STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225723	A. Building B. Wing	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31830 Based on observations and interviews, the facility failed to ensure residents on 3 of 4 units had a dignified dining experience. Specifically, residents were provided with towels as clothing protectors and staff stood while assisting residents with eating their meals. Findings include: During dining observations throughout survey on 4/6/23 through 4/7/23 and 4/10/23 through 4/14/23, the surveyors observed the following on H2, R2 units (identified by staff as units for long term residents) and H3 unit (identified by staff as a secured unit for residents with cognitive issues). On 4/6/23 at 12:33 P.M., five residents were seated in the H2 activity room for lunch. All five residents had white towels draped around their necks as clothing protectors. One staff member stood beside a resident and fed him/her. On 4/11/23 at 12:41 P.M., four residents were seated in the H2 activity room for lunch. There was a soap opera on the television. All four residents had white towels draped around their necks as clothing protectors. One staff member stood beside a resident and fed him/her. On 4/12/23 at 12:45 P.M., four residents were seated in the H2 activity room for lunch. One resident had a white towel draped around his/her neck as staff stood beside the resident and fed him/her. On 4/14/23 at 11:50 A.M., nine residents were seated in the H3 activity room for lunch. One staff member stood beside a resident and fed him/her. On 4/14/23 at 12:20 P.M., 11 residents were seated in the R2 activity room for lunch. The surveyor observed a Certified Nursing Aide (CNA) #3 leave the R2 activity room and return with two white towels which she draped around the neck of two separate residents as staff assisted these residents with lunch. On 4/14/23 at 12:25 P.M., four residents were seated in the H2 activity room. There was a western on the television. One resident had a white towel draped around his/her neck as staff assisted the resident with the meal. (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 - Some	During an interview on 4/14/23 at 12:30 P.M., CNA # 3 said there were no clothing protectors available. CNA #3 said sometimes clothing protectors were delivered on the linen truck and sometimes not. CNA #3 said she used towels when there were no clothing protectors available as towels worked good too. During an interview on 4/14/23 at 1:10 P.M., the Director of Nurses said it was the expectation that all residents had a dignified and enjoyable dining experience. She said staff should use clothing protectors, not towels, and should not stand up while assisting residents with meals.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 36542 Based on observations, interviews, and record review, the facility failed to provide accommodations to assist Resident #34 who was legally blind in locating their bathroom, in a total sample of 27 residents. Findings include: Resident #34 was admitted to the facility in October 2022 with a diagnosis of legal blindness. Review of the Minimum Data Set assessment, dated 1/4/23, indicated Resident #34's vision was severely impaired and Resident #34 scored a 12 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. Review of the care plan indicated: Focus: impaired visual function Goal: maintaining optimal quality of life within limitations imposed by visual function Interventions: ensuring appropriate visual aids available to participate in activities and identifying factors affecting visual function including environment (poor lighting, monochromatic color scheme) and choices. Review of the Occupational Therapy Treatment Note, dated 11/29/22, indicated Resident #34 was educated regarding using tactile aids for topographical orientation and locating the bathroom independently. When cued, the Resident was able to utilize their left hand on the wall, the vinyl strip attached to the bathroom door, and the cloth on the doorknob as a tactile aid. On 4/6/23 at 9:30 A.M., the surveyor observed Resident #34 exit his/her room and ambulate in the hallway using a cane for the blind. Nurse #8 approached Resident #34 at this time and asked him/her what they were looking for. The Resident said he/she was looking for the bathroom. During an interview on 4/6/23 at 10:10 A.M., Resident #34 said he/she had difficulty finding the bathroom in his/her room and did not have any accommodations in place to assist in finding the bathroom. At this time, the surveyor observed two small Velcro taped squares on the bathroom door in the Resident's room. There was also a cloth tied to the bathroom doorknob. On 4/12/23 at 12:05 P.M., the surveyor observed Resident #34 exit his/her room and ambulate in the hallway using a cane for the blind. Nurse #12 was observed to ask Resident #34 what he/she was looking for. The Resident responded he/she was looking for the bathroom. During an interview on 4/12/23 at 12:10 P.M., Nurse #12 said Resident #34 had difficulty finding the bathroom and she was not sure what accommodations were in place to help the Resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/23 at 2:57 P.M., the Director of Rehabilitation said when Resident #34 was discharged from Occupational Therapy the plan was for a blue vinyl strip to be across the bathroom door of Resident #34 to help him/her find the bathroom, in addition to the cloth on the doorknob. She said the blue vinyl should have continued to be in place to assist the Resident in finding the bathroom.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 36542 Based on observation, interview, and record review, the facility failed to notify the physician of changes in condition, to re-evaluate the potential need to alter the treatment plan for three Residents (#53, #44, and #34), from a total sample of 27 residents. Specifically, the facility failed to notify the primary physician when: 1. Resident #53 had changes to a right foot lesion including signs and symptoms of infection; 2. Resident #44 received critically high laboratory values; and 3. Resident #34 had a recommendation for eye drops. Findings include: 1. Resident #53 was admitted to the facility in September 2010 with a diagnosis of skin cancer. Review of the Physician's Orders included an order initiated on 4/4/22 to monitor the right foot lesion every shift and to notify the Physician or Nurse Practitioner if abnormalities or signs and symptoms of infection are noted. Review of the Treatment Administration Record for 4/1/23 through 4/6/23 included a check mark on every shift by the nurse to indicate the foot lesion was monitored. On 4/6/23 at 9:39 A.M., the surveyor observed Resident #53 to be lying in bed. The surveyor observed a flat, golf ball sized open area to the right dorsal foot. The observed area had dried bloody drainage dripping from the base of the wound to the bottom of the foot. There were multiple spots of dried blood outside of the wound bed. The wound bed was observed to be a beefy red in the top portion and to have darkened areas towards the bottom portion. The surrounding tissue was observed to be reddened approximately a half inch around the wound. On 4/6/23 at 11:30 A.M., the surveyor observed the Resident in bed. The surveyor observed the right foot to no longer have dried bloody areas surrounding the wound and no drainage dripping to the bottom of the foot but continued to have reddened tissue surrounding the lesion. The foot was now resting on a disposable incontinent pad. On 4/6/23 at 4:04 P.M., the surveyor observed the Resident in bed. The wound had two areas of bloody drainage, one trailing to the heel and one trailing to the bottom of the foot. There was dried blood covering the ankle. The surrounding tissue continued to be red. There were blood-soaked areas on the incontinent pad. Review of the Nursing Progress Notes and the Physician's Orders from 3/29/23 through 4/6/23 failed to include any documentation of the wound description, surrounding area redness, or physician notification of changes as indicated in the order. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/12/23 at 11:04 A.M., Nurse #7 said she had worked from 7:00 A.M. to 7:00 P.M. on 4/6/23 with Resident #53. She said she was unfamiliar with the baseline of the skin lesion to the right foot for Resident #53 and did not know if there were any changes from the baseline. She said on 4/6/23 she had used a wound cleanser on the right foot lesion, and she was not sure if there was an order for this. She said she had not noticed the reddened surrounding tissue and had not contacted the physician, as indicated in the order. On 4/7/23 at 7:03 A.M., the surveyor observed Resident #53 lying in bed with their left heel resting on top of their right foot. The skin lesion to the right foot was observed to have bloody drainage including dripping blood trailing to the heel and four trails of blood to the bottom of the foot and then pooling on the blanket below the foot. The surrounding tissue continued to be reddened. During an interview on 4/7/23 at 9:05 A.M., Nurse #6 said she cared for Resident #53 on Tuesday 4/4/23 and the right foot lesion had some bloody drainage on Tuesday and said based on observation with surveyor at this time, the bloody drainage had increased. She said the current plan for the skin lesion was that when Resident #53 was cleaned up by the Certified Nursing Assistants, they would notify the nurse who would clean the wound with a wound cleanser. She said she had not contacted the physician either on 4/4/23 with the change or this morning. Review of the Physician's Progress Note written by the Nurse Practitioner, dated 4/7/23, indicated Resident #53 was seen for a wound evaluation of a chronic wound to the right outer ankle (right foot lesion) with surrounding erythema (reddening of the skin). The Nurse Practitioner noted a diagnosis of cellulitis (infection of the skin) with a new order for Doxycycline (antibiotic) 100 milligrams twice per day for 10 days and a new physician order dated 4/7/23 to culture the wound. During an interview on 4/12/23 at 11:30 A.M., the Director of Nurses said the expectation would be that the nurses would have notified the physician of any changes to the area and obtained an order for a dry protective dressing. During an interview on 4/13/23 at 4:04 P.M., the Assistant Director of Nurses said there was no baseline of the right foot skin lesion documented in the medical record for the nurses to determine if there was a change in the skin lesion per the physician's order. She said the nurse should have been able to identify the reddened surrounding tissue and should have notified the physician of the changes. 2. Resident #44 was admitted to the facility in January 2023. Review of the medical record indicated Resident #44 had a laboratory draw on 4/4/23 for a Comprehensive Metabolic Panel (CMP) and a Complete Blood Count (CBC). Review of the results indicated Resident #44 had the following abnormal results: Immature Grans % (percentage of type of white blood cells): critically high BUN (kidney function): high Creatine (kidney function): high Glucose (blood sugar): high (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Total Protein: low Bilirubin Total (checks liver health): high GFR (checks kidneys): low RBC (red blood cells): low HGB (hemoglobin level): low HCT (level of healthy red blood cells): low MCV (size of red blood cells): high RDW-SD (variation in size of red blood cells): high Platelet Count: Low Lymphs (type of immune cell): low ABS Immature Grans (white blood cell level): high Review of the paper and electronic medical record on 4/13/23, including the printed laboratory results and the nursing progress notes, failed to indicate a physician was notified of the laboratory results. During an interview on 4/13/23 at 9:49 A.M., Nurse #10 said there was no indication the physician was notified of the abnormal laboratory results, including the critically high result. During an interview on 4/13/23 at 2:38 P.M., the Director of Nurses said she had spoken with the Nurse Practitioner for Resident #44 who was unaware of the critical laboratory results and there was no indication a Physician was notified of the results by the nursing staff. 3. Resident #34 was admitted to the facility in October 2022 with a diagnosis of legal blindness. Review of the consultant Eye Care Group visit, dated 11/7/22, indicated Resident #34 was seen by an Optometrist for Resident complaints of persistent dry eye and morning eye debris. The plan indicated a new medication recommendation for Refresh Tears ophthalmic solution, apply 1 drop to both eyes, twice daily for indefinite period. Review of the medical record including Medication and Treatment Administration Records did not indicate the Refresh Tear drops were administered. Review of the nursing progress notes did not indicate the attending physician or Nurse Practitioners were notified of the recommended change in treatment. On 4/12/23 at 4:12 P.M., the surveyor requested information regarding the physician notification for the recommended eye drops. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/12/23 at 4:53 P.M., the Staff Development Coordinator (SDC) reviewed the medical record for Resident #34 and said the recommendation for eye drops had not been addressed. The SDC said she contacted the Nurse Practitioner today and confirmed that neither the Nurse Practitioner nor the physician were previously made aware of the recommendation.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 34145 Based on observation and staff interview, the facility failed to ensure for one Resident (#126), out of a total sample of 27 residents, the right to personal privacy of his/her own physical body during medical treatment was maintained. Findings include: On 4/7/23 at 2:35 P.M., the surveyor observed Resident #126 lying in bed with a hospital gown pulled up and bunched up around his/her waist exposing his/her legs and groin while Physician #3 and the Assistant Director of Nursing (ADON) performed wound care to the Resident's legs. The door to the Resident's room was wide open and the privacy curtain was not pulled around the bed. The Resident's body was in full view of passersby in the hallway, including one surveyor, one Certified Nursing Assistant, and one resident. During an interview on 4/7/23 at 2:55 P.M., Nurse #3 said the Physician and ADON should have closed the door or pulled the privacy curtain prior to performing wound treatment to protect Resident #126's privacy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 31830 Based on observation and interview, the facility failed to maintain a clean, sanitary, and homelike environment for residents residing on four of four units. Specifically, the survey team observed: environmental cleanliness concerns in resident rooms and resident showers which included dirty wall surfaces, wall surfaces in disrepair, broken blinds, missing tiles, dirty vents, dirty air conditioner filters and floors in need of washing. Findings include: On 4/10/23 at 8:15 A.M., the surveyor conducted environmental rounds throughout the facility and made the following observations: 1. R1 Unit - room [ROOM NUMBER]: the ceiling tile by the overhead light was heavily stained with water type stains. - room [ROOM NUMBER]: the slats of the window blind were broken, there were water type stains on the ceiling corner tile, the cover of the light fixture was missing and observed on the floor in the corner of the room. - room [ROOM NUMBER]: there were water type stains on the ceiling tiles in the corner, one ceiling tile was pushed up which exposed an open area, and the slats of the window blind were broken. - room [ROOM NUMBER]: the slats of the window blind in two sections were broken. - room [ROOM NUMBER]: there were water type stains on the ceiling tiles, the dresser for A bed was missing a drawer, the light over the A bed was broken and rested on the top of the fixture and the wall was observed to be dirty with marks and dried type of material. - room [ROOM NUMBER]: the middle slats of the window blind were broken. - room [ROOM NUMBER]: there were four broken panels on the radiator and the wall behind the beds was painted only halfway and did not continue the entire length of the wall. - room [ROOM NUMBER]: there were four broken panels on the top of the radiator. - room [ROOM NUMBER]: the closet doors were missing, exposing belongings of both residents and the blind had missing and broken slats. - Day Room: there were water type stains on seven ceiling tiles. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Shower Room: there were two shower stalls observed. One stall had two cans of shaving cream, a bottle of spray soap, a plastic soap holder and a can of hair spray placed on the handrail. All personal care items were unmarked, making it difficult to identify what product belonged to which resident. The other stall was cluttered with chairs and wheelchairs, making it difficult for resident use. - Tub Room: there was multiple chairs stacked on top of other durable medical equipment. 2. R2 Unit - room [ROOM NUMBER]: the armoire door was missing, exposing resident belongings, the privacy curtain was not fully attached to the ceiling track, the bedside table for B bed was missing the bottom door and the air conditioner unit was observed to be visibly dirty. - room [ROOM NUMBER]: the slats of the window blind were broken, the floor was visibly dirty around the radiator with dried liquid type of substance, the wall was gouged in areas and visibly dirty with marks and there was no cover on the overbed light. - room [ROOM NUMBER]: the cover to the nightlight was broken with glass pieces inside the lighted area, the air conditioner filter was dirty, and the floor was visibly dirty with debris and dried material observed. - room [ROOM NUMBER]: there was no room number on the wall to identify the room, the slats of the window blind were broken, and the air conditioner was not functioning. - room [ROOM NUMBER]: the wall behind the beds was scratched and gouged with the plaster exposed. - room [ROOM NUMBER]: the slats of the window blind were broken. - room [ROOM NUMBER]: the bottom of the blinds was bowed with broken bottom slats, and there was no cover on the overbed light. - room [ROOM NUMBER]: the slats of the window blind were broken, there was a hole in the wall behind the beds, the vinyl baseboard was pulled away from the wall exposing a hole with spray foam in it and the floor was visibly dirty with food particles. - room [ROOM NUMBER]: sections of the privacy curtain was hanging off the ceiling track, the air conditioner filter was dirty and a plastic glove was observed stuck in the air vent of the air conditioner. - room [ROOM NUMBER]: there were floor tiles missing along the window and a strong scent of urine was present. - room [ROOM NUMBER]: the vinyl baseboard was pulled away from the wall behind the beds, the wall behind the beds was heavily gouged exposing the wall board and the floor was visibly stained with dried type of liquid, food crumbs, and dust. - room [ROOM NUMBER]: the entire front cover of the heating unit was missing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- room [ROOM NUMBER]: there was no privacy curtain at all. - room [ROOM NUMBER]: the slats of the window blind were broken, the heating unit cover was not attached, and the floor was visibly dirty with debris and food particles. - Shower Room: the floor of the shower was visibly dirty with the shower nozzle lying on the shower floor, the control nozzle was loose from the wall with an exposed hole, and the wall was separated from the tile. A large metal storage rack in the shower room was observed to have several clear plastic bags with clothing, several loose pieces of clothing, pictures from residents, and numerous other resident belongings. Several ceiling tiles had water type stains. 3. H2 - room [ROOM NUMBER]: the air conditioner filter was dirty. - room [ROOM NUMBER]: the window screen had a large hole, and the air conditioner filter was dirty. - room [ROOM NUMBER]: the nightlight cover was broken. - room [ROOM NUMBER]: the slats of the window blind were broken, the wall behind the bed was gouged and dirty with stained type of liquid, the left side of the air conditioner unit was falling off and the bedside table was missing a door. - room [ROOM NUMBER]: the bottom of the window blinds was bowed, and the slats were broken, the floors were visibly dirty and the wall behind the bed was gouged, and the air conditioner filter was dirty. - room [ROOM NUMBER]: the pull cord for the call light was broken. - room [ROOM NUMBER]: the floor mats were observed to have cracked vinyl sides and the air conditioner filter was dirty. - room [ROOM NUMBER]: there was no cover on the overbed light, and the floor was visibly dirty with liquid type stains, dirt, and food particles. - room [ROOM NUMBER]: the slats on the window blinds were broken, the wall behind the beds was heavily gouged, and the nightlight was dirty. - Shower Room: there was a dried brown type of substance on the shower floor, and a large gaping hole in the bottom of the wall running along the entire section between the two shower stalls was observed. Dirty linen was stored in the shower room and a strong, unpleasant smell was present. The floor was dirty around the trash can in the side room of the shower. There was a heavily stained mattress on top of upholstered chairs. 4. H3 Unit - room [ROOM NUMBER]: sections of the privacy curtain were hanging off the ceiling track. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- room [ROOM NUMBER]: the floor was visibly dirty with stained type of dried liquid, the vinyl baseboard molding was pulled off the wall, exposing a hole in the bottom of the wall and the walls were stained with glue-like substance and dried liquid type of substance. - room [ROOM NUMBER]: the floor was visibly dirty with debris and dried type of liquid substance, the vinyl baseboard molding was pulled away from the wall approximately two feet long with an exposed large hole. The air conditioner screen was dirty. In the corner of the room was a chair stacked with a leg exercise machine, wheelchair leg rest cushions, and Hoyer pads. - room [ROOM NUMBER]: there was no blind on the window, the air conditioner filter was dirty with a thick coat of dust and there was a bed rail on the floor behind the door. - room [ROOM NUMBER]: the air conditioner filter was dirty with a thick layer of lint type material and the wall behind the bed had large gouge marks. - room [ROOM NUMBER]: the privacy curtain was not hung properly, and sections were hanging off the ceiling track. - room [ROOM NUMBER]: the bottom half of the window blind was broken and missing and was not able to block the sun. - room [ROOM NUMBER]: the bedside cabinet door was missing, and the drawer was broken, the air conditioner filter was dirty, and the floor was visibly dirty with dried liquid type substance and debris. - room [ROOM NUMBER]: sections of the privacy curtain were hanging off the ceiling track and the floor was visibly dirty with debris. - room [ROOM NUMBER]: the window screen had a large, ripped section and the air conditioner filter was dirty. - room [ROOM NUMBER]: the bedside table was missing a door, the top dresser drawer was not able to close straight and the bottom drawer had handles which were falling off. The slats of the window blind were broken. The cover of the nightlight was broken, and sections of the privacy curtain were hanging off the ceiling track. The floor tiles in the bathroom were in disrepair and there was foam sealant around a gap in the pipe which did not fully fill the gap. - room [ROOM NUMBER]: there was a dirty television on the floor, there were large gouges on the wall behind the bed, the air conditioner filter was dirty. There was foam sealant around a gap in the pipe which did not fully fill the gap. - room [ROOM NUMBER]: sections of the privacy curtain were hanging off the ceiling track and the nightlight cover was broken. - Shower Room: there was a gray wash basin with multiple personal care items, a pair of sneakers left on a table and a scale which was dirty with dust buildup. The two shower floors were observed to be dirty with grime like material and dirty grout. One shower was observed with the drain cap to not be secured in the floor and wall tiles were missing around the bottom of the shower. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Day Room: the heater units grates were visibly dirty, the cover to the control unit was missing and the side panel was dislodged off. There was a wall divider on the left of the room which was pulled away from the wall which exposed a large hole. The floor was visibly soiled with debris and dried liquid type substance. During an interview on 4/10/23 at 2:00 P.M., the Maintenance Director and the surveyor walked throughout different areas in the facility and reviewed the observations. The Maintenance Director said he was new (two months) to the position and could only do so much, or words to that effect. During an interview on 4/11/23 at 9:31 A.M., the surveyor reviewed the environmental concerns and observations with the Administrator. The Administrator said the facility did not have a maintenance log but used the TELS (web-based program designed to help maintenance teams track facility maintenance and building services) and all staff had access to the TELS and could put in a work order for maintenance issues such as broken blinds. The Administrator said he was unsure how the air conditioning units were maintained and was unaware if the units had recently been cleaned. The Administrator said the facility had one full-time employee for the Maintenance Department, two floor techs for buffing and floor maintenance, and each unit had one housekeeping position.

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F 0607 Level of Harm - Actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34145 Based on record review, policy review, and interview, the facility failed to ensure staff implemented the facility's abuse policy for two Residents (#55 and #95), out of a total sample of 27 residents. Specifically, the facility failed to: 1. For Resident #55, follow their policy and ensure an allegation of a resident-to-resident altercation was thoroughly investigated, protective interventions were implemented, and the altercation was reported to the Department of Public Health (DPH) within two hours resulting in the Resident experiencing psychosocial distress; and 2. For Resident #95, implement the facility's abuse policy and thoroughly investigate the Resident's missing iPad as a potential allegation of misappropriation. Findings include: Review of the facility's policy titled Abuse Identification and Reporting, dated 11/2017, indicated but was not limited to: - Each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property. - Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical hurt or pain or mental anguish to a resident. - Misappropriation of Resident Property: the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. - All alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process. - Report to DPH and local law enforcement any reasonable suspicion of a crime committed against an individual who is a resident of, or receiving care from, the facility. If the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately (but not later than two hours) after forming the suspicion. Otherwise, the report must not be made later than 24 hours after forming the suspicion. - Any suspected allegation of abuse shall be immediately reported to the Executive Director or his/her designee. - Each facility shall immediately report to the DPH, suspected resident abuse, neglect, mistreatment or misappropriation of resident property. - The Executive Director or his/her designee will immediately take action to ensure resident safety. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	- If the suspected perpetrator is another resident, the Director of Nursing Services or his/her designee shall separate the residents so they do not have access to each other until the circumstance of the alleged incident can be determined. - An alleged violation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, will be reported immediately, but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury. 1. Resident #55 was admitted to the facility in October 2017 with diagnoses including adjustment disorder with mixed anxiety and depressed mood and reaction to severe stress. Review of the 1/18/23 Minimum Data Set assessment indicated Resident #55 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Resident #1A was admitted to the facility in July 2022 with diagnoses including hypertension and Crohn's disease. Review of the entire clinical record indicated Resident #1A had a history of violent behavior toward others. The Resident was discharged in February 2023. Review of the 2/1/23 MDS assessment indicated Resident #1A was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Review of Resident #1A's medical record indicated a 1/16/23 Nurse's Note. The note indicated Resident #55 told a nurse that his/her roommate (Resident #1A) said, If you keep me up tonight, I am going to hold a pillow over your head. Review of the Health Care Facility Reporting System (HCFRS-system used by facilities to report suspected abuse/misappropriation), dated 1/16/23 through 4/13/23, failed to indicate a report was filed regarding a resident-to-resident incident involving Residents #1A and #55 that occurred on 1/16/23. Further review of Resident #55's medical record indicated the Social Worker met with the Resident on 2/8/23 to check in on his/her psychosocial status following an incident with his/her roommate that occurred approximately three weeks ago (23 days after Resident #1A threatened Resident #55). The Social Worker documented that following her meeting with Resident #55, she informed the Administrator and Director of Nursing of the Resident's statements regarding the incident. On 2/16/23, the Social Worker accompanied Resident #55 while speaking with two community liaisons regarding the incident with Resident #1A. Subsequently, Resident #1A was discharged from the facility on 2/16/23. Resident #55 expressed nervousness, anxiety, and fear of retaliation by Resident #1A's family and friends for reporting the incident. During an interview on 4/12/23 at 10:05 A.M., the Social Services Director said she found out about Resident #55's roommate's threat to put a pillow over his/her head during morning meeting on 1/17/23. She said she met with the Administrator and Director of Nursing to update them on her meeting with Resident #55. The Social Worker said an investigation was conducted by Resident #1A's community liaisons, but she was not involved in it. She said Resident #55 and Resident #1A remained roommates until Resident #1A was discharged into the custody of the community liaisons on 2/16/23 (31 days). No protection was provided to Resident #55. The Social Worker said she made a referral for Resident #55 to be seen by the consultant psychiatric service for support. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	During an interview on 4/12/23 at 10:50 A.M., the Administrator said he really didn't know anything about the incident and was not sure of the details that occurred between Resident #1A and Resident #55 and would have to look into it. During an interview on 4/12/23 at 10:58 A.M., the Director of Nursing (DON) and Corporate Nurse reviewed Residents #1A and #55's medical record. The DON said the incident should have been reported to DPH immediately, investigated, and protection provided to Resident #55. She said the facility should have acted but did not. During an interview on 4/12/23 at 12:35 P.M., the Consultant Psychiatric Nurse Practitioner (NP) said he met with Resident #55 on 2/21/23 to address ongoing anxiety related to his/her roommate's threat that occurred in January 2023. The Resident said he/she felt guilt over testifying to the community liaison about the incident, but knew it was for his/her own safety. The NP said the Resident requested something for anxiety and he prescribed as needed anti-anxiety medication to treat the Resident's anxiety related to the incident. During an interview on 4/13/23 at 12:45 P.M., Resident #55 said his/her former roommate (Resident #1A) threatened to kill him/her by putting a pillow over his/her head. The Resident said he/she was scared, very anxious and afraid of his/her roommate and had to share a room with him/her for a month. The Resident said he/she had to speak to a community liaison to tell him what happened and said that experience was frightening. Shortly after speaking to the community liaison, his/her roommate was taken out of the facility. Resident #55 said he/she was scared that his/her roommate's family or friends were going to come in to pick up their belongings and take it out on me. The Resident said it still makes him/her upset every time he/she thinks about it. Resident #55 said that although he/she did not utilize the medication the NP prescribed, he/she felt better that it was available if needed. 31830 2. Resident #95 was admitted to the facility in October 2022 with diagnoses which included paranoid personality disorder and contracture of the left forearm muscle. Review of the Minimum Data Set assessment, dated 1/23/23, indicated Resident #95 was able to make self understood and able to understand others. Review of Resident #95's medical record included a Nursing Progress Note, dated 3/23/23, which indicated the Resident approached the nurses' station and told the staff member, his/her iPad (specific type of tablet computer) was missing from the dresser drawer. The Resident said he/she noticed the iPad was missing the day prior, around 3:30 P.M. The Resident said he/she did not tell anyone because they wouldn't do anything about it anyway and was filling out a grievance. The progress note indicated that the Administrator and Director of Nurses were made aware. During an interview on 4/7/23 at 3:04 P.M., Resident #95 said he/she filed a grievance regarding his/her stolen iPad which had been missing for several weeks. Resident #95 said the Administrator was aware, but the Resident had not received any information about the stolen iPad. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #95's Grievance/Complaint, dated 3/29/23, indicated the grievance was filed by Resident #95's community case manager on behalf of Resident #95. The grievance indicated that the Resident reported to the case manager, his/her black booklet style tablet had been missing since 3/15/23. The grievance indicated that the Resident chose not to report the issue to the social worker and requested the community case manager file the grievance on his/her behalf. The grievance indicated the case manager would forward the receipt from the tablet as the case manager had helped the Resident make the purchase. Continued review of the section on the grievance form titled Findings of Investigation, indicated Resident #95 was interviewed by an unidentified person, with no identified date of the interview. The form indicated the Resident declined to have staff help search his/her room, said the tablet was missing for months, and the Resident would tell staff if he/she found it. The grievance indicated the unidentified staff member observed a Fire (specific line of tablet computers) Tablet box in an open drawer. The grievance form was signed and dated 4/6/23 by the Administrator. A posted note was stuck on the front of the grievance/complaint form, dated 4/6/23, which included the words still waiting on MFP to send receipt. The posted note was not signed. During an interview on 4/13/23 at 11:30 A.M., the Administrator said he did not have any additional information related to the grievance/complaint to provide to the surveyor. He said the community case manager provided a receipt on 4/11/23 for Resident #95's tablet to verify purchase by the Resident. The Administrator said he did not consider this grievance as an issue of misappropriation. The Administrator said if he/she had reported this concern as misappropriation, he would file the report as a missing personal item versus misappropriation. The Administrator said he would only consider a report to be misappropriation if a resident lost money or used the word stolen when referencing an item that was missing. The Administrator said if a resident used words such as, I can't find my stuff or words to that effect, he would not consider that issue to be abuse and misappropriation and would not file a report. In addition, the Administrator said if a resident used words such as, Someone stole my stuff or words to that effect, he would consider that misappropriation and would file a report with DPH. The Administrator said the word stolen would clarify to him if an issue was a reportable event or not. During a subsequent interview on 4/13/23 at 12:15 P.M., the Administrator said Resident #95 did not use the word stolen when the grievance was filed, so he did not file a report with the Department of Public Health and did not have any additional information regarding any type of investigation or statements related to Resident #95's missing tablet to provide to the surveyor. During an interview on 4/13/23 at 12:20 P.M., the Director of Social Services said although she assisted Resident #95's community case manager with the grievance, she would not consider the missing property to be considered as misappropriation as the word stolen was not used when referencing the missing tablet. She said if the word stolen was used, she would consider that to be an issue of misappropriation which would need to be reported.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34145 Based on record review, policy review, and interview, the facility failed to report an allegation of a resident-to resident altercation to the Department of Public Health (DPH) within two hours as required for one Resident (#55), out of a total sample of 27 residents. Findings include: Review of the facility's policy titled Abuse Identification and Reporting, dated 11/2017, indicated but was not limited to: - Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical hurt or pain or mental anguish to a resident. - Misappropriation of Resident Property: the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. - All alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process. - Report to DPH and local law enforcement any reasonable suspicion of a crime committed against an individual who is a resident of, or receiving care from, the facility. If the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately (but not later than two hours) after forming the suspicion. Otherwise, the report must not be made later than 24 hours after forming the suspicion. - Any suspected allegation of abuse shall be immediately reported to the Executive Director or his/her designee. - Each facility shall immediately report to the DPH, suspected resident abuse, neglect, mistreatment or misappropriation of resident property. - An alleged violation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, will be reported immediately, but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury. Resident #55 was admitted to the facility in October 2017 with diagnoses including adjustment disorder with mixed anxiety and depressed mood and reaction to severe stress. Review of the 1/18/23 Minimum Data Set assessment indicated Resident #55 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Resident #1A was admitted to the facility in July 2022 with diagnoses including hypertension and Crohn's disease. Review of the entire clinical record indicated Resident #1A had a history of violent behavior toward others. The Resident was discharged in February 2023. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 2/1/23 MDS assessment indicated Resident #1A was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Review of Resident #1A's medical record indicated a 1/16/23 Nurse's Note. The note indicated Resident #55 told facility staff that his/her roommate (Resident #1A) said, If you keep me up tonight, I am going to hold a pillow over your head. Further review of Resident #55's medical record indicated the Social Worker met with the Resident on 2/8/23 to check in on his/her psychosocial status following an incident with his/her roommate that occurred approximately three weeks ago (23 days after Resident #1A threatened Resident #55). The Social Worker documented that she informed the Administrator and Director of Nursing of Resident #55's statements. During an interview on 4/12/23 at 10:05 A.M., the Social Services Director said she found out about Resident #55's roommate's threat to put a pillow over his/her head during morning meeting on 1/17/23. She said she met with the Administrator and Director of Nursing to update them on her meeting with Resident #55. The Social Worker said an investigation was conducted by Resident #1A's community liaison, but she was not involved in it. During an interview on 4/12/23 at 10:58 A.M., the Director of Nursing (DON) and Corporate Nurse reviewed Residents #1A and #55's medical record. The DON said the incident that occurred on 1/16/23 in which Resident #1A threatened Resident #55 should have been reported to DPH immediately and it was not. Review of the Health Care Facility Reporting on 4/12/23 indicated a report was filed regarding a resident-to-resident incident involving Residents #1A and #55 that occurred on 1/16/23, 86 days after the incident was reported to facility staff.

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F 0610 Level of Harm - Actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 34145 Based on policy review, record review, and interview, the facility failed to thoroughly investigate an allegation of abuse, specifically, a resident-to-resident altercation, and implement protective interventions resulting in the Resident experiencing psychosocial distress for one Resident (#55), out of a total sample of 27 residents. Findings include: Review of the facility's policy titled Abuse Identification and Reporting, dated 11/2017, indicated but was not limited to: - Each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property. - Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical hurt or pain or mental anguish to a resident. - Misappropriation of Resident Property: the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. - Any suspected allegation of abuse shall be immediately reported to the Executive Director or his/her designee. - All alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process. - Each facility shall immediately report to the DPH, suspected resident abuse, neglect, mistreatment or misappropriation of resident property. - The Executive Director or his/her designee will immediately take action to ensure resident safety. - If the suspected perpetrator is another resident, the Director of Nursing Services or his/her designee shall separate the residents so they do not have access to each other until the circumstance of the alleged incident can be determined. Resident #55 was admitted to the facility in October 2017 with diagnoses including adjustment disorder with mixed anxiety and depressed mood and reaction to severe stress. Review of the 1/18/23 Minimum Data Set assessment indicated Resident #55 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Resident #1A was admitted to the facility in July 2022 with diagnoses including hypertension and Crohn's disease. Review of the entire clinical record indicated Resident #1A had a history of violent behavior toward others. The Resident was discharged in February 2023. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Some	Review of the 2/1/23 MDS assessment indicated Resident #1A was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Review of Resident #1A's medical record indicated a 1/16/23 Nurse's Note. The note indicated Resident #55 told facility staff that his/her roommate (Resident #1A) said, If you keep me up tonight, I am going to hold a pillow over your head. During an interview on 4/12/23 at 10:05 A.M., the Social Services Director said she found out about Resident #55's roommate's threat to put a pillow over his/her head during morning meeting on 1/17/23. She said she met with the Administrator and Director of Nursing to update them on her meeting with Resident #55. The Social Worker said an investigation was conducted by Resident #1A's community liaison, but she was not involved in it. She said Resident #55 and Resident #1A remained roommates until Resident #1A was discharged into the custody of the community liaisons on 2/16/23 (31 days). No protection was provided to Resident #55. During an interview on 4/12/23 at 10:58 A.M., the Director of Nursing (DON) and Corporate Nurse reviewed Residents #1A and #55's medical record. The DON said they should have investigated the allegation, put something into place to protect Resident #55 and not had them remain roommates for 31 days before Resident #1A was discharged . She said the facility should have acted but did not. During an interview on 4/12/23 at 12:35 P.M., the Consultant Psychiatric Nurse Practitioner (NP) said he met with Resident #55 on 2/21/23 to address ongoing anxiety related to his/her roommate's threat that occurred in January 2023. The Resident said he/she felt guilt over testifying to the community liaison about the incident, but knew it was for his/her own safety. The NP said the Resident requested something for anxiety and he prescribed as needed anti-anxiety medication to treat the Resident's anxiety related to the incident. During an interview on 4/13/23 at 12:45 P.M., Resident #55 said his/her former roommate (Resident #1A) threatened to kill him/her by putting a pillow over his/her head. The Resident said he/she was scared, very anxious and afraid of his/her roommate and had to share a room with him/her for a month. The Resident said he/she had to speak to a community liaison to tell him what happened and said that experience was frightening. Shortly after speaking to the community liaison, his/her roommate was taken out of the facility. Resident #55 said he/she was scared that his/her roommate's family or friends were going to come in to pick up their belongings and take it out on me. The Resident said it still makes him/her upset every time he/she thinks about it. Resident #55 said that although he/she did not utilize the medication the NP prescribed, he/she felt better that it was available if needed.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 46862 Based on record review and staff interview, the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the Resident's status for two Residents (#130 and #142), out of a total sample of 27 residents. Specifically, the facility failed to: 1. For Resident #130, accurately reflect that the Resident was receiving hospice services; and 2. For Resident #142, accurately code the MDS as a discharge to the community. Findings include: 1. Resident #130 was admitted to the facility in November 2022 with diagnoses which included chronic obstructed pulmonary disease, chronic respiratory failure, and acute diastolic heart failure. Review of the Physician's Orders, dated 4/12/23, indicated Resident #130 was admitted to hospice on 12/6/22. Review of the quarterly MDS assessment, dated 3/8/23, indicated the Resident was not under hospice care, as assessed in section O Special Treatments, Procedures, and Programs. During an interview on 4/12/23 at 10:10 A.M., the surveyor and the MDS Coordinator reviewed section O on the MDS. The MDS Coordinator said the Resident is on hospice service and a correction would need to be made. 31830 2. Resident #142 was admitted to the facility in January 2023 with diagnoses which included alcohol dependence and injury of the kidney. Review of the discharge MDS assessment, dated 2/21/23, section A, indicated Resident #142 was discharged to an acute hospital. Review of the medical record indicated Resident #142 was discharged to the community with home care services. During an interview on 4/14/23 at 1:34 P.M., the MDS Coordinator reviewed Resident #142's MDS, section A and said the assessment was miscoded and a correction would need to be made.

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F 0655 Level of Harm - Minimal harm or potential for 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 34145 Based on record review and interview, the facility failed to ensure staff developed and implemented a baseline care plan within 48 hours of the resident's admission for one Resident (#139), in a total sample of 27 residents. Specifically, the facility failed to develop a baseline care plan for the Resident's diagnosis and treatment of a seizure disorder within 48 hours as required. Findings include: Review of the facility's policy, Care Plans-Baseline (last revised 11/2017), included but was not limited to: -The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. Resident #139 was admitted to the facility in March 2023 with diagnoses including seizure disorder. Review of the 3/20/23 Minimum Data Set (MDS) assessment indicated Resident #139 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, required extensive assistance from staff for bed mobility, dressing, bathing and toileting and had a seizure disorder. Review of the medical record failed to indicate a baseline or comprehensive care plan had been developed within 48 hours for the Resident's care and treatment of a seizure disorder to address his/her immediate needs as required. During an interview on 4/12/23 at 11:45 A.M., Unit Manager #1 could not explain why a baseline or comprehensive care plan had not been developed within 48 hours to address Resident #139's seizure disorder as required.

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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. 46862 Based on observation, policy review, record review, and interviews, the facility failed to develop a comprehensive person-centered care plan for three Residents (#43, #90 and #139), out of a total sample of 27 residents. Specifically, the facility failed: 1. For Resident #43, to develop a comprehensive care plan for the use of an anticoagulant medication; 2. For Resident #90, to ensure the plan of care for a positioning neck pillow was implemented; and 3. For Resident #139, to develop a comprehensive care plan for the Resident's diagnosis of seizure disorder within seven days of the completion of the required comprehensive assessment. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated 11/2017, indicated but was not limited to the following: - A Comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -The comprehensive, person-centered care plan should be developed within seven (7) days of the completion of the required comprehensive assessment (MDS) (14 days). -Reflect currently recognized standards of practice for problem areas and conditions. 1. Resident #43 was last admitted to the facility in March 2023 with diagnoses which included heart failure, obstructive sleep apnea, and diabetes. Review of the current Physician's Orders for Resident #43 indicated: -Xarelto (a blood thinner) oral tablet 20 Milligrams (MG). Give 20 MG by mouth one time a day related to Heart Failure, dated 1/23/23. Review of the Medication Administration Record for April 2023 indicated Resident #43 was administered Xarelto per the physician's orders. Review of Resident #43's current Comprehensive Care plan indicated but was not limited to: -Potential alteration in skin integrity -Resident is at nutritional risk (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Potential for hyperglycemia/hypoglycemia -Resident is at risk for injuries related to decreased mobility and impaired balance Review of Resident #43's Interdisciplinary Care Plans failed to include any documented evidence the facility developed a care plan which addressed the use of an anticoagulant. During an interview on 4/12/23 at 7:00 A.M., the Minimum Data Set (MDS) Nurse #1 said the nurse on the floor generated the resident care plans based off the admission data. MDS Nurse #1 said there was no care plan for anticoagulant use. During an interview on 4/12/23 at 7:10 A.M., the Director of Nurses (DON) said every resident on an anticoagulant should have a care plan for anticoagulant use. 36542 2. Resident #90 was admitted to the facility in 2016 with a diagnosis of monoplegia of the upper limb affecting the left non-dominant side. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/2/23, indicated Resident #90 needed extensive assist from two staff members with bed mobility, totally dependent of two staff members for dressing, and totally dependent of one staff person for hygiene needs. Review of the care plan indicated Resident #90 had decreased physical ability, poor endurance and poor strength with interventions of wearing a neck collar when in the wheelchair and wearing a travel pillow when in bed. Review of the Physician's Orders indicated an order for an orthopedic head and neck pillow to the neck/skull when in bed as tolerated, initiated 10/19/21. Review of the Occupational Therapy Progress Note, dated 3/21/23, indicated a goal of improving passive range of motion of the neck and indicated education was provided to caregivers regarding placement of the neck pillow except during meals. On 4/6/23 at 11:40 A.M. and at 3:06 P.M., the surveyor observed Resident #90 lying in bed with his/her head tilted to the right side (ear touching the shoulder). The surveyor observed a travel pillow across the room, on top of some blankets, and not in use. On 4/7/23 at 11:29 A.M., the surveyor observed Resident #90 lying in bed with his/her head tilted to the right shoulder with no devices in place. On 4/12/23 at 8:53 A.M., the surveyor observed Resident #90 in a high back wheelchair. There was a travel neck pillow in place around the left side of the neck, the right side of the travel pillow was not positioned between the head and the neck but rested on the Resident's shoulder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/23 at 2:50 P.M., the Director of Rehabilitation said when Resident #90 was discontinued from Occupational Therapy on 3/22/23 the plan was for the travel neck pillow to be in place at all times, except for meals. She said the neck pillow should be worn while the Resident was in bed and the pillow should be between the head and the shoulder to prevent the head from resting on the shoulder. 34145 3. Resident #139 was admitted to the facility in March 2023 with diagnoses including a seizure disorder. Review of the 3/20/23 Minimum Data Set (MDS) assessment indicated Resident #139 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, required extensive assistance from staff for bed mobility, dressing, bathing and toileting and had a seizure disorder. Review of comprehensive care plans failed to indicate a comprehensive person-centered care plan had been developed within seven days of completion of the required comprehensive assessment (MDS) for the Resident's care and treatment of a seizure disorder as required. Further review of the medical record indicated an interdisciplinary care plan meeting was held on 3/27/23 to review Resident #139's plan of care and no changes were made to the patient-centered care plan to include the Resident's diagnosis of seizure disorder. During an interview on 4/12/23 at 11:45 A.M., Unit Manager #1 could not explain why a comprehensive care plan had not been developed to address Resident #139's seizure disorder within seven days of completion of the MDS as required.

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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. 43935 Based on record review, policy review, observation, and interview, the facility failed to consistently follow professional standards of practice for four Residents (#143, #24, #30, and #44), out of a total sample of 27 residents. Specifically, the facility failed to: 1. For Resident #143, identify, during medication reconciliation, that the physician's order did not include a dosage strength before administering Fish Oil supplements to the Resident; 2. For Resident #24, ensure medications were not left unattended in the room; 3. For Resident #30, ensure the air mattress was in place and functioning properly; and 4. For Resident #44, follow a physician's order for a psychiatric evaluation to determine competency. Findings include: 1. Review of the facility's policy titled Administering Oral Medications, dated as revised 11/2017, indicated but was not limited to the following: -verify that there is a physician's medication order for this procedure -check the label of the medication and confirm the medication name and dose with the medication administration record (MAR) -check the medication dose and recheck to confirm proper dosage -prepare the correct dose of medication Review of the facility's policy titled Physician Orders, dated as revised 3/2019, indicated but was not limited to the following: -when recording orders for medications specify the type, route, dosage, frequency, and strength of the medication ordered During a medication pass observation with interview on 4/7/23 at 9:55 A.M., Nurse #4 prepared Fish Oil one capsule, 1000 milligrams (mg) for Resident #143. While viewing the order and bottle of Fish Oil to administer to the Resident, Nurse #4 said, This is what we had in the cart so this must be what we give. Review of the active Physician's Orders for Resident #143 indicated the following order for Fish oil: -Fish Oil one capsule by mouth two times a day for supplement (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/7/23 at 10:50 A.M., Nurse #4 reviewed Resident #143's physician's orders and said the order for Fish Oil was incomplete and it should have had a dosage strength. Nurse #4 said she administered 1000 mg of Fish Oil because that is what was available in the medication cart. She looked at the dosage strengths in the facility's system and said there were about 12 different strengths available. During an interview on 4/7/23 at 10:51 A.M., Unit Manager #1 said the discharge paperwork used for medication reconciliation for this Resident did not have a dosage strength on it and therefore she did not clarify one with the Nurse Practitioner when reconciling the orders and entered the order as Fish Oil one capsule. During a follow-up interview on 4/7/23 at 11:41 A.M., Unit Manager #1 reviewed the reconciled medications and said although there was no dosage on the Fish Oil order there should have been. She said the lack of dosage on the discharge medication list from the previous facility is how she missed the dosage. 46562 2. Resident #24 was admitted to the facility in February 2019 with diagnoses which included Alzheimer's disease, hypertension (high blood pressure), and asthma. Review of the Minimum Data Set (MDS) assessment, dated 1/4/23, indicated Resident #24 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the Resident had moderately impaired cognition. Review of Resident #24's current Physician's Orders indicated but was not limited to: -Risperdal Tablet (Risperidone) (anti-psychotic) give 0.75 mg by mouth two times a day, dated 10/11/22. Further review of the Physician's Orders indicated Resident #24 did not have an order to self-administer medication. During an observation with interview on 4/10/23 at 9:51 A.M., the surveyor entered Resident #24's room and observed a medication cup on the dresser behind the television. The medication cup contained two small, round orange pills labeled on one side Z and the other side 4. The surveyor notified Nurse #8, who said the medication looked like Risperdal. Nurse #8 said she had administered all the Resident's medication this morning and she was not sure who left the pills there or how long they had been there. On 4/10/23, the surveyor and Nurse #8 reviewed Resident #24's medication card (bubble pack) which indicated: -Labeled Resident #24 -Risperidone 0.25 mg tablet -Give 0.75 mg by mouth two times a day for anxiety related to Alzheimer's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Administer three tablets to equal 0.75 mg -The medication tablets were small, round, orange and were labeled with a Z on one side and a 4 on the other side. The surveyor identified the Risperidone 0.25 mg tablets as the same pills left unattended in Resident #24's room. Nurse #8 removed the medication cup containing the pills from Resident #24's room to dispose of them. Review of the April Medication Administration Record (MAR) indicated Resident #24 had been administered all doses of Risperidone as prescribed for the month of April. During an interview on 4/12/23 at 7:23 A.M., the Director of Nurses (DON) said she was made aware that medications were observed unattended at the bedside. The DON said the facility was investigating why there were only two Risperdal tablets when Resident #24 was scheduled for three with each pass. There were no residents who could self-administer medications. The expectation was that no medications were to be left at the bedside. 31830 3. Resident #30 was admitted to the facility in November 2022 with diagnoses which included acute respiratory failure, paralytic syndrome (complete loss of strength in an affected limb or muscle group), and contractures. Review of the most recent Minimum Data Set assessment, indicated Resident #30 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 0 out of 15, required extensive assistance with bed mobility, had range of motion impairment on both sides, and had no skin issues. Review of the Physician's Orders, dated 4/2023, included but was not limited to: - Relief Aire Low Air Loss 48 air mattress, set 180, check function every shift for decreased mobility, date ordered,10/21/21 The surveyor made the following observations of Resident #30: - 4/6/23 at 5:17 P.M., Resident was lying in bed with the head of the bed elevated. The air mattress was set at static (lacking in movement) and set at 250. - 4/12/23 at 10:50 A.M., Resident was lying in bed with the head of the bed elevated. The air mattress was off, and no settings were visible. - 4/12/23 at 12:45 P.M., Resident was lying in bed with the head of the bed elevated. The air mattress was off, and no settings were visible. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/12/23 at 5:00 P.M., Resident was lying in bed with the head of the bed elevated. The air mattress was off, and no settings were visible. During an interview on 4/12/23 at 5:02 P.M., Nurse #8 and the surveyor observed Resident #30 lying in bed with the head of the bed elevated. Nurse #8 observed the air mattress and after pushing several buttons and knobs on the control panel at the foot of the bed, said the air mattress was not on. Nurse #8 left the room and returned to Resident #30's room with Certified Nurse Aide (CNA) #9. CNA #9 said the air mattress was not on and looked behind the bed and plugged the bed in. The surveyor observed the air mattress turn on and be set on static and 250. CNA #9 said the mattress was off as it was not plugged in, and the mattress settings were done by the company who provided the mattress. CNA #9 said the facility staff did not touch the settings. During an interview on 4/12/23 at 5:20 P.M., Nurse #8 and the surveyor reviewed the Physician's Order on the Treatment Administration Record (TAR), dated 4/1/23 through 4/30/23. Nurse #8 confirmed the physician's order indicated: Relief Aire Low Air Loss 48 Air Mattress Set at 180, Check Function Every Shift for Decreased Mobility, order date, 10/21/21. Continued review of the TAR for 4/12/23 with Nurse #8 indicated Nurse #8 had signed off on the day and evening shift for Check Every Shift for Function. The surveyor reviewed the air mattress observations made throughout 4/12/23 with Nurse #8. Nurse #8 said she was not sure what happened to the air mattress and was unable to account as to why the TAR had been documented as the air mattress was functioning. During an interview on 4/13/23 at 7:45 A.M., the Director of Nurses said the expectation was all air mattresses should be set per the physician's orders, checked every shift as ordered by the Physician, and documented as ordered on the TAR. 36542 4. Resident #44 was admitted to the facility in January 2023 with diagnoses of bipolar disorder, major depressive disorder, severe with psychotic features, and anxiety disorder. Review of the medical record included a handwritten physician's order, dated 3/9/23, for a psychiatric evaluation to determine competency, signed by the Nurse Practitioner. Further review of the medical record failed to include a psychiatric evaluation for competency. During an interview on 4/13/23 at 9:15 A.M., Nurse #10 said she was unable to locate any documentation in the medical record to indicate the psychiatric evaluation for competency was completed as ordered. She said when a psychiatric evaluation is ordered the consultant Psychiatrist can determine competency. Nurse #10 said the Psychiatric Progress Notes (Medication Follow-up Visits), dated 3/7/23, 3/21/23, and 4/4/23, did not indicate the Resident was evaluated for competency. During an interview on 4/13/23 at 12:06 P.M., the Social Worker said she reviewed the information with the consultant psychiatric services and Resident #44 had not had a psychiatric evaluation for competency.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 36542 Based on observations, interviews, and record review, the facility failed to provide Resident #34, out of a total sample of 27 residents, an activity program that engaged the Resident and supported their physical, mental, and psychosocial well-being. Findings include: Resident #34 was admitted to the facility in October 2022 with a diagnosis of legal blindness. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 10/12/22, indicated the following activities were very important to Resident #34: listening to music, keeping up with the news, doing things in groups, doing favorite activities, and religious activities. The most recent MDS assessment, dated 1/4/23, indicated Resident #34's vision was severely impaired and Resident #34 scored a 12 out of 15 on the Brief Interview for Mental Status, indicating a moderate cognitive impairment. Review of the care plan indicated a Focus of Activities for Resident #34 with a vision impairment and the Resident would be assisted to and from activities of interest. The goals of the care plan included attending a group activity one time per week and to participate in self-directed activities of choice daily. Review of the Recreation Admission Assessment, dated 10/7/22, indicated the Resident was legally blind and enjoyed listening to romance and comedy movies, country music, game shows, and Channel 7 news. Review of the Recreation Quarterly Assessment and Notes, dated 3/18/23, indicated the following entertainment appliances or materials were in the room: phone, television, and radio. Review of the Activity attendance indicated from 3/13/23 through 4/12/23 Resident #34 participated in independent activities and 1:1 (one to one) activities. During an interview on 4/6/23 at 10:10 A.M., Resident #34 said he/she enjoyed listening to love stories and previously had books on tape. The surveyor observed the Resident room and there were no devices to play books on tape. The surveyor observed the following throughout the survey: 4/6/23 at 3:05 P.M., the Resident was lying on their bed, eyes open, no music, no books on tape device, and the television was not on. 4/7/23 at 11:21 A.M., the Resident was lying on their bed, eyes open and responded to verbal interaction, there was no music, no books on tape device, and the television was not on. The surveyor observed multiple residents in the unit day room watching the Price is Right. 4/11/23 at 4:27 P.M., the Resident was lying on their bed, eyes open, no music, no books on tape device, and the television was not on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/12/23 at 9:43 A.M., the Resident was lying on their bed, eyes open, no music, no books on tape device, and the television was not on. During an interview on 4/12/23 at 9:43 A.M., the Resident said he/she had a device for books on tape at the previous facility but was unsure what had happened to it and enjoyed listening to books on tape. The Resident also said they enjoyed listening to the television, especially Channel 7 but the television would turn on and be static and the channels did not work and had been like that for a while. The surveyor turned on the television to find there was power, but the television was not connected to the cable cord. During an interview on 4/12/23 at 11:49 A.M., the Activity Assistant said she normally works on the unit with Resident #34. She said Resident #34 will often say no to attending the group activities in the unit day room. She said 1:1 activities were occasionally provided to Resident #34 through morning visits which included informing the Resident of group activities. During an interview on 4/12/23 at 11:50 A.M., the Activity Director said Resident #34 only enjoyed attending concerts on the unit or movie events on the unit and did not attend the daily activities. She said the expectation was for the Activity Assistant or the unit staff to help set the Resident up with either television or music in his/her room. She said she was not aware that Resident #34 did not have a tape player, books on tape, a radio in the room, or that the television was not working.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36542 Based on observations, interviews, and record review, the facility failed to ensure quality care was provided to one Resident (#53), out of a total sample of 27 residents. Specifically, the facility failed to monitor, document, and assess the Resident's identified foot lesion, resulting in an infection. Findings include: Review of the facility's Wound Documentation Skills Checklist, undated, indicated the following: -this table represents wound document parameters that must be met in order for the nursing staff to provide quality nursing care -the skills check list provides an evaluation tool to measure and record each step of the skill that staff is expected to successfully perform in order to safely identify and document wounds including: type, location, partial or full thickness, size, undermining/tunneling/sinus tracts, exudate type and amount, odor, description of characteristics of wound bed tissue, wound edges, surrounding tissue, indicators of infection, pain, interventions for healing, conditions that would affect wound healing, any topical treatments and response to treatments. Resident #53 was admitted to the facility in September 2010 with diagnoses of skin cancer, schizophrenia, and dementia with behaviors. Review of the medical record indicated Resident #53 had a history of a skin lesion to the right dorsal (top) foot with a related hospital admission in June 2021. The Hospital Discharge Summary indicated the court appointed guardian declined aggressive treatment and the hospital recommended to treat the skin lesion conservatively with a dressing to the area to avoid any trauma. Review of the care plans for Resident #53 included: -Focus of pain with an alteration in comfort related to cancer of the skin including the right foot -Goal of the Resident being able to verbalize having no pain within 20 minutes of receiving as needed medication. -Interventions included educating Resident and family about comfort measures, analgesic medications and discussing fears/concerns regarding pain, comfort and disease process, and to monitor and report to nurse signs and symptoms of pain and worsening pain. The care plans did not include any other goals or interventions regarding the skin lesion to the right foot. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Physician's Orders included an order initiated on 4/4/22 to monitor the right foot lesion every shift and to notify the Physician or Nurse Practitioner if abnormalities or signs and symptoms of infection are noted. Review of the Treatment Administration Record for 4/1/23 through 4/6/23 included a check mark on every shift by the nurse to indicate the foot lesion was monitored. The order did not include a description of the foot lesion (wound bed, size, shape, drainage, condition of surrounding tissue.) As of 4/6/23 there were no additional physician's orders regarding the right foot lesion. On 4/6/23 at 9:39 A.M., the surveyor observed Resident #53 lying in bed. The surveyor observed a flat, golf ball sized open area to the right dorsal foot. The observed area had dried bloody drainage dripping from the base of the wound to the bottom of the foot. There were multiple spots of dried blood outside of the wound bed. The wound bed was observed to be a beefy red in the top portion and to have darkened areas towards the bottom portion. The surrounding tissue was observed to be reddened approximately half inch around the wound. The foot was resting on a folded blanket. On 4/6/23 at 11:30 A.M., the surveyor observed the Resident in bed. The surveyor observed the right foot to no longer have dried bloody areas surrounding the wound and no drainage dripping to the bottom of the foot but continued to have reddened tissue surrounding the lesion. The foot was now resting on a disposable incontinent pad. On 4/6/23 at 4:04 P.M., the surveyor observed the Resident in bed. The wound had two areas of bloody drainage, one trailing to the heel and one trailing to the bottom of the foot. There was dried blood covering the ankle. The surrounding tissue continued to be red. There were blood-soaked areas on the incontinent pad. Review of the Wound Consultant's Wound Evaluation and Management Summary and Skin Evaluations from 3/1/23 through 4/6/23 failed to include any documentation to describe the right foot lesion. Review of the Nursing Progress Notes indicated on 3/10/23 the right foot lesion was dry, scabbed with no signs of infection and on 3/29/23 the right foot lesion was chronic, large dry scab without signs or symptoms of infection. There were no descriptions of the wound between 3/10/23 and 3/29/23 or after 3/29/23. Review of the Nursing Progress Notes and Physician's Orders from 3/29/23 through 4/6/23 failed to include any documentation of the wound description, surrounding area redness or physician notification as indicated in the order. During an interview on 4/12/23 at 11:04 A.M., Nurse #7 said she had worked from 7:00 A.M. to 7:00 P.M. on 4/6/23 with Resident #53. She said she worked for an agency and was not employed directly by the facility and had not worked on this unit in a couple of months. She said she was unfamiliar with the baseline of the skin lesion to the right foot for Resident #53 and did not know if there were any changes from the baseline. She said on 4/6/23 she had used a wound cleanser on the right foot lesion, and she was not sure if there was an order for this. She said she had not noticed the reddened surrounding tissue and had not contacted the physician, as indicated in the order. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/7/23 at 7:03 A.M., the surveyor observed Resident #53 lying in bed with their left heel resting on top of their right foot. The skin lesion to the right foot was observed to have bloody drainage including dripping blood trailing to the heel and four trails of blood to the bottom of the foot and then pooling on the blanket below the foot. The surrounding tissue continued to be reddened. During an interview on 4/7/23 at 9:05 A.M., Nurse #6 said she regularly worked at the facility and was familiar with Resident #53 and the chronic right foot lesion. She said she cared for Resident #53 on Tuesday 4/4/23 and the right foot lesion had some bloody drainage on Tuesday and said based on observation with surveyor at this time, the bloody drainage had increased. She said the current plan for the skin lesion was that when Resident #53 was cleaned up by the certified nursing assistants, they would notify the nurse who would clean the wound with a wound cleanser. She said there were no treatments provided to the lesion as the Resident was on hospice and did not want any biopsies or extractions. During an interview on 4/7/23 at 11:12 A.M., Nurse #7 said she had contacted the Nurse Practitioner who ordered a wound cleanser and Cavilon spray (a liquid barrier film that dries quickly to form a breathable, transparent coating on the skin) and the Resident would be seen by the Nurse Practitioner for the reddened surrounding tissue which may indicate an infection. During an interview on 4/7/23 at 2:35 P.M., the Wound Physician Consultant said she did not follow the right foot skin lesion for Resident #53 as the family did not want any treatments. She said the Resident was previously followed for this area and when the skin lesion is dry and crusted it is best to be left open to air. She said she could recommend a powder to dry the area, but the family declined treatment. She said the Resident had a history of pulling off wound dressings. The wound physician said she has continued to recommend wound dressings to other open skin areas, but no longer followed or monitored this open skin lesion. During an interview on 4/7/23 at 2:35 P.M., Nurse #7 said the surrounding tissue of the skin lesion looked worse than it had that morning when she cleaned the area. During an interview on 4/7/23 at 2:45 P.M., the court appointed guardian for Resident #53 said due to the overall decline of the Resident through the previous years the decision had been made not to treat the cancer aggressively. She said that did not mean that wound dressings or recommendations for wound care could not be followed. She said the main goal was for the Resident to be comfortable. She said she had spoken with Nurse #7 earlier in the week who had notified her that the right foot skin lesion was bleeding. Review of the Physician's Progress Note, dated 4/7/23, indicated Resident #53 was seen for a wound evaluation of a chronic wound to the right outer ankle (right foot lesion) with surrounding erythema (reddening of the skin). The Nurse Practitioner noted a diagnosis of cellulitis (infection of the skin) with a new order for Doxycycline (antibiotic) 100 milligrams twice per day for 10 days and a new physician order dated 4/7/23 to culture the wound. During an interview on 4/12/23 at 11:30 A.M., the Director of Nurses said the expectation would be that the nurses would have notified the physician of any changes to the area and obtained an order for a dry protective dressing, regardless of the behaviors (of removing a dressing) for Resident #53. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/13/23 at 4:04 P.M., the Assistant Director of Nurses said there was no baseline of the right foot skin lesion documented in the medical record for the nurses to determine if there was a change in the skin lesion per the physician's order. She said the nurse should have been able to identify the reddened surrounding tissue and should have notified the physician of the changes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34145 Based on observations, record review, and interview, the facility failed to ensure for one Resident (#68), out of a total sample of 27 residents, that care and treatment interventions were implemented as ordered to prevent and to promote healing of pressure injuries. Specifically, the facility failed to ensure a pressure-relieving air mattress was set according to physician's orders to help promote healing of a Stage 3 pressure area to the Resident's coccyx. Findings include: Review of the facility's policy titled Support Surface Guidelines, last revised May 2018, included but was not limited to: -Preparation: Review the resident's care plan to assess for any special needs of the resident. -General Guidelines: -Redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide relief or reduction. -Support surfaces are modifiable. Individual resident needs differ. -Guidelines for Selecting Appropriate Pressure-Relieving Devices: -Use a pressure ulcer risk scale such as the Norton Scale to help determine the need for an appropriate type of pressure-relieving devices. -Nurses will check placement, function and settings for comfort at least daily. Resident #68 was admitted to the facility in January 2023 with diagnoses including a Stage 3 pressure area to the coccyx. Review of the 1/31/23 Minimum Data Set assessment indicated Resident #68 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15, required extensive assistance from staff for activities of daily living, had one unhealed unstageable area, was at risk for developing pressure ulcers, and had a pressure reducing device for his/her bed. Review of March 2023 Physician's Orders included but was not limited to: -Alternating Air Mattress: Setting-set at resident's weight. Check function and setting every shift (3/20/23) Review of Resident #68's weight record indicated the Resident's last measured weight was 163.9 pounds (lbs.) on 3/23/23. The surveyor made the following observations: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/6/23 at 9:14 A.M., Resident #68 was lying in bed; the air mattress was on, and the dial set between 240 lbs. and 300 lbs. -On 4/7/23 at 2:30 P.M., Resident #68 was lying in bed; the air mattress was on, and the dial set between 240 lbs. and 300 lbs. -On 4/10/23 at 2:20 P.M., Resident #68 was lying in bed; the air mattress was on, and the dial set between 240 lbs. and 300 lbs. -On 4/13/23 at 8:55 A.M., Resident #68 was lying in bed; the air mattress was on, and the dial set between 240 lbs. and 300 lbs. Review of the April 2023 Treatment Administration Record indicated staff signed off that Resident #68's air mattress was set at the Resident's weight on the days and times of the surveyor's observations. During an interview on 4/13/23 at 2:35 P.M., the surveyor and Staff Development Coordinator (SDC) observed Resident #68's air mattress. The air mattress was on, and the dial set between 240 lbs. and 300 lbs. She said the setting should be according to the Resident's weight as ordered and staff should not be signing off that it is set accurately when it is not. She said the air mattress should be set at 164 lbs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43935 Based on observation, interview, and policy review, the facility failed to maintain a safe environment, free of accident hazards. Specifically, the facility failed to ensure residents who smoke do not have possession of their own smoking materials including lighters while in the facility. Findings include: Review of the facility's policy titled Smoking - Residents, dated as revised 11/2017, included but was not limited to the following: -Residents who have independent smoking privileges are not permitted to keep cigarettes, or other smoking articles in their possession; all forms of lighters, including matches are prohibited -Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer at all times while smoking -The facility maintains the right to remove any smoking articles found in violation of the smoking policy On 4/6/23 at 11:07 A.M., the surveyor observed eight residents smoking in the enclosed courtyard in possession of their own smoking materials, including cigarettes and lighters. During an interview on 4/6/23 at 11:09 A.M., Certified Nursing Assistant (CNA) #4 said she was supervising the smokers and does so about once per week. She said she does not transport the residents or gather any smoking materials including cigarettes and lighters and the residents are all down in the hall awaiting smoking time when she arrives. She said the residents keep their own smoking materials with them and use them independently when they go outside, her only responsibility is to be there to supervise the process. During an interview on 4/6/23 at 2:00 P.M., Nurse #1 and Nurse #2 said the residents are supposed to have their cigarettes and lighting materials locked up in the medication room for safety. Nurse #2 said he did not provide Resident #54 with any cigarettes or a lighter to smoke throughout the day because the Resident keeps his/her own cigarettes and lighter in his/her room. Nurse #2 said Resident #54's family will come in and visit the Resident and provide the Resident directly with cigarettes and a lighter and the Resident will not surrender them. Nurse #1 said smoker's safety is a problem because some smokers have been found to smoke in inappropriate areas in the past. On 4/7/23 from 11:02 A.M. to 11:15 A.M., the surveyor made the following observations: -Resident #91 had his/her own cigarettes and own lighter on his/her person. During an interview with Resident #91 at this time he/she said they keep possession of their own cigarettes and lighter and does not pass them to the staff for safe storage. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #104 took the lighter of Resident #91 and lit his/her cigarette which they pulled out of their pocket. During an interview with Resident #104 at this time he/she said he/she keeps his/her own cigarettes and does not pass them into any staff member. -Resident #21 removed a cigarette from his/her pack which was in their pocket and requested to use Resident #91's lighter. During an interview with Resident #21 at this time he/she said they do not have a lighter of their own and relies on the other residents in the smoking area to let him/her use their lighters. Resident #21 said they cannot recall a time when the staff supervising the smoking area was capable of providing him/her with a lighter to light his/her cigarette. Resident #21 said he/she keeps their cigarettes in their room and does not pass them into the staff. -Resident #52 pulled cigarettes out of his/her pocket along with a lighter and lit his/her own cigarette before handing the lighter to Resident #130. -Resident #130 removed a cigarette from a small pouch and requested the use of Resident #52's lighter to light his/her cigarette. -Resident #126 had his/her cigarettes and lighter in their pocket. The Resident removed a cigarette and lit it independently. During an interview with Resident #126 at this time he/she said they keep both the cigarettes and lighter in their room because they are theirs. -Resident #146 removed his/her own cigarettes and lighter from their left pocket. During an interview with Resident #146 at this time he/she said they have never been asked to surrender their lighter or cigarettes to the staff and keeps them on their person. -A small, covered box was mounted to the outside of the facility wall with chairs placed in front of it. Resident #130 said it was a lighter device that was flameless. He/she said they would have to lean forward towards the device and inhale while their cigarette was pressed up against the metal plate in order to get their cigarette lit by the device. He/she said they cannot recall seeing it used and usually just use another resident's lighter when he/she comes out to smoke. -Resident #104 said he/she didn't think the exterior lighting device worked any longer and said it is blocked by chairs and wouldn't be safe for the residents to use. During an interview at 11:11 A.M., CNA #5 said she supervises the smokers typically twice a week when working. She said she does not collect cigarettes or lighters before or after and all the residents have their own cigarettes and lighters. She said she has never provided any of the residents with a lighter or seen any resident use the lighter device mounted outside of the facility. She said the residents are responsible for managing their own cigarettes and lighters. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/7/23 at 3:05 P.M., the Administrator was made aware of the surveyor's observations of resident smoking and said the facility has tried to get the lighters from the residents in the past without success. He said visitors and families bring cigarettes or lighters into the residents and it is hard to get them once the residents have them. He said the residents possessing their own smoking materials and lighters was a violation of the smoking policy in the facility and the issue is an ongoing work in progress.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 43935 Based on observation and interview, the facility failed for three Residents (#54, #130, and #43), out of a total sample of 27 residents, to safely maintain and store respiratory equipment when not in use by the Resident. Specifically, the facility failed to: 1. For Residents #54 and #130, store oxygen tubing in a manner to keep them off the floor and clean from environmental germs; and 2. For Residents #54 and #43, store nebulizer equipment in a manner to protect it from environmental germs and debris to prevent potential infections. Findings include: Review of the facility's policy titled Cleaning and Disinfection of Environmental Surfaces, dated as revised 4/2018, included but was not limited to the following: -Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (respiratory equipment), such devices should be free from microorganisms 1. On 4/6/23 at 11:07 A.M., the surveyor observed Resident #54 and Resident #130 outside the facility in the designated smoking area. Their portable oxygen tanks and oxygen tubing were observed on the floor inside the facility, adjacent to the door leading out to the smoking patio. The tubings were not secured in a manner to prevent germs or debris from contaminating the nasal cannulas, which are placed on the Residents' face and inserted into their nose when in use. During an interview on 4/6/23 at 11:09 A.M., Certified Nursing Assistant (CNA) #4 said the Residents' oxygen is stored in the facility when the Residents are outside smoking on the patio, either hanging on the hook to the left of the door or on the floor to the right of the door. She said there were no respiratory storage bags or process to store the tubing while it was not in use. CNA #4 observed the nasal cannulas from the oxygen tubing touching the floor for both Resident #54 and Resident #130 and said it was on the floor and was dirty. She said the tubing should not be put on the floor and then back on the face of the Residents. During an interview on 4/6/23 at 2:00 P.M., Nurse #2 said he was made aware of the concerns with Resident #54's oxygen tubing and replaced the contaminated tubing. He said he was not aware of any process currently in place to protect the nasal cannulas when not in use while the Residents are outside smoking. During an interview on 4/7/23 at 2:17 P.M., the Director of Nurses (DON) said she was made aware of the concerns of the nasal cannula oxygen tubing for the smokers being stored on the floor and touching the floor when not in use during smoke breaks. She said it was an infection control concern and the facility did not realize that this was happening. 2. Review of the facility's policy titled Aerosolized Medication Administration, undated, indicated but was not limited to the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-once a treatment is complete the nebulizer should be dismantled and rinsed under a stream of sterile water, then allowed to air dry on a paper towel, once dry, reassembled and placed in a plastic storage bag On 4/6/23 at 10:10 A.M., the surveyor observed Resident #54's nebulizer mask and tubing left out on the bedside table, open to germs and environmental debris, not stored in a plastic storage bag. On 4/6/23 at 1:46 P.M., the surveyor observed Resident #43's nebulizer mask and tubing left out on the bedside table, open to germs and environmental debris, not stored in a plastic storage bag. Review of the April 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #54 and Resident #43 indicated the nebulizer tubing was changed weekly but failed to indicate documentation for cleaning or storage of the equipment. During an interview on 4/7/23 at 2:17 P.M., the DON said respiratory equipment tubing and nebulizer masks and tubing not in current use by the residents should be cleaned and stored in a plastic respiratory equipment storage bag that is left in the room for each resident. The DON was made aware of the surveyor's observations and said the expectation and policy were not followed as it should have been.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 31830 Based on interview, record review and policy review, the facility failed to ensure dialysis treatment, care and services were consistent with professional standards of practice for two Residents (#118 and #115), out of total sample of 27 residents. Specifically, the facility failed: a) to ensure the communication book used to refer information between the facility and dialysis clinic was available, up-to-date and contained pertinent information including dialysis treatment outcomes; b) to ensure a coordinated care plan for dialysis treatment was developed which included required components including accurate contact information for the dialysis facility; and c) to have a signed, current agreement in place for the provision of dialysis treatment at an end-stage renal disease (ESRD) facility. Findings include: Review of the facility's policy titled End Stage Renal Disease, Care of Resident, dated 11/2017, indicated but was not limited to the following: - Residents with end-stage renal disease will be cared for according to currently recognized standards of care. - Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: a. How the care plan will be developed and implemented; b. How information will be exchanged between the facilities; and c. Responsibility for waste handling, sterilization and disinfection of equipment. - The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. 1. For Resident #118, the facility failed to ensure the communication book used to refer information between the facility and dialysis was available, up to date and contained pertinent information for coordination of services and failed to ensure a coordinated care plan for treatment included accurate contact information for dialysis clinic in case of immediate need for contact with concerns/issues. Resident #118 was admitted to the facility in January 2022 with diagnoses which included end stage renal disease and dependence of renal dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 12/21/22, indicated Resident #118 received dialysis treatment. Review of the Physician's orders included, but was not limited to: - Dialysis Center #1 Days: Monday, Wednesday, Friday, date ordered, 12/16/21 Review of the comprehensive care plans included, but was not limited to: Focus: - Potential for complications related to hemodialysis for diagnoses of End Stage Renal Failure (4/19/22) Interventions: - Coordinate Resident's care in collaboration with dialysis center (9/26/22) - Dialysis Center #2, Dialysis Center Emergency Contact #833-356-2966, - Dialysis days: Monday, Wednesday and Friday - Check right chest permacath site for signs and symptoms of infection, pain, or bleeding daily and as needed 9/26/22 Goals: - Resident will have no signs or symptoms of infection of access site through next review (1/3/23) During an interview on 4/6/23 at 1:53 P.M., Nurse #2 said Resident #118 received dialysis on Monday, Wednesday and Friday. The surveyor requested the dialysis communication book (tool used to communicate between providers) which accompanied the Resident to and from the dialysis clinic for each visit. Nurse #2 looked throughout the nurses' station and was unable to locate the book. Nurse #2 said Resident had received dialysis the day prior, and perhaps the communication book had not returned with the Resident. During a subsequent interview on 4/6/23 at 1:59 P.M., Nurse #2 said he telephoned the dialysis clinic and was informed the communication book for Resident #118 could not be located. Nurse #2 said he might need to start a new communication book for the Resident as his/her book was missing. Nurse #2 said there was no other dialysis communication he could provide to the surveyor for review. Review of Resident #118's medical record included only one completed dialysis communication form, dated 2/6/23, no additional dialysis communication forms/information were located in the medical record. During an interview on 4/6/23 at 2:14 P.M., Family Member #1 said Resident #118 no longer received dialysis at Dialysis Center #1 and began dialysis at Dialysis Center #3 approximately two weeks prior. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent review of Resident #118's medical record indicated a physician's order for the Resident to receive dialysis at Dialysis Center #1 Days: Monday, Wednesday, Friday, date ordered, 12/16/21. There was no order in place which indicated the Resident was now receiving dialysis services at another clinic. On 4/7/23 at 11:35 A.M., the surveyor overheard the Emergency Medical Technician ask Nurse #2 for the dialysis communication book for Resident #118 as the Resident was to be transported to the dialysis clinic for treatment. Nurse #2 said he was unable to locate the book and was unable to find the book the day prior. On 4/11/23 at 12:17 P.M., during review of the Dialysis Communication Book for Resident #118, which was located at the nurses' station indicated the Resident received dialysis treatment at the Dialysis Center #3. The communication book included two dialysis communication forms titled: Dialysis Center #3. One form, dated 3/27/23, was left blank in the section titled To Be Completed by Skilled Nursing Care Facility. The section titled To Be Completed by Dialysis Center was completed and signed by a nurse. The second form was dated 3/31/23 and 4/4/23 and was not completed by the Skilled Nursing Care Facility or the Dialysis Center. Subsequent review included a white sheet of paper, undated, with some type of clinical update written on the paper. The paper did not include any identifier to indicate where or when the update was provided. The communication book failed to include any additional information. During an interview on 4/11/23 at 12:45 P.M., Nurse #8 said Resident #118 received dialysis treatment at a new dialysis clinic, Dialysis Center #3 on Monday, Wednesday, and Friday. During an interview on 4/12/23 at 10:50 A.M., Nurse #2 said Resident #118 received dialysis at the Dialysis Center #3 on 4/7/23 and 4/10/23. Nurse #2 said the communication book had been missing for some time and was unable to locate the book for 4/7/23 and 4/10/23 treatments. Nurse #2 said the dialysis clinic should send information back to the facility related to Resident's dialysis treatment. Nurse #2 said he called the dialysis clinic again on 4/7/23 and was told the communication book could not be found. Nurse #2 said he sent communication to the dialysis clinic on 4/10/23 on a sheet of paper placed in a folder. Nurse #2 said the Resident returned from treatment on 4/10/23 without the folder. The surveyor and Nurse #2 reviewed the communication book which was located at the nursing station. Nurse #2 said this book was new and further review of the communication book failed to include any information related to dialysis treatment the Resident received on 4/7/23 or 4/10/23. Review of the medical record failed to include new physician's orders for a change in dialysis clinic and failed to include updated information on the comprehensive care plan for emergency contact for dialysis concerns or emergencies. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/23 at 1:50 P.M., the Director of Nursing said the physician orders and care plan should reflect the change in dialysis clinics. The Director of Nurses said, although there was a new dialysis communication book in place, she was not aware the communication book for Resident #118 had gone missing. The surveyor and Director of Nurses reviewed the blank communication sheets located in the new communication book, and the Director of Nurses said the expectation would be for communication between the dialysis clinic and the facility in order to monitor for any information or changes for Resident #118. 34145 2. Resident #115 was originally admitted to the facility in February 2023 with diagnoses including end stage renal disease. The Resident had a five-day hospitalization and was readmitted in March 2023. Review of the 2/27/23 Minimum Data Set assessment indicated Resident #115 received dialysis treatment. Review of the Physician's Orders included but was not limited to: -Dialysis Center #4; Days: Monday, Wednesday, Friday (2/21/23) a. During interviews with the Administrator on 4/10/23 at 9:40 A.M. and 4/11/23 at 10:44 A.M., he said the facility does not have an Agreement/contract with the dialysis center Resident #115's uses. He provided the surveyor with a copy of an Agreement /contract that he had signed and said he is awaiting the dialysis center to review and sign the contract. The Administrator confirmed that until he receives the signed Agreement/contract from the dialysis center, there is no signed agreement with them and there never has been one in place. b. Review of Resident #115's Comprehensive Care Plans included but was not limited to: -Focus: Resident needs hemodialysis (2/22/22) -Interventions: Protect access site from injury. Site: (blank); avoid constriction on affected arm. No BP on limb with shunt/CV (central venous) dialysis catheter (2/22/22) -Goal: The resident will have immediate intervention should any signs/symptoms of complications from dialysis occur through the review date (2/22/23); The resident will have no signs/symptoms of complications from dialysis through the review date (2/22/23) The comprehensive care plan for hemodialysis failed to identify: -Specific type and location of dialysis services -Transportation arrangements -Which arm to use for blood pressure monitoring (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Review of the March and April 2023 Medication/Treatment Administration Records (MAR/TAR) indicated Resident #115 had 21 scheduled dialysis sessions since his/her re-admission to the facility. During an interview on 4/10/23 at 2:05 P.M., Unit Manager #1 said that Resident #115 goes for dialysis treatments three days a week and all communication between the facility and the Dialysis Center is located in the Resident's Dialysis Communication Book. Review of Resident #115's Dialysis Communication Book indicated the following: -Six Dialysis Communication Forms that were not completed by the facility nurses prior to Resident #115 attending dialysis treatment. -Five Dialysis Communication Forms that were not completed by the Dialysis Center after Resident #115 received dialysis treatment. -No Dialysis Communication Forms for review on the following dates: 3/27/23, 4/10/23, and 4/12/23. Review of Resident #115's medical record failed to reflect evidence of ongoing nursing clinical notes/oral reports provided to the Dialysis Center by the nursing center for the above six dialysis treatment dates, failed to reflect communication by the Dialysis Center to the nursing facility for the above five dialysis treatment dates and failed to reflect any communication between the facility and the Dialysis Center for three dialysis treatment dates that were missing communication forms in the Resident's dialysis book. During an interview on 4/13/23 at 2:48 P.M., the surveyor reviewed Resident #115's Dialysis Communication Book with the Staff Development Coordinator. She said nursing staff is supposed to complete the communication form and send it along with the Resident to dialysis and the Dialysis Center is supposed to complete the post treatment portion of the form and send it back to the facility with the Resident.

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F 0711 Level of Harm - Actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 34145 Based on interviews and record review, the facility failed to ensure the physician included an evaluation of the resident's condition and total program of care, including the accuracy of orders for medications, for one Resident (#139), out of a total sample of 27 residents, which resulted in the Resident being administered the wrong anti-seizure medication for 28 days, had three transfers to the hospital emergency department and one five-day hospitalization due to the onset of seizure activity. Findings include: Resident #139 was admitted to the facility in March 2023 with diagnoses including weakness and epilepsy. Review of the 3/20/23 Minimum Data Set (MDS) assessment indicated Resident #139 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, required extensive assistance from staff for bed mobility, dressing, bathing and toileting and had epilepsy. Review of the hospital documentation, Medication Administration Record (MAR), Transfer Report, dated 3/8/23, indicated that Resident #139's Active Medication Orders (at home) included: -Divalproex ER (brand name Depakote extended release (stays longer in the body), anticonvulsant used to treat seizures) 1500 milligrams (mg) by mouth two times a day -Carbamazepine ER (brand name Tegretol anticonvulsant used to treat seizures) 1200 mg two times a day. Review of a 2/8/23 Neurology progress note indicated Resident #139's home medications were Divalproex ER 1500 mg by mouth two times a day and Carbamazepine ER 1200 mg two times a day. The neurology note indicated Resident #139's last seizure was on 10/7/22. Further review of the medical record indicated a verbal order was obtained from the Nurse Practitioner for Divalproex ER 1500 mg by mouth two times a day and Carbamazepine ER 1200 mg two times a day on 3/14/23. Review of the March 2023 Physician's Orders indicated: - Depakote ER 1500 mg two times a day - Tegretol 1200 mg two times a day The Tegretol order was transcribed in the medical record for standard immediate release and not extended release as indicated by the NP's verbal order. (continued on next page)

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F 0711 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record indicated a 3/15/23 New Admission History & Physical Note, signed by Resident #139's Attending Physician on 3/22/23. The Physician indicated he reviewed the Resident's medications, Medication Administration Record (MAR), hospital discharge summary, and reviewed the plan of care with nursing staff. The Physician's note failed to indicate he identified the incorrect medication order for Tegretol. Review of a subsequent New Admission History & Physical Note, dated 4/5/23 and signed by the Physician on 4/10/23, indicated he reviewed the Resident's medications, MAR, hospital discharge summary, and reviewed the plan of care with nursing staff. The Physician's note failed to indicate he identified the incorrect medication order for Tegretol. During an interview on 4/12/23 at 12:19 P.M., the surveyor reviewed Resident #139's medical record with Physician #1. The Physician said he did see Resident #139 on 3/15/23 and 4/5/23, but he did not review the Resident's medical record. He said when he comes into the facility, he speaks to nursing staff and takes their information as they relay it about the Resident and uses that information in his assessments. He said he did not know Resident #139 was being administered Tegretol immediate release and not Tegretol Extended Release. He said Resident #139 had been having uncontrolled seizures because he/she had been receiving the wrong medication since admission to the facility.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 36542 Based on interviews and record review, the facility failed to ensure required physician visits (every 30 days for the first 90 days) alternated between the Physician and the Nurse Practitioner for Resident #44, in a total sample of 27 residents. Findings include: Resident #44 was admitted to the facility in January 2023. Review of the medical record indicated Resident #44 was seen by the primary Physician on 1/16/23 and all subsequent visits were conducted by a Nurse Practitioner. During an interview on 4/13/23 at 2:38 P.M., the Director of Nurses said she had reviewed all physician visits and contacted the physician's office. She said Resident #44 was only seen by the primary Physician on 1/16/23 and the primary Physician should have alternated required visits with the Nurse Practitioner.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 36542 Based on interview and record review, the facility failed to provide Social Services to one Resident (#34), from a total sample of 27 residents, who was legally blind and wished to be connected with outside resources for additional services. Findings include: Resident #34 was admitted to the facility in October 2022 with a diagnosis of legal blindness. Review of the Minimum Data Set (MDS) assessment, dated 1/4/23, indicated Resident #34's vision was severely impaired and Resident #34 scored 12 out of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. Review of the care plan indicated: Focus: impaired visual function Goal: maintaining optimal quality of life within limitations imposed by visual function Interventions: ensuring appropriate visual aids available to participate in activities and identifying factors affecting visual function including environment (poor lighting, monochromatic color scheme) and choices. Review of the Occupational Therapy Treatment Note, dated 11/29/22, indicated Resident #34 was educated regarding using tactile aids for topographical orientation and locating the bathroom independently and when cued, the Resident was able to utilize their left hand on the wall and touch the vinyl strip attached to the bathroom door and cloth on the doorknob as tactile aids. On 4/6/23 at 9:30 A.M., the surveyor observed Resident #34 exit his/her room and ambulate in the hallway using a cane for the blind. Nurse #8 approached Resident #34 at this time and asked him/her what they were looking for. The Resident said he/she was looking for the bathroom. During an interview on 4/6/23 at 10:10 A.M., Resident #34 said he/she had difficulty finding the bathroom in his/her room and did not have any accommodations in place to assist in finding the bathroom. At this time, the surveyor observed two small Velcro taped squares on the bathroom door in the Resident's room, there was no vinyl strip. There was a cloth tied to the bathroom doorknob. In addition, Resident #34 said he/she enjoyed listening to love stories and previously had books on tape. The surveyor observed the Resident room and there were no devices to play books on tape. The surveyor observed the Resident in his/her room through all days of survey to not have a vinyl strip across the bathroom door and to not have any devices to assist with books on tape including on 4/6/23 at 10:10 A.M. and 3:05 P.M., on 4/7/23 at 11:21 A.M., on 4/11/23 at 12:40 P.M. and 4:27 P.M. and on 4/12/23 at 9:43 A.M. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/23 at 12:05 P.M., the surveyor observed Resident #34 exit his/her room and ambulate in the hallway using a cane for the blind. The surveyor observed Nurse #12 ask Resident #34 what he/she was looking for. The Resident responded he/she was looking for the bathroom. During an interview on 4/12/23 at 12:10 P.M., Nurse #12 said Resident #34 had difficulty finding the bathroom and she was not sure what accommodations were in place to help the Resident. Review of the Social Service progress note, dated 11/6/22, indicated the Social Worker contacted the Massachusetts Commission for the Blind (a state agency offering services provided by specially trained specialists that facilitate the accomplishment of routine daily tasks and ensure that individuals with visual impairments live independent and productive lives) to inquire if Resident #34 was enrolled with services as the Resident could benefit from more services at the facility and left a message for call back. Review of the Social Service progress note, dated 1/5/23 at 8:45 A.M., indicated another call was made to the Massachusetts Commission for the Blind (two months after the first call) and a message was left for a call back. Review of an additional Social Service note, dated 1/5/23 at 11:10 A.M., indicated the Social Worker had received a call back from the Massachusetts Commission for the Blind and was given instructions on how to register the Resident for the services and instructed the Social Worker to call back in one week if there was no response. As of 4/12/23, three months later, there was no further documentation to indicate the Social Workers had followed up with the Massachusetts Commission for the Blind. During an interview on 4/12/23 at 9:43 A.M., Resident #34 said he/she did not recall meeting with anyone from the Massachusetts Commission for the Blind. During an interview on 4/12/23 at 11:55 A.M., the Social Worker said the calls made to the Massachusetts Commission for the Blind were made by the previous Social Worker and there had been no follow up for services for Resident #34 since January 2023, three months prior.

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F 0756 Level of Harm - 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. 34145 Based on record review and interviews, the facility failed to ensure the consultant pharmacists identified and reported irregularities (use of a medication that is inconsistent with accepted standards of practice) for two Residents (#139 and #70), out of a total sample of 27 residents. Specifically, the facility failed: 1. For Resident #139, to ensure the Consultant Pharmacists reviewed the Resident's medical record and identified and reported an irregularity regarding inaccurate transcription of an order for an anti-seizure medication upon admission and monthly review which resulted in the Resident receiving the wrong medication for 28 days, had three transfers to the hospital emergency department and one five-day hospitalization due to the onset of seizure activity; and 2. For Resident #70, a. to ensure the Consultant Pharmacist identified and reported an irregularity regarding the continued use of an antibiotic, and b. the attending Physician failed to document that an identified irregularity of blood thinner use had been reviewed and failed to document the rationale for the continued use. Findings include: Review of the facility's policy, Pharmscript-Medication Regimen Review, dated 8/2020, included but was not limited to: Policy: -The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review (MRR) includes evaluation of the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. Procedures: -If a consultation is needed when the pharmacist is off-site, the consultant pharmacist works with facility personnel and electronic records to gather pertinent information related to the resident's status and/or request for consultation. -The consultant pharmacist identifies irregularities through a variety of sources including the resident's clinical record, pharmacy records, and other applicable documents. (continued on next page)

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F 0756 Level of Harm - Actual harm Residents Affected - Few	-Resident-specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing (DON), Medical Director, and/or prescriber as appropriate. -Recommendations are acted upon and documented by the facility staff and/or prescriber. 1. Resident #139 was admitted to the facility in March 2023 with diagnoses including weakness and epilepsy. Review of the 3/20/23 Minimum Data Set (MDS) assessment indicated Resident #139 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, required extensive assistance from staff for bed mobility, dressing, bathing, and toileting and had epilepsy. Review of the hospital documentation, Medication Administration Record (MAR), Transfer Report, dated 3/8/23, indicated that Resident #139's Active Medication Orders (at home) included: -Divalproex ER (brand name Depakote extended release (stays longer in the body), anticonvulsant used to treat seizures) 1500 milligrams (mg) by mouth two times a day -Carbamazepine ER (brand name Tegretol anticonvulsant used to treat seizures) 1200 mg two times a day. Further review of the medical record indicated a verbal order was obtained from the Nurse Practitioner for Divalproex ER 1500 mg by mouth two times a day and Carbamazepine ER 1200 mg two times a day on 3/14/23. The Tegretol order was transcribed in the medical record for standard immediate release and not extended release as indicated by the NP's verbal order. Review of a 3/15/23 Interim Medication Regimen Review, signed by Pharmacist #3 indicated Based on information submitted for review, I have no recommendations at this time. The pharmacist failed to identify and report the inaccurate transcription of the Resident's Tegretol. During a telephone interview on 4/14/23 at 10:38 A.M., Pharmacist #3 said he is responsible for standard admission medication regimen reviews for the facility, and he conducted an admission medication review for Resident #139 off-site on 3/15/23. The pharmacist said he reviewed the Resident's medical record remotely, specifically physician's orders and the MAR, and found no irregularities. The surveyor asked him if he reviewed hospital documentation including hospital medication orders as a part of his review and he said he did not. On 3/19/23 at approximately 3:50 P.M., Resident #139 had a seizure and was transferred to the hospital. Hospital documentation indicated the Resident's home medication list included Depakote ER and Tegretol ER (not immediate release Tegretol). The Resident returned to the facility with no new orders and the previous medication orders were resumed (including the incorrect medication orders for immediate release Tegretol). (continued on next page)

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F 0756 Level of Harm - Actual harm Residents Affected - Few	On 4/3/23, Resident #139 was transferred to the hospital for seizure-like activity. The Resident returned with no new orders and the previous medication orders were resumed (including the incorrect medication orders for immediate release Tegretol). Review of a 4/4/23 Medication Regimen Review indicated: -Based upon the information available at the time of the review and assuming the accuracy and completeness of such information, it is my personal judgement that at such time the resident's medication regimen contained no new irregularities. For purposes of the foregoing statement, the term irregularity means an event or circumstance that is substantially inconsistent with customary, accepted clinical approaches to providing pharmaceutical products and services or that could reasonably be expected to impede or interfere with the achievement of intended or reasonably expected outcomes. The pharmacist failed to identify and report the inaccurate transcription of the Resident's Tegretol following two hospital visits for seizures. Review of the medical record indicated on 4/6/23, Resident #139 suffered multiple seizures, was transferred to the hospital, and admitted for five days. During a telephone interview on 4/13/23 at 12:01 P.M., Pharmacist #1 said she reviewed Resident #139's medical record when she conducted her MRR on 4/4/23 and did not pick up any irregularities with the Resident's orders. During an interview on 4/12/23 at 12:19 P.M., the surveyor reviewed Resident #139's medical record with Physician #1. He said the medication transcription error should have been picked up each time the Resident returned from the hospital and medication orders were reviewed. 36542 2. Resident #70 was admitted to the facility in February 2015 with a diagnosis of diabetes and was readmitted with a diagnosis of a foot wound infection in December 2022. a. Review of the Hospital Discharge Summary, dated 12/6/22, indicated Resident #70 had a worsening left foot ulcer with suspicion of possible cellulitis (bacterial infection of the skin) without osteomyelitis (bone infection). The Resident was seen by Infectious Disease, received IV (intravenous) antibiotics and then upon discharge would switch to oral antibiotics for a total of 10 days. Review of the discharge medications indicated the following orders: Ceftin (antibiotic) 500 milligrams (mg) every 12 hours, for a total of 20 doses (10 days) and Doxycycline (antibiotic) 100 mg twice per day for a total of 20 doses (10 days). Review of the Medication Administration Record (MAR) indicated Resident #70 had an order dated 12/6/22 for Doxycycline 100 mg two times per day for antibiotic treatment for foot wounds. Review of the April 2023 MAR indicated Resident #70 continued to receive Doxycycline 100 mg twice per day and now indicated no stop date. Review of the monthly Medication Regimen Reviews, dated 1/3/23, 2/1/23, 3/1/23, and 4/4/23, failed to include the reporting of irregularities related to the continued use of an antibiotic, without duration. (continued on next page)

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F 0756 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/13/23 at 12:12 P.M., the Consultant Pharmacist said during the Medication Regimen Review she reviews the antibiotic use to ensure the antibiotic stewardship program is being followed. She said she will usually request documentation for continuation and need for antibiotic use, unless it's already in the medical record. She said she had not seen or requested documentation of a continued infection for Resident #70 and had assumed the wound infection continued. She said she had not made any recommendations regarding the extended use of the antibiotic for four months because it contained the words no stop date and she did not want to interfere with care. b. Review of the electronic medical record indicated the Consultant Pharmacist made a recommendation regarding an irregularity on 1/3/23 and indicated to see the recommendation. Review of the paper and electronic medical record on 4/12/23 failed to include the Consultant Pharmacist Recommendation to Prescriber form and the form was requested from the Director of Nurses. Review of the Consultant Pharmacist Recommendation, dated 1/3/23, indicated Resident #70 was currently receiving Lovenox (blood thinner) therapy and to review the order for a stop date based on diagnosis, clinical guidelines, or patient mobility. The form indicated the Medication Regimen Review was conducted on 1/3/23 and the form was printed on 1/28/23. The prescriber response box was checked off as disagree with a date of 1/17/23 handwritten next to it and indicated there was an upcoming appointment and to follow up at Vascular. The form was not signed and did not indicate who made the decision. During an interview on 4/13/23 at 8:57 A.M., the Director of Nurses said this was the only copy of the form she had and there was no signed copy from a physician. She said she had called the nurse on the unit of Resident #70 and the nurse had said the plan was to wait for Vascular, she said she did not know which Physician made this determination. The surveyor requested documentation to indicate the attending Physician had reviewed the irregularity and had documented their rationale in the medical record. During an interview on 4/13/23 at 2:46 P.M., the Director of Nurses said there was no documentation in the medical record regarding the continued use of the Lovenox.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 36542 Based on interviews, record review, and policy review, the facility failed to ensure for one Resident (#70), out of a total sample of 27 residents, that the Resident's drug regimen was free from unnecessary drugs. Specifically, the facility failed to ensure an antibiotic was administered for the appropriate duration and with adequate indications for use. Findings include: Review of the facility's policy for Antibiotic Stewardship- Orders for Antibiotics, dated November 2017, indicated: - prescriber will provide complete antibiotic orders including the following elements: drug name, dose, frequency of administration, duration of treatment (start and stop date or number of days of therapy), route of administration and indications for use -appropriate indication for use of antibiotics include: criteria met for clinical definition of active infection Resident #70 was admitted to the facility in February 2015 with a diagnosis of diabetes and was readmitted with a diagnosis of a foot wound infection in December 2022. Review of the Hospital Discharge Summary, dated 12/6/22, indicated Resident #70 had a worsening left foot ulcer with suspicion of possible cellulitis (bacterial infection of the skin) without osteomyelitis (infection of bone). The Resident was seen by Infectious Disease, received IV (intravenous) antibiotics and then upon discharge would switch to oral antibiotics for a total of 10 days. Review of the discharge medications indicated the following orders: Ceftin (antibiotic) 500 milligrams (mg) every 12 hours, for a total of 20 doses (10 days) and Doxycycline (antibiotic) 100 mg twice per day for a total of 20 doses (10 days). Review of the Medication Administration Record (MAR) indicated Resident #70 had an order dated 12/6/22 for Doxycycline 100 mg two times per day for antibiotic treatment for foot wounds. Review of the April 2023 MAR indicated Resident #70 continued to receive Doxycycline 100 mg twice per day and the order now indicated no stop date. Review of the Consultant Wound Physician's Wound Evaluation and Management Summary, dated 12/13/22, indicated the following skin areas to the left foot: unstageable area (due to necrosis (premature death of cells in living tissue)) of the left lateral fifth toe unstageable area (due to necrosis) of the left medial fifth toe unstageable area (due to necrosis) of the left, distal, dorsal, lateral foot (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Evaluation and Management Summary indicated there were no signs of infection in any of the open areas. Review of the Consultant Wound Physician's Wound Evaluation and Management Summary from the following dates did not indicate any signs or symptoms of infection to the left foot: 12/20/22, 1/3/23, 1/10/23, 1/17/23, 2/8/23, 2/17/23, 2/21/23, 3/3/23, 3/7/23, 3/14/23, 3/24/23, 3/31/23, and 4/7/23. Review of the Physician's Progress Note, dated 1/17/23, indicated the left fifth toe was gangrenous (decaying tissue due to loss of blood flow) and Resident #70 had an angiogram (scan to show blood flow) scheduled to determine next steps. The Progress Note did not indicate the need to continue an antibiotic or any current infections. Review of the Physician's Progress Note, dated 3/31/23, indicated Resident #70 was being followed by Vascular who had decided against amputation at this time. The Progress Note did not indicate the need for the continued use of an antibiotic or any current infections. During an interview on 4/12/23 at 2:07 P.M., the Infection Control Preventionist said Resident #70 had continued an antibiotic since December related to the foot wound. The Infection Control Preventionist said the unit nurse had said the consultant Vascular Physician or the Podiatrist had wanted to continue to the antibiotic until the wound was healed. Review of the Report of Consultation from the Vascular Physician, dated 1/17/23 and 2/9/23, did not indicate any signs or symptoms of infection and did not indicate the continued use of an antibiotic. Review of the Report of Consultation from the Podiatrist, dated 2/28/23, did not indicate any signs or symptoms of infection and did not indicate the continued use of an antibiotic. During an interview on 4/12/23 at 2:54 P.M., the Infection Control Preventionist said she was unable to locate any documentation to indicate the continued need for an antibiotic. She said there was no reference to the continued use in the nursing progress notes or the Physician Progress Notes. During an interview on 4/13/23 at 9:08 A.M., the Infection Control Preventionist said she contacted the Podiatrist for Resident #70. She said the Podiatrist had not recommended to continue the antibiotic and made the recommendation to discontinue the antibiotic at this time as the Resident did not need it.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 34145 Based on interview and record review, the facility failed to ensure five Residents (#12, #115, #121, #44, and #25) were free from unnecessary psychotropic medications, in a total sample of 27 residents. Specifically, the facility failed to ensure: 1. For Resident #12, resident specific, targeted behaviors were monitored for the use of the antipsychotic medication Abilify; 2. For Resident #115, resident specific, targeted behaviors were monitored for the use of the antidepressant medication Sertraline (Zoloft); 3. For Resident #121, resident specific, targeted behaviors were monitored for the use of the antidepressant medications Lexapro and Mirtazapine; 4. For Resident #44, documentation of the re-evaluation and continued use for an as needed psychotropic medication Ativan; and 5. For Resident #25, documentation of the re-evaluation and continued use for an as needed psychotropic medication Clonazepam. Findings include: Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, last revised 11/2017, included but was not limited to: -The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes; -When medications are prescribed for behavioral symptoms, documentation will include: -Rationale for use; -Potentially underlying causes of behavior; -Specific target behaviors and expected outcomes; Monitoring: If the resident is being treated for altered behavior or mood, the interdisciplinary team will seek and document any improvements or worsening in the individual's behavior, mood and function. 1. Resident #12 was admitted to the facility in February 2023 with diagnoses including bipolar disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 2/16/23 Minimum Data Set (MDS) assessment indicated Resident #12 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15, had a diagnosis of bipolar disorder, and received antipsychotic medication daily. Review of the Physician's Orders included but was not limited to: -Abilify (antipsychotic) 20 milligrams (mg) in the morning for bipolar disorder (1/31/23) -Monitoring: -behavior toward others: hit, kick, push, scratch, grab, abusing others sexually -verbal toward others: threat, scream, cursing -self: hit self, scratch self, pacing, rummaging, public sexual acts, disrobing in public, throwing food or bodily waste, screaming or other disruptive sounds -refusing/rejecting care: labs, imaging, medication, ADL (activities of daily living), wandering The physician's order failed to include monitoring of targeted behaviors, signs/symptoms of bipolar disorder for the use of Abilify as required. Review of comprehensive care plans included but was not limited to: -Focus: Psychotropic/antipsychotic: Psychotropic drug use related to diagnosis of: behavior dyscontrol (3/1/23) -Interventions: Additional Approaches: (blank) (3/1/23); Administer medication as prescribed by the Physician (3/1/23); AIMS/DISCUS review every six months and as needed (3/1/23); Documentation of mood/behavior issues (3/1/23) The comprehensive care plan for antipsychotic medication use failed to identify resident specific, targeted behaviors for the use of the antipsychotic medication for bipolar disorder and failed to include non-pharmacological approaches to care. 2. Resident #115 was originally admitted to the facility in February 2023 with diagnoses including depression. The Resident had a five-day hospitalization and was readmitted in March 2023. Review of the 2/27/23 MDS assessment indicated Resident #115 was cognitively intact as evidenced by a BIMS score of 15 out of 15, had a diagnosis of depression and received antidepressant medication daily. Review of the Physician's Orders included but was not limited to: -Sertraline HCl 25 mg one time a day for depression (2/23/23) -Monitoring: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-behavior toward others: hit, kick, push, scratch, grab, abusing others sexually -verbal toward others: threat, scream, cursing -self: hit self, scratch self, pacing, rummaging, public sexual acts, disrobing in public, throwing food or bodily waste, screaming or other disruptive sounds -refusing/rejecting care: labs, imaging, medication, ADL (activities of daily living), wandering The physician's order failed to include monitoring of targeted behaviors, signs/symptoms for the use of Sertraline for depression as required. Review of comprehensive care plans included but was not limited to: -Focus: Resident (sic) uses antidepressant medication (2/27/23) -Interventions: Administer antidepressant medication as ordered by the Physician. Monitor/document side effects and effectiveness every shift (2/27/23); Monitor/document/report prn (as needed) adverse reactions to antidepressant therapy (2/27/23) -Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (2/27/23); The resident will show decreased episodes of signs/symptoms of depression through the review date (2/27/23) The comprehensive care plan for antidepressant medication use failed to identify resident specific, targeted behaviors for the use of the antidepressant medication for depression and failed to include non-pharmacological approaches to care. 3. Resident #121 was admitted to the facility in February 2023 with diagnoses including major depressive disorder and anxiety. Review of the 2/23/23 MDS assessment indicated Resident #121 was cognitively intact as evidenced by a BIMS score of 15 out of 15, had a diagnosis of depression and anxiety and received antidepressant medication daily. Review of the Physician's Orders included but was not limited to: -Lexapro (antidepressant) 20 mg in the morning for depression (3/23/23) -Mirtazapine (antidepressant) 22.5 mg in the evening for depression (4/13/23) -Monitoring: -behavior toward others: hit, kick, push, scratch, grab, abusing others sexually -verbal toward others: threat, scream, cursing (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-self: hit self, scratch self, pacing, rummaging, public sexual acts, disrobing in public, throwing food or bodily waste, screaming or other disruptive sounds -refusing/rejecting care: labs, imaging, medication, ADL (activities of daily living), wandering The physician's order failed to include monitoring of targeted behaviors, signs/symptoms of for the use of Lexapro and Mirtazapine as required. Review of comprehensive care plans included but was not limited to: -Focus: The resident uses antidepressant medication (2/10/23) -Interventions: Administer antidepressant medications as ordered by the Physician; monitor/document side effects and effectiveness (2/10/23); monitor/document/report as needed adverse reactions to antidepressant therapy (2/10/23) The comprehensive care plan for antidepressant medication use failed to identify resident specific, targeted behaviors for the use of the antidepressant medication for depression and failed to include non-pharmacological approaches to care. During an interview on 4/13/23 at 2:48 P.M., the surveyor reviewed Residents #12, #113 and #121's medical records with the Staff Development (SDC). She said documentation for residents prescribed psychotropic medications need to include specific targeted behaviors or symptoms, monitoring of these behaviors or symptoms, and non-pharmacologic approaches and they do not. 36542 4. Resident #44 was admitted to the facility in January 2023 with a diagnosis of anxiety disorder. Review of the medical record indicated the Resident had the following orders for Ativan (an antianxiety medication), as needed: 1/14/23 Ativan milligram (mg) every 8 hours as needed (PRN) for 14 days, with an end date of 1/28/23; 2/3/23 Ativan 1 mg three times per day, PRN for 30 days with a nursing note to re-evaluate on 3/5/23; 3/7/23 Ativan 1 mg three times per day, PRN until 4/7/23; 4/9/23 Ativan 1 mg three times per day, PRN for 14 days. Review of the Physician Progress Note, dated 1/31/23, indicated anxiety: stable upper time (he/she) will be continued are Lorazepam as needed. No additional information was provided. Review of all subsequent Physician Progress Notes from 2/2/23 through 3/9/23 (the most recent physician visit) failed to indicate the PRN Ativan was re-evaluated with a documented rationale for continued use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/13/23 at 9:33 A.M., Nurse #10 said the Ativan for Resident #44 was re-ordered on 3/7/23. The nurse reviewed the Physician Progress Note, dated 3/7/23, and said the Ativan was not re-evaluated in the Progress Note. During an interview on 4/13/23 at 2:43 P.M., the Director of Nurses said the Nurse Practitioner re-ordered the PRN Ativan and considered this a re-evaluation for the continued use. 5. Resident #25 was admitted to facility in July 2020 with a diagnosis of anxiety. Review of the medical record indicated Resident #25 had an order dated 2/7/23 for as needed Clonazepam 0.25 mg, used to treat anxiety. Review of the medical record indicated the consultant pharmacist made a recommendation to document continued need and specify a stop date. Review of the Consultant Pharmacist Recommendation to Prescriber form, indicated a note from the physician to continue the as needed medication for 60 days. Review of the Physician's Order, dated 2/7/23, indicated the Clonazepam 0.25 mg was to be given every 24 hours as needed and to re-evaluate on 4/4/23. Review of all Physician Progress Notes and the Psychiatric Services Medication Follow-up Visit on 4/4/23 failed to indicate the continued use of Clonazepam was re-evaluated by a physician. Review of the Medication Administration Record indicated Resident #25 was administered the Clonazepam on 4/11/23 and 4/12/23, after the re-evaluation date. During an interview on 4/13/23 at 2:52 P.M., the Director of Nurses said there was no re-evaluation completed for the Clonazepam as ordered on 2/7/23.

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 34145 Based on record review and interviews, the facility failed to ensure for one Resident (#139), out of a total sample of 27 residents, that medications were accurately reconciled by nursing, to ensure he/she was free from a significant medication error. As a result of medication reconciliation error, Resident #139 went 29 days without being administered the correct antiseizure medication and required three transfers to the hospital emergency department and one five-day hospitalization due to the onset of seizure activity. Findings include: Review of the facility's policy titled Reconciliation of Medications on Admission, last revised April 2018, indicated use of an approved medication reconciliation form, the discharge summary from the referring facility, the most recent medication administration record, and a medication history from the resident/family were to be used to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission for accurate communication to the attending physician. The Policy further indicated that medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points of care. The Policy indicated that medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking will continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. Resident #139 was admitted to the facility in March 2023 with diagnoses including weakness and epilepsy. Review of the 3/20/23 Minimum Data Set (MDS) assessment indicated Resident #139 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 10 out of 15, required extensive assistance from staff for bed mobility, dressing, bathing, and toileting and had epilepsy. Review of the hospital documentation, Medication Administration Record (MAR), Transfer Report, dated 3/8/23, indicated that Resident #139's Active Medication Orders (at home) included: -Divalproex ER (brand name Depakote extended release (stays longer in the body), anticonvulsant used to treat seizures) 1500 milligrams (mg) by mouth two times a day -Carbamazepine ER (brand name Tegretol anticonvulsant used to treat seizures) 1200 mg two times a day. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	Further review of the medical record indicated a verbal order was obtained from the Nurse Practitioner for Divalproex ER 1500 mg by mouth two times a day and Carbamazepine ER 1200 mg two times a day on 3/14/23. The Tegretol order was transcribed in the medical record for standard immediate release and not extended release as indicated by the NP's verbal order. Review of Resident #139's March 2023 MAR indicated the inaccurate order for immediate release Tegretol 1200 mg two times a day was administered 33 times instead of Tegretol ER. Further review of Resident #139's medical record and documentation related to his/her admission indicated there was no documentation to support that a medication reconciliation was performed by nursing, and the facility was unable to provide the surveyor with a copy of Resident #139's medication reconciliation form that should have been completed by nursing upon admission. The American Society of Health-System Pharmacists, Inc. (website) Tegretol ER (an anticonvulsant or antiepileptic drug) indicated it is used to prevent and control seizures. It works by reducing abnormal electrical activity in the brain. This medication works best when the amount of drug in the body is kept at a constant level. Seizures can become worse when the drug is suddenly stopped. If you miss a dose, take it as soon as you remember. However, if it is almost time for the next dose, skip the missed dose and continue your regular dosing schedule. The extended-release tablet does not dissolve in the stomach after swallowing. It slowly releases the medicine as it passes through your digestive system. Review of a 3/20/23 Nurse's Progress Note indicated Resident #139's Neurology NP called the facility with an order to increase the dose of Depakote ER to 2000 mg twice daily and obtain Valproic Acid level in two weeks. There was no evidence in the medical record that the Resident's current medication orders for antiseizure medication was reviewed with the NP. The incorrect medication orders for immediate release Tegretol was continued. Review of 3/31/23 lab results indicated Resident #139's Valproic Acid level was flagged high and was greater than 150 ug (micrograms)/mL (milliters) with a reference range of 50-100; Tegretol level was flagged as critically high and was 14.0 ug/mL with a reference range of 4.0-10.0. Review of Resident #139's Nursing Progress Notes indicated that Resident #139 required transfers to the emergency room following seizure activity on 3/19/23, 4/3/23, and 4/6/23. Resident #139 was hospitalized from 4/6/23 to 4/11/23 for multiple seizures. Upon return to the facility from each visit to the hospital, the facility failed to ensure a medication reconciliation was conducted to ensure the correct medication was resumed/ordered. The inaccurate order for Resident #139's Tegretol was not identified by the facility until 29 days after Resident #139's admission, when the surveyor brought the error to the Physician's attention. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	During interviews on 4/12/23 at 11:45 A.M. and 4/14/23 at 1:30 P.M., Unit Manager #1 said when Resident #139 was admitted to the facility, he/she came directly from the emergency room and there was no medication list to reconcile because he/she was treated in the emergency room and was not actually admitted to the hospital. Unit Manager #1 said she called the Resident's Neurologist in the community to request a medication list. She said she received the Neurologist's note, reviewed the medications with the Resident's attending Physician's Nurse Practitioner (NP) and entered the orders into the electronic medical record. She said she did not utilize a medication reconciliation form per facility policy. The surveyor and Unit Manager #1 reviewed the Neurologist's note, and she confirmed that the medication list she reviewed with the Resident's NP included Depakote ER 500 mg 3 tabs (1500 mg) twice a day and Tegretol ER 200 mg 6 tabs twice a day. She was not aware that the Tegretol orders were entered into the electronic medical record incorrectly. During an interview on 4/12/23 at 12:19 P.M., the surveyor reviewed Resident #139's medical record with Physician #1. The Physician said that Resident #139's admission medication orders that were authorized verbally, were not entered accurately into the electronic medical record upon admission. He said a medication reconciliation should have been done by the nurse upon the Resident's admission to the facility and each time the Resident returned from the hospital.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 46862 Based on policy review, record review, and staff interviews, the facility failed to ensure that services were coordinated with the Hospice providers to implement the Resident's plan of care as required in the provider contract agreement for three Residents (#130, #2, and #68), out of a total sample of 27 residents. Specifically, the facility failed to coordinate, collaborate, and monitor the delivery of hospice services. Findings include: 1. Resident #130 was admitted to the facility in November 2022 with diagnoses which included chronic obstructed pulmonary disease, chronic respiratory failure, and acute diastolic heart failure. Review of the Minimum Data Set (MDS) assessment, dated 3/8/23, indicated Resident #130 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of the Physician's Orders, dated 4/12/23, indicated Resident #130 was admitted to hospice #1 on 12/6/22. Review of the Hospice Nursing Facility Services Agreement, dated October 1, 2019, indicated the following but was not limited to: Section 2: Responsibilities of Facility (f)- Coordination of care: -(i) General, Facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Inpatient and Facility Services. Hospice and Facility shall communicate with one another regularly and as needed for each Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day. Section 3: Responsibilities of Hospice (b)-Professional Management Responsibility -(iii) Coordination and Evaluation, Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients, which shall include coordination of Inpatient and Facility Services. (e)-Provision of Information, Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of inpatient and Facility Services under this agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and care coordination. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #130's hospice binder on 4/12/23 included a hospice recertification dated 3/6/23-6/3/23. Hospice services to be provided included: - Nurse frequency: one-two times per week and as needed, - Social Worker/Counselor frequency: one-two times per month and as needed, - Aide frequency: three times per week, - Chaplain frequency: one -two times per week and as needed. There was no documented evidence that a schedule for hospice visits was provided to the facility. During an interview on 4/13/23 at 11:39 A.M., Nurse #9 said she had no schedules for hospice visits, and she did not know when hospice would be at the facility from week to week. Nurse #9 said hospice staff just show up usually three times a week. Hospice staff will speak with the facility staff only if they have a concern. During an interview on 4/12/23 at 11:40 A.M., Social Worker #1 said she oversees hospice services but does not have a schedule for hospice visits. During an interview on 4/12/23 at 11:41 A.M., the Director of Nurses (DON) said the facility must have a schedule. The DON said she does not know who posts the hospice schedules. During an interview on 4/13/23 at 3:15 P.M., Nurse Manager (NM) #2 said there are no hospice schedules posted on the unit. NM #2 said the facility has not been getting hospice schedules. 31830 2. For Resident #2, the facility failed to have a schedule of hospice services, including involvement and collaboration of the coordinated plan of care. Resident #2 was admitted to the facility in June 2015 with diagnoses which included multiple sclerosis. Review of Resident #2's current Physician's Orders included: -Admit to hospice #2, date ordered, 3/24/23. Review of the Nursing Facility Services Agreement, dated 3/21/23, with the elected hospice provider indicated but was not limited to: the plan of care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated a Hospice Certification and Plan of Care with certification period of 3/24/23 through 6/21/23. The plan of care indicated frequency and duration of visits for the skilled nurse to be twice weekly for 13 weeks and for the Home Health Aide, three times weekly for 13 weeks. During an interview on 4/12/23 at 12:35 P.M., Nurse #8 said Resident #2 currently received hospice services and said, although hospice employees were in the facility all the time, she was unaware of an official schedule of hospice services. Nurse #8 said the hospice nurse usually told the staff what services would be provided but Nurse #8 said she was unaware of the day or time services will be provided to Resident #2. During an interview on 4/12/23 at 1:50 P.M., the Director of Nurses said it was the expectation the hospice agency would provide a schedule of services to the facility in order for services to be coordinated. 34145 3. For Resident #68, the facility failed to ensure: a. an integrated care plan was developed to reflect services provided by both the Hospice provider and facility staff; and b. the Hospice provided information and required documentation regarding care and services as required in the provider contract agreement and facility policy. Review of the Nursing Facility Services Agreement with Hospice provider #3, signed 3/21/23, included but was not limited to: -Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice patient; -Facility shall ensure that each Hospice patient's care plan includes both the most recent Hospice Plan of Care and a description of the facility services furnished by the facility to attain or maintain the Hospice patient's highest practicable physical, mental and psychosocial well-being as required by federal regulation; -At a minimum, the Hospice shall provide the following information to the facility for each Hospice patient residing at the facility: -Plan of Care, Medications and orders. The most recent Plan of Care, medication information and physician orders specific to each Hospice patient; -Election form. The Hospice election form and any advanced directives; -Certifications. Physician certifications and recertifications of terminal illness Review of the facility's policy titled Hospice Services, last revised in April 2018, included, but was not limited to: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Facility staff will coordinate care provided to the resident with the Hospice staff. He/she is responsible for the following: -collaborating with Hospice representatives and coordinating facility staff participation in the Hospice care planning process for residents receiving these services; -obtaining the following information from the Hospice: -the most recent Hospice plan of care specific to each resident; -Hospice election form; -Physician certification and recertification of the terminal illness specific to each resident; -Hospice medication information specific to each resident; -Hospice physician and attending physician (if any) orders specific to each resident Resident #68 was admitted to the facility in January 2023 with diagnoses including colon cancer. Review of the 3/30/23 Minimum Data Set assessment indicated Resident #68 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15, required extensive assistance from staff for activities of daily living, and received Hospice services. Review of the March 2023 Physician's Orders included but was not limited to: -Admit to Hospice-3/24/23 a. Review of comprehensive care plans included but was not limited to: -Focus: Hospice services elected on 3/24/23-end stage diagnosis of malignant neoplasm of sigmoid colon (3/27/23) -Interventions: Administer pain medication and other medication per physician (MD) orders; contact family to discuss their ideas related to coping strategies; coordinate resident's daily care with Hospice and/or palliative care givers; honor resident's preferences and choice whenever possible; notify Hospice of changes in resident's condition or changes in care plan; organize care to provide for rest and periods of uninterrupted sleep to minimize pain; point out and reinforce the resident's strengths, do not focus on deficits; provide care when best tolerated by resident (3/27/23) -Goal: Resident will establish trust in caregivers (3/27/23) The care plan failed to include a description of the facility and Hospice services provided to the Resident. b. Review of the medical record indicated two Hospice notes: -3/28/23 Hospice Visit Note (skilled nursing); and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/11/23 Hospice Recommendations Note (no discipline identified) No other information regarding Hospice services was in the medical record and there was no separate Hospice binder or folder on the unit. During an interview on 4/06/23 at 9:35 A.M., Unit Manager #1 (UM #1) said the Hospice provider has not provided a binder with required information about the Resident's services and the only information provided are the two notes in the medical record. The Unit Manager confirmed there was no election form, no physician certification of terminal illness, no coordinated plan of care, and no Hospice medications and Hospice physician orders in the medical record. She said she had asked for the information repeatedly, but the Hospice still has not brought it in. UM #1 said that there is no schedule posted of when the Hospice staff come into the facility to provide services to Resident #68. She said she has only seen the Hospice nurse and does not know if the Resident has any other care providers.

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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. 43935 Based on observation, interview, and policy review, the facility failed to ensure standard infection control and prevention practices were consistently implemented for two Residents (#143 and #115), out of a total sample of 27 residents. Specifically, the facility failed: 1. For Resident #143, to ensure there was no cross contamination (transfer of pathogens (biological contaminant) from one surface to another) of the nurse's hands with medications or water during an observed medication pass; and 2. For Resident #115, to implement contact precautions for a foot wound with Methicillin-Resistant Staphylococcus Aureus (MRSA- a type of staph infection that is difficult to treat because of resistance to some antibiotics). Findings include: 1. Review of the facility's policy titled Administering Oral Medications, dated as revised 11/2017, indicated but was not limited to the following: -Staff follows established facility infection control procedures (handwashing, aseptic techniques, gloves, isolation, etc.) for the administration of medications as applicable. -Do not touch the medication with your hands. On 4/7/23 at 9:55 A.M., the surveyor observed Nurse #4 prepare the following medications for Resident #143: -Colace 100 milligrams (mg) -Ferrous Sulfate 325 mg -Fish Oil one capsule -Metoprolol Tartrate 25 mg -Gabapentin 600 mg -Oxybutin Chloride 10 mg (two tablets of 5 mg each were prepared for a total dose of 10 mg) -Nicotine Patch 14 mg/24 hours topical patch During the preparation of the above medications, the surveyor observed Nurse #4 place her right index finger into the lip of the bottle and touch the medication to retrieve the Colace pill and dispense it into the administration cup. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/23 at 10:08 A.M., the surveyor observed Nurse #4 walking to Resident #143's room carrying a cup of pills in her left hand and a cup of water in her right hand. The tips of her right index and middle fingers were over the top lip of the water cup, resting inside the cup. During an interview on 4/7/23 at 10:22 A.M., Nurse #4 said she should not have touched the pills with her fingers or placed her fingers into the water cup of Resident #143 when carrying it and both were breeches of standard infection control practices. 34145 2. Resident #115 was originally admitted to the facility in February 2023 with diagnoses including end stage renal disease and bilateral foot wounds. The Resident had a five-day hospitalization and was readmitted in March 2023. Review of the 4/3/23 Minimum Data Set assessment indicated Resident #115 had surgical wounds and diabetic ulcers on his/her feet. Review of the medical record indicated during a dressing change on 3/15/23, the Resident's foot wounds were noted to be warm with redness and purulent (thick fluid caused by infection that includes white blood cells and cellular debris, may be white, yellow, or pink or green tinged), foul smelling drainage. A new order was given to obtain wound cultures. Review of the culture report results, dated 3/18/23, indicated the right foot wound culture was positive for Pseudomonas Aeruginosa (a type of germ that can cause infections in humans) and the Resident was prescribed Cipro 250 milligrams for seven days. Review of the culture report results, dated 3/19/23, indicated the left foot wound culture was positive for MRSA. The Physician gave orders for Augmentin (antibiotic) and for the Resident to be placed on contact precautions (contact precautions require the routine use of gowns and gloves for care which involves contact with the patient or the patient's environment). On 4/6/23 at 12:30 P.M., the surveyor observed no signs to indicate a resident in the room was on contact precautions and no personal protective equipment set up in the vicinity of Resident #115's room. During an interview on 4/7/23 at 9:05 A.M., Resident #115 said he/she needs help from staff to get in and out of bed and they don't wear any type of personal protective equipment when they assist him/her. During an interview on 4/10/23 at 2:05 P.M., Unit Manager #1 said Resident #115's wound cultures indicated the Resident was positive for Pseudomonas and MRSA and was started on treatment. She said the Resident should have been placed on precautions when the Physician gave the order on 3/19/23 and remained on precautions until a culture was done to determine if the infection was no longer present. During an interview on 4/11/23 at 1:09 P.M., the Infection Preventionist (IP) said staff should have implemented contact precautions on 3/19/23 as ordered by the Physician and maintained the precautions until the Physician ordered for it to be discontinued.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 34145 Based on interview, record review, and policy review, the facility 1. Failed to implement their Antibiotic Stewardship program; and 2. Failed to ensure antimicrobial medications were used for an acceptable and prescribed indication and duration of time for one Resident (#70), in a total sample of 27 residents. Findings include: 1. Review of the facility's policy for Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, dated November 2017 included but was not limited to: -Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. -As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP), or designee. -The IP, or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. -Therapy may require further review and possible changes if therapy was started awaiting culture, but culture results and clinical findings do no indicate continued need for antibiotics. -All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: -Resident name and medical record number; -Unit and room number; -Date symptoms appeared; -Name of antibiotic; -Start date of antibiotic; -Pathogen identified; -Site of infection; -Date of culture; -Stop Date; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Total days of therapy; -Outcome; and -Adverse events. According to the Centers for Disease Control and Prevention (CDC), the core elements of Antibiotic Stewardship included but were not limited to the following: -Facility leadership commitment to safe and appropriate antibiotic use -Implement policy(ies) or practice to improve antibiotic use -Track measures of antibiotic use in the facility Review of Infection Control Logs (line listings) from January 2023 to April 2023 indicated a standardized log which included the following categories: -Room -Resident Name -admitted -Onset date -Site -Meets McGeer's Definitions? -Infection related diagnosis -Culture (yes/no) -Reculture -X-ray -Organism -Antibiotic -Isolation (yes/no) -HAI (healthcare associated infection) -Resolved (date) (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/11/23 at 1:09 P.M., the IP said she is responsible for the Antibiotic Stewardship Program. She said that the facility is supposed to use the McGeer's criteria (surveillance tool to assist in the clinical presentation of the resident and what would be considered an infection) for initiation of antibiotic therapy. She said the lab provides information, but the facility doesn't do anything with the information. She said during QAPI (Quality Assurance Performance Improvement) meetings, the committee reads the report provided by the lab and then it is filed. There is no review of the data, no analysis, no discussion related to Antibiotic Stewardship. The surveyor and IP reviewed the facility's infection line listings for January 2023 through April 2023 which indicated: -January 2023: 54 antibiotics were administered to residents. Of those, only 8 met McGeer's criteria. No signs/symptoms of infection were noted. -February 2023: 46 antibiotics were administered to residents. Of those, only 8 met McGeer's criteria. No signs/symptoms of infection were noted. -March 2023: 41 antibiotics were administered to residents. Of those, only 6 met McGeer's criteria. No signs/symptoms of infection were noted. -April 2023: 9 antibiotics were administered to residents. Of those, only 2 met McGeer's criteria. No signs/symptoms of infection were noted. The IP said that although physicians are supposed to go by McGeer's criteria for infection before prescribing an antibiotic, they do not. She said physicians and Nurse Practitioners frequently prescribe antibiotics before culture results come back. The IP said more than half of the residents in the facility that have received antibiotic therapy have actually needed it, and the other residents didn't need to be treated with antibiotics. She said the line listings do not identify signs and symptoms because nursing staff are not documenting signs and symptoms of infection in the medical record despite educating them multiple times. The IP said she completes Monthly Infection Control Analysis forms to calculate the infection rates but does not utilize the information for any analysis of antibiotic use. During an interview on 4/12/23 at 12:19 P.M., Physician #1 said antibiotic stewardship is important to prevent the development of antibiotic resistance. He said he believes the physicians and nurse practitioners are really not following the program's principles and prescribe antibiotics without meeting criteria for their use. The surveyor and Physician #1 reviewed the infection line listings from January 2023 through April 2023. He said, There are so many residents prescribed antibiotics without meeting criteria. There is a lot of overuse of antibiotics here. Something needs to be done. During an interview on 4/14/23 at 11:59 A.M., Consultant Laboratory Staff #1 said she does not keep track of antibiotic use, but she does provide the facility with a quarterly Anti-Biogram summary report (an overall profile of antimicrobial susceptibility testing results of a specific microorganism to a battery of antimicrobial drugs). She said she has never been asked any questions about the data in the report. 36542 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the facility's policy for Antibiotic Stewardship- Orders for Antibiotics, dated November 2017 indicated: - prescriber will provide complete antibiotic orders including the following elements: drug name, dose, frequency of administration, duration of treatment (start and stop date or number of days of therapy), route of administration and indications for use -appropriate indication for use of antibiotics include: criteria met for clinical definition of active infection Resident #70 was admitted to the facility in February 2015 with a diagnosis of diabetes and was readmitted with a diagnosis of a foot wound infection in December 2022. Review of the Medication Administration Record (MAR) indicated Resident #70 had an order dated 12/6/22 for Doxycycline 100 mg two times per day for antibiotic treatment for foot wounds. Review of the April 2023 MAR indicated Resident #70 continued to receive Doxycycline 100 mg twice per day and the order now indicated no stop date. Review of the Consultant Wound Physician's Wound Evaluation and Management Summary, dated 12/13/22, indicated the following skin areas to the left foot: unstageable area (due to necrosis (premature death of cells in living tissue)) of the left lateral fifth toe unstageable area (due to necrosis) of the left medial fifth toe unstageable area (due to necrosis) of the left, distal, dorsal, lateral foot The Wound Evaluation and Management Summary indicated there were no signs of infection in any of the open areas. Review of the Consultant Wound Physician's Wound Evaluation and Management Summary from the following dates did not indicate any signs or symptoms of infection to the left foot: 12/20/22, 1/3/23, 1/10/23, 1/17/23, 2/8/23, 2/17/23, 2/21/23, 3/3/23, 3/7/23, 3/14/23, 3/24/23, 3/31/23, and 4/7/23. Review of the Physician's Progress Note, dated 1/17/23, indicated the left fifth toe was gangrenous (decaying tissue due to loss of blood flow) and Resident #70 had an angiogram (scan to show blood flow) scheduled to determine next steps. The Progress Note did not indicate the need to continue on an antibiotic or any current infections. Review of the Physician's Progress Note, dated 3/31/23, indicated Resident #70 was being followed by Vascular who had decided against amputation at this time. The Progress Note did not indicate the need for the continued use of an antibiotic or any current infections. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/12/23 at 2:07 P.M., the Infection Control Preventionist said Resident #70 had continued an antibiotic since December related to the foot wound. The Infection Control Preventionist said when an antibiotic was continued without a stop date, she would discuss the antibiotic use with the nurses on the unit. She said the unit nurse had said the consultant Vascular Physician or the Podiatrist for Resident #70 had wanted to continue the antibiotic until the wound was healed. During an interview on 4/12/23 at 2:54 P.M., the Infection Control Preventionist said she was unable to locate any documentation from any physician to indicate the continued need for an antibiotic. She said there was no reference to the continued use in the nursing progress notes or the Physician Progress Notes. During an interview on 4/13/23 at 9:08 A.M., the Infection Control Preventionist said she contacted the Podiatrist for Resident #70. She said the Podiatrist was not aware the Resident had continued an antibiotic and made the recommendation to discontinue the antibiotic at this time as the Resident did not need it.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 34145 Based on record review and interview, the facility failed to ensure staff administered the influenza vaccine after obtaining consent for one Resident (#344), out of five applicable sampled residents. Findings include: Resident #344 was admitted to the facility in March 2023. Review of the Immunization Consent, signed and dated 3/27/23, indicated the Resident/Resident Representative signed consent to receive the annual influenza vaccination. Review of the clinical record did not indicate the influenza vaccination was administered to the Resident after the consent for administration was obtained. During an interview on 4/10/23 at 2:00 P.M., the surveyor and Infection Preventionist reviewed Resident #344's medical record. She said Resident #344 signed the consent and wanted to receive the flu vaccine but did not get it.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. 34145 Based on interview and record reviews, the facility failed to ensure resident representatives/families were notified of each new COVID-19 positive resident case by 5:00 P.M. the following day. Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance titled Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated February 2022, indicated but was not limited to the following: -Notify residents and families promptly about identification of SARS-CoV-2 in the facility and maintain ongoing frequent communication with residents and families with updates on the situation and facility actions During an interview on 4/10/23 at 8:25 A.M., the Director of Nursing said the Activity Director is responsible for notifying residents and families of the COVID status of the building. She said the last resident to test positive for COVID-19 was on 2/18/23 and the last staff to test positive was on 3/10/23. During an interview on 4/10/23 at 1:25 P.M., the Infection Preventionist (IP) provided the surveyor with resident and staff COVID-19 testing and surveillance documentation. Review of testing documentation indicated: 12/25/22 - 1 resident tested positive for COVID-19 12/28/22 - 1 resident tested positive for COVID-19 1/5/23 - 1 resident tested positive for COVID-19 1/9/23 - 3 residents tested positive for COVID-19 1/10/23 - 2 residents tested positive for COVID-19 1/12/23 - 1 resident tested positive for COVID-19 1/14/23 - 1 resident tested positive for COVID-19 1/15/23- 3 residents tested positive for COVID-19 1/17/23- 2 residents tested positive for COVID-19 1/19/23- 1 resident tested positive for COVID-19 1/20/23- 3 residents tested positive for COVID-19 (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1/24/23- 1 resident tested positive for COVID-19 1/29/23- 1 resident tested positive for COVID-19 1/31/23- 1 staff tested positive for COVID-19 2/1/23- 1 staff tested positive for COVID-19 2/9/23- 8 residents tested positive for COVID-19 2/12/23- 1 resident tested positive for COVID-19 2/14/23- 2 residents tested positive for COVID-19 2/15/23- 1 resident and 1 staff tested positive for COVID-19 2/16/23- 2 residents tested positive for COVID-19 2/18/23- 1 resident tested positive for COVID-19 3/10/23- 1 staff tested positive for COVID-19 During an interview on 4/11/23 at 12:05 P.M., the Activity Director (AD) said she is responsible for notifying families and responsible parties of COVID cases. She said when the Administrator tells her to, she makes the calls to the families and responsible parties, documents the contact in the medical record under Activity Progress Notes and keeps a folder to track it. Review of the contact folder indicated the last contact with families and responsible parties was on 11/22/22. The AD said the Administrator has not asked her to make any more calls since 11/22/22. The facility was unable to provide evidence of notification of new positive COVID-19 cases identified on 12/25/22, 12/28/22, 1/5/23, 1/9/23, 1/10/23, 1/12/23, 1/14/23, 1/15/23, 1/17/23, 1/19/23, 1/20/23, 1/24/23, 1/29/23, 1/31/23, 2/1/23, 2/9/23, 2/12/23, 2/14/23, 2/15/23, 2/16/23, 2/18/23, and 3/10/23. During an interview on 4/13/23 at 2:48 P.M., the IP said that residents, families and responsible parties should have been notified of each new employee and resident COVID case.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 34145 Based on interview, document review, and policy review, the facility failed to develop and implement their COVID-19 vaccination exemption policy for medical exemptions that was inclusive of all regulatory requirements and documents for one COVID-19 unvaccinated employee. Findings include: Review of the facility's policy titled Employee COVID-19 Vaccine, last revised 11/2022, indicated but was not limited to the following: -Facilities should follow employee COVID-19 vaccination protocols as established by State and Federal agencies including Massachusetts Department of Public Health (DPH) and/or Centers for Medicare and Medicaid Services (CMS). -All employees should be fully vaccinated, unless otherwise granted an approved exemption as outlined herein. -If an employee has not been fully vaccinated, he/she may submit for an exemption for a documented medical contraindication from a licensed provider, temporary or delayed vaccination or a Request for religious exemption for a sincerely held religious belief, in all cases the request must be reviewed and approved by the [NAME] President of Administration and Compliance Officer. -Approved/granted exemptions will be reviewed at a minimum of one year from the approved exemption by the Compliance Officer. -All reviews for an exemption will receive a Determination of COVID-19 Vaccine Exemption form (form ADMINF0012) indicating if approved or denied. -Requests for a medical contraindication should include specifying which of the authorized COVID-19 vaccines are clinically contraindicated and a statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements. -In addition, this needs to be signed and dated by the authenticating practitioner. Review of the Centers for Medicare and Medicaid Services (CMS) Memorandum (QSO-23-02-ALL) titled Revised Guidance for Staff Vaccination Requirements; Attachment A, dated 10/26/22 indicated the following: -To protect long term care (LTC) residents from COVID-19, each facility must develop and implement policies and procedures as specified in S483.80(i) to ensure that all LTC staff are fully vaccinated against COVID-19. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility must track and securely document staff who have been granted an exemption from vaccination (this should include the type of exemption and supporting documentation) and staff for whom COVID-19 vaccination must be temporarily delayed. For temporary delays, facilities should track when the identified staff can safely resume their vaccination. -Certain allergies or recognized medical conditions may provide grounds for a medical exemption. With regard to recognized clinical contraindications to receiving a COVID-19 vaccine, facilities should refer to the CDC (Centers for Disease Control and Prevention) informational document titled: Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States. -Medical exemption documentation must specify which authorized or licensed COVID-19 vaccine is clinically contraindicated for the staff member and the recognized clinical reasons for the contraindication. The documentation must also include a statement recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements based on the medical contraindications. -Facilities must have a process to track and secure documentation of the vaccine status of staff whose vaccine is temporarily delayed. CDC recommends a temporary delay in administering the COVID-19 vaccination due to clinical considerations, including known COVID-19 infection until recovery from the acute illness (if symptoms were present) and criteria to discontinue isolation have been met. Review of the facility's COVID-19 Staff Vaccination Status for Providers indicated there were a total of 116 staff members; 115 staff members who were completely vaccinated from COVID-19 and one staff member with a granted exemption. Review of the exemption documentation provided by the facility for Nurse #9 indicated a physician's note and a facility form titled Determination of COVID-19 Vaccine Exemption. The physician's note indicated Nurse #9 had a history of seizures and reoccurrence of seizures creates a lot of mental anxiety in patients and can be deadly if the seizure reoccurs in certain circumstances. The physician indicated the effect of the vaccine on patients with epilepsy is not known and it was his opinion that he/she (sic) not receive the vaccination. The physician's documentation did not include any specification of which licensed or authorized COVID-19 vaccine is clinically contraindicated for the staff member. The form was signed and dated by a physician in September 2021 (19 months prior to the review). Review of the facility form titled Determination of COVID-19 Vaccine Exemption indicated the staff member was seeking a medical exemption due to a medical contraindication. The Compliance Officer reviewed Nurse #9's submission and approved the medical exemption from the COVID-19 vaccine on 9/30/21. During an interview on 4/12/23 at 7:25 A.M., the surveyor and Staff Development Coordinator (SDC), who was responsible for oversight of the staff vaccination program, reviewed the medical exemption for COVID-19 vaccination guidelines and Nurse #9's COVID-19 vaccination exemption documentation. She confirmed the documents did not meet the policy or guidance for a medical exemption to be granted and was not reviewed annually. She said she would check with the Director of Nursing and would verify no other documents were available. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/14/23 at 11:39 A.M., the SDC confirmed that there was no documentation to indicate Nurse #9's physician provided any additional documentation to indicate his/her medical exemption met regulatory requirements and confirmed that the medical exemption was not reviewed annually as required.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 31830 Based on observation, record review, and interview, the facility failed to ensure the placement of a pressure-reducing mattress on the bed frame was assessed for risk of entrapment prior to use for one Resident (#2), out of a total sample of 27 residents. Findings include: Review of the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/2006, indicated: The term entrapment describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Resident entrapments may result in deaths and serious injuries. There are 7 zones of bed entrapment: Zone 1 (within the rail), Zone 2 (under the rail), Zone 3 (between rail and mattress), Zone 4 (Under the rail, at the ends of the rail), Zone 5 (between split bed rails), Zone 6 (between the end of the rail and the side edge of the head or foot board) and Zone 7 (Between the head or foot board and the mattress end). Review of guidance from the FDA titled Recommendations for Health Care Providers about Bed Rails, dated 07/09/2018, included: -Be aware that not all side rails, mattresses, and bed frames are interchangeable and not all bed rails fit all beds. Check with the manufacturer(s) to make sure the side rails, mattress, and bed frame are compatible. -Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and/or depth, the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. -Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. Resident #2 was admitted to the facility in June 2015 with diagnoses which included multiple sclerosis and functional quadriplegia. Review of the Minimum Data Set (MDS) assessment, dated 1/8/23, indicated Resident #2 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 9 out of 15 and required extensive assistance of two people for bed mobility and transfers. Review of Resident #2's current Physician's Orders included: - Two 1/4 side rails up in bed to help promote bed mobility, safety, and positioning, date ordered, 4/12/21. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Alternating pressure air mattress, setting set at resident's weight, check air mattress function and settings every shift, date ordered, 2/7/23. - Admit to hospice, date ordered, 3/24/23. Review of progress notes, dated 4/7/23, indicated the facility air mattress was removed and hospice delivered a new air mattress, pending to be applied by maintenance. On 4/13/23 at 4:10 P.M., the surveyor observed Resident #2 lying in bed sleeping with the head of the bed slightly elevated. Bilateral 1/4 side rails were observed up and in use. Upon observation, the distance between the air mattress and bilateral side rails appeared wide, potentially placing the Resident at risk for entrapment. During an interview on 4/14/23 at 10:40 A.M., the Maintenance Director said the nursing department would contact him through the TELS (web-based program designed to help maintenance teams track facility maintenance and building services) when a mattress needed to be replaced or changed out so he could complete an assessment for entrapment. He reviewed the TELS with the surveyor, but said he was confused about the room number on the TELS sheet and said he was unsure if he had completed an entrapment assessment for replacement of the air mattress for Resident #2. The Maintenance Director was unable to provide the surveyor with the entrapment assessment. During an interview on 4/14/23 at 11:00 A.M., Nurse #11 said hospice ordered a new air mattress for Resident #2. Nurse #11 said she was present in the facility when the new air mattress was delivered but was unsure if and when the new mattress was placed on the bed frame. Nurse #11 said she would contact the Maintenance Director only if there was an issue with the mattress when staff placed a new mattress on the bed. During an interview on 4/14/23 at 11:20 A.M., the Director of Nurses verified Resident #2 was lying in bed on an air mattress which was provided by hospice. The Director of Nurses said anytime a new piece of durable medical equipment (DME) was ordered and delivered from an outside provider such as hospice, she needed to be notified. She said when a new mattress is delivered or a mattress is replaced, the Maintenance Department must complete an assessment for entrapment. The Director of Nurses said the mattress provided to Resident #2 did not have the entrapment assessment as needed and the assessment fell through the cracks.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41106 Based on observation, record review, and interview, the facility failed to implement an effective pest control program, as evidenced by sanitation concerns, mice and cockroach sightings, and mice droppings on two of three units and in the basement. Specifically, the facility failed to: 1. Maintain the basement hall floor free of mice droppings; 2. On R1, H2, R2, and H3 Units, maintain cleanliness and sanitation, eliminate alternate food sources, clean old mice droppings from behind wall furniture and borders of the rooms, and seal all holes in walls of resident rooms; and 3. Maintain effective logging of all pest sightings and droppings. Findings include: Review of the facility's Pest Control program provided by their contracted pest control company, dated 2023, indicated but was not limited to the following: -Recordkeeping/ logbook: the contractor will keep a logbook on site so inspectors, health services and city officials can observe the pest control practices/ pest control activity for the building. -The contractor meets with the staff during each visit to discuss ways they can help limit pest activity in the building. -We also recommend integrated pest management (IPM)- Integrated steps such as door sweeps, patchwork near heaters and monitoring of community rooms. IPM: -IPM is a commonsense approach used to obtain long-term solutions to pest problems while reducing the reliance on pesticides and thereby minimizing any potential risk to human health and the environment. -IPM uses several methods to control pests beginning with proper pest identification, and inspection of the premises, identifying potential conditions favorable to pest activity, using corrective sanitation practices. -The contractor considers the diverse techniques of IPM programs as an opportunity to educate the customer about corrective and preventative measures for long-term pest solutions -To be successful, an IPM program requires customer support and cooperation to address conditions favorable to past activities. By following the recommendations of the pest management Professional, the customer can help in preventing and reducing future pest problems and diminish the need for otherwise unwarranted treatments. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/8/23 at 1:43 P.M., the Administrator said the facility had pest control services the last couple months due to an infestation problem. He said the pest control service was originally coming monthly, then increased to weekly, then twice weekly and now three times a week over the last nine months. In addition, he said the facility purchased an ultrasonic plug in which he feels helped the pest control problem getting under control. On 4/10/23 at 8:15 A.M., the surveyor toured the facility and made the following observations in the basement, H2, R2 and H3 Units: 1. Basement: -Exit door by the kitchen, on the left wall behind the rolling carts, there were mice droppings and dead cockroaches. Stuck to one of the wheels of the carts was a sticky pad with evidence of more dead cockroaches. 2a. R1 Unit: -Shower room (By room [ROOM NUMBER]) was full of clutter including but not limited to: Piles of clothing including plastic bags of clothing on the countertop under the chandelier. The shower stalls had wheelchairs, bed overlays, plastic drawers, and boxes, and in the middle of the room was an exercise bike, Sara lift (sit to stand aid), commode seats, and shower chairs. In the tub room, there were mattresses, shower chairs, dining room chairs, wheelchairs, and other miscellaneous items. There was a sticky pad on the ground with evidence of cockroaches. During an interview on 4/10/23 at 11:41 A.M., Certified Nursing Assistant (CNA) #2 said the facility had only one shower room for resident showers. The other shower room was used for storage and could not be used for residents. b. H2 Unit: During an interview on 4/10/23 at 1:15 P.M., CNA #5 said there has been a problem with mice on this unit. During an interview on 4/10/23 at 1:15 P.M., Resident #79 said just a couple days ago he/she saw two rats in his/her room. Resident #79 said he/she told the nurse that was on that night. -Linen room: Located in between R2 and H2 units, there was a sticky pad trap turned upside down with visible cockroaches. The floor was visibly dirty, and the bottom floor molding was missing on two of the walls. -room [ROOM NUMBER]: The floor was visibly dirty with liquid stains and dirt and food particles. -room [ROOM NUMBER]: The floor was visibly dirty. -room [ROOM NUMBER]: The floor was visibly dirty. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-room [ROOM NUMBER]: The surveyor observed a large amount of mice droppings along the wall and behind the bed, on both sides of the corner unit, and under the wheelchair cushion lying against the wall. The corner unit was pulled away from the wall and behind the unit was dirt, debris (including a disposable under garment), and a large amount of mice droppings. The floor was visibly dirty around both beds. There were mice droppings behind the recliner chair in the right corner of the room. -room [ROOM NUMBER]: Observed live ants and mice droppings along the walls. -room [ROOM NUMBER]: Observed live ants behind the door and along the walls. -room [ROOM NUMBER]: Observed live ants on the floor by the window and behind the dresser. -room [ROOM NUMBER]: Observed live ants and evidence of mice droppings along the wall. -The shower room was observed to be visibly dirty with a dark, dried brown-like substance on the floor. There was a large hole created by missing tiles between the two shower stalls. The floor was dirty in the shower area and inside the tub. There was a large amount of mice droppings all along three walls in the tub room that could be viewed by the surveyor. The wall to the right in the tub room could not be viewed because of the clutter including chairs, wheelchairs, and a dirty mattress draped over the pile of chairs. During an interview on 4/10/23 at 1:25 P.M., Housekeeper #1 said she only cleans the open areas in the tub room and did not move the items stored in the tub room to clean behind them. c. R2 Unit: During an interview on 4/10/23 at 12:35 P.M., Family Member #1 said last week there were cockroaches in his/her family member's room. He/she said the problem was the floors were dirty and there were food crumbs all over the floor and under both beds. -room [ROOM NUMBER]: The floor behind the bed was dirty with evidence of mice droppings. -room [ROOM NUMBER]: Behind the A bed, the floor border was pulled away from the wall, leaving a two-foot section of the wall with a hole. Mice droppings were visible in the hole. The floor was dirty with stains and food particles. -room [ROOM NUMBER]: The floor by A bed was visibly dirty with stains and food particles. -room [ROOM NUMBER]: The floor was visibly dirty by A and B bed, with dried liquids, debris, and food particles. Behind bed A, the floor border was pulled away from the wall, leaving a hole in the wall. -room [ROOM NUMBER]: The floor was visibly dirty under both the A and B beds with an old facemask, tissues, and food debris. -room [ROOM NUMBER]: The floor was visibly dirty. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-room [ROOM NUMBER]: The floor was visibly dirty, and against the radiator, there was a dried liquid stain. -Shower room: The floor was dirty, the right side of the of the wall panel was pulling away from the wall leaving an approximate three-foot hole along the top and down the side of the panel. The shower valve fixture had broken away from the wall, leaving a large hole in the tile. There was a banana on the bench. The side room was cluttered with chairs and wheelchairs. d. H3 Unit: -Dayroom: the floor molding was pulled away from the wall leaving a large hole. The floor by the hole was observed to be visibly dirty. To the left of the hole, in the corner, there was evidence of mice droppings on the floor. The top of both radiators was dirty with debris and food particles. The left radiator's side panel was pulled off. -Kitchenette: one sticky pad trap under the sink and second sticky pad trap in the bottom right cabinet with evidence of cockroaches. There was a cockroach observed on the second shelf in front of a loaf of bread. The corners of the floor had evidence of mice droppings. -room [ROOM NUMBER]: Around the radiator, along the wall, and behind the wall furniture there were mice droppings. The resident had items stacked on both sides of the dresser from the floor to the top of the dresser. The surveyor pulled the dresser away from the wall and there were mice droppings visualized. The floor molding behind the bed was separated from the wall, leaving a one-foot-long hole in the wall. -room [ROOM NUMBER]: The floor was stained with a dried liquid and was sticky. The floor molding was pulling off the wall leaving a hole in the wall. There were brown, dried liquid stains noted on the walls. -room [ROOM NUMBER]: Signs of mice droppings were noted behind the wall furniture. -room [ROOM NUMBER]: There were mice droppings along the wall and behind the dresser. Behind the door was a bed railing and a plastic bag of clothes. Under the plastic bag of clothes there were mice droppings. -room [ROOM NUMBER]: Floor was visibly dirty and stained with dried liquid and sticky. Floor molding was pulling off the wall, leaving a hole in the bottom of the wall. There were dried liquid stains on the walls. -room [ROOM NUMBER]: Floor around A bed was dirty and stained. -room [ROOM NUMBER]: There were mice droppings along the wall and behind the dressers. The floor was visibly dirty with debris and food particles. -room [ROOM NUMBER]: There were mice droppings along the wall, the corner of the room was dirty and there were mice droppings. The shade of the night light built into the wall was broken and inside the light receptacle were mice droppings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225723	A. Building B. Wing	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-room [ROOM NUMBER]: Behind the wall furniture there were mice droppings. The floor around the A bed was visibly dirty with stains and food particles. There was a mouse bait station at the foot of the A bed. -room [ROOM NUMBER]: There were mice droppings along the walls and behind the wall furniture. -Clean utility room was observed to be dirty, behind the sink the splash board had fallen away from the wall leaving a hole. -room [ROOM NUMBER]: There were mice droppings behind the wall furniture. In the back corner of the room, around a mouse bait station there was a large amount of white stone material with mice droppings mixed in. In the bathroom, the tiles were broken under the sink. -Shower Room: Two shower stalls, the first stall on the left was cluttered with three dining room chairs and two shower chairs. The shower room floor, including the standing scale was dirty with debris. The ground level tiles were missing on the left front side of the shower stall wall, leaving a hole. 3. Review of the facility's Pest Sighting Log binder for April 2023 indicated the following: -R1 Unit: There were no entries -R2 Unit: There were two entries for cockroach sightings, one on 4/4/23 in the nourishment kitchen and a second on 4/5/23 in the nurses' station. -H2 Unit: Four entries: -4/4/23 resident's high back wheelchair a roach -4/4/23 nurses' station roach -4/6/23 cockroaches -4/6/23 shower room cockroach infestation -H3 Unit: There were no entries. During an interview on 4/10/23 at 9:05 AM., Resident #70 said he/she had seen four mice in his/her room recently and the staff were aware of it. Resident resides on the H3 Unit. Review of the Pest Sighting log indicated there were no reported mouse sightings in Resident #70's room for 2023. During an interview on 4/10/23 at 12:35 P.M., Family Member #1 said last week he/she saw cockroaches in his/her spouse's room. The Resident resides on R2 Unit. Review of the Pest Sighting log indicated there were no reported cockroach sightings in the Resident's room for 2023. During an interview on 4/10/23 at 9:12 AM., Resident #51 said he/she has seen a mouse every now and then. The Resident resides on the H3 Unit. Review of the Pest Sighting log indicated there was one mouse sighting recorded on 3/31/23 of a mouse dying on a sticky pad trap in the Resident's room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/10/23 at 1:15 P.M., Resident #79 said just a couple days ago, he/she saw two rats in his/her room and told the nurse. Resident resides on H2 Unit. Review of the Pest Sighting log indicated there were no reported rat sightings in the Resident's room for 2023. Review of additional facility Pest Control Log sheets provided to the surveyor indicated but was not limited to the following: -R1: Cockroach sightings reported every month since March 2022, mouse sightings August and November 2022 -R2: Cockroaches and mice sightings every month since May 2022 -H2: Cockroaches and mice sightings every month since March 2022 -H3: Mice sightings every month since January 2022, and cockroach sightings since August 2022. During an interview on 4/10/23 at 1:55 P.M., the Director of Maintenance said the facility recently had an uptick in a pest/rodent problem, which he attributed to the seasonal change. He said the pest control problem in the building had been out of control for approximately four months, and now the facility was trying to get ahead of it. He said housekeeping did extra spot cleaning and paid close attention to the areas that needed to be cleaned and monitored for pest droppings. He said currently the focus had been on the H3 Unit, where there were some concerns with residents storing food and snacks in their room. On 4/10/23 at 2:00 P.M., the surveyor reviewed areas of concern in the building with the Administrator and Director of Maintenance which included but was not limited to: -Cleanliness and sanitation on all units, including an alternate food source for the pests/rodents of food particles and dried liquid stains on the floors and walls. -The observed mice droppings along walls, behind furniture, in outlets and in cluttered shower rooms and evidence of cockroach activity. -Areas of disrepair, leaving holes in walls and outlets. During an interview on 4/10/23 at 2:05 P.M., the Pest Control Contractor said he was here a year ago for a cockroach concern in the kitchen/dish room and an occasional mouse sighting. He said he cleared up the problem in two and half months and the plan was for the facility to be on a monthly maintenance plan. He felt due to complacency, which he would not identify who was complacent, the rodent problem was allowed to get out of control in the building. He was brought back into the building three weeks ago, and he said just about every room had mice holes. He started plugging the holes and added mouse bait stations to almost every room, and was trying to get the roach and mice problems under control. He said now both second floor units are pretty good with no sightings in the past couple weeks and there was just an occasional sighting on R1 unit and the kitchen. He said there continues to be a problem with rodents on the H3 Unit. He feels there are good control measures in place now since he plugged all the holes and applied the poison. He said the building must maintain a level of sanitation to eliminate the food supply and clean up the old mice droppings. (continued on next page)

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