STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225493	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Rehab & Nursing Care Center	321 Centre Street Dorchester, MA 02122

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. Based on observations, record review and interview, the facility failed to maintain a dignified existence for residents during mealtimes on two out of three units. Specifically, 1. Staff stood over residents while assisting with meals on two out of three units. 2. Staff referred to residents as feeders on one out of three units. Findings include: Review of facility policy titled Quality of Life- Dignity, dated September 20, 2018, indicated the following: -Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. -Residents shall always be treated with dignity and respect. -Resident who require staff assistance for feeding shall be fed by the staff member who is seated in a chair next to the resident. Staff shall not feed residents while in a standing position. -Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. 1. On 2/3/25 during the breakfast meal, staff were observed standing while assisting two residents on the fourth floor with their breakfast. On 2/3/25 during the breakfast meal, staff were observed standing while assisting one resident on the third floor with their breakfast On 2/3/25 during the lunch meal, staff were observed standing while assisting two residents on the fourth floor with their lunch. On 2/4/25 during the breakfast meal, staff were observed standing while assisting four residents on the fourth floor with their breakfast. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 during the lunch meal, staff were observed standing while assisting two residents on the fourth floor with their breakfast. On 2/4/25 during the lunch meal, staff were observed standing while assisting one resident on the third floor unit with their breakfast. During an interview and observation on 2/04/25 at 12:03 P.M., Nurse #3 observed staff standing while assisting two residents with their meals and said that staff should be sitting down to assist with meals. During an interview on 2/4/25 at 12:07 P.M. Unit Manager #2 said that staff should be sitting next to residents at eye level when assisting with meals and standing over them would be a dignity concern. During an interview on 2/4/25 at 2:05 P.M., the Director of Nursing said that staff should be sitting when assisting residents with meals and not standing over them. 2. On 2/4/25 at 8:17 A.M., on the third-floor unit, the Minimum Data Set (MDS) Nurse was heard asking if a resident was a feeder outside of patient rooms, in a tone audible to several residents. During an interview on 2/4/25 at 12:03 P.M., Nurse #3 said that staff should not refer to residents as feeders because it is not dignified. During an interview on 2/4/25 at 12:07 P.M., Unit Manager #2 said that it is undignified to refer to a resident as a feeder. During an interview on 2/4/25 at 2:05 P.M., the Director of Nursing said that staff should not be using the term feeders to refer to residents and that it would be a dignity concern.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed for 2 Residents (#15 and #44) out of a total sample of 31 residents, to ensure: 1. Resident #15 was equipped with a call bell that functioned for him/her and, 2. That Resident #44 had a Broda chair available for when he/she chose to get out of bed. Findings include: Review of the facility's policy entitled, Call light policy, revision date 1/2025 indicated the following: Resident will have a functioning call light at their bedside for use to alert staff that they need assistance. Resident #15 was admitted to the facility in July 2022 with diagnoses that include chronic obstructive pulmonary disease and colostomy status. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #15 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition and requires partial/moderate assistance with bathing and has an ostomy. During an observation and interview on 2/3/25 at 8:32 A.M., Resident #15 said he/she was concerned that his/her call bell did not work and that he/she told staff about one month ago. Resident #15 said he/she had terminal cancer, and it would be nice to have a call bell that worked. Resident #15 had a call bell with a bulb. Resident #15 squeezed the bulb, and the call light did not illuminate. The surveyor pressed the bulb, and the light illuminated outside of Resident #15's room. Resident #15 said he/she wanted a call bell that worked for him/her. During an interview and observation on 2/4/25 at 10:20 A.M., Resident #15 squeezed the bulb of the call bell. The call light did not illuminate outside of his/her room, thus not alerting staff if he/she required assistance. During an observation on 2/4/25 10:31 A.M., Nurse #2 and the surveyor observed Resident #15 squeeze the bulb of the call light. The call light did not illuminate outside of the room to alert staff. Resident #15 said he/she wants it to work so he/she can get the help he/she needs for his/her colostomy bag. Nurse #2 said it would be addressed. During an interview and observation on 2/5/25 at 10:55 A.M., Resident #15 was resting in bed. He/she squeezed the call light bulb, which did not illuminate in the hall to alert staff. Resident #15 said he/she thought they took care of it yesterday. On 2/5/25 at approximately 11:00 A.M., the Administrator in Training (AIT) went to Resident #15's room with the surveyor. Resident #15 squeezed the call light bulb which did not illuminate in the hall. Resident #15 said he/she wanted a call bell that worked and that last night he/she had to walk down the hall to let staff know he/she had a full colostomy bag. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #44 the facility failed to have his/her Broda Chair available for when he/she chose to get out of bed. Review of the facility's Guideline: Assistive Equipment and Devices effective date 1/24/2025 indicated, Policy Statement: Our facility provides and maintains the use of assistive devices and equipment for residents. 1. Devices and equipment that assist with resident mobility, safety and independence are provided for residents. These include, but are not limited to a. Wheelchairs (manual and powered). 2. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident's plan of care. Resident #44 was admitted to the facility in December 2023 and has diagnoses that include hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting right dominant side. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #44 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition and is dependent on staff for bed to chair transfers and uses a wheelchair. Further review of the MDS, indicated Resident #44 did not display any behaviors including rejection of care. During an interview on 2/3/25 at 8:16 A.M., Resident #44 said he/she retired from work, had a stroke and requires care. Resident #44 said he/she recently moved from a room down the hall and has a wheelchair that he/she used when he/she got out of bed. Resident #44 said he/she has not seen the wheelchair and has not got out of bed. Observation of Resident #44's area including the bathroom and adjacent hallway failed to reveal a chair was present. On 2/3/25 at 3:52 P.M., Resident #44 was observed in bed. There was no chair available in his/her vicinity. Review of Resident #44's medical record indicated the following: -A physician's order OOB (out of bed) to Broda chair (a type of wheelchair that supports mobility, and safe, comfortable positioning) active 2/14/23. -A care plan focus Resident has an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Alzheimer's, confusion due to dementia, dated 5/24/2021 with the Intervention/Task TRANSFER: Resident #44 is dependent of 2 staff via mechanical lift for transfers to BRODA. Resident often refuses out of bed bound by preference. On 2/4/25 at 7:56 A.M., Resident #44 was in bed. There was no Broda chair in his/her vicinity. During an interview on 2/4/25 at 11:10 A.M., Resident #44 said he/she used to get up in a high (back) chair but has not got up and said his/her chair may have been left behind in his/her previous room when he/she moved last week. On 2/4/25 at 12:28 P.M., Resident #44 was observed in bed eating his/her lunch. No chair was in his/her vicinity. (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 2/4/25 at 1:02 P.M., Certified Nursing Assistant (CNA) #1 said Resident #44 is dependent on staff for transfers out of bed using a Hoyer lift (a mechanical lift). CNA #1 said Resident #44 recently moved rooms. CNA #1 said Resident #44 will get out of bed 2 to 3 times a week when he/she wants. CNA #1 said the Resident has a wheelchair which is usually in his/her room. CNA #1 looked in both Resident #44's old room and new room with the surveyor present and could not locate the Resident's Broda chair. At this time CNA #1 stopped an Occupational Therapist (OT) in the hallway and asked about Resident #44's chair. The OT said the Resident uses a Broda chair and at times refuses to get out of bed. The OT said she took the Broda chair at the end of last week to trial it for another resident. The OT said it had not been returned yet. Review of documentation provided by the OT indicated the the trial of the Broda chair for another resident as dated 1/31/24, indicating Resident #44 was without his/her Broda Chair for five days. During an interview and observation on 2/5/25 at approximately 10:50 A.M., Resident #44 said he/she had his/her chair back and wanted to get out of bed. Resident #44 said his/her left leg was hurting and getting out of bed helps. During an interview on 2/05/25 at 11:10 A.M., the Director of Nursing said they have enough equipment for mobility and Resident #44 should have had his/her chair available.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop a skin impairment care plan for one Resident (#33) out of a total sample of 31 residents. Findings include: Resident #33 was admitted to the facility in October 2022 with diagnoses including cerebral hemorrhage and hemiplegia. Review of Resident #33's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) exam and staff had assessed him/her to have moderate cognitive impairment. The MDS also indicated Resident #33 is dependent on staff for self-care and mobility tasks. Review of the wound physician note dated 1/30/25 indicated Resident #33 had a non-pressure wound on his/her sacrum for over 11 days measuring 1.4 x 1.3 x 0.1 cm (centimeters). Review of Resident #33's care plans failed to indicate a care plan for actual skin impairment was developed when the Resident's wound began. During an interview on 2/5/25 at 6:55 A.M., the Director of Nursing said Resident #33 developed a new wound on his/her buttocks with a self-inflicted scratch. The Director of Nursing said any resident with a newly developed wound should have a care plan for skin impairment developed.

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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 observations, interviews, and record review the facility failed to ensure care plans were reviewed with the interdisciplinary team (IDT) as required for one Resident (#69) out of a total sample of 31 residents. Specifically for Resident #69 the facility failed to review and revise the care plan related to the use of an air mattress. Findings include: Review of facility policy titled Care Plan- Nursing, dated October 7, 2021, indicated the following: -The care plan is to be reviewed and revised by all staff providing care or services for the resident at least 92 days following the completion of every MDS. The Care plan includes a statement of problem; reasonable, measurable and time limited goals; and specific interventions, along with the discipline responsible. -When there are changes in resident's condition, the comprehensive care plan is updated as needed to change goals, time frames or interventions. Resident #69 was admitted to the facility in October 2020 with diagnoses that include major depressive disorder and weakness. Review of Resident #69's most recent Minimum Data Set (MDS) Assessment, dated 12/4/24, indicated the Resident was unable to participate in a Brief Interview for Mental Status and was assessed by staff as having severe cognitive impairment. The MDS further indicated that the Resident is at risk for developing pressure ulcers. Review of Resident #69's Norton Assessment (an assessment to determine the risk of pressure ulcer development), dated 10/5/24 indicated a score of 7, indicating high risk for skin breakdown. Review of Resident #69's physician's orders indicated the following order dated as 2/9/24: -Air mattress setting at 100 lbs. (pounds). Monitor setting and functioning every shift for prevention of skin breakdown. -On 2/3/25 at 8:18 A.M. and 12:28 P.M., the surveyor observed Resident #69 lying in bed on an air mattress. The air mattress was set at 400 lbs. -On 2/4/25 at 8:02 A.M., the surveyor observed Resident #69 lying in bed on an air mattress. The air mattress was set at 100 lbs. Review of Resident #69's active care plan indicated the following care plan, initiated on 10/22/20: -[Resident] has Potential for Pressure ulcer r/t [related to] cognitive impairment, advanced age, end of life care, decreased mobility, incontinent of bowel and bladder. Interventions in the care plan included the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Peri-care after incontinent episodes, apply barrier cream, wears disposable adult Brief size: medium Pressure redistribution mattress on bed Reposition as [resident] allows with a draw sheet. The care plan failed to indicate the use of an air mattress and the required settings. During an interview on 2/5/25 at 10:30 A.M., Nurse #4 said that the use of an air mattress should be included in the care plan with settings so that all staff caring for the resident know the plan of care. She said the Resident is unable to change the settings on the air mattress independently. During an interview on 2/5/25 at 10:38 A.M., Unit Manager #2 said that yesterday afternoon she found the Resident's air mattress set to 400 and changed it to the correct setting. She said the air mattress was in place for prevention of skin breakdown. Unit Manager reviewed Resident #69's care plan and said that the air mattress was not addressed in the care plan, and it should have been. Unit Manager #2 updated the care plan at this time. She said that it should be in the care plan so that the Certified Nurse's Aides (CNA) know the settings for the air mattress because they do not have access to physician's orders but can pull up the care card for the Resident in their documentation portal to see the settings, if it is in the care plan. During an interview on 2/5/25 at 11:44 A.M., the Director of Nurses (DON) said that she would expect the use of the air mattress to be indicated the Resident's care plan so that the CNAs and other care staff are aware of the appropriate settings.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure a physician's order was implemented for three Residents (#28, #101 and #69) out of a total sample of 31 residents. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #28 was admitted to the facility in January 2024 with diagnoses including diabetes, chronic diabetic ulcer of the left foot, and tachycardia. Review of Resident #28's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #28 requires substantial assistance from staff for functional daily tasks. Review of Resident #28's physician orders indicated the following orders: -Bi-lat (bilateral) LE (lower extremity) ACE wraps, initiated 11/28/24. -Abdominal binder daily for orthostasis hypotension, every day and evening shift for Orthostatic Hypotension Wear when OOB (out of bed). May remove for ADLs, initiated 11/27/24 On 2/3/25 at 9:19 A.M., Resident #28 was observed in his/her room. The Resident was not wearing an abdominal binder and did not have an ace wrap to his/her right leg. On 2/4/25 at 8:51 A.M., 10:05 A.M., and 11:00 A.M., Resident #28 was observed in his/her room. The Resident was not wearing an abdominal binder and did not have an ace wrap to his/her right leg. During an interview on 2/4/25 at 10:10 A.M., Resident #28 said he/she never has an ace wrap to his/her right leg and has not worn his/her abdominal binder in a few weeks. During an interview on 2/5/25 at 7:48 A.M., Nurse #1 said all physician orders should be followed as written. Nurse #1 said she was unaware of Resident #28's order for bilateral ace wraps, and she did not complete the order as written. Nurse #1 said Resident #28 did not wear his/her abdominal binder on 2/4/25 as ordered. During an interview on 2/5/25 at 11:45 A.M., the Director of Nursing said all physician orders should be followed as written. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #101 was admitted to the facility in May 2024 with diagnoses including diabetes, adult failure to thrive and depression. Review of Resident #101's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #101 is dependent on staff for all functional tasks. Review of Resident #101's physician orders indicated the following orders: -Prevelon boots to bilateral feel on as tolerated, every shift, initiated on 7/22/24 -Monitor RUE (right upper extremity) edema elevate on pillow, every shift for edema notify MD (physician) if increased edema is noted or if pt (patient) c/o (complain of)pain, initiated on 11/22/24 On 2/3/25 at 8:21 A.M., Resident #101 was observed lying in bed. The Resident was wearing a prevalon boot on his/her left foot only and his/her right upper extremity was not elevated. There was no prevalon boot observed in the room and there was no pillow observed that could be used to elevate the Resident's arm. On 2/3/25 at 10:58 A.M., Resident #101 was observed lying in bed. The Resident was wearing a prevalon boot on his/her left foot only and his/her right upper extremity was not elevated. There was no prevalon boot observed in the room and there was no pillow observed that could be used to elevate the Resident's arm. On 2/3/25 at 4:06 P.M., Resident # 101 was observed sitting in broda chair with his/her arms resting on his/her lap, not elevated. The Resident was wearing a prevalon boot on his/her left foot only. On 2/4/25 at 6:40 A.M., 9:43 A.M., and 11:00 A.M., Resident #101 was observed lying in bed. The Resident was wearing a prevalon boot on his/her left foot only and his/her right upper extremity was not elevated. There was no prevalon boot observed in the room and there was no pillow observed that could be used to elevate the Resident's arm. During an interview on 2/5/25 at 7:48 A.M., Nurse #1 said all physician orders should be followed as written. Nurse #1 said she was unaware of Resident #101's physician orders for bilateral prevalon boots and elevation of the right upper extremity and that these orders were not followed. During an interview on 2/5/25 at 11:45 A.M., the Director of Nursing said all physician orders should be followed as written.3. Review of facility policy titled Skin Management Guideline, dated as revised August 17, 2022, indicated the following: -Assess the resident's skin on admission (within eight hours) for existing pressure ulcer/ injury risk factors or other skin conditions such as skin tears, bruising, surgical wounds, etc. Repeat the risk assessment weekly and upon any changes in condition. -Evaluate, report and document potential changes in the skin on the weekly skin check in the [electronic medical record] or in a daily progress note. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Document licensed nurse weekly skin assessment on the Treatment Administration Record (TAR) and UDA (user defined assessment) [in the electronic medical record]. Resident #69 was admitted to the facility in October 2020 with diagnoses that include major depressive disorder and weakness. Review of Resident #69's most recent Minimum Data Set (MDS) Assessment, dated 12/4/24, indicated the Resident was unable to participate in a Brief Interview for Mental Status and was assessed by staff as having severe cognitive impairment. The MDS further indicated that the Resident is at risk for for developing pressure ulcers. Review of Resident #69's Norton Assessment (an assessment to determine the risk of pressure ulcer development), dated 10/5/24 indicated a score of 7, indicating high risk for skin breakdown. Review of Resident #69's active care plan indicated the following care plan, initiated on 10/22/20: -[Resident] has Potential for Pressure ulcer r/t [related to] cognitive impairment, advanced age, end of life care, decreased mobility, incontinent of bowel and bladder. Review of Resident #69's physician's orders indicated the following order, dated 4/17/24: -Complete weekly Skin check, every Wednesday 3-11 shift. Review of Resident #69's Weekly Skin Assessments indicated that from August 2024 to February 2025 weekly assessments were completed on the following dates: -8/21/24, 8/28/24, 12/25/24, 1/15/25, and 1/29/25. Review of the medical record indicated that out of 26 opportunities, from 8/1/24 to 2/1/25 the weekly skin assessment was completed five times. Review of Resident #69's nursing progress notes failed to indicate that weekly skin checks had been completed as indicated in the physician's orders. Review of Resident #69's September, October and November 2024 Treatment Administration Record (TAR) was signed off indicating that skin checks were completed, when they were not. During an interview on 2/5/25 at 10:30 A.M., Nurse #4 said that skin checks are done weekly, and nurses should complete them based on physician's orders. Nurse #4 said that it should be signed off on the TAR, and then entered into the weekly assessment. During an interview on 2/5/25 at 10:38 A.N., Unit Manager #2 said that Resident #69 is at risk for skin breakdown. Unit Manager #2 said that skin checks are completed weekly, and the weekly skin assessment should be completed in the assessments tab in the electronic medical record. The Unit Manager reviewed completed assessments and said that they have not been completed as indicated in the physician's orders. She said that nurses should not sign off on physician's orders that they are not completing. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 11:44 A.M., the Director of Nursing said that she would expect orders to be followed as written. The process in the facility is weekly skin checks and they should be completed as indicated in the physician's orders. She further said that nurses should not sign off on physician's orders that they are not completing.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2a. For Resident #25 the facility failed to ensure the Resident was provided the necessary assistance and supervision during his/her meals. Resident #25 was admitted to the facility in January 2013 and has diagnoses that include unspecified dementia, anemia, major depressive disorder, osteoarthritis, and dysphagia, oropharyngeal phase (a disruption or delay in swallowing). Review of Resident #25's Minimum Data Set assessment, dated 11/20/24 indicated Resident #25 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately impaired cognition and required supervision/touching assistance for eating. During an observation on 2/3/25 at 8:28 A.M., Resident #25 was sitting up in bed approximately 60 degrees, using a fork and eating a cut up banana from his/her plate. The tray ticket indicated minced moist. There was no staff in the room at the time of the observation. Further observations on 2/3/24 included: -At 8:46 A.M., Resident #25 was slowly eating, with some of the food on his/her plate partially eaten. No staff were in his/her room providing supervision or touching assistance. -At 9:08 A.M., Resident #25 was touching his/her milk carton, was not actively eating, staring, with no staff were present. The plate of food was partially consumed. Review of Resident #25's medical record indicated the following: -A physician's order House diet Dysphasia Mechanical (minced and Moist-MM5) texture, thin (thin-TNO) consistency, Lip plate with meals. Add extra sauce/gravy with meals, active 9/12/24. -The Kardex dated as of 2/5/24 indicated Eating/Nutrition, allow ample time to complete meals with max 1:1 assist to increase endurance, encourage Resident to utilize safe swallow strategies-Allow whole banana, SOFT COOKIES, CAKE, MUFFINS and graham/saltine/peanut butter crackers at this time. NO SOLID DRY BREADS/TOAST. NO STRAWS. Review of the care plan with the focus: Resident presents to skilled ST (speech therapy) for cognitive and swallowing treatment dated 5/22/24. Interventions included: allow ample time to complete meals with max assist 1:1 assist to increase endurance, Position: (staff identified to provide the intervention) (C.N.A. (certified nursing assistant)). Encourage Resident to utilize safe swallow strategies, Position N (nurse) dated 6/5/2024. Review of the Activities of Daliy Living care plan printed and provided to the surveyor did not indicate the level of assistance Resident #25 required for eating. On 2/3/25 at 12:17 P.M., Resident #25 was observed up in a chair in his/her room. A lunch tray was in front of him/her. Resident #25 was not actively eating, nor was there any staff present in his/her room. Further observations on 2/3/25 included: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:27 P.M., Resident #25 using a fork in his/her right hand and was slowly eating, then he/she slowly picked up a glass, there was no staff present providing supervision or touching assistance. At 12:34 P.M., Resident remained in his/her room alone and eating slowly. At 12:46 P.M., Resident #25 had his/her head leaning on his/her right hand, and his/her left hand was resting inside of his/her soup bowl. Resident #25's plate was minimally consumed. There was no staff observed in Resident #25's room. On 2/4/25 at 8:09 A.M., 2 staff members were observed boosting Resident #25 in bed. One of the staff exited the room. Further observations on 2/4/25 included: At 8:11 A.M., staff set up the tray, exited the room returned with a towel, placed the towel on the Resident, assisted the resident to pick up a spoon, then the staff exited the Resident's room. From 8:15 A.M., till 8:21 A.M., Resident was using a spoon to eat his/her banana, and no staff was present to provide supervision or touching assistance. On 2/4/25 at 12:15 P.M., Resident #25 was observed sitting up in a chair in his/her room. Resident #25's lunch was on the tray in front of him/her. Resident #25 was holding Glucerna (a nutritional supplement drink). Further observations on 2/4/25 included: At 12:22 P.M., Resident #25 lunch tray was in front of him/her and some food was partially consumed. Resident #25 was staring and not actively eating. There was no staff present. At 12:27 P.M., Resident #25 was staring at the lunch tray, there was no staff present. At 12:30 P.M., a staff member entered the room and started to feed Resident #25. At 12:31 P.M., the staff member exited Resident #25's room. At 12:35 P.M., staff entered Resident #25's room and began feeding him/her. During an interview on 2/5/25 at 11:54 A.M., CNA #6 said Resident #25 requires staff to feed him/her, and there are times the Resident will use a spoon and try to feed him/herself but needs staff to supervise his/her during meals. During an interview on 2/05/25 at 12:07 P.M., the Director of Nursing said a resident who requires supervision for eating should have staff present. 2b. For Resident #55 the facility failed to ensure the Resident was assisted during meals in accordance with his/her plan of care. Resident #55 was readmitted to the facility in April 2024 and has diagnoses that include cognitive communication deficit, heart failure and dysphagia (a swallowing disorder). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #55's Minimum Data Set assessment, dated 12/18/24 indicated Resident #55 scored a 5 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severely impaired cognition and requires supervision/touching assistance with eating. During an observation on 2/3/25 at 8:50 A.M., Resident #55 was siting up in bed and had a partially consumed breakfast tray in front of him/her. Resident #55 was using adaptive utensils and his/hands were shaking. Resident #55 had some food particles on the front of him/her. There was no staff in Resident #55's room. Review of Resident #55's medical record indicated the following: -A physician's order, House Diet, regular (regular-RG7) texture, thin (thin-TNO) consistency, fortified foods BID (twice a day) -A Kardex dated as of 2/5/25 indicated: Oral/Nutrition follow safe swallow strategies, monitor coughing episodes and report increased wet productive cough during meals. Eating/Nutrition: Eating: Resident requires supervision for eating with use of weighted utensils at all meals. A care plan with focus: Resident presents to ST (speech therapy) due to increased coughing episodes during meals. Dated 7/27/24. Care Plan interventions included: Follow for safe swallow strategies, monitor coughing episodes and report increased wet productive cough during meals dated 7/27/24. An Activities of Daily Living care plan indicated: Resident has an ADL self-care performance deficit related to Activity Intolerance, Fatigue, Impaired Balance, Limited Mobility dated 11/2/2020. Interventions included: Eating: Resident requires supervision for eating with use of weighted utensils at all meals. On 2/3/24 the following observations were made during Resident #55's lunch meal: At 12:20 P.M., Resident #55 was sitting up in bed, with his/her meal in front of him/her. Resident #55 was drinking from a cup. No staff present. At 12:29 P.M., Resident #55 was sitting up in bed, he/she was chewing on pie and was heard coughing. Resident #55 continued to eat his/her pie, and no staff was present to support safe swallow strategies. At 12:39 P.M., Resident #55's hand had a bowl raised. Resident #55's hand had a tremor. Resident #55 coughed. No staff were present to provide supervision, safe swallow strategies or hear his/her coughing. At 12:45 P.M., Resident #55 pushed his/her partially consumed lunch away. No staff were present. On 2/04/25 the following observations were made during Resident #55's breakfast meal: At 8:07 A.M., Resident #55's breakfast tray was delivered, he/she was assisted by staff to sit up in bed. After staff set up the breakfast tray they exited the room. Resident #55 was not actively eating his/her meal and was heard clearing his/her throat. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:12 A.M., Resident #55 was not actively eating, his/her mouth was gaped open, and his/her eyes were closed. No staff were present. At 8:17 A.M., a staff member entered the room, woke him/her up and said they would come back and exited the room. At 8:22 A.M., Resident #55 was heard coughing. Staff then entered and began to assist Resident #55 with breakfast. Fifteen minutes had passed. On 2/4/25 at the following observation were made during Resident #55's lunch meal: At 12:11 A.M., Resident #55 was in bed with his/her lunch tray in front of him/her. There was no staff present. Resident #55 eyes were closed. At 12:26 P.M., After fifteen minutes where staff were not present to supervise, provide touching assistance, provide safe swallow strategies or monitor for wet coughing, staff entered the room and began feeding Resident #55. During an interview on 2/5/25 at 11:30 A.M., Certified Nursing Assistant (CNA) #5 said Resident #55 used to just need a set up for his/her meals but more recently Resident #55 needs someone to supervise and be with him/her during meals. CNA #5 said staff tried to go back and forth to the rooms of residents who requires supervision, but supervision means someone needs to be with the Resident. During an interview on 2/05/25 at 12:07 P.M., the Director of Nursing said a resident who requires supervision for eating should have staff present. Based on observations, record review and interviews, the facility failed to: 1) provide assistance with incontinence care for two Residents (#60 and #33) and 2) provide assistance with meals for two Residents (#25 and #55) out of a total sample of 31 residents. Findings include: Review of the facility policy titled, ADL (Activities of Daily Living) Policy, dated 1/2025, indicated the following: -Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent if the resident and in accordance with the plan of care, including appropriate support and assistance with: c. elimination (toileting) and d. toileting (meals and snacks). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Incontinence Policy, dated 1/2025, indicated the following: -The staff and practitioner will appropriately screen for, and manage, individuals with urinary and bowel incontinence. -If the resident does not respond and does not try to toilet, or for those with such severe cognitive impairment, staff will use the check and change strategy. -A check and change strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goal is to maintain dignity and comfort and to protect the skin. 1a. Resident #60 was admitted to the facility in November 2018 with diagnoses including chronic obstructive pulmonary disease. Review of Resident #60's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 9 out of a possible 10 on the Brief Interview for Mental Status (BIMS) exam, indicating he/she had moderate cognitive impairment. The MDS also indicated Resident #60 is frequently incontinent and is dependent on staff for toileting needs. Review of the Bowel and Bladder assessment dated [DATE], indicated Resident #60 is incontinent all the time, is never aware of need to toilet, and never voids appropriately without incontinence. The assessment also included a care plan intervention to check the Resident every two hours and assist with toileting as needed. Review of Resident #60's bladder incontinence care plan initiated on 5/27/23 indicated the following intervention: -Clean peri-area with each incontinence episode. Review of Resident #60's potential for skin impairment care plan initiated on 5/26/23 indicated the following interventions: -Clean peri-area with each incontinence episode -Provide peri-care after incontinence episodes, apply barrier cream, wears adult brief Review of Resident #60's activities of daily living care plan initiated on 5/26/23 indicated the following intervention: -(the Resident) requires total assist of 1 staff for toileting and incontinent care Review of the Documentation Survey Report for January and February 2025 indicated Resident #60 is incontinent of bowel and bladder daily. Review of Resident #60's Kardex (a form indicating the level of care required for a resident) indicated the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Clean peri-area with each incontinence episode. -(the Resident) requires total assist on 1 staff for toileting and incontinent care On 2/4/25 at 8:14 A.M., Resident #60's morning care had been completed by the Certified Nursing Assistant (CNA). From 8:00 A.M. until 11:15 A.M., the surveyor observed the hallway outside of Resident #60's room and did not see any staff enter his/her room to provide care or check for incontinence. During an interview on 2/4/25 at 12:46 P.M., CNA #1 said she often takes care of Resident #60 and that he/she is not always continent. CNA #1 said the Resident will use the call light for care however he/she often has already been incontinent. CNA #1 said she had provided morning care for Resident #60 but had not yet gone back in to check for or provide incontinence care. CNA #1 said she usually waits until after lunch to provide care again. During an interview on 2/04/25 at 1:01 P.M., CNA #1 said the Resident was still eating lunch so she was going on her break and would check on the Resident after she returned to the floor. On 2/4/25 at 1:43 P.M., CNA #1 entered Resident #60's room to provide incontinence care. The surveyor observed Resident #60's brief after care was provided. The brief was filled with a significant amount of stool and urine. During an interview on 2/4/25 at 1:00 P.M., Nurse #1 said residents who are incontinent should be changed every two hours or as needed. During an interview on 2/5/25 at 6:55 A.M., the Director of Nursing said rounds should be completed every couple of hours and any resident with known incontinence should be checked. The Director of Nursing said incontinent care should be provided during rounding and as needed. 1b. Resident #33 was admitted to the facility in October 2022 with diagnoses including cerebral hemorrhage and hemiplegia. Review of Resident #33's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) exam and staff had assessed him/her to have moderate cognitive impairment. The MDS also indicated Resident #33 is always incontinent and is dependent on staff for toileting tasks. On 2/4/25 at 7:59 A.M., Resident #33's morning care was completed by the Certified Nursing Assistant (CNA). From 8:00 A.M. until 11:15 A.M., the surveyor observed the hallway outside of Resident #33's room and did not see any staff enter his/her room to provide care or check for incontinence. Review of the Bowel and Bladder assessment dated [DATE], indicated Resident #33 is incontinent all the time, is never aware of need to toilet, and never avoids appropriately without incontinence. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #33's bladder incontinence care plan initiated on 10/21/22 indicated the following intervention: -BRIEF USE: The resident uses disposable briefs. Check and change q2 (every 2) hours and prn (as needed). Review of Resident #33's potential for skin impairment care plan initiated on 10/21/22 indicated the following interventions: --BRIEF USE: The resident uses disposable briefs. Check and change q2 hours and prn -Clean peri-area with each incontinence episode apply barrier cream, wears adult brief Review of Resident #33's activities of daily living care plan initiated on 10/21/22 indicated the following intervention: -Toileting hygiene: (the Resident) is dependent, and the helper provides all the effort to complete activity. Review of the Documentation Survey Report for January and February 2025 indicated Resident #33 is incontinent of bowel and bladder daily. Review of Resident #33's Kardex (a form indicating the level of care required for a resident) indicated the following: -Check resident every two hours and assist with toileting as needed -Clean peri-area with each incontinence episode. -Provide pericare after each incontinent episode -Toileting Hygiene: (the Resident is dependent, and the helper provides all the effort to complete the activity. During an interview on 2/4/25 at 1:00 P.M., Nurse #1 said residents who are incontinent should be changed every two hours or as needed. During an interview on 2/4/25 at 12:40 P.M., CNA #2 said she had provided morning care for Resident #33 this morning and had not gone in again to check for possible incontinence or to check the Resident. During an interview on 2/5/25 at 6:55 A.M., the Director of Nursing said rounds should be completed every couple of hours and any resident with known incontinence should be checked. The Director of Nursing said incontinent care should be provided during rounding and as needed.

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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. Based on record review and interview the facility failed to ensure services consistent with professional standards were provided for one Resident (#75) who required dialysis (a procedure to remove waste products and excess fluid from the body when the kidneys stop working properly), out of total sample of 31 residents. Specifically, the facility failed to follow physician's orders to ensure that blood pressure readings were not taken on the arm where the dialysis shunt (an access point from the dialysis machine to a blood artery) is located. Findings include: Review of facility policy titled Home Dialysis Program: Hemodialysis Access Site Care, dated November 1, 2023, indicated the following: -Care of AVFs (arteriovenous fistula): -h. Do not use the access arm to take blood pressure. Resident #75 was admitted to the facility in October 2022 with diagnoses that include end stage renal disease, dementia and diabetes. Review of the most recent Minimum Data Set (MDS) Assessment, dated 1/1/25, indicated that the Resident was unable to complete the Brief Interview for Mental Status and was assessed by staff as having moderately impaired cognition. The MDS further indicated that the Resident received dialysis. On 2/05/25 at 10:24 A.M., the surveyor observed Resident #75 in bed with a bracelet to the left wrist indicating no blood pressures on that arm. The Resident was unable to say why he/she had the bracelet on his/her wrist. Review of Resident #75's physician's orders indicated the following: -No B/P (blood pressure) On left arm every shift for AV (arteriovenous) Fistula Placement, dated 1/10/24. -Monitor left AV Fistula for Bruits and Trills every shift for HD (hemodialysis), dated 1/10/24. Review of Resident #75's active care plan indicated the following: -A care plan that indicated the Resident is at risk for complications and requires on-going dialysis due to end stage renal disease with interventions that included do not draw blood or take B/P in left arm with fistula. Review of Resident #75's blood pressure readings in the electronic medical record (EMR) indicated the following: -34 times in January 2025 blood pressure was documented as taken on left arm. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Four times in February 2025 between 2/1/25 and 2/4/25 blood pressure was documented as taken on the left arm. During an interview on 2/5/25 at 10:30 A.M., Nurse #4 said that Resident #75 has a fistula to his/her left arm, and you cannot draw blood or take blood pressures on that arm. She said staff should not be documenting blood pressures taken on the left arm. During an interview on 2/5/25 at 10:51 A.M., Unit Manager #2 said that staff should not be obtaining blood pressures on the left arm and documenting it in the medical record. She further said that Resident #75 is not able to tell staff not to use his/her left arm for blood pressures. During an interview on 2/5/25 at 11:54 A.M. the Director of Nursing said that when a resident has a fistula, no blood draws or blood pressures should be taken on that arm. She would expect that staff are not taking blood pressures on Resident #75's left arm and are documenting accurately in the medical record.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to complete annual Certified Nurse Aide (CNA) performance reviews for 2 out of 2 eligible sampled CNAs. Findings include: During review of 3 CNA employee records, the Surveyor was unable to locate annual performance reviews for 2 out of 2 eligible CNAs. The third CNA had not yet been at the facility for a year. During an interview on 2/05/25 at 11:33 A.M., the Human Resource Director said the annual reviews were not completed and he was unsure why. During an interview on 2/5/25 at 11:45 A.M., the Director of Nursing was unable to say why the annual reviews had not been completed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure medications were stored in accordance with professional standards of practice. Specifically, 1 Medication used for Residents #15 and #18 were left unsecured in the resident's room, 2 Medication carts were left unattended and opened 3. Keys to the medication cart were left on top of the cart and unattended, and 4. Medication was administered and left by the bedside of a resident. Findings include: Review of the Manual title: LTC Facility's Pharmacy Services and Procedure Manual indicated the following: The Policy 5.3 sets for the procedures relating to the storage and expiration date of medications, biologicals, syringes and needles. Procedure 1 Facility should ensure that only authorized Facility staff, as defined by Facility, should have procession of the keys, access cards, electronic code, or combinations which open medication storage areas. 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that in inaccessible to by residents or visitors. 1a. Resident #15 was admitted to the facility in July 2022 with diagnoses that include chronic obstructive pulmonary disease and colostomy status. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #15 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition. During an observation and interview on 2/3/25 at 8:32 A.M., Resident #15 was sitting on the side of his/her bed. A tube of ointment labeled clotrimazole betamethasone was on his/her tray table. Resident #15 said the staff use it for his/her stoma. Review of Resident #15's medical record failed to indicate an assessment for self-administration of medications (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #15's current physician's orders failed to indicate an order to self-administer medications. Further review of Resident #15's physician's order indicated the following: -Lotrisone Cream 1-0.05% (clotrimazole Betamethasone) apply to stoma area topically two times a day for skin condition. On 2/3/25 at 12:19 P.M., Resident #15 was observed in his/her room eating lunch, the tube of clotrimazole Betamethasone ointment was on his/her tray table next to his/her meal tray. On 2/04/25 at 6:58 A.M., Resident #15 was resting in bed. A tube of clotrimazole betamethasone ointment was observed on the tray table. During an observation and interview on 2/4/25 at 9:57 A.M., Nurse #2 said she did not know of any residents who are assessed for self-administration of medication. Nurse #2 said all treatments are stored in the treatment cart and should not be left in a resident's room. On 2/4/25 at approximately 10:30 A.M., Nurse #2 and the surveyor observed two tubes of ointment on Resident #15's bedside table. 1b. For Resident #18 the facility failed to ensure topical medication used to treat a rash was stored safely. Resident #18 was admitted to the facility in November 2021 and has diagnoses that include acute and chronic respiratory failure. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #18 scored 15 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having intact cognition and is dependent on staff for bathing and toileting. Review of Resident #18's medical record indicated an administration informed consent assessment dated [DATE] that indicated I wish to have the Med nurse administer my medications Review of the physician's orders indicated the following: Hydrocortisone External Cream 1% (topical) Apply to left posterior shoulder topically two times day for left posterior shoulder rash. Active 11/13/24. During an interview and observation on 2/3/25 at 8:16 A.M., Resident #18 was observed in bed with oxygen being administered via a nasal cannula. On the windowsill next to the Resident was a tube of hydrocortisone cream and a box with a tube of hydrocortisone. Resident #18 said he/she could not apply the ointment him/herself. On 2/3/25 at 12:32 P.M., one tube and one box of hydrocortisone was observed on the windowsill next to Resident #18's bed. On 2/3/25 at 3:52 P.M., one tube and one box of hydrocortisone was observed on the windowsill next to Resident #18's bed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 9:57 A.M., Nurse #2 said all treatments are to be stored in the treatment cart. Nurse #2 and the surveyor observed the hydrocortisone ointment and box of hydrocortisone on Resident #18's windowsill. Nurse #2 said Resident #18 could not apply the treatment him/herself, had an order for the hydrocortisone topical cream and it should be stored in the treatment cart and not in the Resident's room.2. On 2/3/25 at 7:15 A.M., the surveyor observed a medication cart left open and unattended the nurse was off the unit. During an interview on 2/3/25 at 7:15 A.M., Nurse #7 said he locked the medication cart before he left the unit and did not know why it was still unlocked. He said medications carts are to be locked at all times if nurse On 2/3/25 at 9:15 A.M., the surveyor observed a nurse walk away from her medication cart and briefly go into a resident room, the nurse left the top drawer wide open. 3 During a medication pass on the second-floor unit, the surveyor observed the following: On 2/4/25 at 8:44 A.M., the surveyor observed Nurse #5 leave his medication cart open at the nurse's station and went to administer medication into a resident room. 3. On 2/4/25 at 8:45 A.M., as Nurse #7 was administering medications to the resident, the surveyor observed a medicine cup with one capsule (yellow/green). The Resident said that was his/her medication from last night that the nurse had left, and he/she was too sleepy to take. The pill was identified as Flomax (a medication used to treat benign prostatic hyperplasia). 4. On 2/4/25 at 9:32 A.M., Nurse #7 left his medication cart keys on top of the medication cart and went into a resident room to administer medications, the medication cart was not in the direct view of the nurse. During an interview on 2/4/25 at 9:35 A.M., Nurse #7 said medication carts should be locked while unattended, medication keys always kept with the nurse and nurses are to ensure residents take all their medications before leaving the room. He said not unless the residents are assessed for self-administration. During an interview on 2/5/25 at 7:20 A.M., the Director of Nursing said medications carts are to be locked while unattended, medication cart keys are to be on the person at all times and nurses should ensure all medications are taken by the residents before they leave or unless the residents have been assessed for self-administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed 1. Ensure food items were properly dated and stored in the main kitchen. 2. Ensure food items and food preparation equipment were not stored with chemicals. Findings include: Review of the facility's Food Storage Guideline, effective date January 3, 2022, indicated: Policy Statement Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination. 4. Chemical must be clearly labeled, kept in original containers, when possible, kept in a locked areas and stored away from food. 8. Plastic containers with tight-fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables and broken lots of bulk foods or open packages. All containers or storage bags must be legible and accurately labeled and dated. 11. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. 12 Refrigerated food storage: f. All food should be covered, labeled, and dated and routinely monitored to assure that foods parentheses (including leftovers) will be consumed by their safe use by dates, or frozen where applicable, or discarded. 13. Frozen foods: c. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. During an interview and observation of the main kitchen on 2/3/25 at 7:16 A.M., the following was observed: At 7:19 A.M., the walk-in refrigerator was left open with no staff present going in or out. At 7:20 A.M., kitchen staff closed the door. At 7:20 A.M., the Food Service Director observed the kitchen with the surveyor and the following observations were made: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The gasket around the milk chest cover, used to seal the chest had an area that was pulled away and not secured around the cover. The chest contained individual milk cartons. The FSD said it has been that way for a few weeks and has not impacted the internal temperature at this time. The FSD said he did email to company to have it fixed. A box of bananas and box of potatoes stored on the floor, next to a container that the FSD said contained used cleaning rags. The FSD said the banana and potatoes should not be on the floor. Observation of the walk-in freezer revealed the following: The floor had debris on it. A plastic bag tied in a knot of meatballs not labeled or dated. An open box of pie shells not labeled or dated. A plastic wrapped meat product not labeled or dated, the FSD said it was boloney. A box with an internal bag that was opened and not secured, of frozen omelets did not have an open date. The top of a frozen omelet had a buildup of ice particles. The FSD said food items should be sealed and have the date they were opened. Observation of the walk-in refrigerator indicated the following: An open bag tied in a knot of coleslaw mix was not labeled or dated. A container with muffins was not labeled or dated. Observation of the dry food storage area revealed the following: A packet of taco seasoning was opened and not dated. A large, opened bag tied in a knot of toasted oat cereal was not labeled or dated. An open bag tied in a knot of dry past was not labeled or dated. The FSD said food that is opened should be labeled, dated and secured in a sealed bag or container. On 2/5/25 at 9:42 A.M., the surveyor with the FSD and Regional FSD conducted a tour of the kitchen resulting in the following observations: A storage cabinet in the food preparation area had the following: - parts to food preparation equipment, including a large whisk, -a can of stainless-steel cleaner and polish, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-a bottle of Liquid Cream Cleanser that was covered with brown debris and dented, -a bag of dry beef stew mix, -a box of food that the Regional FSD said was ethnic food, -1 can of oven cleaner, -a box of food scrubbers, -boxes of gloves. The FSD said it is not policy to store chemicals with food or appliances for food preparation. Observation of the walk-in freezer revealed a box containing an open bag of omelets. An omelet had a thin layer of ice. The FSD said he expects the staff to follow the policy of securing the bag and dating the food when opened. The Regional FSD said food should not have ice crystals on it. During an observation of the dry storage room the following was observed: 1 open bag, tied in a knot of toasted oat cereal not labeled or dated. 1 open bag, tied in a knot of pasta, not labeled or dated. The FSD said food items should be labeled, dated with the date it was opened.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, record review and interview the facility failed to ensure garbage and trash were disposed of properly. Specifically, the area around the two dumpsters had a large volume of various debris, garbage and trash. Findings include: Review of the facility Guideline: Waste Policy, revision date 1-2025 indicated Garbage will be disposed of as needed throughout the day and the end of each day. Guideline: 1. Prior to disposal, all waste shall be kept in leak-proof, non-absorbent, fireproof containers that are kept covered when not in use. 2. Containers will be emptied as often as necessary throughout the day and at the end of each day. Trash bags will be sealed prior to removing then from the facility. Trash will be deposited into a sealed container outside the premises. 5. Dumpsters will be emptied and maintained on a schedule determined by vendor. Dumpster lid will be closed to contain trash when not in use. During an observation and interview on 2/5/25 at 10:16 A.M., the Food Service Director (FSD) and Surveyor observed the area where two dumpsters were located outside the facility. Upon reaching the area the FSD said often there is no room in the dumpster so staff leave trashed bags outside of the dumpster. With the FSD present the surveyor made the following observation: -The ground in front of the left dumpster was covered with various debris. - The area between the two dumpsters had an accumulation of trash on the ground including gloves, unidentified debris, a decomposing flat box, many plastic lids, wet/decomposing papers, condiment containers, small milk cartons, plastic forks, stacked cardboard, a box of oatmeal pies, yogurt containers, 2 chairs, a broken tray table. -The back of the dumpster on the left had at least three full trash bags piled next to the dumpster. One bag was open with the contents spilling out. The area surrounding the trash bags had an abundance of accumulated trash which not all could be identified. There was an accumulation of food container debris including multiple milks cartons, plastic covers, juice containers, plastic utensils, a large unlabeled crushed can covered in dirt, plastic lids, condiment containers, plastic bowls, deterioated paper plates. The FSD said the trash should be contained and staff are leaving the bags outside of the dumpster. The FSD said he did not know how the trash bag became opened and said that by having all the trash around the dumpsters it creates a risk for mice and rats. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/05/25 at 12:37 P.M., the Maintenance Director said all trash should be contained. The Regional Maintenance Director said having trash not contained increases the risk for having mice and rats.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure accurate medical records were completed for three Residents (#28, #101 and #33) out of a total sample of 31 residents. Specifically, 1) for Residents #28 and #101 the facility failed to ensure physician orders were documented accurately and 2) for Resident #33 skin assessments were completed accurately. Findings include: 1a. Resident #28 was admitted to the facility in January 2024 with diagnoses including diabetes, chronic diabetic ulcer of the left foot, and tachycardia. Review of Resident #28's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #28 requires substantial assistance from staff for functional daily tasks. Review of Resident #28's physician orders indicated the following orders: -Bi-lat (bilateral) LE (lower extremity) ACE wraps, initiated 11/28/24. -Abdominal binder daily for orthostasis hypotension, every day and evening shift for Orthostatic Hyptotension Wear when OOB (out of bed). May remove for ADLs, initiated 11/27/24 On 2/4/25 at 8:51 A.M., 10:05 A.M., and 11:00 A.M., Resident #28 was observed in his/her room. The Resident was not wearing an abdominal binder and did not have an ace wrap to his/her right leg. During an interview on 2/4/25 at 10:10 A.M., Resident #28 said he/she never has an ace wrap to his/her right leg and has not worn his/her abdominal binder in a few weeks. Review of the February 2025 Treatment Administration Record indicated the nurse documented the physician orders for abdominal binder and bilateral ace wraps were completed on 2/4/25. During an interview on 2/5/25 at 7:48 A.M., Nurse #1 said all physician orders should be followed as written and should never be marked as completed if not actually done. Nurse #1 said she was unaware of Resident #28's order for bilateral ace wraps, did not complete the order as written, and should not have marked the order as completed. Nurse #1 said Resident #28 did not wear his/her abdominal binder on 2/4/25 as ordered because it was in the laundry, and she should not have marked the order as completed. During an interview on 2/5/25 at 11:45 A.M., the Director of Nursing said physician orders should only be documented as completed if the order was done. 1b. Resident #101 was admitted to the facility in May 2024 with diagnoses including diabetes, adult failure to thrive and depression. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #101's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, which indicated he/she had moderate cognitive impairment. The MDS also indicated Resident #101 is dependent on staff for all functional tasks. Review of Resident #101's physician orders indicated the following orders: -Prevelon boots to bilateral feel on as tolerated, every shift, initiated on 7/22/24 -Monitor RUE (right upper extremity) edema elevate on pillow, every shift for edema notify MD (physician) if increased edema is noted or if pt (patient) c/o (complain of)pain, initiated on 11/22/24 On 2/3/25 at 8:21 A.M., Resident #101 was observed lying in bed. The Resident was wearing a prevalon boot on his/her left foot only and his/her right upper extremity was not elevated. There was no prevalon boot observed in the room and there was no pillow observed that could be used to elevate the Resident's arm. On 2/3/25 at 10:58 A.M., Resident #101 was observed lying in bed. The Resident was wearing a prevalon boot on his/her left foot only and his/her right upper extremity was not elevated. There was no prevalon boot observed in the room and there was no pillow observed that could be used to elevate the Resident's arm. On 2/3/25 at 4:06 P.M., Resident # 101 was observed sitting in broda chair with his/her arms resting on his/her lap, not elevated. The Resident was wearing a prevalon boot on his/her left foot only. On 2/4/25 at 6:40 A.M., 9:43 A.M., and 11:00 A.M., Resident #101 was observed lying in bed. The Resident was wearing a prevalon boot on his/her left foot only and his/her right upper extremity was not elevated. There was no prevalon boot observed in the room and there was no pillow observed that could be used to elevate the Resident's arm. Review of the February 2025 Treatment Administration Record indicated the nurse documented the physician orders for elevation of the right arm and bilateral prevalon boots were completed on 2/3/25 and 2/4/25. During an interview on 2/5/25 at 7:48 A.M., Nurse #1 said all physician orders should be followed as written. Nurse #1 said she was unaware of Resident #101's physician orders for bilateral prevalon boots and elevation of the right upper extremity and that these orders were not followed. Nurse #1 said she should not have marked these orders as completed. During an interview on 2/5/25 at 11:45 A.M., the Director of Nursing said physician orders should only be documented as completed if the order was done. 2. Resident #33 was admitted to the facility in October 2022 with diagnoses including cerebral hemorrhage and hemiplegia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #33's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status (BIMS) exam and staff had assessed him/her to have moderate cognitive impairment. The MDS also indicated Resident #33 is dependent on staff for self-care and mobility tasks. Review of the wound physician note dated 1/22/25 indicated Resident #33 had a non-pressure wound on his/her sacrum for 3 days measuring 1.4 x 1.7 x 0.1 cm (centimeters). Review of Resident #33's weekly skin assessment completed 1/29/25 failed to indicate Resident #33's sacral wound. Review of the wound physician note dated 1/30/25 indicated Resident #33 had a non-pressure wound on his/her sacrum for over 11 days measuring 1.4 x 1.3 x 0.1 cm (centimeters). During an interview on 2/4/25 at 8:43 A.M., Nurse #2 said weekly skin assessments are completed on all residents and any skin impairment should be included on the assessment. During an interview on 2/5/25 at 6:55 A.M., the Director of Nursing said any skin impairment observed should be documented on the weekly skin assessment to ensure accurate documentation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment that prevents the development and transmission of communicable diseases and infections for five Residents (#89, #33, #84 , #15 and #217) out of a total sample of 31 Residents. The facility also failed to implement and follow Enhanced Barrier Precautions (EBP) and droplet precautions for residents who were positive for influenza. Specifically, 1. For Resident #89 and Resident #33, the facility failed to maintain infection control practices during a wound dressing change 2. For Resident #84 and Resident #15, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented in accordance with the infection prevention control program. 3. For Resident #217, the facility failed to ensure isolation/droplet precaution signage was applied on the Resident's door. 4. The facility failed to follow Enhanced Barrier Precautions on one out of three units 5. The facility failed to follow Droplet Precautions for residents who have influenza on two out of three outs. Findings include: Review of Facility policy titled Infection Prevention and Control dated as revised January 16, 2024 indicated the following: -An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. -Prevention of infection: Important facets of infection prevention include: -Educating staff and ensuring that they adhere to proper techniques and procedures. -Implementing appropriate isolation precautions when necessary. Review of facility policy titled Policy Glove use, dated as 1/24/25 indicated the following: -Gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin. -Wash hands after removing gloves. May use alcohol gel. Review of facility policy titled Dressing Change, dated as revised on 1/2025, indicated the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Rehab & Nursing Care Center	321 Centre Street Dorchester, MA 02122

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Steps in the Procedure: 3. Tape a biohazard or plastic bag on the bedside stand or use a waste basket below the clean field. 5. Wash and dry your hands thoroughly. May use alcohol gel. 6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. May use alcohol gel. 9. Open dry clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. 12. Wash and dry your hands thoroughly, May use alcohol gel. 13. Put on clean gloves. 15. Cleanse the wound with ordered cleanser 17. Apply the ordered dressing. 19. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. 1a. Resident #89 was admitted to the facility in April 2024 with diagnoses that include pressure ulcer of the sacral region, stage 4, pressure ulcer of the left heel stage 4 and pressure ulcer of the right heel stage 4. Review of Resident #89 most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/25/25, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating that the Resident is cognitively intact. The MDS further indicated that the resident has one or more unhealed pressure ulcers, indicating three stage 4 pressure ulcers that were present on admission to the facility. Review of the Consulting Wound Physician's note dated 1/30/25 indicated that Resident #89 had a stage 4 pressure ulcer to their sacrum, a stage 4 pressure ulcer to the left heel and a stage 4 pressure ulcer to the right heel. A stage 4 pressure ulcer extends below the subcutaneous fat into deep tissues, including muscle, tendons and ligaments. In severe cases, they can even reach the cartilage or bone posing a high risk of infection. Review of Resident #89's physician's orders indicated the following: - Left heel cleanse area with wound cleanser, gently pat dry. Calcium Algenate, foam silicone boarder. Wrap with kerlix. Off- loading boot when out of bed and as needed, dated 2/4/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Right heel cleanse area with wound cleanser, gently pat dry. Calcium Alginate, foam silicone boarder. Wrap with kerlix. Offloading boot when out of bed and as needed, dated 2/4/25. - Sacral wound: NSW [normal saline wash], pat dry, apply Skin prep to peri wound, apply alginate calcium pack into wound bed, cover with Foam silicone boarder daily, dated 11/13/24. Review of Resident #89's active plan of care indicated the following care plan, dated June 2024: -Resident has osteomyelitis (an infection in the bone) of sacrum related to stage 4 pressure injury. On 2/4/25 at 11:13 A.M., the surveyor observed Nurse #4 perform wound care and dressing changes to Resident #89's sacral wound as well as the left and right heel wounds. The following observations were made: -Nurse #4 set up a trash bag on the Resident's bag, at the level of the wounds and utilized it to dispose of soiled dressings and other soiled materials used during the dressing change. -After cleansing the sacral wound, Nurse #4 removed her gloves, and applied new gloves without sanitizing her hands between glove use. -After completing the sacral wound dressing, Nurse #4 removed her gloves, sanitized her hands and applied new gloves. She then removed the right heel dressing, and without changing gloves or sanitizing her hands, she removed the left heel dressing as well. - After removing both heel dressings, she sanitized her hands, applied new gloves and continued to provide the treatment to both the left and right heel at the same time, moving back and forth between the two wounds. During an interview on 2/4/25 at 2:02 P.M., the Director of Nurses, who is also the Infection Preventionist for the facility said that she would expect hand hygiene in between all glove changes, and she would expect that one wound treatment is being completed at a time. She also said that the trash bag should not have been on the Resident's bed. During an interview on 2/5/25 at 10:26 A.M., Nurse #4 said that she should have sanitized her hands between all glove changes and should have only changed the dressing for one wound at a time. During an interview on 2/5/25 at 10:48 A.M., Unit Manager #2 said that she would expect hand hygiene between all glove changes, and that only one wound should be dressed at a time to prevent the spread of any potential infections. 1b. Resident #33 was admitted to the facility in October 2022 with diagnoses that include nontraumatic intracerebral hemorrhage in cerebellum and abnormal weight loss. Review of Resident #33's most recent Minimum Data Set (MDS) Assessment, dated 1/13/25, indicated that the Resident was unable to complete a Brief Interview for Mental Status and was assessed by staff as having moderate cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #33's physician's orders indicated the following: Cleanse wound right buttock with Normal Saline Spray pat dry apply house barrier cream every day shift on even days for right buttock wound, dated 2/2/25. -House Barrier Cream - apply to coccyx, buttocks, and groin every shift for preventative skin care every shift for prevention, dated 11/7/24. On 2/4/25 at 12:53 P.M., the surveyor observed Nurse #2 perform wound to Resident #33's right buttock. The following observations were made: -Nurse #2 performed hand hygiene, then opened the treatment cart draw to take out supplied and place them on top of the treatment cart. Nurse #2 then rolled multiple gloves and the treatment supplied in a paper towel, entered Resident #33's room and rolled out the paper towel with the gloves and supplied on the Resident's bedside table. -Nurse #2 then sanitized her hands and applied gloves. With her gloved hands, she was utilizing the bed controller to raise the height of the Resident's bed, and then assisted the resident in removing a brief to access his/her right buttock. Without changing her soiled gloves, she cleansed the Resident's buttock. While cleaning the Resident's buttock, she cleaned between the resident's buttock, wiping stool from the buttock, and then patting the same gauze over the superficial area on the Resident's buttock twice. - Nurse #2 then removed her gloves and applied clean gloves without performing hand hygiene and applied barrier cream, as ordered, to the Resident's buttock. -Nurse #2 then removed her gloves and without performing hand hygiene, applied clean gloves, and assisted the resident in changing his/her brief. During an interview on 2/4/25 at 1:59 P.M., the Director of Nurses, who is also the Infection Preventionist for the facility said that hand hygiene should be performed between all glove changes. She also said that when cleaning the wound, Nurse #2 should not have patted the open area with a gauze that had stool on it from cleaning up the resident.3. For Resident #217, the facility failed to ensure isolation/droplet precaution signage was applied on the Resident's door. Review of facility policy titled 'Transmission Based Precautions' dated December 2019, indicated the following but not limited to: -When transmission-based precautions are implemented, the infection preventionist (or designee): - Clearly identify the type of precautions, the anticipated durations, and the personal protective equipment (PPE) that must be used. -Determines the appropriate notification on the room entrance door so that personnel and visitors are aware of the need for and type of precautions. -The signage informs the staff of the type of Centers for Disease Control (CDC) precaution(s), instructions for use of PPE, and /or instructions to see a nurse before entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #217 was admitted to the facility in January 2025 with diagnoses including maxilla (facial) fractures. Review of Resident #217's Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 8 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was moderately cognitively impaired. On 2/3/25 at 8:58 A.M., Resident #217 doorway had an Enhanced Barrier Precaution (EBP) signage at the door. The surveyor observed Resident #217 lying in his/her bed. On 2/3/25 at 9:00 A.M., the surveyor observed staff going in and out of the Resident's room wearing surgical masks only. On 2/3/25 at 12:44 P.M., a Certified Nursing Assistant was observed delivering a lunch tray to the Resident and only wearing a surgical mask. The CNA assisted the Resident with the tray set up in the room. On 2/4/25 at 8:10 A.M., the surveyor observed Resident #217's doorway with an EBP signage. On 2/4/25 at 8:10 A.M., the surveyor observed CNA #3 enter the Residents room wearing only a surgical mask. CNA #3 said most rooms on the unit have the EBP sign on the door and staff only need to wear full PPE (personal protective equipment) when giving direct care to the residents. Review of Resident #217's medical record indicated the following: -On 1/31/25 Resident #217 tested positive for influenza A -A physician order dated 1/31/25: isolation precaution (droplet/contact). All nursing care and therapy to be done in room every shift. -A physician order dated 1/31/24: Tamiflu oral capsule 30 mg (milligram) give one capsule by mouth two times a day for influenza treatment for 5 days. During an interview on 2/4/25 at 8:09 A.M., Charge Nurse #3 said the Resident had tested positive for the influenza and should have been on droplet precaution, she said the signage on the door should say isolation/droplet precaution for staff to be aware what PPE to wear. 4. During an observation on 2/4/25 at 10:46 A.M., the surveyor observed a Certified Nurses Aide (CNA) changing linen while the resident was in bed, without the use of PPE (Personal Protective Equipment). A sign on the resident ' s door indicated that the resident was on Enhanced Barrier Precautions. The CNA said that she was changing the bed because the resident felt hot, but said she should not have handled the linen and changed the bed without appropriate PPE (personal protective equipment). During an interview on 2/4/25 at 1:37 P.M., the Director of Nursing who is also the Infection Preventionist for the facility said that she would expect that Enhanced Barrier Precautions would be implemented for all high contact care, including changing and handling linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of facility policy titled Transmission Based Precautions, dated as revised May 5, 2023, indicated the following: -Droplet Precautions: used for diseases or germs that are spread in tiny droplets caused by coughing and sneezing (examples: respiratory MRSA [Methicillin-resistant Staphylococcus aureus] pneumonia, influenza, whooping cough, bacterial meningitis, RSV [Respiratory syncytial virus], Covid-19). Droplet precaution signs throughout the facility indicated the following: Staff and providers must: -Clean hands: when entering and exiting. -Gown- change between each resident. -N95 Respirator (face mask is acceptable if N95 not available). -Eye Protection (goggles or face shield). -Gloves- change between each resident. During an observation on 2/3/25 at 7:11 A.M., on the second-floor unit the surveyor observed two staff members enter a resident room wearing only a surgical mask. A sign on the doorway indicated that the resident was on droplet precautions. The staff member did not perform hand hygiene when entering or exiting the room. There was a precaution cart outside of the resident ' s room, with no PPE (personal protective equipment, including gloves, gowns, masks) inside the cart. During an observation on 2/3/25 at 7:33 A.M., on the second- floor unit, the surveyor observed three precaution carts outside of resident rooms that indicated the residents were on droplet precautions without any PPE in them. During an observation on 2/3/25 at 8:16 A.M., the surveyor observed an Activities Assistant entering and hanging calendars in a resident room wearing only a surgical mask. A sign on the doorway indicated that the resident in that room was on droplet precautions. The Activities Assistant said she is new here and sanitizes her hands between resident rooms. She said she was not sure why this resident was on precautions. During an observation on 2/3/25 at 9:03 A.M., the surveyor observed a staff entering a resident room on the second- floor unit with no PPE. The sign on the resident ' s door indicated that the resident was on isolation/ droplet precautions. During an observation on 02/3/25 at 8:39 A.M., on the third- floor unit, a Certified Nursing Assistant (CNA) was feeding a resident wearing a mask and no other PPE. The sign next to the entrance of the resident room, indicated droplet precautions. The CNA exited the resident's room carrying the meal tray, went to the food cart in the hall, touched the cart, placed the tray in the cart and continued down the hall. The CNA did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/3/25 at 12:22 P.M., the surveyor observed a staff member on the third-floor unit assisting a resident with their lunch meal. The staff member was wearing only a surgical mask. The sign on the resident ' s door indicated that the resident was on droplet precautions. During an observation on 2/3/25 at 12:36 P.M., the surveyor observed a staff member exit a room on the third floor of a resident on droplet precautions with a dirty lunch tray, placed it in the meal truck, then proceeded to another resident room without performing hand hygiene and removing the dirty lunch tray to put into the meal cart, again no hand hygiene was performed. The staff member then entered another resident room, without performing hand hygiene, touched the tray table, raised up the bed and said to the resident, time to eat. During an observation on 2/4/25 at 6:43 A.M., a CNA was observed providing care to a resident on the third-floor unit. The CNA was wearing only a surgical mask. A sign on the resident ' s door indicated that the resident was on droplet precautions. During an observation on 2/4/25 at 8:19 A.M., a staff member entered a resident room on the third-floor unit wearing only a surgical mask. The sign on the resident ' s door indicated that the resident was on droplet precautions. There was a precaution cart outside of the resident ' s door with PPE in the cart for use. During an observation on 2/4/25 at 9:48 A.M., a nurse on the second floor entered a resident ' s room wearing only a surgical mask and stood next to the resident conversing. A sign on the resident ' s door indicated that they were on droplet precautions. During an observation on 2/4/25 at 10:18 A.M., a nurse entered a resident room on the third-floor unit wearing only a surgical mask. A sign on the resident ' s door indicated that the resident was on droplet precautions. During an interview on 2/5/25 at 11:30 A.M., CNA #5 said that when a resident is sick there will be a sign on the door to let staff know what PPE to use in the room. CNA #5 said the PPE should be worn at all times and be worn for both residents in the room. During an interview on 2/4/25 at 1:37 P.M., the Director of Nursing who is also the Infection Preventionist for the facility, said that she would expect full PPE to be worn for any resident on droplet precautions, including both residents in the room. She said PPE should be changed, however, between caring for each resident. She said she would expect the staff to refill precautions carts that are empty and utilize PPE for all resident interactions. She said there is a flu outbreak right now in the facility and this is why residents are on droplet precautions. 2. For Resident #84 and Resident #15 the facility failed to ensure enhanced barrier (EHB) precautions were implemented in accordance with the infection prevention control program. Review of the facility's Guideline: Enhanced Barrier Precautions, effective date April 1, 2024, indicated the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with and MDRO as well as those residents at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). High-Contact Resident Care Activities requiring a gown and glove use for enhanced barrier are defined as: dressing, bathing/showering, transferring, providing hygiene care, changing linens, changing briefs, or assisting with toileting, and devise care that includes Central Venous Access Devices, Urinary Catheters, Gastrostomy Tubes, and wound care that requires a dressing Guidelines: 3. Post clear signage outside of resident rooms indicating the type of PPE (personal protection equipment) required defining high risk resident care activities. For Resident #84 the facility failed to ensure enhanced precautions were implemented in accordance with the infection control program. 2a. Resident #84 was admitted to the facility in September 2021 and has diagnoses that include aphasia and cerebral infarction. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #84 scored an 11 out of 15 on the Brief Interview for Mental Status, is dependent on staff for care including toileting and bathing and has the nutritional approach of a feeding tube. Review of Resident #84's Physician's orders indicated the following: -An enteral feed order at bedtime flush tube with 250 cc water then hang overnight continuous feed of jevity 1.5 at 60 ml/hour x 12 hours, active 11/25/24. -Enhanced Barrier Precautions secondary to: gastric tube, every shift. Ensure signage is in place, active 10/31/24 Review of Resident #84's care plans indicated: -Resident requires Enhanced Barrier Precautions during high contact care activities that include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, d/t (due to) gastric tube, dated 10/31/24. During an observation on 2/3/25 at 10:20 A.M., Resident #84 was in bed with his/her eyes closed and did not respond to the surveyors greeting. A pole with a pump was near the head of Resident #84's bed. There was no Enhanced Barrier Precaution signage on the door or the vicinity of the room. The following observations made on 2/3/25 at 1:00 P.M., 2/3/25 and at 4:00 P.M., failed to reveal a sign was posted alerting staff that Resident #84 required enhanced barrier precautions. On 2/4/25 at 6:59 A.M., Resident was observed with his/her enteral feeding running through the pump. There was no enhanced barrier precaution signage on the outside of Resident #84's room alerting staff to use enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at approximately 8:22 A.M., Nurse #2 was observed going into Resident #84's room. Nurse #2 said she was flushing the Resident's g-tube. Nurse #2 did not don a gown for the flushing of the g tube which requires high contact care. During an interview on 2/4/25 at 10:30 A.M. Nurse #2 said a resident with a g-tube should be on enhanced barrier precautions. 2b. For Resident #15 the facility failed to implement enhanced barrier precautions in accordance with the facility infection prevention program. Resident #15 was admitted to the facility in July 2022 with diagnoses that include chronic obstructive pulmonary disease and colostomy status. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #15 scored a 15 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition and requires partial/moderate assistance with bathing and had an ostomy. During an observation and interview on 2/3/25 at 8:32 A.M., Resident #15 said he/she has a colostomy, and that staff provide a cream to his/her stoma (A stoma is an opening in your belly's wall that a surgeon makes for waste to leave your body if you can't have a bowel movement through your rectum). Resident #15's ostomy bag was visible as he/she sat on the side of his/her bed. Resident #15's room did not have an enhance barrier precaution sign outside his/her room on the door or near the door. The following observations on 2/3/25 at 12:19 P.M., 2/03/25 at 4:00 P.M., and on 2/4/25 at 6:57 A.M., failed to reveal an enhanced barrier precaution sign was posted to inform staff of the need for PPE. During an interview on 2/4/25 at 10:19 A.M. Nurse #2 said any resident who has an open area, g-tube (gastrostomy), catheter or colostomy requires enhanced barrier precautions. Nurse #2 said a sign is used outside the resident's room to identify a resident who needs enhanced barrier precautions. Nurse #2 went to Resident #15's room and said he/she has a stoma and said staff providing care are to use gowns and gloves.