resident #88 was admitted to the facility in [DATE] with diagnoses including Alzheimer's disease and malnutrition. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #88's most recent Minimum Data Set assessment dated [DATE] indicated that he/she is severely cognitively impaired and requires assistance with eating, dressing and toileting. Review of the Unit Manager #2's witness statement dated [DATE] indicated that on [DATE] Resident #88's roommate reported that Resident #88 was not fed his/her dinner meal by CNA #1. CNA #1 was asked to leave the facility pending an investigation but went to Resident #88's room and then questioned Resident #88's roommate about the lies he/she told when he/she alleged that CNA #1 did not feed Resident #88 his/her meal. Unit Manager #2's statement indicated that Resident #88's roommate reported to her 3 times that CNA #1 questioned him/her and he/she felt anxious about it. Unit Manager #2's statement also indicated that she informed CNA#1 she could not question Resident #88's roommate as it was intimidation and CNA #1 kept refusing to leave the building. During an interview with DON #2 on [DATE] at 12:31 P.M., she said that she was called on [DATE] because CNA#1 refused to leave the building pending an investigation after he/she was alleged to have neglected Resident #88. DON #2 acknowledged that CNA #1 was terminated effective [DATE] from the facility for the neglect of a Resident. 43807 3. Resident #82 was admitted to the facility in [DATE] with diagnoses including muscle weakness, unsteadiness on feet and difficulty in walking. Review of the most recent Minimum Data Set, dated dated dated [DATE] indicated that the Resident had a brief interview for mental status (BIMS) score of 15 out of a possible 15 indicating intact cognition. Review of the fall packet completed on [DATE] indicated the following: Nurse's description: Resident #82 was observed by Nurse #12 soaking wet, Nurse #12 told CNA #4 to change him/her, CNA #4 refused, Resident #82 was found on the floor soaking wet. Resident's description: Resident #82 was trying to go to the bathroom, when he/she lost control and slid on the floor, denied hitting his/her head. Review of a progress note completed by Nurse #12 on [DATE] indicated the following: She observed Resident #82 with some confusion, she last saw him/her around 6:25 A.M., to give him/her a synthroid dose, the nurse noticed his/her feet hanging by the side of the bed, Nurse #12 helped Resident #82 get comfortable, Nurse #12 then asked CNA #4 who was assigned to the Resident to change him/her, CNA #4 told Nurse #12 that the 7A-3P staff will do it. At 7:15 A.M., another CNA from the 7A-3P shift came to notify Nurse #12 that Resident #82 was found on the floor next to his bed. Nurse #12 proceeded to complete an incident report. During an interview with Unit Manager (UM #2) on [DATE] at 9:24 A.M., she said when she reported for work on [DATE], 7A-3P shift, Nurse #12 informed her of the incident that occurred with Resident #82 after CNA #4 was asked to change him/her and refused to. UM #2 said she completed a fall incident report, UM #2 reported the incident to the Director of Nurses (DON#2). UM #2 said CNAs should take care of Residents on their assignments. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview with DON#2 on [DATE] at 9:47 A.M., she said she did not initiate an abuse and neglect investigation after UM #2 informed her of the incident but looking at the incident at this moment, she should have suspended CNA #4 and initiated an abuse and neglect investigation. Review of CNA #4's work schedule indicated that she worked on the following dates after the incident was reported on [DATE], [DATE], 3:30P-11:15P, [DATE], 3:30P-11:15P, [DATE], 3:,d+[DATE]:15P, [DATE], 2:45P-11:15P, [DATE], 3:30P-11:15P, [DATE], 3:30P-11:15P, [DATE], 3:30P-11:15P. During an interview with DON #1, Administrator #1, and Administrator #2, on [DATE] at 11:05 A.M., DON#1 said the expectation after UM #1 reported the incident would have been to immediately suspend her, get her off the schedule pending an abuse and neglect investigation, report the incident to the Department of Public Health (DPH) within 2 hours, start an investigation with the staff on the shift, collect witness statements, check on the Resident, inform the responsible party and physician, transport the Resident to the emergency room if ordered by the physician, and start an abuse and neglect education with staff in the facility. DON#1 acknowledged that since CNA #4 was not suspended and no abuse and neglect investigation was completed, having her on the schedule after the incident put all Residents in the facility at possible risk and harm.

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F 0604 Level of Harm - 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** 15016 Based on record review, interview, and observation, the facility failed to ensure 1 Resident (#30) of 38 residents was free of an unnecessary physical restraint. On 12/8/22 and 12/9/22, staff placed Resident #30 (a resident who is severely cognitively impaired) in a wheelchair between a wall and table, preventing him/her from rising. Using the reasonable person concept, a person would experience distress having their movement restricted without the ability to understand why. Findings include: Resident #30 was admitted to the facility in June 2021 and had diagnoses which included neurocognitive disorder with Lewy Bodies, Parkinson's disease, muscle weakness (generalized), and difficulty walking. Review of Resident #30's quarterly Minimum Data Set (MDS) assessment, dated 11/16/22, indicated: a Brief Interview for Mental Status Score of 1 (indicating severe cognitive impairment), required extensive two-person assist with mobility on the unit, and had no functional impairment in his/her upper or lower body range of motion. Review of Resident #30's medical record indicated there was no assessment or physician's order for a physical restraint, and no signed consent for a physical restraint. Review of Resident #30's plan of care, dated 7/27/22, indicated he/she had the potential to exhibit physical behaviors and verbal behaviors: Kicking and punching, cursing, screaming and threatening staff related to cognitive loss/dementia, and he/she was at risk for falls related to cognitive loss, and lack of safety awareness. Resident #30's plan of care did not identify restraints as an issue or intervention. During observations on 12/8/22 at 10:59 A.M., 11:20 A.M. to 11:45 A.M., and at 12:15 P.M., Resident #30 was sitting in his/her wheelchair at the [NAME] Unit dining room. Staff had placed the back of his/her wheelchair against a side wall and pushed a dining table above his/her knees. Due to the placement of the wheelchair between the wall and table, Resident #30 was unable to rise from the wheelchair. Resident #30 made multiple attempts to rise from the wheelchair but was unable to stand due to the placement of the wheelchair. During the observation, Resident #30 yelled, Nobody can get out!, and I want to get out of here. At 11:20 A.M., Resident #30 told staff he/she needed to use the toilet. Staff pulled the table away from him/her and then pulled the wheelchair away from the wall. Resident #30 cursed and tried multiple times to kick staff as they wheeled him/her to the bathroom. During observations on 12/9/22 at 9:41 A.M., 10:10 A.M., and 10:17 A.M., Resident #30 was in his/her wheelchair at the [NAME] Unit dining room. Staff had placed the back of his/her wheelchair against a side wall and pushed a dining table above his/her knees. Due to the placement of the wheelchair between the wall and table, Resident #30 was unable to rise from the wheelchair. During an interview with Unit Manager #3 on 12/9/22 at 10:20 A.M., she said Resident #30 had the functional ability to rise from his/her wheelchair. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview with Corporate Nurse #1 on 12/9/22 at 10:45 A.M., in view of the [NAME] Unit dining room and Resident #30, she said the table and wall prevented Resident #30 from rising from the wheelchair.

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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** 36876 Based on record review and interview, the facility failed to 1.) report to the Department of Public Health (DPH) a full and accurate allegation of abuse and neglect after it was alleged that Certified Nurses Aide (CNA) #1 neglected to feed Resident #88 his/her meal and then refused to leave the building and 2.) report an allegation of abuse and neglect to DPH within 2 hours for Resident #82, out of a total of 38 sampled Residents. Findings include: Review of the facility's Abuse Prohibition Policy, updated 10/24/22 indicated: *Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, injury, or mental anguish. *Neglect is defined as the failure, indifference, or disregard of the Center, its employees or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish or emotional distress. *The employee alleged to have committed the act of abuse will be immediately removed from duty pending investigation. *Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will report the allegations involving abuse, (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made. 1. Resident #88 was admitted to the facility in October 2022 with diagnoses including Alzheimer's disease and malnutrition. Review of Resident #88's most recent Minimum Data Set assessment dated [DATE], indicated that he/she is severely cognitively impaired and requires assistance with eating, dressing and toileting. Review of the facility's submitted report to the state agency indicated that on 10/22/22, Resident #88's roommate alleged that CNA #1 failed to feed Resident #88 his/her dinner meal the previous evening (10/21/22). The facility reported that they investigated the incident and were unable to substantiate the claim. Review of the internal investigation included a witness statement from Unit Manager #2 dated 10/22/22, which indicated that on 10/21/22 CNA #1 was asked to leave the facility pending an investigation but instead, CNA #1 went to Resident #88's room and then questioned Resident #88's roommate about the lies he/she told when he/she alleged that CNA #1 refused to feed Resident #88. Unit Manager #2 indicated that she informed CNA#1 she could not question Resident #88's roommate as it was intimidation and CNA #1 continued to refuse to leave the building. Unit Manager #2's statement also indicated that Resident #88's roommate reported to her 3 times that CNA #1 questioned him/her and he/she felt anxious about it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) #2 on 12/12/22 at 12:31 P.M., she said that staff from the facility telephoned her on 10/22/22 because CNA#1 refused to leave the building pending an investigation after he/she was alleged to have refused to feed Resident #88. DON #2 acknowledged that CNA #1 was terminated from the facility effective 10/27/22 due to an allegation of neglect by a Resident. The facility failed to include in its report to the state agency that CNA #1 refused to feed Resident #88, refused to leave the facility pending an investigation, and intimidated Resident #88's roommate who was a witness to the alleged incident, and was also terminated effective 10/27/22 for the neglect of a resident. 43807 2.) Resident #82 was admitted to the facility in June 2019 with diagnoses including muscle weakness, unsteadiness on feet and difficulty walking. Review of the most recent Minimum Data Set, dated dated dated [DATE] indicated he/she had a brief interview for mental status (BIMS) score of 15 out of a possible 15, indicating intact cognition. Review of Resident #82's fall investigation, dated 9/19/22 indicated the following: Nurse #12 observed that Resident #82 was soaking wet. Nurse #12 told Certified Nurse Aide (CNA) #4 to change him/her, CNA #4 refused, and later staff found that Resident #82 had fallen to the floor and was still soaking wet. The fall investigation indicated that Resident #82 said he/she was trying to go to the bathroom and while walking lost control and slid to the floor. Resident #82 said he/she did not hit his/her head on the floor. Review of Nurse #12's progress note, dated 9/19/22, indicated she observed Resident #82 and he/she appeared confused. Nurse #12 indicated she last saw Resident #82 around 6:25 A.M., to give him/her medication. Nurse #12 indicated that Resident #82 was dangling his/her feet over the side of the bed. Nurse #12 indicated she helped Resident #82 get comfortable, and then asked CNA #4 (who was assigned to Resident #82) to change his/her clothing. Nurse #12 indicated that CNA #4 told Nurse #10 that the 7:00 A.M. to 3:00 P.M. staff will do it. Nurse #12 indicated that at 7:15 A.M., another CNA from the 7:00 A.M. to 3:00 P. M. shift notified Nurse #12 that Resident #82 was found on the floor next to his/her bed. Nurse #12 proceeded to complete an incident report. During an interview with Unit Manager (UM) #2 on 12/14/22 at 9:24 A.M., she said when she reported for work on 9/19/22, 7:00 A.M. to 3:00 P.M. shift, Nurse #12 informed her of the incident that occurred with Resident #82 after CNA #4 was asked to change him/her and refused to. UM #2 said she completed a fall incident report, UM #2 said she told reported Director of Nurses (DON) #2 about the incident. UM #2 said CNAs should take care of Residents on their assignments. During an interview with DON #1, Administrator #1, and Administrator #2, on 12/14/22 at 11:05 A.M., DON #1 said the expectation after UM #2 reported the incident would have been to immediately suspend CNA #4, get her off the schedule pending an abuse and neglect investigation, and report the incident to the Department of Public Health (DPH) within 2 hours.

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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** 43807 Based on interviews and record review, the facility failed to investigate an allegation of neglect and abuse for 1 Resident (#82) out of a sample of 38 Residents. Findings include: Review of the facility policy titled Abuse Prohibition, revised 10/24/22, indicated the following: *Staff will identify events such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse and determine the direction of the investigation. *The employee alleged to have committed the act of abuse will be immediately removes from duty, pending investigation. Resident #82 was admitted to the facility in June 2019 with diagnoses including muscle weakness, unsteadiness on feet and difficulty in walking. Review of the most recent Minimum Data Set, dated dated dated [DATE] indicated that the Resident had a brief interview for mental status (BIMS) score of 15 out of a possible 15 indicating intact cognition. Review of the fall packet completed on 9/19/22 indicated the following: Nurse's description: Resident #82 was observed by Nurse #12 soaking wet, Nurse #12 told CNA #4 to change him/her, CNA #4 refused, Resident #82 was found on the floor soaking wet. Resident's description: Resident #82 was trying to go to the bathroom, when he/she lost control and slid on the floor, denied hitting his/her head. Review of a progress note completed by Nurse #12 on 9/19/22 indicated the following: She observed Resident #82 with some confusion, she last saw him/her around 6:25 A.M., to give him/her a synthroid dose, the nurse noticed his/her feet hanging by the side of the bed, Nurse #12 helped Resident #82 get comfortable, Nurse #12 then asked CNA #4 who was assigned to the Resident to change him/her, CNA #4 told Nurse #12 that the 7A-3P staff will do it. At 7:15 A.M., another CNA from the 7A-3P shift came to notify Nurse #12 that Resident #82 was found on the floor next to his bed. Nurse #12 proceeded to complete an incident report. During an interview with Unit Manager (UM #2) on 12/14/22 at 9:24 A.M., she said when she reported for work on 9/19/22, 7A-3P shift, Nurse #12 informed her of the incident that occurred with Resident #82 after CNA #4 was asked to change him/her and refused to. UM #2 said she completed a fall incident report and reported the incident to the Director of Nurses (DON#2). UM #2 said CNAs should take care of Residents on their assignments. During an interview with DON #1, Administrator #1, and Administrator #2, on 12/14/22 at 11:05 A.M., DON#1 said the expectation after UM #2 reported the incident would have been to immediately suspend CNA #4, get her off the schedule pending an abuse and neglect investigation. CNA #4 was not suspended and no abuse and neglect investigation was completed.

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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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F 0655 Level of Harm - Actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44095 Based on record reviews and interviews, for one of 38 sampled Residents (Resident #124) the facility failed to ensure its staff developed and implemented a baseline care plan that included the instructions needed to provide effective and person-centered care for him/her, resulting in a fall, spinal injury and hospitalization . Findings include: Review of the facility policy titled, Person-Center Care Plan, dated as reviewed 10/22, indicated: -the Center must develop and implement a baseline person-centered care plan with-in 48 hours of admission for each resident that includes instructions needed to provide effective and person-centered care that meets professional standards of quality care. -a comprehensive, individualized care plan will be developed with-in 7 days after completed of a comprehensive assessment. Resident #124 was admitted to the facility in October 2022 with a diagnosis of hemiplegia (paralysis on one side of the body) following cerebral infraction (stroke) affecting the right dominant side and left humerus (bone in the upper arm) fracture. Review of Resident #124's discharge summary transfer form, dated 10/7/22, indicated he/she required an assistance of two and was non-weight bearing to his/her left upper extremity. Review of Resident #124's lift transfer reposition assessment, dated 10/8/22, indicated he/she required two staff members for repositioning in bed. Review of Resident #124's Occupational Therapy Evaluation, dated 10/8/22, indicated he/she had a prior level of function of a maximum assistance of two for bed mobility. Review of Resident #124's Physical Therapy Evaluation, dated 10/10/22, indicated he/she required maximum assist for bed mobility including rolling from the left to the right. The evaluation indicated he/she was non-weight bearing on his/her left shoulder because of a fracture and wore a sling and had right sided hemiparesis (inability to move). Review of Resident #124's Social Services Assessment, dated 10/11/22, indicated he/she was alert and oriented. The assessment indicted he/she could make self understood and could understand others. Review of the nursing progress note, dated 10/22/22, indicated Resident #124 was readmitted after a cervical spine 5 and cervical spin 6 anterior cervical discectomy and fusion (ACDF) on 10/16/22. Review of Resident #124's medical record indicated there was no documentation to support a baseline care plan was developed and implemented, that included the instructions needed to provide effective and person-centered care related to activities of daily living was developed until 10/30/22. (continued on next page)

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F 0655 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #124's incident report, dated 10/15/22, indicated Resident #124 rolled off the bed while receiving care from Certified Nurse Aide (CNA) #1. During a phone call to interview CNA #1 on 12/13/22 at 4:14 P.M., CNA #1 answered her phone, she identified herself and declined an interview with the surveyor. During an interview on 12/13/22 at 5:16 A.M., Nurse #2 said that Resident #124 required two people for bed mobility. Nurse #2 said she didn't know why CNA #1 provided care alone and said that Resident #124 could not move his/her left or his/her right side. During an interview on 12/14/22 at 8:11 A.M., Director of Nursing (DON) #2 said that nursing should have developed and implemented a baseline care plan for Resident #124.

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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. 44095 Based on observation, interviews and record review, the facility failed to ensure that nursing staff consistently implemented a physician's order for a resting hand splint for one Resident (#124) out of a total sample of 38 Residents. Findings include: Resident #124 was admitted to the facility in October 2022 with diagnosis including hemiplegia (paralysis on one side of the body) following cerebral infraction (stroke) affecting the right dominant side and left humerus (bone in the upper arm) fracture. Review of Resident #124's Admission Minimum Data Set assessment, dated 10/25/22, indicated he/she was cognitively intact and could make his/herself understood and he/she understands others. The MDS indicated he/she had a functional limitation in range of motion in the upper extremity on one side (shoulder, elbow, wrist, hand). Review of the physician's order dated, 11/30/22, indicated: -apply right hand brace at bedtime and remove in the morning. Review of the Treatment Administration Record, dated December 2022 indicated on 12/4/22, 12/5/22, 12/7/22, and 12/8/22 the splint was documented as off at bedtime. Review of the Occupational Therapy note dated 12/8/22, indicated that nursing staff are not applying Resident #124's right hand brace. During an observation on 12/8/22 at 8:09 A.M., the hand splint was on the dresser. Resident #124 said staff do not put it on him/her at night. During an observation on 12/9/22 at 6:38 A.M., the hand splint was on the dresser. Resident #124 said staff do not put in on him/her at night. During an interview on 12/8/22 8:08 A.M., Resident #124 said she required a hand splint to his/her right hand. Resident #124 said that nursing does not apply the splint even when she asks for it. During an interview on 12/13/22 at 8:35 A.M., the Occupational Therapist said that nursing was not applying Resident #124's right resting hand splint at night as ordered. During an interview on 12/14/22 at 8:14 A.M., Director of Nursing #2 said that she would look into Resident #124's right resting hand splint.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on interview and record review, the facility failed to 1.) assess competency and capacity before starting a conservatorship process for Resident #62 resulting in emotional harm and distress, 2.) failed to ensure Nurse #7 prepared and administered an injection that met professional standards of quality 3.) and failed to monitor a pacemaker for Resident #90 out of a total of 38 sampled Residents. Findings include: 1. Resident #62 was admitted in March 2022 with diagnoses including anxiety and hypertension (high blood pressure). Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #62 scored an 11 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive loss. During an interview on 12/8/22 at 8:45 A.M., Resident #62 said that she wants to go home and has wanted to go home for months now. Resident #62 said that she cries a lot because of it and feels that staff don't treat her fairly. Review of the clinical record indicated that a Health Care Proxy form was completed, but not invoked; therefore, Resident #62 is his/her own person and can make his/her own decisions. Review of the clinical record indicated that the facility was filing for conservatorship for Resident #62 in the month of May 2022. During an interview on 12/22/22 at 9:30 A.M., Social Worker #1 said that Resident #62 came to stay for rehab and his/her home conditions were unlivable, but that a company had gone in and cleaned Resident #62's home for discharge with a visiting nurse agency (VNA) services. Resident #62 was readmitted and does not have any other family. Because there is no other person, the facility decided to pursue conservatorship. The social worker said that she is not involved in that decision and that the Administrator and Physician made the decision. The social worker said that there was not a psych evaluation completed for Resident #62 to determine if she was appropriate for conservatorship. The social worker said that the psych doctor would be the one to make that evaluation. During an interview on 12/22/22 at 9:43 A.M., the psych doctor said that he had not completed an interview for formal capacity on Resident #62. During an interview on 12/14/22 at 1:20 P.M., Physician #1 said that Resident #62 was put on conservatorship this year and has some cognition deficits. Physician #1 said that Resident #62 was seen by psych services prior, but could not say who made a complete evaluation of Resident #62. Physician #1 said that Resident #62's health care proxy was not invoked and should have been. During an interview with Resident #62 on 12/16/22 at 7:53 A.M., he/she that he/she has no idea what is going on with his/her money. Resident #62 said that all he/she knows is that the facility takes money from his/her bank to pay themselves but knows nothing else about his/her financial matters. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44095 2.) For Resident #49, the facility failed to ensure Nurse #7 prepared and administered an injection that met professional standards of quality when Nurse #7 did not clean a rubber seal of an insulin pen and she did not prime the injection prior to administering the injection. (removing the air from the needle and the cartridge that may collect during normal use. It is important to prime the pen before each injection so that the injection will work correctly. If a nurse does not prime before each injection, a nurse may get too much or too little insulin, resulting in the incorrect dose). Review of the Basaglar (long acting insulin) pen (insulin pen) manufacture's instructions, dated as reviewed 2022, indicated: - Wipe the rubber seal with an alcohol swab. - Push the capped needle straight onto the pen (rubber seal) and twist the needle on. - Prime the needle - To prime the pen, turn the dose knob to select 2 units. - Hold the pen with the needle pointing up. - Tap the cartridge holder gently to collect air bubbles at the top. - Continue holding your pen with the needle pointing up. - Push the dose knob in until it stops, and 0 is seen in the dose window. - Hold the dose knob in and count to 5 slowly. - You should see insulin at the tip of the needle, meaning the pen is primed and ready to use to ensure the correct dose. - If you do not see insulin, repeat the priming steps. During the medication pass observation on 12/9/22 at 8:28 A.M., Nurse #7 prepared and administered Resident #49's Basaglar pen 8 units subcutaneously (under the skin) -Nurse #7 did not wipe the rubber seal with an alcohol swab prior to use. -Nurse #7 pushed the capped needle straight onto the pen (rubber seal). -Nurse #7 did not prime the needle -Nurse #7 did not prime the pen -Nurse #7 did not ensure she could see insulin at the tip of the needle, meaning the pen is primed and ready to use to ensure the correct dose. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #7 administered the insulin, without following the manufactures guidelines. During an interview on 12/9/22 at 9:05 A.M., Nurse #7 said she should have followed the manufactures guidelines and primed the insulin pen prior to administering Resident #49's medication to ensure the correct dose was administered. During an interview on 12/14/22 at 9:19 A.M., Director of Nursing #2 said Nurse #7 should have followed the manufactures guidelines and primed the insulin pen prior to administration. 36876 3. For Resident #90, the facility failed to monitor his/her pacemaker. Resident #90 was admitted to the facility in October 2020 with diagnoses including end stage renal failure and chronic systolic heart failure. Review of Resident #90's most recent Minimum Data Set assessment dated [DATE] indicated he/she is cognitively intact and requires assistance with bathing/dressing and toileting. Review of Resident #90's clinical record indicated that Resident #90 was admitted to the facility with a pacemaker. Review of the facility's Pacemaker Care policy dated 6/1/21 indicated: *Upon admission of patient who as a pacemaker: Identify pacemaker type, serial number and manufacturer of pacemaker, date and site of implementation, and cardiologists/surgeons name in medical record. *Document schedule for patient's pacemaker check ins with patient care plan and on Treatment Administration Record Review of Resident #90's physician's orders and care plans failed to identify Resident #90's pacemaker, a means to monitor the pacemaker or parameters for his/her pulse. During an interview with Unit Manager #1 on 12/9/22 at 1:27 P.M., she said that there should be a physicians order and a care plan for staff to follow to provide care regarding the make, model, and pulse setting for Resident #90's pace maker.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 15016 Based on interview, record review and observation, the facility failed to follow the rehabilitation plan of care and physician's orders for 2 (#100, #30) of 38 Residents. Findings include: 1. Resident #100 was admitted to the facility in February 2020 and had diagnoses which included muscle weakness (generalized), contracture right knee, and aphasia following cerebral infarction. Resident #100's quarterly Minimum Data Set (MDS) assessment, dated 9/6/22, indicated a Brief Interview for Mental Status (BIMS) examination score of 0, indicating severe cognitive impairment, and extensive staff assistance with dressing and toileting. Review of Resident #100's Occupational Therapy Discharge Evaluation, dated 7/16/21, indicated he/she was to wear a right resting hand splint daily overnight to reduce a worsening contracture. Review of Resident #100's Physical Therapy Functional Maintenance Program, dated 1/6/22, indicated nursing staff were to place a knee brace on his/her right leg and secure with straps, and to leave on for between 4 to 6 hours. Review of Resident #100's Physical Therapy Discharge Summary, dated 1/19/22, indicated Restorative Nursing/Maintenance Program. Review of Resident #100's Occupational Therapy Discharge Evaluation, dated 2/2/22, indicated he/she was to wear a right palm protector splint up to 24/7, as tolerated. The evaluation indicated nursing staff were educated on the use of the splint. Resident #100's physician orders, dated 7/11/21, indicated Resident to wear right resting hand splint up to 8 hours overnight daily to reduce risk of worsening contracture every day and night shift. Resident #100's physician orders, dated 10/19/21, indicated Resident to wear palm protector up to 24 hours daily as tolerated. Doff for self care routines. Monitor for signs and symptoms of skin breakdown every day and every evening shift. Resident #100's physician orders, dated 1/7/22, indicated Right knee brace to be worn during the day 4 to 6 hours every day shift. Resident #100's plan of care for decreased ability to perform ADLS (activities of daily living) due to limited mobility and right-sided weakness due to status post cerebral vascular accident, dated 2/14/20, indicated Right resting splint off during the day and on at night. Resident #100's plan of care did not reference the use of a palm protector or knee brace. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's Treatment Administration Record (TAR) indicated staff documented that he/she wore a palm protector, wrist splint and right knee brace during the day shifts of 12/8/22 and 12/9/22. During an observation on 12/9/22 at 9:48 A.M., 12:21 P.M. and 1:25 P.M., a sign was posted above Resident #100's headboard indicating he/she was supposed to wear a wrist splint 24/7, except during care. The surveyor observed Resident #100 was not wearing a splint, or any other orthotic device. The surveyor looked in Resident #100's bedroom and bathroom and did not see any orthotic devices. Resident #100 was not interviewed due to his/her cognitive status. During an interview with Unit Manager #3 on 12/9/22 at 1:26 P.M., in Resident #100's bedroom, we observed the sign on the wall indicating the use of a wrist splint, and that he/she was not wearing a splint, or any other orthotics. Unit Manager #3 said Resident #100 did not have a palm protector, wrist splint or brace and that if he/she did they were discontinued a long time ago. During an interview with the Director of Rehabilitation on 12/9/22 at 1:36 P.M., she reviewed Resident #100's occupational and physical therapy discharge summaries and physician orders. The Director of Rehabilitation said these were still in effect and the palm protector, wrist splint and right knee brace are still required to be worn on a daily basis. During an interview with Occupational Therapist (OT) #2 on 12/12/22 at 1:17 P.M., she said she was unable to determine if there had been any change in Resident #100's contracture range of motion since being discharged from services on 7/16/21, because the examining occupational therapist did not document measurements from this date. OT #2 said it was part of a comprehensive discharge assessment to obtain and document these measurements in order to later determine if a change in range of motion occurred. During an interview with the Physical Therapy Assistant (PTA) #1 on 12/14/22 at 10:44 A.M., she reviewed Resident #100's physician orders and Physical Therapy Discharge Summary and said Resident #100 should still be wearing a right knee brace. PTA #1 said that on 12/11/22 she measured Resident #100's knee contracture and determined there had been no decline since discharge from services in January 2022. 2. Resident #30 was admitted to the facility in June 2021, and had diagnoses which included neurocognitive disorder with Lewy Bodies, Parkinson's disease, muscle weakness (generalized), and difficulty walking. Review of Resident #30's physician's order dated 10/7/22, indicated, Bilateral ankle cushion boot to protect feet. Every shift. Resident #30's plan of care for risk for skin breakdown related to impaired mobility and incontinence, revised 11/3/22, indicated Lower extremity protectors. During observations throughout the days on 12/8/22, 12/9/22 and 12/12/22, Resident #30 was in the dining room and seated in a wheelchair. Resident #30 was not wearing ankle boots or other lower extremity protectors. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's Treatment Administration Record, dated 12/8/22, 12/9/22 and 12/12/22, indicated staff placed ankle protectors on him/her, despite the surveyor's observation that these were not present. During an interview with the Director of Rehabilitation on 12/9/22 at 1:36 P.M., she reviewed Resident #30's physician orders, and said these orders required the use of an ankle protector every shift. During an interview with the Director of Nurses (DON) #2 on 12/12/22 at 12:48 P.M., the surveyor informed her that Resident #30 had not worn ankle protectors during observations on 12/8/22, 12/9/22 and 12/12/22, and that staff documented that this treatment had occurred. DON #2 said she did not know why Resident #30 was not wearing ankle protectors while in his/her wheelchair, or why staff documented it was done.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to provide quality care in accordance with professional standards of practice for 1 Resident (#231) out of a total of 38 sampled Residents. While providing care to Resident #231, Certified Nurse Aide (CNA) #2 and CNA #4 observed Resident #231 to have a change in condition as evidenced by vomiting and difficulty breathing. CNA #2 and CNA #4 continued to provide care for Resident #231 and then left him/her alone in bed without alerting licensed nursing staff (Unit Manager #2). Resident #231 was found deceased approximately one hour later. Findings include: Resident #231 was admitted to the facility in [DATE] with diagnoses including type 1 diabetes, ketoacidosis (a serious diabetic reaction where there is not enough insulin in the body), upper gastrointestinal (GI) bleed and kidney failure. Review of the hospital discharge paperwork, dated [DATE] indicated that Resident #231 had a previous hospital admission due to diabetic ketoacidosis and was found unresponsive in his/her home with coffee ground emesis. Review of Resident #231's Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) dated [DATE], indicated he/she was a Do Not Resuscitate (DNR), and wished to be transferred to the hospital in an urgent event. Review of CNA #2's hand written witness statement signed and dated [DATE] indicated that on [DATE] Resident #231 was assigned to CNA #4. CNA #2 was asked by CNA #4 to help change Resident #231. When CNA #2 arrived in the room, Resident #231 had vomited, the bed was soiled and Resident #231 was gasping for air (originally written as help but was crossed out and written to air.) The statement indicated: I stated the Resident is dying, lets do this quick before she dies on me. I did my best to finish and set up everything and I left. It was around 6:30 A.M. I check on the resident before the new shift started and I found him/her dead. During an interview with CNA #2 on [DATE] at 8:29 A.M., he said that on [DATE] CNA #4 asked for help changing Resident #231. CNA #2 said that when he got into the room he was surprised because Resident #231 had vomited a brownish color, he/she was gasping for air and looked like he/she was dying. CNA #2 said he told CNA #4 that Resident #231 was dying and we needed to clean him/her quick. CNA #2 said they positioned Resident #231 on his/her back with the head of the bed propped up. CNA #2 said that when they left Resident #231's room, his/her mouth was open and he/she was still gasping for air. CNA #2 said he thought that because Resident #231 was assigned to CNA #4, she would alert the nurse on duty (Unit Manager #2). CNA #2 said around 7:15 A.M., he went to check on Resident #231. CNA #2 said that Resident #231 was dead and went to tell Unit Manager #2. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of CNA #4's statement dated [DATE] indicated that Resident #231 was assigned to CNA #2 on [DATE]. The statement indicated she assisted CNA #2 in changing Resident #231 and did not include any details of Resident #231's status. Review of Resident #231's Activities of Daily Living (ADL) sheets indicated that CNA #4 had provided care for Resident #231 on [DATE]. During an interview with CNA #4 on [DATE] at 1:27 P.M., she said that she was doing her rounds and saw Resident #231 vomiting. CNA #4 said she made CNA #2 aware that Resident #231 needed assistance and she provided him clean linen for Resident #231. CNA #4 said she did not provide care for Resident #231 on [DATE]. However, CNA #4's interview does not support her written and signed witness statement from [DATE] and clinical documentation in Resident #231's medical record. Review of Unit Manager #2's typed and signed witness statement dated [DATE], indicated that she observed Resident #231 in bed after 6:00 A.M. Unit Manager #2 walked by Resident #231's room around 6:15 A.M. and heard CNA #2 and CNA #4 providing Resident #231's care and overheard CNA #2 and CNA #4 discussing who Resident #231 was assigned to. The statement indicated that on [DATE] at 7:15 A.M., CNA #2 informed Unit Manager #2 that Resident #231 was dead. The statement indicated that CNA #2 made Unit Manager #2 aware at 7:15 A.M., that while he was providing care to Resident #231 there was vomit around his/her mouth and chest and he realized that he/she was dying at that time. Unit Manager #2's statement indicated that she was shocked and went to assess Resident #231 who was found to have no vital signs and he/she had some coffee ground vomit around his/her mouth and he/she was laying flat in the bed. During an interview with Unit Manager #2 on [DATE] at 8:53 A.M., she said that on [DATE] Resident #231 was assigned to CNA #4. She said that sometime after 6:00 A.M., she had observed Resident #231 and he/she was ok. Unit Manager #2 said sometime after that she observed CNA #4 in Resident #231's room and CNA #2 in the hallway discussing who was assigned to the resident, and then they both went into Resident #231's room. Unit Manager #2 said sometime after that, CNA #2 came to her and said that Resident #231 was dead. Unit Manager #2 said she then ran to the room and found the resident without vitals and had vomit on his/her chest. Unit Manager #2 said that she then notified the provider to obtain a death pronouncement order. Unit Manager #2 said that Unit Manager #1 performed the pronouncement. Unit Manager #2 said that she told CNA #2 and CNA #4 that if they are taking care of a Resident they need to leave right away and are required to report a change in condition to the nurse. Unit Manager #2 said I was beside myself, I was crying. Unit Manager #2 said both CNA #2 and CNA #4 had the responsibility to notify her of Resident #231's change in condition. Unit Manager #2 said that had she been made aware, she would have been able call 911 and maybe [Resident #231] would not have died here in the building. I did not have a chance to do anything to prevent it. Unit Manager #2 said that Resident #231's death was not expected. During interviews with Director of Nursing (DON) #2 on [DATE] at 10:03 A.M., and again at 2:33 P.M., she said that both CNA #2 and CNA #4 had the responsibility to notify Unit Manager #2 of Resident #231's change in condition, regardless of who was assigned to the Resident. She said that it is not within the scope of practice for a CNA to assess a resident's condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:00 P.M., the Administrator was provided with the Immediate Jeopardy Template. On [DATE], the facility submitted, and the Department accepted, a Removal Plan and allegation of removal of the Immediate Jeopardy effective [DATE]. On [DATE], it was determined that the Immediate Jeopardy was removed by the facility providing education to all staff regarding the change of patient/resident condition policies and procedures. The Immediate Jeopardy for F684 was removed effective [DATE]. See F580

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on observation, interview and record review, the facility failed to provide audiology services for 1 Resident (#37) out of a total sample of 38 Residents. Findings include: Review of the facility policy titled, Hearing Aid, dated as revised 6/1/21, indicated: -store the hearing aides in a safe place. Resident #37 as admitted to the facility in June 2021 with diagnoses including major depression and anxiety. Review of Resident #37's quarterly minimum data assessment, (MDS) dated [DATE], indicated that he/she can usually make self understood and he/she usually understands others. The MDS indicated he/she had difficulty with hearing and he/she did not have a hearing aid. During an interview on 12/8/22 at 7:59 A.M., Resident #37 said that he/she is hard of hearing and this makes him/her feel empty and lost. Resident #37 said that when he/she admitted to the facility he/she had a hearing aid and someone took the hearing aid. Resident #37 said she would like to see someone to get a new hearing aid. Review of Resident #37's inventory of personal effects sheet, dated 6/14/21, indicated he/she was admitted with a right hearing aid. Review of nursing note, dated 11/21/21, indicated Resident #37 required a hearing aid. Review of the Health Drive Request for Service, dated 12/6/21, indicated that Resident #37 requested to be seen by audiology services. Review of the Resident #37's Grievance Forms, dated as 9/21/21, 10/3/21, and 7/6/22, indicated he/she had missing items. However, these grievances did not indicate his/her right hearing aid was missing. Review of Resident #37's plan of care related to hearing, dated as reviewed 9/20/22, indicated: -staff to speak in a normal tone voice clearly and slowly. Review of the Nurse Practitioner (NP) progress note dated 8/16/22, indicated that Resident #37 had complaints of difficulty hearing. The note indicated that the NP would continue to follow. During an interview on 12/9/22 at 10:14 A.M., Certified Nurse Aide (CNA) #5 said that Resident #37 used to have a hearing aid. CNA #5 said that he/she has difficulty hearing and CNA #5 often has to repeat herself so Resident #37 can hear her. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/9/22 at 12:12 P.M., the Activities Director was observed in the hall way with Resident #37. The Activities Director had to position herself within a foot to Resident #37 and had to repeat herself three times, yelling loudly in a manner that Resident #37 could hear her. The Activities Director said to the surveyor that Resident #37 is hard of hearing. During an interview on 12/13/22 at 7:13 A.M., Resident #37 said she was hard of hearing. Resident #37 said he/she wanted his/her hearing aide back so he/she could hear. Resident #37 showed the surveyor a box of hearing aid batteries that he/she had stored in his/her desk and said he/she really would like a hearing aid. During an interview on 12/13/22 at 9:59 A.M. Nurse Practitioner #2 (NP) said that Resident #37 has difficulty hearing. NP #2 said that Resident #37 has complained that he/she does not have his/her hearing aid. The NP #2 said that Resident #37 has signed consent for audiology services and nursing should have audiology evaluate him/her. During an interview on 12/14/22 at 8:06 A.M., Director of Nursing #2 said Resident #37 has not been seen by audiology services since her admission. DON #2 said that Resident #37 should have been seen for his/her difficulty hearing.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41019 Based on observation, record review, and interview, the facility failed to identify and assess a decline in ambulation status for 1 Resident (#109), out of a total sample of 38 residents. Findings include: Resident #109 was admitted in March 2022 with diagnoses including chronic kidney disease and type II diabetes. Review of the Minimum Data Set (MDS) assessment, dated 9/21/22, indicated that Resident #109 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. Review of the MDS indicated that Resident #109 requires extensive assist with all activities of daily living and supervision with meals. Review of the care plan for Resident #109 indicated that Resident #109 is at risk for a decreased ability to perform activities of daily living due to limited mobility. During an observation and interview on 12/8/22 at 8:15 A.M., Resident #109 was lying in bed and said that he/she used to be able to walk but is now bedbound or in a wheelchair. Resident #109 said that he/she wants to be able to walk again. During an interview on 12/09/22 at 9:43 A.M., Unit Manager #1 said that Resident #109 can stand and pivot and sits in the wheelchair. Unit Manager #1 said the Resident #109 is currently working with therapy for a new chair. During an interview on 12/9/22 at 1:18 P.M., Occupational Therapist #1 said that Resident #109 is on therapy regarding a new chair, but not for ambulation. Review of the Physical Therapy Discharge Summary, dated 4/26/22, indicated that Resident #109 was able to ambulate 100 feet with contact guard assistance from staff. During an interview on 12/13/22 at 10:35 A.M., Physical Therapist #1 said that Resident #109 was on therapy case load in June 2022 and was able to walk 50 feet with moderate assistance from staff. Physical Therapist #1 said that if staff notice a decline and a resident is willing to work with therapy, then a referral to therapy should be made. Physical Therapist #1 said that she had not received a referral for Resident #109 but would do an evaluation in the morning. Review of the Physical Therapy evaluation, dated 12/13/22, indicated that Resident #109 was dependent at baseline and presents with gross deconditioning and decreased strength throughout bilateral extremities. Resident #109 was put on therapy caseload.

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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 0689 Level of Harm - 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** 44095 Based on interview, observation and record review, the facility failed to 1.) ensure Resident #124 received adequate supervision and assistance to prevent a fall with injury and failed to 2.) provide appropriate supervision to Residents on 3 of 4 units as evidenced by staff sleeping during the overnight shift (11:00 P.M. - 7:00 A.M.) on 3 of 4 units. Findings include: 1.) For Resident #124, who had a diagnosis of right sided hemiplegia (paralysis on one side of the body), had a broken left humerus (bone in the upper arm) which required a sling and who was also non-weight bearing to his/her left side and required assistance of two staff members for bed mobility, the facility failed to ensure Resident #124 was provided adequate staff assistance as required to maintain his/her safety to prevent incidents and/or accidents resulting in a fall. -On 10/15/22, Certified Nurse Aide (CNA) #1 provided Resident #124 care in bed and CNA #1 turned to get a washcloth Resident #124 rolled off the bed and onto the floor. Resident #124 was transferred to the hospital and diagnosed with cervical disc herniation with developing spinal cord injury of the cervical spine 5 and cervical spine 6 (C5-6). Review of the facility policy titled, Falls Management, dated as revised 6/15/22, indicated Residents who experience falls will receive appropriate care and post fall interventions will be implemented. Resident #124 was admitted to the facility in October 2022 with diagnoses including hemiplegia (paralysis on one side of the body) following cerebral infraction (stroke) affecting the right dominant side and left humerus (bone in the upper arm) fracture. Review of Resident #124's Discharge Summary Transfer form, dated 10/7/22, indicated he/she required an assistance of two and was non-weight bearing to his/her left upper extremity. Review of Resident #124's Treatment Administration Record, dated October 2022, indicated the following physician's orders: -avoid range of motion of the shoulder (not specified which shoulder), dated as initiated 10/7/22 -wear sling at all times to the left arm, dated as initiated 10/7/22 Review of Resident #124's Lift Transfer Reposition assessment, dated 10/8/22, indicated he/she required two staff members for repositioning in bed. Review of Resident #124's Occupational Therapy Evaluation, dated 10/8/22, indicated he/she had a prior level of function of a maximum assistance of two for bed mobility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #124's Physical Therapy Evaluation, dated 10/10/22, indicated he/she required maximum assist for bed mobility including rolling from the left to the right. The evaluation indicated he/she was non-weight bearing on his/her left shoulder because of a fracture and wore a sling and had right sided hemiparesis. Review of Resident #124's Social Services Assessment, dated 10/11/22, indicated he/she was alert and oriented. The assessment indicted he/she could make self understood and could understand others. Review of Resident #124's medical record indicated there was no documentation to support a plan of care related to activities of daily living (how staff should provide and the level of assistance required) was not developed until 10/30/22. Review of Resident #124's incident report, dated 10/15/22, indicated Resident #124 rolled off the bed while being provided care by Certified Nurse Aide (CNA) #1. Review of CNA #1's written statement, dated 10/15/22, indicated she turned to get a washcloth from the bedside table and Resident #124 rolled off the bed. During a phone call to CNA #1 for interview on 12/13/22 at 4:14 P.M., CNA #1 answered her phone identified herself, and she declined an interview with the surveyor. During an interview on 12/13/22 at 5:16 A.M., Nurse #2 said that she worked the evening shift on 10/15/22 when Resident #124 fell on the floor. Nurse #2 said that she went into Resident #124's room where she found CNA #1 adjusting Resident #124 on the floor. Nurse #2 said she did not know why CNA #1 did not immediately notify her that Resident #124 was on the floor. Nurse #2 said she had observed Resident #124 laying on his/her right side on the floor and that the CNA #1 had moved the nightstand away from Resident #124's head. Nurse #2 said she should have assessed Resident #124 before CNA #1 moved Resident #124 around on the floor. Nurse #2 said she was not sure why CNA #1 was providing care to him/her alone and said that Resident #124 could not move his/her left or his/her right side. Nurse #2 said that CNA #1 said Resident #124 did not hit his/her head on the floor and Nurse #2 did not believe CNA #1 and sent Resident #124 to the hospital. During an interview on 12/9/22 at 10:15 A.M., CNA #5 said that when Resident #124 was first admitted he/she wore a sling and could not do anything with his/her left arm. CNA #5 said that Resident #124's right side was paralyzed, and he/she could not move it. CNA #5 said he/she required two staff to assist Resident #124 with bed mobility. During an interview on 12/14/22 at 10:55 A.M., CNA #6 said that when Resident #124 was first admitted he/she wore a sling and could not do anything with his/her left arm. CNA #6 said that Resident #124's right side was paralyzed and he/she could not move it. CNA #6 said he/she required two staff to assist Resident #124 with bed mobility and he/she was essentially helpless. During an interview on 12/8/22 at 8:08 A.M. and again on 12/14/22 at 10:30 A.M., Resident #124 said that the day he/she had fallen out of bed he/she was receiving care from CNA #1. Resident #124 said CNA #1 was alone and rolled him/her on his/her left side to change his/her brief. Resident #124 said he/she began to slide off of the bed when CNA#1 had him/her positioned on his/her left side and said he/she smashed his/her face on the nightstand and landed face first on the the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing progress note, dated 10/22/22, indicated Resident #124 was readmitted after a C5-6 Anterior Cervical Discectomy and Fusion (ACDF) on 10/16/22. During an interview on 12/14/22 at 8:11 A.M., Director of Nursing (DON) #2 said she completed the investigation into Resident #124's fall. DON #2 said that she received conflicting information from Nurse #2 and CNA#1. DON #2 said that CNA #1 had Resident #124 sitting on the edge of the bed when CNA #1 lowered Resident #124 to the floor. DON #2 said she was not really sure what actually happened to Resident #124 and said that CNA #1 should not have moved Resident #124 until Nurse #2 evaluated him/her. 36876 2. The facility failed to provide appropriate supervision to residents on 3 of 4 units as evidenced by staff sleeping during the 11:00 P.M. - 7:00 A.M. shift on 3 of 4 units. Review of the Employee Handbook dated April 2019 indicated that staff sleeping or failure to remain alert and oriented while on duty constitutes as immediate grounds for dismissal. A. During an early morning visit on 12/13/22 the surveyors observed the following on the [NAME] Unit (a secured unit which houses residents with dementia): -At 4:01 A.M., Nurse #2 was awake and seated behind the nurses station. -2 CNA's were observed asleep in the activity room. They were both under blankets and lounging in reclining positions in chairs. -Resident #30 was observed awake and seated in the same room as the two staff members who were observed asleep. -There were two residents awake and wandering the unit. -The door to lounge area was ajar, and the surveyor attempted to push the door open which hit a chair propped against it. -A CNA was observed laying in total darkness on the sofa in the lounge under blankets with a pillow and jerked upright when the door hit the chair. During an interview with Nurse #2 on 12/13/22 at approximately 5:42 A.M., she said that Resident #30 had been agitated earlier in the night and kept standing up with his/her alarm sounding. Nurse #2 said that Resident #30 had been placed in the activity room to be supervised and acknowledged that the two CNA's in the activity room who were supposed to be supervising him/her were asleep. B. During an early morning visit on 12/13/22 the surveyor observed the following on the Maplewood Unit, (a Rehabilitation Unit housing Resident's for short term rehabilitation requiring subacute medical care after hospitalization s): (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-At 4:02 A.M., Certified Nurse Aide (CNA) #7 was in a chair wrapped in a blanket with her eyes shut. CNA#7 had her personal computer device in front of her and was wearing headphones. The surveyor observed a call bell turned on behind CNA #7's head. -At 4:03 A.M., Nurse #8 was observed at the nurses station, and her head was down and she had her personal cell phone in her lap. The surveyor observed a call bell turned on immediately to Nurse #8's right. -At 4:03 A.M., CNA #2 was observed in a chair with his eyes shut and mouth open. CNA #2 was not wearing a mask. The surveyor observed a call bell turned on behind CNA #2 and directly in front of CNA #2. -At 4:10 A.M., CNA #7 is observed waking up CNA #2. CNA #7 said to CNA #2 that there is a surveyor in the building. During an interview on 12/13/22 at 4:48 A.M., Nurse #8 said that the overnight shift (11:00 P.M.- 7:00 A.M.) is an awake shift. Nurse #8 said staff should not be sleeping. C. During an early morning visit on 12/13/22 the surveyor observed the following on the Oak Grove Unit, (a unit housing Residents with COVID-19): -At 4:05 A.M., CNA#3 was observed sleeping in the hallway, blocking herself with a linen cart. -At 4:10 A.M., Nurse #3 was observed leaving an empty Resident's room, she was incoherent, had sleeping lines on her face. She stated she was tired and she said she has been working a lot of double shifts. During an interview on 12/13/22 at 6:27 A.M. with Director of Nursing (DON) #1, DON #2, and Administrator #1, they said that staff should not be sleeping in Resident areas or while on duty during their assigned shifts.

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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** 44095 Based on observation, record review and interviews, the facility failed to ensure that staff maintained infection control standards of practice related to the care of a nebulizer inhalation face mask for one Resident (#29) out of a total sample of 38 Residents. Findings include: Resident #29 was admitted to the facility in November 2022 with diagnoses including congestive heart failure, neoplasm of the lung and diabetes. Review of Resident #29's Admission Minimum Data Set assessment dated [DATE] indicated that he/she could make self understood and he/she could understand others. Review of the physician's order dated 11/17/22, indicated: -Ipratropium-Albuterol Inhalation Solution (medication used for shortness of breath) 0.5-2.5 (3) milligrams/3 milliliters -1 inhalation inhale orally every 6 hours for Shortness of Breath During an observation on 12/8/22 at 8:29 A.M., the surveyor observed the nebulizer inhalation mask, unlabeled and undated on Resident #29's bedside table in a wash basin with body wash and an open packet of barrier cream. The storage bag was under the basin and was dated 11/14/22. During an observation on 12/8/22 at 11:20 A.M., the surveyor observed the nebulizer inhalation mask, unlabeled and undated on Resident #29's bedside table, lying next to the wash basin. The storage bag was under the basin and was dated 11/14/22. During an observation on 12/9/22 at 6:48 A.M., the surveyor observed the nebulizer inhalation mask, unlabeled and undated on Resident #29's bedside table, lying next to the wash basin. The storage bag was under the basin and was dated 11/14/22. During an observation on 12/9/22 at 9:53 A.M., the Nurse Practice Educator (NPE) and the surveyor observed the nebulizer inhalation mask, unlabeled and undated on Resident #29's bedside table lying next to the wash basin. The storage bag dated 11/14/22 was on the floor. The NPE said that the nebulizer equipment should be dated and labeled. The NPE said that the nebulizer face mask should not be lying on the bedside table and should be stored in a plastic bag when not in use. During an observation on 12/16/22 at 7:57 A.M., the surveyor observed the nebulizer inhalation mask, unlabeled and undated on Resident #29's bedside table lying next to the wash basin next to a roll of toilet paper. There was no storage bag visible. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/14/22 at 8:44 A.M., Director of Nursing (DON) #2 said she was unable to provide the surveyor with a policy for how staff are required to store the nebulizer equipment when not in use. DON #2 said that the nebulizer face mask should not be left lying on the bedside table when not in use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm 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. 44095 Based on observation, interview and record review the facility failed to ensure that Nurse #5 provided nursing services that assured Resident safety. Specifically, on 1/25/23, Nurse #5 documented medications as administered prior to administering medications for 1 Resident (#78) out of a total sample of 18 Residents. Findings include: Review of the facility policy titled, General Dose Preparation and Medication Administration, dated as revised 1/1/22, indicated that after medication administration, facility staff should document medication administration information (when the medication is given) on appropriate form (medication administration record). Review of Nurse #5's competency form titled, Clinical Competency Validation- Medication Administration: Oral dated as 1/5/23, indicated Nurse #5 received education on medication administration including documentation on medication administration record. During the medication pass on 1/25/23 at 8:55 A.M., Nurse #5 selected Resident #78 to administer morning medications to. Nurse #5 opened Resident #5's medication administration record (MAR) and the record indicated that she had already documented as administered (green on the electronic medical record) Resident #78's morning medications. Nurse #5 begun to pour the medications that had been documented as administered. Review of the MAR, dated 1/25/23, indicated the following medications had been administered: -amlodipine, medication used for hypertension -aspirin, medication used for cerebrovascular accident (stroke) -vitamin d, medication used for supplement -hydrochlorothiazide, medication for hypertension -hydroxuria, medication used for cerebral infraction according to his/her physician's order -metformin, medication used to treat diabetes. During an interview on 1/25/23 at 9:00 A.M., Nurse #5 said that she documents medications as administered on the medication administration record before she administers medications. Nurse #5 said she does not want to get in trouble for being late with her medications so she makes herself notes on a paper census sheet. Nurse #5 said she checks the census sheet so she knows which Residents still require medications. Nurse #5 said this is her normal practice for medication administration. (continued on next page)

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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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/23 at 9:10 A.M., the surveyor made the Director of Nursing aware of Nurse #5's medication administration technique. During a follow-up interview on 1/25/23 at 10:10 A.M., the Director of Nursing said that Nurse #5 was not following medication administration procedures.

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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** 43807 Based on interviews and record review, the facility failed to provide behavioral services for one Resident (#55) out of a sample of 38 Residents. Findings include: Review of the facility policy titled Behaviors: Management of Symptoms revised on 10/24/22 indicated the following: *Patients exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to changes in behavior. *Based on the comprehensive assessment, staff must ensure that a patient who displays or is diagnosed with behavioral health disorder or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Resident #55 was admitted to the facility in February 2022 with diagnoses including major depressive disorder and sleep disorder. Review of the most recent minimum data set (MDS) dated [DATE] indicated that Resident #55 had a brief interview for mental status (BIMS) score of 12 out of a possible 15 indicating moderate impairment. Review of Resident #55's mood care plan initiated 2/28/22 indicated he/she was at risk of distressed/fluctuating mood symptoms, depression caused by the diagnosis of major depressive disorder, he/she had recently moved into the facility with the inability to return home. Review of Resident #55's physician's orders indicated an order to treat for psychotropic and psychological health initiated 9/28/22 (approximately 7 months after admission). Review of Resident #55's psychiatric admission/evaluation note dated in 10/5/22 (approximately 7 months after admission) stated that the Resident engaged in the initial evaluation, he/she reported a history of depression, reporting an increase due to being in the facility and his/her unlikelihood of returning home, Resident #55 also reported minimal family support. The therapist stated that Resident #55 will benefit from continued behavioral therapy since he/she responds well to emotional support. During an interview with Resident #55 on 12/9/22 at 8:52 A.M., he/she said he/she has gone through a lot of changes in his/her life,he/she is not able to see his/her family, he/she has always wanted to see a therapist since his/her admission to work through his/her life changes, but none was available until recently. (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 with the Social Worker, (SW#1), on 12/12/22 at 12:14 P.M., she said Resident #55 was admitted in February 2022 and he/she was first provided psychiatric services in 10/5/22, seven months after admission. SW #1 said with his/her history of depression and going through so many life changes, he/she should have been seen by psychiatry at admission and continued to receive therapy through his/her stay. She said every Resident admitted to the facility should be referred to psychiatric services especially if they have any psychiatric diagnoses.

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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. 15016 Based on record review and interview, the facility failed to ensure the physician reviewed and responded to the pharmacy consultant's recommendations for medication changes for 1 (Resident #30) of 38 sampled Residents. Findings include: Resident #30 was admitted to the facility in June 2021, and had diagnoses which included neurocognitive disorder with Lewy Bodies, Parkinson's disease, muscle weakness (generalized), and difficulty walking. Resident #30's medication order, dated 8/18/22, indicated to give aspirin 1 tablet 325 mg (milligrams) by mouth in the morning for anticoagulant. Resident #30's Pharmacy Consultation Report, dated 10/31/22, indicated Please consider decreasing aspirin to 81 mg daily. The Pharmacy Consultation Report was not initialed by the Physician as having been reviewed and there was no response as to whether the recommendation was accepted or declined. Review of Resident #30's Medication Administration Records, dated November 2022 and December 2022, indicated nursing staff continued to administer the aspirin 325 mg after the Pharmacy Consultation Report dated 10/31/22. During an interview with Director of Nurses (DON) #2 on 12/13/22 at 6:51 A.M., she said the Physician had not responded to Resident #30's Pharmacy Consultation Report, dated 10/31/22.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 15016 Based on record review and interview, the facility failed to include an end date or 7-day limit on the physician's order for the use of an as needed (PRN) antipsychotic medication for 1 (Resident #30) of 38 sampled Residents. Findings include: Resident #30 was admitted to the facility in June 2021, and had diagnoses which included neurocognitive disorder with Lewy Bodies (dementia), Parkinson's disease, muscle weakness (generalized), and difficulty walking. Review of Resident #30's medications, dated December 2022, indicated these included: * Quetiapine fumarate [an antipsychotic) tablet 25 mg (milligrams). Give 1 tablet by mouth every 8 hours as needed for agitation, dated 8/17/22. The order did not have an end date or instructions to discontinue use after 7 days, as was required. Resident #30's Treatment Administration Record, dated December 2022, indicated staff administered quetiapine fumarate tablet 25 mg. PRN on 9/30/22, 10/8/22, 11/23/22, and 12/8/22 . There was no end date to the order and it exceeded the original 7-day limit for PRN antipsychotic use. Review of Resident #30's physician notes indicated there was no reference to the continuation of the quetiapine fumarate beyond 7 days after the start date. During an interview with Director of Nurses (DON) #2 on 12/13/22 at 6:51 A.M., she said she did not know why Resident #30's PRN antipsychotic was not discontinued.

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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. 44095 Based on observation, interviews and record review, the facility failed to ensure it was free of a medication error rate of 5% or greater when 3 of 6 nurses on 3 of 3 units, made 5 errors in 28 total opportunities resulting in a medication error rate of 17.86%. This impacted 3 Residents (#51, #65 and #49) out of 7 residents observed. Findings include: Review of the facility policy titled, General Dose Preparation and Medication Administration, dated as revised 1/22, indicated staff should verify the medication to ensure: -correct medication -correct dose -correct time Review of the facility policy titled, Medication- Related Errors, dated as revised 5/10, indicated: *Administration errors include: -administration time error: administration exceeds the time in relation to meals. -administration technique error: administering a medication dose via the correct route and site but improper technique is used. *Dispensing errors include: -dosage form error: dispensing to a resident of a medication in a different form than that ordered by a physician. 1.) During the medication pass observation on 12/8/22 at 5:05 P.M., Nurse #5 administered medications for Resident #51 including: -Ferrous Gluconate Tablet 324 milligrams (mg), 1 tablet Review of Resident #51's active physician's order, dated 8/26/22, indicated: -Ferrous Gluconate Tablet 324 mg, give 1 tablet by mouth two times a day to be given with meals During an interview on 12/9/22 at 8:31 A.M., Nurse #5 said that she should have administered Resident #51's Ferrous Gluconate Tablet with a meal as ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) During the medication pass observation on 12/9/22 at 7:57 A.M., Nurse #6 administered medications for Resident #65 including: -Acetaminophen Tablet 325 milligrams (mg), 3 tablets total dose 975 mg Review of Resident #65's active physician's order, dated 5/21/21, indicated: -Acetaminophen Tablet 325 mg, Give 975 mg by mouth three times a day for moderate pain; scheduled at 6:00 A.M., 2:00 P.M., and 10:00 P.M. Nurse #6 administered the Acetaminophen, 5 hours and 57 minutes before scheduled time and 1 hour and 57 minutes after the last scheduled administration. During an interview on 12/9/22 at 8:15 A.M., Nurse #6 said she made a medication error when she administered Resident #57's acetaminophen too early. 3.) During the medication pass observation on 12/9/22 at 8:28 A.M., Nurse #7 administered medications for Resident #49 including: 3 a) - Multiple Vitamins Tablet, 1 tablet (not administered with minerals) Review of Resident #49's active physician's order, dated 10/17/22, indicated: -Multiple Vitamins-Minerals Tablet, give 1 tablet by mouth one time a day 3 b) -Oxycodone hydrochloride (HCl) 5 milligrams (mg)/5 milliliter (mL) solution, 10mg (incorrect form) Review of Resident #49's active physician's order, dated 10/17/22 indicated: -Oxycodone HCl Oral Tablet 10mg (Oxycodone HCl), Give 10 mg by mouth four times a day for pain 3 c) - Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine), 8 units (Nurse #6, did not prime the pen to ensure the correct dose was administered) Review of Resident #49's active physician's order, dated 11/16/22 indicated: - Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine), 8 unit subcutaneously in the morning for diabetes During an interview on 12/9/22 9:05 A.M., Nurse #7 said she should have administered Resident #49 Multiple Vitamins with Minerals but did not. Nurse #7 said she should have clarified the form of the Oxycodone HCl prior to administering the medication. Nurse #7 said she should have primed the Basaglar KwikPen Subcutaneous Solution Pen-injector prior to administering the medication to ensure the correct dose was administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/14/22 at 9:19 A.M., Director of Nursing #2 was made aware of the medication administration observations. DON #2 said nursing should follow physician's orders during the medication administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41019 Based on record review and interview, the facility failed to administer sliding scale insulin as ordered for 1 Resident (#231) out of a total sample of 38 Residents. Findings include: Resident #231 was admitted to the facility in March 2022 with diagnoses including type 1 diabetes, ketoacidoses (a serious diabetic reaction where there is not enough insulin in the body), upper gastrointestinal (GI) bleed and kidney failure. Review of the Physician orders for March 2022 indicated the following: -Insulin Lispro Solution 100 unit/mL- 6 units subcutaneously three times a day -Insulin Lispro Solution 100 unit/mL - inject as per sliding scale *70-150=0 *151-200 = 1 *201-250= 2 *251-300=3 *301-350=4 *351-400=5 *401+ call the MD/NP Review of the Medication Administration record (MAR) for March 2022 indicated that Resident #231 had a blood sugar on March 30, 2022 of 420. The record does not indicate that any sliding scale insulin had been administered. Review of the MAR for March 2022 indicated that Resident #231 had three blood sugars at 389, 356, and 378. The record does not indicate that any sliding scale insulin had been administered. Review of the MAR for April 2022 indicated that Resident #231 indicated the following blood sugars: -4/1/22: 500 (12:00 P.M.); 581 (4:00 P.M.) -4/2/22: 480 (8:00 A.M.); 470 (12:00 P.M.), 360 (4:00 P.M.) -4/3/22: 354 (8:00 A.M.); 336 (12:00 P.M.), 288 (4:00 P.M.) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated that sliding scale insulin was only administered on 4/1/22 at 4:38 P.M. There was no sliding scale insulin administered for any of the other elevated blood sugars. During an interview with Corporate Nurse #2, Administrator #1, Administrator #2, Director of Nursing #1 and Director of Nursing #2 on 12/14/22 at 2:33 P.M., they acknowledged the medication error.

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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** 44095 Based on observation and interview the facility failed to ensure: 1.) Drugs and biologicals were stored in locked compartments and only authorized personnel had access to the keys. 2.) Drugs and biologicals were stored in secured areas and not left unsecured in residents' rooms. 3.) 1 of 4 medication rooms were locked to prevent unauthorized entry. 4.) Multi-dose insulin vials were dated when opened and that expired vials were disposed for 1 of 8 medication carts. Findings include: Review of the facility policy for Storage and Expiration Dating of Medications, Biologicals, dated [DATE], indicated Facility should ensure that the medications and biological storage areas are locked and do not contain non-medication/biological items. Review of the facility policy titled, Storage and Expiration Dating of Medications, Biologicals, dated as revised [DATE], indicated: -facility staff should have possession of the keys that open medication storage areas. -facility should ensure that all medications and biologicals, including treatment items, are stored in a locked area and is inaccessible to residents and visitors. -bedside medication storage should be in a locked compartment within the resident's room. 1.) The facility failed to ensure drugs and biologicals were stored in locked compartments and only authorized personnel had access to the keys. a) During observations on the Maplewood Unit, the surveyor observed the long hall treatment cart opened and unlocked on: -[DATE] at 8:22 A.M. -[DATE] at 8:50 A.M. -[DATE] at 9:01 A.M. (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 interview on [DATE] at 9:01 A.M., Nurse #7 said that she had the keys to the treatment cart. Nurse #7 said that treatment cart should be locked at all times. Nurse #7 was not aware why the treatment cart was unlocked and open. b) During an observation on the Maplewood Unit on [DATE] at 6:39 A.M., they surveyor observed the long hall medication cart in the hallway. The medication cart had the keys dangling from the lock and there were two nurses observed at the desk engaged in a conversation, neither Nurse was observing the medication cart. During an interview on [DATE] at 6:42 A.M., Nurse #5 said that the medication cart should have been locked and she should have had the medication cart keys on her person. c) During an observation on the [NAME] Unit on [DATE] at 7:55 A.M., Nurse #6 left her medication unlocked and unattended on the dementia unit. Nurse #6 walked away from the medication cart and around the corner where the medication cart was no longer in her view. During an interview on [DATE] at 7:56 A.M., Unit Manager #3 observed the surveyor observing the unlocked and unattended medication cart on the dementia unit. The Unit Manager said Nurse #6 should have locked her medication cart. 2.) The facility failed to ensure that nursing stored all drugs and biologicals in locked compartments specifically when drugs and biologicals were found in Residents' rooms. -During observations in room [ROOM NUMBER] on [DATE] at 8:15 A.M., [DATE] at 4:53 P.M., and [DATE] at 6:38 A.M., the surveyor observed a bottle of Pepto-Bismol (medication used to treat upset stomach) opened on the Resident's bedside table. -During observations in room [ROOM NUMBER] on [DATE] at 8:20 A.M., [DATE] at 2:53 P.M., and [DATE] at 6:39 A.M., the surveyor observed a tube of diclofenac gel (medication used for topical pain relief) on the Resident's bedside table. -During an observation in room [ROOM NUMBER] [DATE] at 8:29 A.M., the surveyor observed one tube of hydrocortisone cream 2.5% (medication used for itch) on the Resident's bedside table. -During observations in room [ROOM NUMBER] on [DATE] at 8:29 A.M., [DATE] at 4:50 P.M., and [DATE] at 6:48 A.M. the surveyor observed a vial of Duoneb (ipratropium and albuterol, medication used for shortness of breath) inhalation solution unopened on the Resident's night stand. -During observations in room [ROOM NUMBER] on [DATE] at 9:19 A.M., [DATE] at 4:51 P.M., and on [DATE] at 6:49 A.M. the surveyor observed a vial of budesonide (medication used for shortness of breath) inhalation solution unopened on the Resident's night stand. During observations on [DATE] at 10:01 A.M., the Nurse Practice Educator (NPE) accompanied by the surveyor observed the bottle of Pepto-Bismol, the tube of diclofenac gel, the vial of Duoneb solution and the vial of budesonide inhalation solution in the Resident's rooms. The NPE said medications should not be left in the Resident rooms unattended. 15016 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) On [DATE] and [DATE] (during 2 shifts) the medication room on the Oak Grove Unit was left unlocked. During an observation on [DATE] at 5:49 A.M. on the Oak Grove Unit, the surveyor opened the medication storage room. The door was unlocked, and staff were not present in the area. The medication storage room held over the counter and prescription medications, including scheduled drugs (in a locked refrigerator). At approximately 5:51 A.M. , a Certified Nurse Aide (CNA) approached the surveyor and said hello. The CNA then left the area and within a minute Nurse #10 arrived and saw the surveyor standing at the open door to the medication room. During an interview with Nurse #10 on [DATE] at 5:53 A.M., she said the CNA told her the surveyor was in the medication room. The surveyor told Nurse #10 the medication room had been unlocked and I was able to enter the room without keys or supervision. Nurse #10 said the door lock was broken and she was unable to lock it, and it had been unlocked yesterday during her shift as well. Nurse #10 said she had not informed anyone of the broken lock. Nurse #10 said she did not know if anyone else was aware the lock was broken. Nurse #10 said she did not know how to address the broken lock because she was from an Agency. The surveyor told Nurse #10 to supervise the room to prevent unauthorized entry and to inform Unit Manager #1 of the broken lock. Unit Manager #1 arrived to the medication room at approximately 4:57 A.M. During an interview with Unit Manager #1 on [DATE] at 5:57 A.M., she said facility policy required the medication room be locked and only the medication nurse should have access. Unit Manager #1 said she was unaware the door lock was broken and that the room could not be locked. Nurse #10 then inserted the medication room key into the lock and demonstrated that she was unable to lock the closed door. Unit Manager #1 then demonstrated that the inside doorknob button needed to be pushed inwards to lock the door and that the lock was functioning properly. 4.) During a medication cart observation on the Maplewood Unit on [DATE] at 6:38 A.M., open multi-dose insulin vials were found in the top drawer and were expired and undated, and available for administration. Review of the facility policy for Storage and Expiration Dating of Medications, Biologicals, dated [DATE], indicated, If a multi-dose vial of an injectable medication has been opened or accessed the vial should be dated and discarded within 28 days unless the manufacturer specified a different (shorter or longer) date for that opened vial. Medications found in the cart: - Novolin R insulin, open and dated [DATE] (expired on [DATE]) - Humulin N insulin, open and undated During an interview with Nurse #11 on [DATE] at 6:40 A.M., she said it was facility policy to dispose of multi-dose insulin vials that had been opened longer than 28 days, or were opened and undated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Director of Nurses #2 on [DATE] at 6:49 A.M., she said it was facility policy to dispose of opened insulin that was greater than 28 days old, and to dispose of opened and undated insulin found in the medication cart.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 44095 Based on record review and interview, the facility failed to obtain laboratory services as ordered by the physician for one Resident (#105), out of 38 sampled Residents. Findings include: Resident #105 was admitted to the facility in April 2022 with diagnosis including malignant neoplasm of the colon and liver. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/11/22 indicated he/she could make him/herself understood and he/she understands others. During an interview on 12/8/22 at 9:02 A.M., Resident #105 said that he/she had burning during urination. He/she said that he/she had a urinalysis (a test to check urinary tract infections) completed two weeks ago but and he/she still had burning and he/she had made nursing aware. During an interview on 12/9/22 at 1:43 P.M Resident #105 said he/she still had burning in his/her urine. There was a urinal at his/her bedside and the urine was dark amber colored and cloudy. During an interview on 12/9/22 at 1:56 P.M., Nurse #7 was made aware of Resident #105's burning during urination. Nurse #7 said she would notify his/her provider and obtain and order for a urinalysis. During an interview on 12/9/22 at 1:59 P.M., Director of Nursing #2 was made aware of Resident #105's burning during urination. DON #2 said she would notify his/her provider During an interview on 12/13/22 at 9:48 A.M., Resident #105 said he/she still had burning during urination and he had not seen anyone about it. During an interview on 12/13/22 at 9:52 A.M., the Nurse Practitioner #2 (NP) said nobody made her aware of Resident #105's burning during urination. Furthermore the NP #2 said she did a urinalysis urinalysis (a test to check urinary tract infections) a few weeks prior and she said she would assess an Resident #105. Review of the physician's order, dated 12/13/22, indicated: -urinalysis (a test to check urinary tract infections) and culture. During an interview on 12/14/22 at 11:00 A.M., Nurse #9 said she reviewed the physician's order on 12/13/22 for Resident #105's urinalysis. Nurse #9 said that Resident #105 uses a urinal and it would be easy to get a urine from him/her. Nurse #9 said she would give him/her a urinal and obtain the urine for the urinalysis. During an interview on 12/16/22 at 7:30 A.M., Resident #105 said he/she still had burning in his/her urination. He/she said nursing has not obtained a urine. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #105's medical record on 12/16/22, indicated there was no documentation to support that nursing had obtained a urine.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, interview, and record review, the facility failed to provide snacks at night and have snacks available in two nourishment kitchens. Findings include: Review of the facility policy titled Snacks, dated 09/2017, indicated the following: - Snacks and beverages will be provided as identified in the individual plans of care. Bedtime snacks will be provided for all residents. Additional snacks and beverages will be available upon request for all residents who want to eat at non-traditional times. - The Dining Services Department assembles on a daily basis snack items for deliver to each resident/patient care area. - Nursing services is responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents. During the Resident group interview, 9 out of 9 Residents in attendance said that there are no snacks offered and that they have to ask for snacks. All the residents in attendance said that there are no snacks available. During observations of the [NAME] Unit (a secured unit which houses Resident's with dementia) nourishment kitchen on 12/13/22 at 6:17 A.M., the surveyor observed there were no snacks available in the cabinet's or refrigerator to the residents on the unit. The surveyor then asked a staff person if there were snacks available in any other places Resident's could access snacks and she said that she was not aware of any other location. During observations of the Maplewood Unit (a short term rehab unit) nourishment kitchen 12/13/22 at 6:19 A. M., the surveyor observed no snacks available in the refrigerator or cabinets. Additionally, in the refrigerator the surveyor observed 3 frozen meals belonging to a Resident in the vegetable drawer which were supposed to be kept frozen. The surveyor then approached CNA #2 and inquired where snacks are available for Residents on the unit and he said snacks are located in the nourishment kitchen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41019 Based on observation, record review and interview, the facility failed to maintain the appropriate temperatures for holding hot food and failed to maintain sanitary practices in the kitchen. Findings include: Review of the facility policy titled Food: Preparation, dated 09/2017, indicated the following: - All foods are prepared in accordance with the FDA (Food and Drug Administration) food code. - The Dining Services Director/Cook will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees Fahrenheit and/or less than 135 degrees Fahrenheit, or per state regulation. - When hot pureed, ground, or diced food drop into the danger zone (below 135 degrees Fahrenheit), the mechanically altered food must be reheated to 165 degrees Fahrenheit for 15 seconds if holding for hot service. - All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (or as state regulation requires) for hot holding, and less than 41 degrees for cold food holding. - Temperature for TCS foods will be recorded at time of service and monitored periodically during meal service periods. During the initial walk through observation on 12/8/22 at 7:47 A.M., the following was identified: - a box of brown, moldy, wilted lettuce heads was in the walk in refrigerator - a smoke alarm in the kitchen by the front door was hanging by wires off the ceiling During an observation on 12/12/22 at 11:16 A.M., a tray of small bowls came out of the clean side of the dish machine and were stacked on top of each other. The small bowls were wet and a staff member placed the stacked, wet bowls on top of clean, dry bowls. Inside the tray with the clean, dry bowls, there was a bowl covered in a white thick substance. During an observation during the kitchen services line on 12/12/22 at 12:39 P.M., the surveyor observed a tray of ground beef on top of the counter that was being used to serve sandwiches. The ground beef was not on the steam table or in any hot holding device. The surveyor obtained a facility thermometer and took the temperature of the ground beef, which was 90 degrees Fahrenheit. The surveyor then took the temperature of the rest of the food on the serving line and obtained the following: - hot turkey sandwich - 90 degrees Fahrenheit - ground beef sandwich - 90 degrees Fahrenheit (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- pureed bread- 90 degrees Fahrenheit - gravy- 80 degrees Fahrenheit Review of the Chef's Daily Temperature Log did not indicate that temperatures had been taken prior to starting lunch service.

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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. 44095 Based on observations, record review and interviews the facility failed to ensure they maintained an accurate and complete medical record in accordance to professional standards for 3 residents (#124, #100 and #30) of a total 38 sampled Residents. Findings include: Review of the facility policy, Support Surfaces: Utilization, Acquisition, and Maintenance, dated as revised 12/1/21, indicated: -initiate settings as indicated 1.) Resident #124 was admitted to the facility in October 2022 with diagnosis including hemiplegia (paralysis on one side of the body) following cerebral infraction (stroke) affecting the right dominant side and left humerus (bone in the upper arm) fracture. Review of Resident #124's weight record, dated 12/6/22, indicated he/she weighted: -152.8 pounds Review of the air mattress settings on Resident #124's air mattress indicated the following settings on a dial: -80 pounds -160 pounds -240 pounds -320 pounds -400 pounds During an observation on 12/8/22 at 8:29 A.M., Resident #124 was in his/her bed and the dial on the air mattress was set to 320 pounds. During an observation on 12/9/22 at 6:38 A.M., Resident #124 was in his/her bed and the dial on the air mattress was set between 240 pounds and 320 pounds. During an observation on 12/13/22 at 9:13 A.M., Resident #124 was in his/her bed and the dial on the air mattress was set to 240 pounds (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/14/22 at 8:11 A.M., Director of Nursing #2 said that air mattresses require settings based on the Resident's weight. DON #2 said that nursing should be documenting in medical record the settings each shift. 15016 2.) Resident #100 was admitted to the facility in February 2020 and had diagnoses which included muscle weakness (generalized), contracture right knee, and aphasia following cerebral infarction. Resident #100's physician orders, dated 7/11/21, indicated Resident to wear right resting hand splint up to 8 hours overnight daily to reduce risk of worsening contracture every day and night shift. Resident #100's physician orders, dated 10/19/21, indicated Resident to wear palm protector up to 24 hours daily as tolerated. Doff for self care routines. Monitor for signs and symptoms of skin breakdown every day and every evening shift. Resident #100's physician orders, dated 1/7/22, indicated Right knee brace to be worn during the day 4 to 6 hours every day shift. During an observation on 12/9/22 at 9:48 A.M., 12:21 P.M. and 1:25 P.M., the surveyor observed Resident #100 in his/her room and not wearing a splint, or any other orthotic device. The surveyor looked in Resident #100's bedroom and bathroom and did not see any orthotic devices. Review of Resident #100's Treatment Administration Record dated 12/9/22, indicated staff applied the wrist splint, palm protector, and right knee brace, despite the surveyor's observations that these were not present. During an interview with Unit Manager #3 on 12/9/22 at 1:26 P.M., in Resident #100's bedroom, we observed that he/she was not wearing a splint, or any other orthotics. Unit Manager #3 said Resident #100 did not have a palm protector, wrist splint or brace and that if he/she did these were discontinued a long time ago. During an interview with Director of Nurses (DON) #2 on 12/12/22 at 12:48 P.M., the surveyor informed her that during observations of Resident #100 he/she was not wearing a wrist splint, palm protector or knee brace, yet staff documented that these were applied. DON #2 said she did not know why staff documented it was done. 3.) Resident #30 was admitted to the facility in June 2021, and had diagnoses which included neurocognitive disorder with Lewy Bodies, Parkinson's disease, muscle weakness (generalized), and difficulty walking. Review of Resident #30's physician's order dated 10/7/22, indicated, Bilateral ankle cushion boot to protect feet. Every shift. During observations throughout the days of 12/8/22, 12/9/22 and 12/12/22, Resident #30 was in the dining room and seated in a wheelchair. Resident #30 was not wearing ankle boots or other lower extremity protectors. (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 #30's Treatment Administration Record, dated 12/8/22, 12/9/22 and 12/12/22, indicated staff placed ankle protectors on him/her during the day shift, despite the surveyor's observations that these were not present. During an interview with DON #2 on 12/12/22 at 12:48 P.M., the surveyor informed her Resident #30 had not worn ankle protectors during observations on 12/8/22, 12/9/22 and 12/12/22, and that staff documented that this treatment had occurred. DON #2 said she did not know why staff documented it was done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43807 Based on observations and interviews, the facility failed to 1.) implement infection control practices during a COVID-19 outbreak in the facility and failed to 2.) implement glove use during an insulin injection. Findings include: Review of the facility policy titled Hand Hygiene revised 11/15/22, indicated the following: *The purpose is to improve hand hygiene practices and reduce the transmission of pathogenic micro-organisms. *Perform hand hygiene before patient care *Perform hand hygiene after patient care Review of the facility policy titled Personal Protective Equipment revised 9/26/19 indicated the following: *The purpose is to prevent transmission of micro-organisms from employee to resident or resident to employee. *When and where there is occupational exposure, the service location will provide, at no cost to the employee, appropriate PPE such as (but not limited to): *Gloves *Gowns *Face shields or masks and eye protection *Staff will perform hand hygiene after removal of PPE 1.)During an interview with the Director of Nurses #2 (DON) on 12/8/22 at 8:02 A.M., she said the facility is currently in a COVID-19 outbreak on 1 of the 4 Resident units, (Oak grove unit), the staff working on the Oak grove unit are expected to wear an N-95 respirator mask and a face shield or goggles, if staff are going into a room to perform any direct care, don a gown prior to room entry, perform hand hygiene before and after wearing gloves. During an observation on 12/9/22 at 8:52 A.M., Nurse #4 was observed entering the Resident's room (who was COVID-19 positive) without a gown, leave a pair of gloves on top of the Resident's bed and exit the room. Nurse #4 was observed returning to the Resident's room, not performing hand hygiene, putting on gloves, walking into the room without donning a gown, wrapped ace wraps on the Resident's legs, Nurse #4 then left the room, removed the gloves, and did not perform any hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Nurse #4 on 12/9/22 at 9:00 A.M., he said he should have performed hand hygiene before and after removing gloves, he also should have worn a gown prior to entering the Resident's room to perform direct care. During an interview with the Unit Manager (UM #2) on 12/9/22 at 9:08 A.M., she said the staff on the COVID-19 unit are expected to wear an N-95 respirator mask, a face shield or goggles at all times while on the unit, if staff are entering Resident's rooms to perform direct care, especially Residents' rooms with COVID-19, the staff are supposed to perform hand hygiene prior to wearing gloves, don a gown, prior to room entry, perform direct care, doff the gown and gloves prior to room exit, then perform hand hygiene. During an interview with the DON #1 on 12/12/22 at 11:32 A.M., she said personal protective equipment (PPE), including gowns, should be worn prior to entering a Resident room with COVID-19 to provide direct care. DON #1 said that hand hygiene should be performed prior to wearing and after removing gloves. 2.)During an observation on 12/13/22 at 4:01 A.M., Certified Nurse Assistant (CNA #3), was observed sitting in the Oak Grove Unit dining room, wearing a surgical mask around her chin, she was not wearing a face shield or goggles. During an interview with the DON #2 on 12/13/22 at 6:38 A.M., she said staff are expected to don PPE, N-95 respirator mask, face shield or goggles) while working on the COVID-19 unit. 3.)During an observation on 12/13/22 at 4:05 A.M., CNA #4 was observed on the Oak Grove COVID-19 unit, with her N-95 respirator mask around her chin, she was not wearing a face shield or goggles. During an interview with the DON #2 on 12/13/22 at 6:38 A.M., she said staff are expected to don PPE, N-95 respirator mask, face shield or goggles) while working on the COVID-19 unit. 44095 4.) During the medication pass observation Nurse #7 failed follow infection control guidelines when she did not wear gloves during an insulin injection per facility policy. Review of the facility policy titled, Medication Administration through Certain Routes of Administration, dated 1/22, indicated to refer to manufactures recommendations for administration. *Subcutaneous injections: -cleanse hands -wear gloves -after injection, remove needle quickly, massage gently, check site for bleeding -cleanse hands (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the medication pass observation on 12/9/22 at 8:28 A.M., Nurse #7 administered medications for Resident #49 including an insulin injection. Nurse #7 administered the injection subcutaneously without wearing gloves per facility policy. During an interview on 12/9/22 at 9:05 A.M., Nurse #7 said she was not aware that she was required to wear gloves during insulin administration. During an interview on 12/14/22 at 9:19 A.M., Director of Nursing #2 said nurses are required to wear gloves during insulin administration.