STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225419	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Manor Nursing Home, IN	34 Agassiz Avenue Belmont, MA 02478

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4.) During an observation of the lunch meal at Station 4, and interview on 12/4/24 at 12:40 P.M., the surveyor observed a Certified Nursing Assistant (CNA) sitting at a table with four residents using her phone. The CNA said she was assisting one of the resident with his/her meal and should not have been on her phone. During an interview on 12/4/24 at 1:16 P.M., Nurse Unit Manager #3 said staff should not be using their cell phones in resident care areas. Based on observation, record review and interview the facility failed to provide a dignified existence for two Residents (#222 and #23) out of a total sample of 24 residents, and for residents on three of four units. Specifically: 1.) For Resident #222, the facility failed to maintain his/her urinary catheter bag in a privacy bag; 2.) For Resident #23, the facility failed to provide a dignified dining experience; and 3.) The facility failed to provide a dignified dining experience on Station 2 unit for residents dependent on staff for eating. 4.) The facility failed to ensure a dignified dining experience on Station 4 unit, when staff was observed using their cell phone during the lunch meal while assisting residents during the meal. Findings include: The facility policy titled 'Dignity', dated as revised 3/28/19, indicated it is the policy of [NAME] Manor Nursing Center to provide care in a dignified manner and to promote a lifestyle that is dignified and respectful to the resident. The facility policy titled 'Indwelling Foley Catheter Care', not dated, indicated that to ensure resident dignity, place catheter drainage bag into a dignity bag. 1.) Resident #222 was admitted to the facility in December 2024 with diagnoses including bladder cancer, pelvic fracture and heart disease. (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	Review of the most recent Minimum Data Set assessment, dated 3/16/24, indicated Resident #222 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. On 12/3/24 at 8:08 A.M., the surveyor observed Resident #222 in bed and his/her urinary catheter bag was visible from the hallway. The urinary catheter bag was not in a privacy bag. During an interview on 12/3/24 at 8:08 A.M., Resident #222 said he/she has a urostomy (a means by which urine drains directly from the kidney circumventing the bladder). Resident #222 said he/she prefers to keep things private and that the urinary catheter bag be covered. Resident #222 said he/she was embarrassed by the exposed urinary catheter bag. On 12/4/24 at 7:20 A.M., the surveyor observed Resident #222 in his/her room and the urinary catheter bag was exposed and visible from the hallway. During an interview on 12/4/24 10:35 A.M., Charge Nurse #1 said that it is the Certified Nurse's Aides and the nurse's responsibility to place catheter bags inside of the privacy bags. 2.) Resident #23 was admitted to the facility in October 2018 and had diagnoses that include Alzheimer's dementia, left eye blindness and unspecified cataract. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/22/24, indicated Resident #23 was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #23 had no behavior of rejecting care. Review of the current Activities of Daily Living (ADL) care plan, last revised 11/26/24, indicated Resident #23 required partial to moderate assistance for eating. Review of the POC (point of care) documentation for 11/28/24 through 12/4/24 indicated that Resident #23 varied between requiring substantial/maximal assistance with eating to dependent. Review of the most recent dietitian progress note, dated 11/21/24, indicated Resident #23 is no longer able to feed him/herself at meals and requires moderate physical assist to complete his/her meals. Review of the most recent Nurse Practitioner note, dated 9/26/24, indicated Resident #23 is dependent for all his/her care/ADLs. On 12/3/24 at 8:39 A.M., Resident #23 was observed seated in the unit dining room with a plate of food in front of him/her. Resident #23 watched his/her table mate eating. At 8:45 A.M., 6 minutes later, a nurse sat down beside Resident #23 to assist with feeding. On 12/3/24 between 12:39 P.M., and 12:50 P.M., Resident #23 was observed seated in the unit dining room. Resident #23's plate of food was out of reach and Resident #23 watched his/her tablemate being fed by staff and periodically looked over at his/her plate of food. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 8:37 A.M., a staff person served Resident #23 in the unit dining room. The staff person placed the breakfast in front of Resident #23, then without offering assistance, walked away and continued passing meals out to other residents. The surveyor continued to make the following observations: - At 8:39 A.M., Resident #23 stuck his/her hand into the syrup on the plate and a moment later wiped the hand on his/her neck. - At 8:43 A.M., a staff person walked over to Resident #23's table, stood beside him/her and while looking down at Resident #23 placed a spoonful of food in his/her mouth, then turned around and walked away to feed another resident. - At 8:46 A.M., the staff returned to Resident #23, stood beside him/her and without speaking a word, placed a spoonful of food in Resident #23's mouth then walked away. During an interview on 12/5/24 at 8:16 A.M., Nurse Unit Manager #2 said that staff should not be standing while feeding residents but rather seated at eye level interacting with the resident as they feed them. As well, she said that residents that require feeding assistance should not be served until staff are ready to provide the assistance. During an interview on 12/5/24 at 8:28 A.M., the Director of Nursing (DON) said staff should be seated at eye level when feeding and should not leave food sitting in front of dependent residents until they are ready to feed them. 3.) During an observation on the Station 2 unit during the breakfast meal on 12/4/24 the surveyor made the following observations: - Between 8:43 A.M., and 8:50 A.M., a staff person walked around the dining room from resident to resident, standing over each resident, placing a spoonful of food in their mouth then walking away. The staff member repeated the same action with each additional resident. During an observation on the Station 2 unit during the lunch meal on 12/4/24, the surveyor made the following observations beginning at 12:41 P.M.: - Two residents were seated at a table (#1) with plates of food in front of them waiting to be fed by staff; and - Two residents were seated at a table (#2). One of the residents was waiting to be fed by staff while watching the tablemate being fed. - At 12:47 P.M., a Certified Nursing Assistant (CNA) sat down at table #1 and began feeding one of the two residents at the table. - 10 minutes after the initial observation, at 12:51 P.M., the second residents at table #1 and table #2 continued to sit with the plate of food in front of them watching their tablemates be fed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 8:16 A.M., Nurse Unit Manager #2 said that staff should not be standing while feeding residents but rather seated at eye level interacting with the resident as they feed them. As well, she said that residents that require feeding assistance should not be served until staff are ready to provide the assistance. During an interview on 12/5/24 at 8:28 A.M., the Director of Nursing (DON) said staff should be seated at eye level when feeding residents and should not leave food sitting in front of dependent residents until they are ready to sit down beside the resident and feed them.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure that one Resident (#118) did not self-administer medications out of a total sample of 24 residents. Specifically, Resident #118 was observed with pills left at bedside for self-administration after he/she was assessed to not be able to self-administer medications. Findings include: Review of the facility policy titled 'Medication Administration - Self-Administration by Resident', dated 11/17, indicated: - If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility. - The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment, which is placed in the resident's medical record. Review of the facility policy titled 'Medication Administration - General Guidelines', dated 9/18, indicated: - Medications are to be administered at the time they are prepared. - The person who prepares the dose for administration is the person who administers the dose. - The resident is always observed after administration to ensure the dose was completely ingested. Resident #118 was admitted to the facility in November 2024 with diagnoses including adult failure to thrive and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/12/24, indicated Resident #118 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #118's assessment titled 'New admission - Self Administration of Medications', dated 11/6/24, indicated: - Due to the resident's cognitive, physical, or visual ability, the Interdisciplinary Team feels this resident is not a candidate for self-administration of medications at this time. On 12/3/24 at 8:27 A.M., the surveyor observed two brown pills in a medication cup on Resident #118's bedside table. Resident #118 was not in the room. During an interview on 12/3/24 at 8:28 A.M., Nurse #2 said Resident #118 went out to an appointment. Nurse #2 entered Resident #118's room and visualized the two brown pills on the bedside table. Nurse #2 said the last nurse must have left them there but should not have. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 2:11 P.M., Resident #118 said last night the nurse left his/her pills on the bedside table for him/her to self-administer later because he/she was sleeping. Resident #118 said he/she took the rest of them but decided not to take the two brown pills so that was why those pills were still on his/her bedside table when he/she left for an appointment. During an interview on 12/4/24 at 11:58 A.M., Charge Nurse #1 reviewed Resident #118's assessment titled 'New admission - Self Administration of Medications', dated 11/6/24, and said based on this assessment Resident #118 should never self-administer medications. Charge Nurse #1 said Resident #118 was never reassessed for self-administration of medication since that assessment, dated 11/6/24, and the pills should never have been left at her bedside unattended. During an interview on 12/4/24 at 12:30 P.M., the Director of Nursing (DON) said on admission Resident #118 was determined to not be able to self-administer any medication. The DON said Resident #118 should not have had any medications or pills left at bedside for self-administration.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review and interview the facility failed to investigate bruises of unknown etiology for one Resident (#4) out of a total sample of 24 residents. Findings include: Review of the facility policy titled 'Incident and Accident Investigating and Reporting', dated as revised 5/22/19, indicated that for a bruise of unknown origin, the facility should obtain caregiver statements from the proceeding 24 hours. Resident #4 was admitted to the facility in December 2016 with diagnoses including Alzheimer's dementia, kidney disease and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/18/24, indicated that Resident #4 is severely cognitively impaired, rarely/never understood and requires maximum assistance with activities of daily living. On 12/3/24 at 9:28 A.M., the surveyor observed Resident #4. The Resident had dark purple areas, consistent with bruises, on both the right and left hands, in between the forefingers and thumbs and covering the dorsal aspect of each hand. Review of the medical record failed to indicate that Resident #4 had bruises on his/her hands. Review of Resident #4's weekly skin checks, dated 11/6/24, 11/13/24, 11/20/24 and 11/27/24, indicated that there were no new skin conditions and that Resident #4's skin was intact. Review of the progress notes for November and December 2024 failed to indicate Resident #4 had bruised hands. During an interview on 12/3/24 at 1:25 P.M., Nurse #2 said that she noticed the bruises that morning but did not tell the charge nurse and should have, in order to start an investigation. During an interview on 12/3/24 at 1:20 P.M., Charge Nurse #1 said that she had not been made aware of the bruises. Charge Nurse #1 said that an investigation should have been started as a bruise of unknown etiology would need to be reported to the state agency with in the required two hour time frame. Charge Nurse #1 said that the lab would not draw blood from the bruised areas. Review of the facility document titled 'Incident/Accident Report', dated 11/18/24, at 1:00 P.M., indicated that Resident #4 had a bruise on his/her left hand. The document failed to indicate that there was a bruise on the right hand. Review of the facility document titled 'Incident/Accident Statement', dated 11/18/24, indicated that Certified Nurse Assistant (CNA) #1 stated that (Resident #4) was fighting with care. (He/she) hit hand off bedrail. I told the nurse (his/her) hand was red. Further review failed to indicate the CNA was questioned as to when he saw the bruising, before or after the Resident hit the siderail with his/her hand. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 2:38 P.M., CNA #1 said that he saw the bruises before he started providing morning care a few weeks ago and before the Resident hit his/her hand on the bedrail. CNA #1 then said that he should have reported the bruise immediately to the manager but he couldn't find her. He said he is supposed to tell the manager about anything he sees that is different before he leaves for the day. He said he told the unit manager in the afternoon. Review of the medical record failed to indicate any other staff members where questioned in relation to the bruised hands. During an interview on 12/4/24, at 12:40 P.M., the Director of Nursing (DON) said that she was not aware of the bruised hands and had not investigated either hand. The DON then said that the bruises should have been investigated thoroughly and reported to the state agency. During an interview on 12/4/24 at 2:30 P.M., The Staff Development Coordinator (SDC) said that she had not been made aware of the bruised right hand and was only made aware of the bruise on the left hand as documented on the incident report, dated 11/18/24. The SDC said that she didn't report the bruise to administration because she thought it was witnessed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report bruises of unknown origin to the state agency as required for one Resident (#4) out of a total of 24 sampled residents. Findings include: Review of the facility policy titled 'Incident and Accident Investigating and Reporting', dated as revised 5/22/19, failed to indicate that injuries of unknown origin are to be reported to the state agency within the required two hour time frame. Resident #4 was admitted to the facility in December 2016 with diagnoses including Alzheimer's dementia, kidney disease and diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/18/24, indicated that Resident #4 is severely cognitively impaired, is rarely/never understood and requires maximum assistance with activities of daily living. On 12/3/24 at 9:28 A.M., the surveyor observed Resident #4. The Resident had dark purple areas, consistent with bruises, on both the right and left hands, in between the forefingers and thumbs and covering the dorsal aspect of each hand. Review of the medical record failed to indicate that Resident #4 had bruises on his/her hands. Review of Resident #4's weekly skin checks, dated 11/6/24, 11/13/24, 11/20/24 and 11/27/24, indicated that there were no new skin conditions and that Resident #4's skin was intact. Review of the progress notes for November and December 2024 failed to indicate Resident #4 had bruised hands. During an interview on 12/3/24 at 1:25 P.M., Nurse #2 said that she noticed the bruises on Resident #4 that morning but did not tell the charge nurse and should have, in order to start an investigation. Nurse #2 then said that the lab would not draw blood from the bruised areas. During an interview on 12/3/24 at 1:20 P.M., Charge Nurse #1 said that she had not been made aware of the bruises on Resident #4. Charge Nurse #1 then said that an investigation should have been started as a bruise of unknown etiology should have been reported to the state agency with in the required two hour time frame. Charge Nurse #1 then said that the lab would not draw blood from the bruised areas. Review of the facility document titled 'Incident/Accident Report', dated 11/18/24, at 1:00 P.M., indicated that Resident #4 had a bruise on his/her left hand. The document failed to indicate that there was a bruise on the right hand. Further review indicated that Patient combative with care, seen that (he/she) hit (his/her) hand off the bedrail. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled 'Incident/Accident statement', dated 11/18/24, indicated that Certified Nurse Assistant (CNA) #1 stated that (Resident #4) was fighting with care. (He/she) hit hand off bedrail. I told the nurse (his/her) hand was red. Further review failed to indicate the CNA was questioned as to when he saw the bruising, before or after the Resident hit the siderail with his/her hand. During an interview on 12/3/24 at 2:38 P.M., CNA #1 said that he saw the bruises before he started providing morning care to Resident #4 a few weeks ago and before the Resident hit his/her hand on the bedrail. CNA #1 then said that he should have reported the bruise immediately to the manager but he couldn't find her. He said he is supposed to tell the manager about anything he sees that is different before he leaves for the day. He said he told the unit manager in the afternoon. Review of the medical record failed to indicate any other staff members where questioned in relation to the bruised hands. During an interview on 12/4/24 at 2:30 P.M., The Staff Development Coordinator (SDC) said that she had not been made aware of the bruised right hand and was only made aware of the bruise on the left hand as documented on the incident report, dated 11/18/24. The SDC said that she didn't report the bruise to administration because she thought it was witnessed. During an interview on 12/04/24 at 12:40 P.M., the Director of Nursing said that all injuries of unknown origin should be reported to the state agency within the required two hour timeframe.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4.) Resident #69 was re-admitted to the facility in August 2024 with diagnoses including dementia, metabolic encephalopathy and acute kidney injury. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #69 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) exam and was severely cognitively impaired. Review of the medical record failed to indicate that a baseline care plan for dementia was developed within the required 48 hours of admission. Review of the comprehensive care plan failed to indicate that the facility developed individualized interventions related to Resident #69's dementia and rate of progression. Further review failed to indicate that Resident #69 had dementia. During an interview on 12/4/24 at 11:49 A.M., Nurse Unit Manager #1 said that any resident with a diagnosis of dementia should have a specific baseline care plan for dementia initiated upon admission and then revised as there are changes in cognition. Nurse Unit Manager #1 then said that if a resident is readmitted to the facility after being hospitalized for a number of days then a new baseline care plan should be developed and the comprehensive care plan revised as needed. Based on record review and interview, the facility failed to ensure staff developed and implemented a baseline care plan for four Residents (#103, #41, #25, and #69), out of a total sample of 24 residents. Specifically, the facility failed to develop a baseline care plan within 48 hours of the Resident's admissions, which included the instructions needed to provide effective and person-centered care to the Residents with Dementia which meet professional standards of quality care. Findings include: Review of the facility policy titled 'Baseline Care Plans', dated revised November 2017, indicated that a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission. 1.) Resident #103 was admitted to the facility in January 2024 with diagnoses including dementia and Parkinson's disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/13/24, indicated that Resident #103 had severe cognitive impairment as evidenced by a staff assessment for Brief Interview for Mental Status (BIMS). Review of the medical record failed to indicate that a baseline care plan for dementia was developed within the required 48 hours of admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan failed to indicate that the facility developed individualized interventions related to Resident #103's dementia and rate of progression. Further review of the comprehensive care plan failed to indicate that Resident #103 had dementia. During an interview on 12/4/24 at 1:07 P.M., Nurse Unit Manager #3 said that nursing staff should have developed a baseline care plan for Resident #103 within 48 hours of admission to the facility. 2.) Resident #41 was admitted to the facility in September 2024 with diagnoses including dementia and bipolar disorder. Review of the most recent MDS assessment, dated 9/17/24, indicated that Resident #41 had severe cognitive impairment as evidenced by a BIMS score of 6 out of 15. Review of the medical record failed to indicate a baseline care plan was developed within 48 hours of admission to the facility. During an interview on 12/4/24 at 1:07 P.M., Nurse Unit Manager #3 said that nursing staff should have developed a baseline care plan for Resident #41 within 48 hours of admission to the facility. 3.) Resident #25 was admitted to the facility in March 2024 with diagnoses including dementia, depression, and anxiety. Review of the most recent MDS assessment, dated 9/13/24 indicated that Resident #25 had severe cognitive impairment as evidenced by a BIMS score of 3 out of 15. Review of the medical record failed to indicate a baseline care plan was developed within 48 hours of admission to the facility. During an interview on 12/4/24 at 1:07 P.M., Nurse Unit Manager #3 said that nursing staff should have developed a baseline care plan for Resident #25 within 48 hours of admission to the facility.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Manor Nursing Home, IN	34 Agassiz Avenue Belmont, MA 02478

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure person-centered care plans with measurable goals and individualized interventions were developed and implemented for one Resident (#103), out of 24 sampled residents. Specifically, for Resident #103, the facility failed to develop a plan of care related to activities of daily living (ADL's) and the use of psychotropic medication. Findings include: Review of Facility policy titled 'Care Plans Comprehensive, Resident', dated March 2010, comprehensive care plans are developed by the members of the Interdisciplinary Team (IDT)/healthcare proxy/resident and the comprehensive assessment form (MDS), ancillary assessments, MD orders/progress notes, hospital documentation and resident/family/other interviews are used to develop the individual comprehensive care plan(s) for the resident. According to the Resident Assessment Instrument (RAI), which is a comprehensive assessment tool used in Long-Term Care to identify resident's needs, preferences, and strengths, for each triggered care area, Care Planning Decision is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. Resident #103 was admitted to the facility in January 2024 and had diagnoses that include dementia with psychotic disturbance, Parkinson's disease, and difficulty walking. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/13/24, indicated Resident #103 had a staff assessment for Brief Interview for Mental Status (BIMS) that indicated severe cognitive impairment, was dependent with ADL's, and was taking an antipsychotic medication. Review of the comprehensive MDS, dated [DATE], indicated at section GG that Resident #103 required dependence with ADL's. Review of the Care Area Assessment Summary (CAA's) ADL function/rehabilitation potential r/t (related to) needing dependence with ADLs would be addressed in a care plan. Review of the comprehensive MDS, dated [DATE], indicated at section N that Resident #103 was taking a psychotropic medication. Review of the CAA's Psychotropic drug use r/t taking psychotropic medication would be addressed in care plan. Review of the medical record failed to include individualized interventions related to Resident #103's ADL needs or his/her psychotropic medication monitoring. Review of Resident #103's care plans failed to indicate a care plan for Resident's ADL needs and for the use of psychotropic medication was developed. During an interview on 12/4/24 at 11:21 A.M., MDS Nurse #2 said the MDS nurse did not develop a care plan for ADL and psychotropic mediation care for Resident #103 and said the CAA referred to Nursing who should have developed a care plan specific to Resident #103's needs. (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 12/4/24 at 1:07 P.M., Nurse Unit Manager #3 said he develops a resident's care plan based on things including their diagnoses, their medications and other care needs. He said Resident #103 should have a care plan to address ADL needs and use of psychotropic medication.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interviews, the facility failed to ensure for one Resident (#32), out of a total sample of 24 residents, that the interdisciplinary team reviewed and revised the plan of care after the quarterly review assessment. Specifically, for Resident #32, the facility failed to review and resolve a care plan for a stage 3 left heel pressure ulcer. Findings include: Resident #32 was admitted to the facility in October 2020 and had diagnoses that include type 2 diabetes mellitus and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of most recent Minimum Data Set (MDS) assessment, dated 9/13/24, indicated Resident #32 scored a 9 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately impaired cognition, displays physical and other behaviors, and does not display behaviors of rejecting care. Further the MDS indicated that Resident #32 did not have any unhealed pressure ulcers/injuries. Review of the physician's orders did not indicate a treatment order for a pressure ulcer/pressure injury. Review of Resident #32's active care plans on 12/4/24 at 8:00 A.M., included a care plan with a problem start date of 3/4/24, Resident has a pressure ulcer R/T (related to) left heel stage 3 pressure ulcer. On 12/3/24 at 9:13 A.M., Resident #32 was observed resting on his/her back, his/her bed was equipped with an air mattress and a blanket cradle (a device to keep covers directly on the feet). Resident #32 made eye contact but did not respond when asked if he/she had any wounds. During an interview on 12/4/24 at 8:10 A.M., Nurse #5 said Resident #32 had a pressure ulcer on his/her left heel that healed a long time ago. Nurse #5 said Nurse Unit Manager #3 updates the care plans. During an interview on 12/4/24 at 1:09 P.M., Nurse Unit Manager #3 said care plans are reviewed and updated as needed and in conjunction with the MDS schedule. Unit Manger #3 said the care plan for Resident #32's pressure ulcer should have been resolved during the care plan review after the quarterly MDS completed on 9/13/24.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure an intervention for contracture management was implemented in accordance with the medical plan of care for one Resident (#32), out of a total of 24 residents. Findings include: Review of the facility's policy titled 'Positioning Devices', not dated, indicated: It is the policy of the facility to attain and maintain good body alignment. The addition of positioning devices to attain and maintain good body alignment will be based on the rehab department recommendation and approved by the MD/NP (medical doctor/nurse practitioner). Examples of positioning devices could include but are not limited to: - Hand roll or hand grips - Splints Procedure: 1. Rehab screen, 2. Implementation of appropriate positioning device is recommended to MD/NP, 3. Education provided for staff, 4. Monitoring of device for appropriate applications and resident acceptance. Resident #32 was admitted to the facility in October 2020 and had diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting his/her right dominant side. Review of the Minimum Data Set assessment, dated 9/13/24, indicated Resident #32 scored a 9 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately impaired cognition, displays physical and other behaviors, and does not display behaviors of rejecting care. Further the MDS indicated Resident #32 had functional limitation in range in motion of his/her upper extremity on one side. Review of Resident #32's medical record indicated the following: - A physician's order, dated 2/7/24, [NAME] (put on) right [NAME] guard as tolerated, may remove for skin hygiene, twice a day; 23:00-07:00, 15:00-23:00 (11:00 P.M-7:00 A.M., 3:00 P.M.-11:00 P.M.) - A Resident Daily Care Plan (used by Certified Nursing Aids to breakdown the plan of care), dated March 9, 2023, Splints R (right) [NAME] guard at HS (hour of sleep) as Tol (tolerated). - A care plan, dated 6/11/24, Resident is limited in range of motion to RUE/RLE (Right upper extremity/right lower extremity) R/T (related to) stroke. Goal Resident's RUE/RLE joint contracture will be free from injury and skin breakdown. Approach: Follow PT (physical therapy) and OT (occupational therapy) recommendations, dated 6/11/24. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An OT- Therapist Progress and Discharge summary, dated and signed by the OT on 5/20/2021, which indicated the recommendation to wear a right hand [NAME] guard overnight for a right 4th/5th digit contracture. On 12/3/24 at 12:57 P.M., Resident #32 was observed with his/her lunch tray, with a Certified Nursing Assistant (CNA) sitting with him/her. Resident #32 had a Geri-sleeve on his/her right forearm. Resident #32's 4th and 5th fingers on his/her right hand were bent towards his/her palm. There was no palmar guard in the residents' vicinity. When asked if he/she wore a splint/brace on his/her right hand Resident #32 shook his/her head as in 'no'. On 12/3/24 at 4:26 P.M., Resident #32 was observed in bed. His/her right hand did not have a palmar guard applied. There was no palmar guard in or around the Resident's room. On 12/4/24 at 3:34 P.M., Resident #32 was observed in bed. His/her right hand did not have a palmar guard applied and no palmar guard was in the Resident's vicinity. On 12/5/24 at 6:50 A.M., Resident #32 was observed in bed. His/her right hand did not have a palmar guard applied and no palmar guard was in the Resident's area. During an interview on 12/5/24 at 6:55 A.M., CNA #4 said he took care of Resident #32 during the 11-7 shift and was not aware of any device that the Resident wears on his/her right hand. During an interview on 12/5/24 at 7:03 A.M., Nurse #6 said the Resident wears a Geri-sleeve on his/her right arm to prevent him/her from scratching. When asked about the palmar guard Nurse #6 said the Resident has behaviors and may not wear it. Nurse #6 said if the Resident refuses to wear it then it should be documented as a refusal and not signed off as being donned on the Treatment Administration Record. Nurse #6 and the surveyor went to Resident #32's room and she had difficulty locating the palmar guard, which was under items in the bottom drawer of the dresser. Review of the progress notes, dated 12/3/24 through 12/5/24, failed to indicate Resident #32 refused to don the palmar guard. Review of the treatment administration record (TAR) on 12/4/24 indicated the palmar guard as signed off as donned on the 3-11 shift on 12/3/24 and 11-7 shift on 12/3/24. During an interview on 12/5/24 at 8:49 A.M., the Director of Rehabilitation said she was the OT that worked with the Resident. The DOR said the right palmar guard should be applied as ordered. The DOR said Resident #32 has a contracture and the palmar guard was used to prevent skin issues and further complications or worsening of the contractures of his/her digits. The DOR said if the Resident is combative and refusing the palmar guard, she would want to reconsulted and had not been made aware that the palmar guard was not being donned. During an interview on 12/5/24 at 9:08 A.M., Nurse Unit Manger #3 said Resident #32 has behaviors and does not always permit the palmar guard to be donned. Nurse Unit Manager #3 said the palmar guard is for the Resident's right hand contractures, so it does not worsen. Nurse Unit Manager #3 said the nurses should be donning the palmar guard and should not be documenting on the TAR that it is on when it is not. Nurse Unit Manager #3 said a referral to rehab should be made if a Resident does not use a recommended intervention.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview the facility failed to implement physician ordered interventions to prevent accidents for two Residents (#77 and #57) out of a total sample of 24 residents. Specifically, for Resident #77 and Resident #57, the facility failed to ensure padded side rails were in place when the residents were in bed. Findings include: 1.) Resident #77 was admitted to the facility in April 2022 and has diagnoses that include Alzheimer's dementia and weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/27/24, indicated that on the Brief Interview for Mental Status exam Resident #77 scored a 5 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #77 had no behaviors. Review of the current physician's orders indicated an order for padded side rails when in bed due to agitation, with a start date of 1/30/24. Review of the record failed to indicate Resident #77 refused the padded side rails or removed the padded side rails. On 12/3/24 at 8:23 A.M., Resident #77 was observed in bed asleep. Both side rails were up and neither were padded. On 12/4/24 at 8:10 A.M., Resident #77 was observed in bed asleep. Both side rails were up and neither were padded. On 12/4/24 at 8:48 A.M., Resident #77 was observed in bed asleep. Both side rails were up and neither were padded. On 12/4/24 at 11:09 A.M., Resident #77 was observed in bed asleep. Both side rails were up and neither were padded. On 12/5/24 at 7:53 A.M., Resident #77 was observed in bed. Both side rails were up and neither were padded. During an interview on 12/5/24 at 7:55 A.M., Resident #77's Nurse (#3) said that when there was an order for a Resident to have padded side rails when in bed, it is the expectation that the order be followed. The surveyor and Nurse #3 observed Resident #77 in bed without padded side rails in place. During an interview on 12/5/24 at 8:07 A.M., Nurse Unit Manager #2 said that if there was an order for a resident to have side rails padded when in bed, it was the expectation that the order be followed and the side rails be padded if the Resident was in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 8:26 AM, the Director of Nursing (DON) said that it was her expectation that if a resident had orders for side rails to be padded when in bed, that the order be followed. 2.) Resident #57 was admitted to the facility in April 2023 and has diagnoses that include epilepsy, dementia and a history of falling. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/27/24, indicated Resident #57 was assessed by staff to have severely impaired cognition. The MDS further indicated that Resident #57 had no behaviors. Review of the current physician's orders indicated an order for padded side rails while in bed, every shift, with a start date of 4/4/23. Review of Resident #57's care plan indicated the following care plan: - Problem: Resident has seizure disorder [sic]. - Goal: Resident will not injure self due to seizure disorder. Review of the record failed to indicate Resident #57 refused the padded side rails or removed the padded side rails. On 12/3/24 at 8:29 A.M., Resident #57 was observed in bed. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/3/24 at 12:52 P.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/4/24 at 8:07 A.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/4/24 at 8:49 A.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/4/24 at 10:49 A.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/5/24 at 7:52 A.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. During an interview on 12/5/24 at 8:00 A.M., Resident #57's Nurse (#3) said that Resident #57 required total care. Nurse #3 said that Resident #57 had a history of seizures and that most recently he recalls Resident #57 having a seizure two months ago while in bed receiving care. The surveyor and Nurse #3 observed Resident #57 in bed with the right side rail padded and the left side rail unpadded. Nurse #3 said that both rails should be padded as Resident #57 could get badly hurt if he/she were to have a seizure and the siderail wasn't padded. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 8:07 A.M., Nurse Unit Manager #2 said that if there is an order for a resident to have side rails padded when in bed, it was the expectation that the order be followed and the side rails be padded if the Resident was in bed. During an interview on 12/5/24 at 8:26 A.M., the Director of Nursing (DON) said that it was her expectation that if a resident had orders for side rails to be padded when in bed, that the order be followed. The DON said that there was a risk of harm to Resident #57 if he/she were to have a seizure in bed without padded side rails.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to maintain acceptable parameters of nutrition status for one Resident (#25) out of a total sample of 24 residents. Specifically, the facility failed to provide interventions to prevent significant weight loss in a timely manner for Resident #25. Findings include: Review of the facility policy titled 'Weight Policy', revised March 2017, indicated: - To provide adequate nutrition and hydration to the residents and prevent weight loss whenever possible. To accomplish this each resident is assessed and monitored to determine if he/she is at risk. For each resident determined to be at risk, treatment and/or preventative measures are instituted. - A Nutrition Alert is to be initiated if a resident has had a 5% weight loss in one month or a 2.5% weight loss in one week and if this occurs, nursing will notify the physician and dietitian. - Weights will be reviewed in a weekly weight meeting that is attended by but limited to Director of Nursing, Registered Dietitian, and Clinical Nurse Manager or charge nurse. - During the weight meeting the dietitian will review the current weight to the last three months, nurse manager will record the current weight and any intervention for weight gain recommended, Director of Nursing will initiate % of supplement as needed. - After the weight meeting the dietitian will be responsible for note in the dietary section of the medical record, nursing will follow up with any notes in the Nurse's note section, and after collaboration with the resident/resident's representative, the dietitian will write out recommendation for nursing to review with physician for approval. Resident #25 was admitted to the facility in March 2024 with diagnoses including dementia, dysphagia (difficulty chewing and swallowing), depression, and anxiety. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/13/24, indicated Resident #25 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. The MDS further indicated Resident #25 had significant weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. Review of Resident #25's plan of care related to nutrition, revised 12/5/24, indicated: - Goal: tolerate least restrictive diet without aspiration or nutritional compromise and improve weight over next 90 days. - House minced and moist nectar thick liquids, allow bread, allow thin liquids between meals, monitor and record intake, monthly weights, encourage nectar thick liquids throughout the day, weekly weights, lip plate at meals, large portions, 2oz med pass (nutritional supplement) three times daily. Physical assist at meals as needed. Remeron (an appetite stimulant medication) 15 mg (milligrams) daily. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #25's Weight Summary report indicated the following weights: - 3/19/24: 165.0 lbs. (pounds) - 3/26/24: 163.6 lbs. - 4/3/24: 164.0 lbs. - 4/8/24: 164.0 lbs. - 4/15/24: 164.2 lbs. - 4/22/24: 162.2 lbs. - 5/3/24: 158.4 lbs. - 5/13/24: 154.6 lbs. - 6/3/24: 153.4 lbs. (7% weight loss since admission) - 7/2/24: 153.2 lbs. - 8/3/24: 148.6 lbs. (10% weight loss in 5 months) - 9/3/24: 139.8 lbs. - 9/23/24: 139.8 lbs. (15% weight loss in 6 months) Review of Dietitian progress note, dated 3/21/24, indicated: - On interview with son (healthcare proxy) present he/she reports he/she has a good appetite without recent changes to weight or appetite. Interventions to include house puree nectar thick liquids, supervise at meals, monitor, and record intake, weekly weights, encourage nectar thick liquids throughout the day. [sic] Review of Resident #25's record failed to indicate that he/she had been seen or assessed by the dietitian between 3/29/24 and 9/19/24 despite the continued and significant weight loss. Review of Dietitian progress note, dated 9/19/24, indicated: - Significant weight loss over six months of 11% body weight. Records and observation indicate a healthy appetite consuming 100% of meals. Interventions to include to add lip plate due to spillage noted during meals, large portions since he/she is eating well, will request Occupational Therapy screen since he/she needs assistance to complete meal at times, will add 4oz house supplement three times daily and weekly weight. Review of all progress notes from March 2024 until December 2024 failed to indicate any notification to health care proxy or physician about Resident #25's weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #25's physician's order, initiated 9/19/24, indicated: - Diet house minced, nectar thick liquids, large portions, weekly weight. During an interview on 12/5/24 at 9:55 A.M., the Dietitian said she expects nursing to notify her if there are any abnormal weight changes. The Dietitian said she was never notified of Resident #25's significant weight loss that was documented in the weight log on 6/3/24, 7/2/24, 8/3/24, or 9/3/24, but only noticed it when reviewing weights during her routine quarterly assessment. The Dietitian said even though all residents are discussed in monthly weight meeting, the weights are not always available when the weight meeting is held. The Dietitian said that obtaining weights timely has been an ongoing issue that she has reported to the Director of Nursing, but the issue continues. The Dietitian said if the weight is not available to review at the weight meeting, she would not know that weight loss had occurred unless it was brought to her attention. The Dietitian said that Resident #25's weight loss should have been reported to her sooner and that interventions should have been put in place earlier to achieve stability in Resident #25's weight but was not.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview the facility failed to provide respiratory care services in accordance with professional standards of practice for two Residents (#223 and #53) out of a total sample of 24 Residents. Specifically: 1.) For Resident #223 and Resident #53, the facility failed to ensure the oxygen filters were clean and that there was a process was in place for the cleaning/maintenance of the concentrators; and 2.) For Resident #53, the facility failed to ensure the oxygen tubing changed as ordered. Findings include: Review of the facility policy titled 'Oxygen Administration', undated, failed to indicate when to change/clean the oxygen concentrator filters. Further review failed to indicate how often to change oxygen tubing. 1.) Resident #223 was admitted to the facility in September 2024 with diagnoses including pneumonia, chronic obstructive pulmonary disease and dependence on supplemental oxygen. On 12/3/24 at 10:28 A.M., the surveyor observed Resident #223 lying in bed, receiving oxygen at 2 liters per minute (lpm) via nasal cannula. The surveyor also observed the concentrator air filter to have a thick layer of a gray fuzzy substance on it. On 12/4/24 at 7:18 A.M., the surveyor observed Resident #223 lying in bed, receiving oxygen at 2 lpm via nasal cannula. The surveyor also observed the concentrator air filter to have a thick layer of a gray fuzzy substance on it. During observation and interview on 12/4/24 10:35 A.M., the surveyor and Charge Nurse #1 observed Resident #223 lying in bed, receiving oxygen at 2 lpm via nasal cannula. The surveyor and Charge Nurse #1 observed the concentrator filter to be covered in a thick layer of a fuzzy gray substance. Charge Nurse #1 then said she didn't know who was supposed to clean the filter or how often it was to be cleaned. During an interview on 12/4/24 at 1:13 P.M. and 1:53 P.M., the Maintenance Director said that a company should be coming in weekly to clean all the oxygen concentrator filters. The Maintenance Director said that the facility did not have documentation to show that the oxygen filters were being cleaned, and that he did not have a system for tracking if, or when, each machine was cleaned. During an interview on 12/4/24 at 12:40 P.M., the Director of Nursing said that she was going to talk with maintenance to find out who cleans the oxygen concentrator filters and how often. 2a) Resident #53 was admitted to the facility in November 2020 with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of the most recent Minimum Data Set (MDS) assessment, dated 10/4/24, indicated that Resident #53 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating the Resident was cognitively intact. (continued on next page)

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Belmont Manor Nursing Home, IN	34 Agassiz Avenue Belmont, MA 02478

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's care plan indicated that the Resident had impaired gas exchange related to COPD and received supplemental oxygen. On 12/3/24 at 8:33 A.M., the surveyor observed Resident #53 sleeping in bed while wearing his/her nasal canula connected to an oxygen concentrator. On 12/3/24 at 10:45 A.M., the surveyor observed the filter on Resident #53's oxygen concentrator. The filter was covered in a gray substance. During an observation and interview on 12/4/24 at 9:18 A.M., the surveyor observed that the filter on Resident #53's oxygen concentrator remained covered in a gray substance. Resident #53 said he/she wears the nasal canula every night. During an interview and observation on 12/4/24 at 12:50 P.M., Nurse Unit Manager #4 observed the filter on Resident #53's oxygen concentrator with the surveyor. Nurse Unit Manager #4 said based on how much dust there was on the filter that the filter should be cleaned. Nurse Unit Manager #4 said the filters should be cleaned weekly and that she would defer to the maintenance department for ensuring the filters were cleaned. During an interview on 12/4/24 at 1:13 P.M. and 1:53 P.M., the Maintenance Director said that a company should be coming in weekly to clean all the oxygen concentrator filters. The Maintenance Director said that the facility did not have documentation to show that the oxygen filters were being cleaned, and that he did not have a system for tracking if, or when, each machine was cleaned. During an interview on 12/4/24 at 12:40 P.M., the Director of Nursing said that she was going to talk with maintenance to find out who cleans the oxygen concentrator filters and how often. 2b) Resident #53 was admitted to the facility in November 2020 with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of the most recent Minimum Data Set (MDS) assessment, dated 10/4/24, indicated that Resident #53 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating the Resident was cognitively intact. Review of Resident #53's care plan indicated that the Resident had impaired gas exchange related to COPD and received supplemental oxygen. Review of Resident #53's current physician orders indicated the following active order: - Change oxygen tubing weekly on Monday, initiated 12/1/22. On 12/3/24 at 8:33 A.M., the surveyor observed Resident #53 sleeping in bed while wearing his/her nasal canula connected to an oxygen concentrator. The nasal canula tubing was labeled and dated as 10/29/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/4/24 at 9:18 A.M., the surveyor observed Resident #53's nasal canula tubing remained dated 10/29/24. Resident #53 said the nurses left new tubing for the Resident to change the tubing him/herself on 12/2/24, however, Resident #53 said she had not changed the tubing yet. Resident #53 said she wears the nasal canula every night. Review of medical record failed to indicate that Resident #53 had refused to have his/her oxygen tubing changed on 11/4/24, 11/11/24, 11/18/24, or 11/25/24. Further review of the record failed to indicate a physician's order for Resident #53 to change his/her own oxygen tubing or that Resident #53 had been assessed as able to change his/her oxygen tubing. During an interview on 12/4/24 at 10:27 A.M., Nurse #4 said oxygen tubing should be changed and dated once a week. Nurse #4 said that Resident #53 often changes the tubing him/herself and that the nurses leave the tubing in the Resident's room and then check back to make sure that the tubing was changed. Nurse #4 said that if the Resident had not changed the tubing, that nursing will then do it, which Resident #53 allows. Nurse #4 said she would expect the Resident to be assessed to determine if the Resident was capable of changing his/her own oxygen tubing and that this would be documented in a progress note. During an interview 12/4/23 at 12:29 P.M., the Director of Nursing (DON) said oxygen tubing should be changed weekly and as needed. The DON said that nurses change the tubing unless a resident was assessed and determined to be able to change his/her own tubing. During a follow-up interview on 12/5/24 at 7:52 A.M., the DON said that Resident #53 had not been assessed to be able to change his/her own oxygen tubing.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on interview and record review the facility failed to ensure that residents' individualized dementia care needs are met through the assessment, development, and implementation of care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative for five Residents (#21, #103, #41, #25, and #69), out of a total sample of 24 residents. Specifically, for Residents #21, #103, #41, #25, and #69, the facility failed to develop an interdisciplinary dementia care plan to ensure the Resident received appropriate treatment and services specific to his/her needs for dementia care. Findings include: 483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Review of the document titled 'Dementia Special Care Unit (DSCU) Disclosure Form' indicated on 2/28/2024 the facility disclosed they meet the specific state licensure requirements to provide specialized care for resident with dementia. 1.) Resident #21 was admitted to the facility in August 2024 and had a diagnosis of unspecified dementia, severe with agitation. Review of Resident #21's Minimum Data Set (MDS) assessment, dated 11/8/24, indicated he/she scored 2 out of 15 on the Brief Interview for Mental Status exam indicating Resident #21 as having severe cognitive impairment and is dependent on staff for all self-care daily activities. Further, the MDS indicated Resident #21 displayed behaviors of delusions, physical and verbal behaviors, and rejected care. On 12/4/24 at 8:33 A.M., Resident #21 was observed resting in bed. He/she did not respond to the surveyor's greeting. On 12/4/24 review of the Care Area Assessment (CAA) Summary (Part of a comprehensive MDS, to assist in developing the resident care plans) indicated that Resident #21 triggered cognitive loss/dementia. Review of the active care plans failed to indicate a person-centered care plan for dementia with a measurable goal and individualized interventions was developed. During an interview on 12/4/24 at 11:21 A.M., MDS Nurse #2 said the MDS nurse did not develop a care plan for dementia care for Resident #21 and said the CAA referred to Social Services who should have developed a care plan specific to Resident #21's cognitive loss/dementia diagnosis. During an interview on 12/4/24 at 11:47 A.M., Social Worker #1 said Resident #21 is confused related to dementia and requires a great deal of care and supervision from the specialized dementia care unit. Social Worker #1 said she did not develop a specific dementia care plan. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/4/24 at 1:08 P.M., Nurse Unit Manager #3 said a resident with a diagnosis of dementia should have a dementia care plan with individualized interventions. 5.) Resident #69 was re-admitted to the facility in August 2024 with diagnoses including dementia, metabolic encephalopathy and acute kidney injury. Review of the Minimum Data Set (MDS) assessment, dated 8/23/24, indicated that Resident #69 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) exam and was severely cognitively impaired. Review of the medical record failed to indicate that a baseline care plan for dementia was developed. Review of the comprehensive care plan failed to indicate that the facility developed individualized interventions related to Resident #69's dementia and rate of progression. Further review of the comprehensive care plan failed to indicate that Resident #69 had dementia. During an interview on 12/4/24 at 11:49 A.M., Nurse Unit Manager #1 said that any resident with a diagnosis of dementia should have a specific baseline care plan for dementia initiated upon admission and then revised as there are changes in cognition. Nurse Unit Manager #1 then said that if a resident is readmitted to the facility after being hospitalized for a number of days then a new baseline care plan should be developed and the comprehensive care plan developed and revised as needed. 2.) Resident #103 was admitted to the Facility in May 2024 with diagnoses including dementia and Parkinson's disease. Resident #103 resides on the designated DSCU. Review of the most recent MDS assessment, dated 9/13/24, indicated that Resident #103 had severe cognitive impairment as evidenced by a staff assessment for Brief Interview for Mental Status (BIMS). Review of the clinical record indicated no development of an interdisciplinary dementia care plan. During an interview on 12/4/24 at 1:07 P.M., Nurse Unit Manager #3 said he would expect a dementia care plan to have been developed as the Resident lives on a DSCU (Dementia Special Care Unit) and clearly has dementia. 3.) Resident #41 was admitted to the facility in September 2024 with diagnoses including dementia and bipolar disorder. Resident #41 resides on the designated DSCU. Review of the most recent MDS assessment, dated 9/17/24, indicated that Resident #41 had severe cognitive impairment as evidenced by a BIMS score of 6 out of 15. Review of the clinical record indicated no development of an interdisciplinary dementia care plan. During an interview on 12/4/24 at 1:07 P.M., Nurse Unit Manager #3 said he would expect a dementia care plan to have been developed as the Resident lives on a DSCU (Dementia Special Care Unit) and clearly has dementia. 4.) Resident #25 was admitted to the facility in March 2024 with diagnoses including dementia, depression, and anxiety. Resident #25 resides on the designated DSCU. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent MDS assessment, dated 9/13/24 indicated that Resident #25 had severe cognitive impairment as evidenced by a BIMS score of 3 out of 15. Review of the clinical record indicated no development of an interdisciplinary dementia care plan. During an interview on 12/4/24 at 1:07 P.M., Nurse Unit Manager #3 said he would expect a dementia care plan to have been developed as the Resident lives on a DSCU (Dementia Special Care Unit) and clearly has dementia.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 3.) Resident #32 was admitted to the facility in October 2020 and had diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting his/her right dominant side. Review of the Minimum Data Set assessment, dated 9/13/24, indicated Resident #32 scored a 9 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately impaired cognition, displays physical and other behaviors, and does not display behaviors of rejecting care. Further the MDS indicated Resident #32 had functional limitation in range in motion of his/her upper extremity on one side. Review of Resident #32's medical record indicated the following: - A physician's order, dated 2/7/24, [NAME] (put on) right palmer guard as tolerated, may remove for skin hygiene, twice a day; 23:00-07:00, 15:00-23:00 (11:00 P.M-7:00 A.M., 3:00 P.M.-11:00 P.M.) On 12/3/24 at 12:57 P.M., Resident #32 was observed with his/her lunch tray, with a Certified Nursing Assistant (CNA) sitting with him/her. Resident #32 had a Geri-sleeve on his/her right forearm. Resident #32's 4th and 5th fingers on his/her right hand were bent towards his/her palm. There was no palmar guard in the residents' vicinity. When asked if he/she wore a splint/brace on his/her right hand Resident #32 shook his/her head as in 'no'. On 12/3/24 at 4:26 P.M., Resident #32 was observed in bed. His/her right hand did not have a palmar guard applied. There was no palmar guard in or around the Resident's room. On 12/4/24 at 3:34 P.M., Resident #32 was observed in bed. His/her right hand did not have a palmar guard applied and no palmar guard was in the Resident's vicinity. On 12/5/24 at 6:50 A.M., Resident #32 was observed in bed. His/her right hand did not have a palmar guard applied and no palmar guard was in the Resident's area. During an interview on 12/5/24 at 6:55 A.M., CNA #4 said he took care of Resident #32 during the 11-7 shift and was not aware of any device that the Resident wears on his/her right hand. During an interview on 12/5/24 at 7:03 A.M., Nurse #6 said the Resident wears a Geri-sleeve on his/her right arm to prevent him/her from scratching. When asked about the palmar guard Nurse #6 said the Resident has behaviors and may not wear it. Nurse #6 said if the Resident refuses to wear it then it should be documented as a refusal and not signed off as being donned on the Treatment Administration Record. Nurse #6 and the surveyor went to Resident #32's room and she had difficulty locating the palmar guard, which was under items in the bottom drawer of the dresser. Review of the progress notes, dated 12/3/24 through 12/5/24, failed to indicate Resident #32 refused to don the palmar guard. Review of the treatment administration record (TAR) on 12/4/24 indicated the palmar guard as signed off as donned on the 3-11 shift on 12/3/24 and 11-7 shift on 12/3/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 9:08 A.M., Nurse Unit Manger #3 said Resident #32 has behaviors and does not always permit the palmar guard to be donned. Nurse Unit Manager #3 said the palmar guard is for the Resident's right hand contractures, so it does not worsen. Nurse Unit Manager #3 said the nurses should be donning the palmar guard and should not be documenting on the TAR that it is on when it is not. Nurse Unit Manager #3 said a referral to rehab should be made if a Resident does not use a recommended intervention. Based on observation, record review and interview the facility failed to accurately document in the medical record for four Residents (#77, #57, #53, and #32) out of a total sample of 24 residents. 1.) For Resident #77 and #57, the facility documented padded side rails were in place when the Residents were in bed, when they were not. 2.) For Resident #53, the facility documented that the Resident's oxygen tubing was changed when it was not. 3.) For Resident #32, the facility documented that a palmar guard (a device for contracture management) had been applied when it was not. Findings include: Review of the undated facility policy titled 'Documentation', dated January 2008, indicated the following: - Documentation should be an accurate written account of the resident's current condition, response to events and to medication, care and treatment. - Documentation should be accurate, current, brief, concise and legible. 1a.) Resident #77 was admitted to the facility in April 2022 and had diagnoses that include Alzheimer's dementia and weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/27/24, indicated that on the Brief Interview for Mental Status exam Resident #77 scored a 5 out of a possible 15, indicating severely impaired cognition. The MDS further indicated Resident #77 had no behaviors. Review of the current physician's orders indicated an order for padded side rails when in bed due to agitation, with a start date of 1/30/24. On 12/3/24 at 8:23 A.M., Resident #77 was observed in bed asleep. Both side rails were up and neither were padded. On 12/4/24 at 8:10 A.M., Resident #77 was observed in bed asleep. Both side rails were up and neither were padded. On 12/4/24 at 8:48 A.M., Resident #77 was observed in bed asleep. Both side rails were up and neither were padded. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 11:09 A.M., Resident #77 was observed in bed asleep. Both side rails were up and neither were padded. On 12/5/24 at 7:53 A.M., Resident #77 was observed in bed. Both side rails were up and neither were padded. Review of the December 2024 Treatment Administration Record (TAR) indicated that nursing had documented on 12/3/24 and 12/4/24, all three shifts that the side rails were padded while Resident #77 was in bed and had documented on the 12/5/24 day shift that the padded side rails were in place, contrary to direct observation by the surveyor. During an interview on 12/5/24 at 8:07 A.M., the surveyor shared the three days of observations of Resident #77 in bed without padded siderails with Nurse Unit Manager #2. Nurse Unit Manager #2 and the surveyor reviewed the TAR together and she said that the staff should not be documenting that the side rails are padded when they are not. During an interview on 12/5/24 at 8:26 A.M., the Director of Nursing (DON) said that it is her expectation that if a resident has orders for side rails to be padded when in bed, that the order be followed. As well, it is her expectation that the documentation in the TAR be accurate and that if for some reason a resident refuses or removes padding that nursing document that. 1b.) Resident #57 was admitted to the facility in April 2023 and had diagnoses that include epilepsy, dementia and a history of falling. Review of the most recent Minimum Data Set (MDS) assessment, dated 11/27/24, indicated Resident #57 was assessed by staff to have severely impaired cognition. The MDS further indicated that Resident #57 had no behaviors. Review of the current physician's orders indicated an order, with a start date of 4/4/23, for padded side rails while in bed, every shift. On 12/3/24 at 8:29 A.M., Resident #57 was observed in bed. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/3/24 at 12:52 P.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/4/24 at 8:07 A.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/4/24 at 8:49 A.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/4/24 at 10:49 A.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. On 12/5/24 at 7:52 A.M., Resident #57 was observed in bed asleep. Both side rails were up. The right side rail was padded and the left side rail was not. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the December 2024 Treatment Administration Record (TAR) indicated that nursing had documented on 12/3/24 and 12/4/24, all three shifts that the side rails were padded while Resident #57 was in bed, contrary to direct observation by the surveyor. During an interview on 12/5/24 at 8:07 A.M., the surveyor shared the three days of observations of Resident #57 in bed without a left siderail padded with Nurse Unit Manager #2. Nurse Unit Manager #2 and the surveyor reviewed the TAR together and she said that the staff should not be documenting that the side rails are padded when they are not. During an interview on 12/5/24 at 8:26 A.M., the Director of Nursing (DON) said that it is her expectation that if a resident has orders for side rails to be padded when in bed, that the order be followed. As well, it is her expectation that the documentation in the TAR be accurate and that if for some reason a resident refuses or removes padding that nursing document that. 2.) Resident #53 was admitted to the facility in November 2020 with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of the most recent Minimum Data Set (MDS) assessment, dated 10/4/24, indicated that Resident #53 scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, indicating the Resident was cognitively intact. Review of Resident #53's care plan indicated that the Resident had impaired gas exchange related to COPD and received supplemental oxygen. Review of Resident #53's current physician's orders indicated the following active order: - Change oxygen tubing weekly on Monday, initiated 12/1/22. On 12/3/24 at 8:33 A.M. and 10:45 A.M., the surveyor observed that Resident #53's nasal canula tubing was dated 10/29/24, indicating the tubing was last changed five weeks ago. Review of Resident #53's Medication Administration Record (MAR) indicated that nursing had documented the the oxygen tubing was changed on 11/1/24, 11/11/24, 11/18/24, and 11/25/24. During an interview on 12/4/24 at 12:29 P.M., the Director of Nursing (DON) said that nurses should not document in the MAR that they had changed the oxygen tubing, if they had not.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and staff interviews, the facility failed to follow infection control standards of practice for the cleaning of shared resident equipment. Findings include: Review of the facility policy titled 'Cleaning/Disinfection of Resident Care Equipment', dated 6/2019, indicated supplies and equipment will be cleaned immediately after use and/or when indicated. Specifically, For cleaning of resident equipment-vital sign machine. - Clean the machine with disinfectant wipe after each use on resident. On 12/4/24 at 9:29 A.M., the surveyor observed Nurse #2 enter the room of a resident on enhanced barrier precautions (EBP) and utilized the portable vital sign caddy (a device that measures vital signs including blood pressure, pulse, temperature, and oxygen saturation) to measure vital signs of the resident thus contaminating the caddy. The surveyor then observed Nurse #2 enter a different room of a resident that was also on EBP without disinfecting the contaminated caddy to measure a different resident's vital signs. During an interview on 12/4/24 at 9:29 A.M., Nurse #2 said she did not disinfect the vital sign caddy, but she should have. During an interview on 12/4/24 at 9:35 A.M., Nurse Unit Manager #1 said shared resident equipment should be disinfected/cleaned before use for another resident.