STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225341	A. Building B. Wing	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamstown Commons Nursing & Rehab	25 Adams Road Williamstown, MA 01267

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on interviews, and record review, the facility failed to ensure its staff promoted and facilitated Activities of Daily Living (ADLs) preferences relative to bathing, for one Resident (#97), out of 27 total residents sampled. Specifically, the Resident would prefer showers and is scheduled twice/weekly but showers are not being done as scheduled. Findings include: Resident #97 was admitted to the facility in September 2019. Review of the Minimum Data Set assessment dated [DATE], indicated a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating Resident #97 was cognitively intact. Review of the ADLs Care plan initiated on 10/1/19, indicated the Resident is dependent with an assist of one staff, for bathing/grooming. Review of the Bathing and Hygiene by Day report for the month of October indicated: -no documentation noted for the Resident's scheduled shower days on: 10/3/22, 10/6/22, 10/10/22, and 10/13/22. -Additionally, the report indicated the Resident only received bed baths when hygiene care was provided on the following non-scheduled shower days: 10/1/22, 10/2/22, 10/11/22 and 10/14/22. During an interview on 10/12/22 at 10:10 A.M., Resident #97 told the surveyor that he/she does not get a shower because there are not enough people to help. He/she said that the facility usually will provide a bed bath when they are unable to provide a shower but he/she would prefer to have a shower. During an interview, and document review on 10/17/22 at 9:53 A.M., Unit Manager (UM) #1 said that Resident #97 is scheduled to receive a shower on Mondays and Thursdays during the day shift. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 10/17/22 at 10:28 A.M., UM #1 said that something should be documented if the activity occurred. If nothing is documented, we are to assume that it did not occur. She further said that it appears that the Resident did not receive a scheduled shower for the month of October, prior to today.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44129 Based on interviews, and record review, the facility failed to ensure its staff notified the attending Physician of a significant treatment change for one Resident (#45) out of a total sample of 27 residents. Specifically, the attending Physician was not notified that the Resident was unable to utilize his/her Bilevel Positive Airway Pressure (BiPAP) machine (a machine that uses pressure to push air into one's lungs to assist with breathing) that was prescribed and medically needed for daily use. Findings include: Resident #45 was admitted to the facility in June 2020, with the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD) with respiratory failure, and Hypoventilation Syndrome (breathing at an abnormally slow and shallow rate, that causes too much carbon dioxide to build up in the blood). Review of the October 2022 Physician's Orders included the following: - Apply BiPAP at bedtime (HS) and remove in the morning upon rising. -Apply one liter (L) of Oxygen through BiPAP, Inspiratory Positive Airway Pressure (IPAP- the amount of pressure with inhalation), 16 centimeters (cm) of water (H2O) and Expiratory Positive Airway Pressure (EPAP- the amount of pressure with exhalation), 10 cm H2O, initiated 8/31/22. Review of a Nursing Progress Note, dated 8/31/22 indicated the Resident's BiPAP mask was broken. Review of the September and October 2022 Treatment Administration Records indicated the Resident's BiPAP was held (not applied) due to machine being inoperable. During an interview on 10/14/22 at 4:30 P.M., Unit Manager (UM) #1 said the Physician should have been notified the Resident was unable to utilize his/her BiPAP machine, and she is unsure if the notification occurred. During an interview on 10/18/22, at 3:45 P.M., the Director of Nursing (DON) said the Medical Record should indicate Physician notification if the Resident was not able to utilize his/her BiPAP machine. Review of the Medical Record did not indicate any evidence the Physician was notified that the Resident was unable to utilize his/her BiPAP machine, as ordered.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 37400 Based on interview, and record review, the facility failed to ensure its staff completed a Discharge Minimum Data Set (MDS) Assessment for one Resident (#1) out of a total sample of two residents reviewed for the Resident Assessment Task. Findings include: Review of the Long Term Survey Process tasks, which are generated after finalization of resident sample selection, indicated Resident #1 had an MDS Assessment that was over 120 days (therefore overdue). Resident #1 was admitted to the facility in May 2022. Review of the clinical record indicated the Resident was discharged home from the facility on 6/17/22. Further review of the clinical record did not indicate that a Discharge MDS Assessment was completed as required, when he/she was discharged . During an interview on 10/18/22 at 9:18 A.M., the MDS Coordinator said she reviewed the clinical record for Resident #1 and that a Discharge MDS Assessment was not completed and should have been.

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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** 44129 Based on observations, interviews, and record review, the facility failed to ensure its staff implemented the plan of care for one Resident (#121). Specifically, the facility failed to ensure staff applied prescribed lymphedema wraps (bandages used to help control swelling by encouraging fluids to move away from affected tissues and go back to the vessels so they can circulate back to the heart) in a timely manner for Resident #121, putting him/her at risk for increased lower extremity swelling, associated skin breakdown and cardiac (heart) burden. Findings include: Resident #121 was admitted to the facility in November 2021 with diagnoses including lower extremity lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that is usually drained through the body's lymphatic system) and Heart Failure (HF). Review of the October 2022 Physician's Orders included the following: - Bilateral lower legs: [NAME] wraps (a brand of compression wrap for lymphedema) to be applied every morning at 8:00 A.M., and removed every evening, initiated 9/25/22. Review of the October 2022 Treatment Administration Record (TAR) indicated the wraps were applied late on the following dates and times: 10/3/22 at 1:30 P.M. 10/4/22 at 10:51 A.M. 10/6/22 - not applied at all - coded as M for missing 10/7/22 at 12:30 P.M. 10/8/22 at 10:04 A.M. 10/9/22 at 10:57 A.M. 10/11/22 at 1:39 P.M. 10/12/22 at 1:56 P.M. 10/13/22 at 1:32 P.M. 10/14/22 at 11:24 A.M. 10/15/22 at 3:03 P.M. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/17/22 at 1:11 P.M. 10/18/22 at 10:34 A.M. During an observation on 10/12/22 at 10:57 A.M., the surveyor observed the Resident seated in a chair at his/her bedside. His/her legs were very swollen and there were bandages on both of his/her lower legs. Additionally, the surveyor observed a sign above the Resident's bed and next to his/her chair indicating the following: Please put on wraps with morning care and take off with evening care. The surveyor observed the Resident was not wearing the wraps and noted the wraps were placed on a chair across the room. The surveyor observed the Resident without his/her wraps applied on the following dates and times: 10/12/22 at 2:15 P.M. and 4:15 P.M. 10/13/22 at 8:18 A.M., 9:08 A.M., and 11:36 A.M. Review of the Nurse Practitioner Progress Notes included the following: -9/7/22: Asked to see patient today due to lower extremity edema. -Unfortunately his/her wraps are currently not in place. -Make sure lymphedema wraps are put on daily. During an interview on 10/14/22 at 4:50 P.M., Unit Manager #1 said the wraps should have been applied within an hour of the scheduled administration time of 8:00 A.M., in order to be effective in controlling the Resident's edema.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation and interview the facility failed to ensure its staff provided Activities of Daily Living (ADLs)relative to nail care, for one Resident (#124), out of a total sample of 27 residents. Findings include: Resident #124 was admitted to the facility in June 2022 with diagnoses including: Arthritis and polyneuropathy (damage or disease affecting peripheral nerves in roughly the same areas on both sides of the body, featuring weakness, numbness, burning pain and that typically starts in the hands and feet). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview of Mental Status (BIMS) score of 13 out of 15, indicating Resident #124 was cognitively intact. During an observation and interview on 10/12/22 at 1:27 P.M., the surveyor observed that Resident #124 had long nails with debris underneath them. Resident #124 said that he/she asked to have his/her nails clipped, yet no one had done them. Review of the ADLs care plan, updated on 9/3/22, indicated that the Resident required constant supervision, with an assist of one staff for bathing and grooming. Review of the Shower Schedule provided by the nursing staff indicated that Resident #124 was scheduled to receive a shower on Mondays during the day shift. Review of the October Bathing and Hygiene by Day report indicated the following: -R=Refused -N=No -On 10/3/22, 10/10/22 and 10/17/22 (scheduled shower days), R was noted for 'Bathing completed'. -On 10/10/22 and 10/17/22, N was noted for 'Nail Care completed'. During an interview on 10/17/22 at 4:16 P.M., Unit Manager #1 said that nail care is typically provided at the scheduled shower time. She said that a notation of N, indicated no nail care was completed on his/her scheduled shower day. She also said that even if a shower is refused, nail care should still be offered. If the Resident refuses the nail care, an R should be documented. She further said that it did not appear that nail care was offered or refused. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up observation and interview on 10/18/22 at 10:06 A.M., the surveyor observed Resident #124's nails to be long, and jagged. He/she said that no one offered to clip his/her nails yesterday, during his/her scheduled shower time and that he/she would have allowed them to do so. He/she further said that because his/her nails are so long, they leave scratch marks when he/she itches him/herself.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42690 Based on observations, interviews, and record review, the facility failed to ensure its staff provided quality of care, according to the Residents' plans of care, facility policy, and professional standards of practice for one Resident (#47), out of a sample of 27 residents. Specifically, the facility failed to provide the following care and services for a Resident who was at risk for re-opening a pressure wound located on the coccyx (also known as the tailbone, is a small, triangular bone located at the bottom of the spine) that had been recently resolved and considered to still be a fragile area, and also had a current Urinary Tract Infection (UTI): 1) reposition the Resident as indicated in his/her plan of care, 2) provide incontinence care per the Resident's care plan, and 3) provide timely care and services when using a bed pan. Finding include: Resident #47 was admitted to the facility in May 2022 with diagnoses that include Dementia, UTI and Anxiety disorder. Review of the Minimum Data Set Assessment, dated 5/20/22, indicated the resident required an extensive assist of two people for bed mobility and an extensive assist of one person for toilet use. 1) The facility failed to reposition Resident #47 per his/her care plan. Review of the facility policy titled Pressure Ulcer Prevention Protocol, last revised in 12/2015, indicated to reposition resident in bed and chair at least every two hours. Review of the Skin Breakdown Care Plan, initiated on 5/23/22, indicated to reposition the resident every two hours in bed and every one hour in the chair. 2) The facility failed to provide incontinence care per his/her care plan. Review of the Urinary Incontinence Care Plan, initiated on 5/23/22, indicated the following interventions: -Toilet the Resident during their individual morning and evening care. -Toilet the Resident before and after meals and before going back to bed. -Toilet the Resident if he/she appears restless and if requested. -Provide incontinence care as needed. Review of the UTI Care Plan, initiated on 5/25/22, indicated the following interventions: -Toileting needs may increase during an active UTI. -Provide toileting assistance as needed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the October Physician's Orders indicated an order for Nitrofurantoin Macrocrystals (an antibiotic used to treat UTI's) with a start date of 10/6/22, for a UTI. On 10/13/22 the Surveyor made the following observations from 9:37 A.M. through 11:54 A.M., and from 12:41 P.M. through 1:20 P.M: -From 9:37 A.M. through 11:26 A.M. (1 hour and 49 minutes) the Resident was seated in a wheelchair in the day room after breakfast, in the same position (chair tilted back). The facility staff did not reposition the Resident every hour as per his/her plan of care, until 11:26 A.M., when the chair was shifted upright. At 11:54 A.M. the Resident was brought from the day room to the dining room (2 hours and 17 minutes since original observation). The surveyor had not yet observed the Resident to be provided with incontinence care every two hours and was not provided hourly repositioning as per his/her plan of care. -At 12:41 P.M., the surveyor observed the facility staff bring Resident #47 from the dining room to the dayroom immediately following lunch. -At 12:51 P.M., the Resident repeatedly asked for someone to help him/her. -At 12:56 P.M., the Resident said to another resident that he/she needed to go to the bathroom. -At 12:58 P.M., the Activity Aide removed Resident #47 from the dayroom and placed him/her next to the nurse's medication cart near the nurse's station. Unit Manager (UM) #1 asked the Resident what he/she needed, and he/she responded, I need to go to the bathroom. -At 1:01 P.M., the Resident asked facility staff as they passed by if they could help her. -From 1:06 P.M. through 1:20 P.M., the Resident repeatedly said the following phrases, please, help me, take me to the bathroom please, nurse, nurse, nurse with increased volume at times. During continued observation at 1:09 P.M., the Resident asked Nurse #2 to be taken to the bathroom please, repeatedly (approximately ten times). Nurse #2 continued working, said the Resident's name and explained that he/she had to wait until she could find help. -At 1:15 P.M., The surveyor noted the Resident's mouth to be turned down at the corners with a frowning face, and staff indication that more staff were needed to toilet the Resident. -At 1:20 P.M., (29 minutes later) Certified Nursing Assistant (CNA) #1 and Nurse #2 brought the Resident to his/her room to put him/her to bed and to use the bed pan. The surveyor approached the facility staff and requested to observe incontinence care being provided as well as to assess the newly healed pressure wound. While the facility staff were providing incontinence care, the surveyor observed the Resident's buttocks and thighs to have deep creases and the incontinence brief to be saturated with yellow urine. The surveyor held the Resident's urine-soaked brief in a gloved hand and observed it to be heavy. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/13/22 at 1:43 P.M., CNA #1 said that Resident #47 could tell staff when he/she needed to use the bathroom and is able to make his/her basic needs known. CNA #1 said that the Resident was last changed around 10:00 A.M., and should be changed every two hours or sooner if requested and that the Resident was not changed in a timely manner. CNA #1 said that the Resident would sit on the bed pan for a good hour, sometimes even fall asleep, at times will not let staff take him/her off of it. Lastly, she said that the facility policy is every two hours to reposition the resident and/or address their bathroom needs, and that did not occur as required. 3) The facility failed to ensure its staff provided timely care and services when using a bed pan. Review of an article titled, Nursing Bedpan Management, from the National Library of Medicine (at NIH) and last updated on 7/25/22, indicated if a bed pan is to be used, it should be for a short duration. There are countless cases of pressure sores, ulcers and neuropathy (damage to the peripheral nerves) from patients being left too long on the bed pan. Review of the Wound Care Specialist Progress Note, dated 10/10/22, indicated the coccyx wound was resolved and had fragile epithelial tissue (thin tissue forming on the outer layer of the body). On 10/17/22 at 9:39 A.M., the surveyor observed the Resident being taken into his/her room by CNA #2. -At 10:38 A.M., the surveyor heard Resident #47 repeatedly yelling out from his/her room, help me. -At 10:40 A.M., the surveyor overheard an employee say that they needed help getting the Resident off the bed pan. On 10/17/22 at 10:46 A.M., the surveyor heard the Resident continuing to yell help me repeatedly at varying volumes. During an interview on 10/17/22 at 10:56 A.M., as CNA #3 exited the Resident's room, she said that she just took the Resident off the bed pan. She said that she was not the one who put the Resident on the bed pan so she could not say how long he/she was on it for, only that it had been a while. During an interview on 10/17/22 at 1:15 P.M., CNA #2 said that when she and another staff person put the Resident back into bed that morning (at 9:39 A.M., the time the surveyor observed CNA #2 bring the Resident to his/her room) they placed him/her on the bedpan. During an interview on 10/17/22 at 3:50 P.M., the Director of Nursing (DON) said that the Resident should not have been left on the bedpan for that long. Refer to F690 and F744

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42690 Based on observations, interview, and record review, the facility failed to ensure its staff provided timely incontinence care for one Resident (#47), out of a sample of 27 residents, who was receiving treatment for a current Urinary Tract Infection (UTI). Findings include: Resident #47 was admitted to the facility in May 2022 with diagnoses including Dementia and UTI. Review of the October 2022 Physician's Orders indicated an order for Nitrofurantoin Macrocrystals (an antibiotic used to treat UTI's) with a start date of 10/6/22, for a UTI. Review of the Urinary Incontinence Care Plan, initiated on 5/23/22, indicated the following interventions: -Toilet the Resident during their individual morning and evening care. -Toilet the Resident before and after meals and before going back to bed. -Toilet the Resident if he/she appears restless and if he/she requested. -Provide incontinence care as needed. Review of the UTI Care Plan initiated on 5/25/22, indicated the following interventions: -Toileting needs may increase during active UTI. -Provide toileting assistance as needed. On 10/13/22 the Surveyor made the following observations from 9:37 A.M. through 11:54 A.M., and from 12:41 P.M. through 1:20 P.M: -From 9:37 A.M. through 11:26 A.M. the Resident was seated in a wheelchair in the day room after breakfast. -At 11:54 A.M., the Resident was brought from the day room to the dining room (2 hours and 17 minutes since original observation). The surveyor had not yet observed the Resident receiving incontinence care as per his/her plan of care. -At 12:41 P.M., the surveyor observed the facility staff bring Resident #47 from the dining room to the day room immediately following lunch. -At 12:51 P.M., the Resident repeatedly asked for someone to help him/her. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:56 P.M., the Resident said to another resident that he/she needed to go to the bathroom. -At 12:58 P.M., the Activity Aide removed Resident #47 from the day room and placed him/her next to the nurse's medication cart near the nurse's station. Unit Manager (UM) #1 asked the Resident what he/she needed, and he/she responded, I need to go to the bathroom. -At 1:01 P.M., the Resident asked facility staff as they passed by if they could help her. There was no response. -From 1:06 P.M. through 1:20 P.M., The Resident repeatedly said the following phrases, please, help me, take me to the bathroom please, nurse, nurse, nurse with increased volume at times. During this observation period, at 1:09 P.M., the Resident asked Nurse #2 to be taken to the bathroom please, repeatedly (approximately ten times). Nurse #2 continued working, said the Resident's name and explained that he/she had to wait until she could find help. -At 1:20 P.M., Certified Nursing Assistant (CNA) #1 and Nurse #2 brought the Resident to his/her room to put him/her to bed and to use the bed pan. The surveyor approached the facility staff and requested to observe incontinence care being provided. While facility staff were providing incontinence care, the surveyor observed the Resident's buttocks and thighs with creases and the incontinence brief to be saturated with yellow urine. The surveyor held the Resident's urine-soaked brief in a gloved hand and observed it to be heavy. During an interview on 10/13/22 at 1:43 P.M., CNA #1 said that Resident #47 could tell staff when he/she needed to use the bathroom. and can make their basic needs known. CNA #1 said that the Resident was last changed around 10:00 A.M., and should be changed every two hours or sooner if requested. CNA #1 also said that the Resident was not changed in a timely manner (3 hours and 20 minutes from the time the CNA said she last provided care), as required. Refer to F684 and F744

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observation, interviews, and record review, the facility failed to ensure its staff provided the necessary respiratory care and services consistent with professional standards of practice in accordance with the Resident's care plan for one Resident (#45) out of a total sample of 27 residents. Specifically, 1) The facility failed to ensure its staff provided necessary equipment (a mask) required for the function of a BiPAP device (bilevel positive airway pressure device, that provides non-invasive mechanical ventilation that uses pressure to push air onto one's lungs to assist with breathing and maintain an open airway). 2) Substituted a non-equivalent respiratory intervention (Oxygen therapy and inhaled Albuterol medication) for BiPAP therapy, and 3) Failed to ensure staff had the proper training and education related to the utilization of Oxygen and respiratory equipment which put the Resident at risk for respiratory compromise. Findings include: Review of the research article titled: Hypoventilation Syndrome, updated 7/22/21, authored by Jazeela [NAME], DO, accessed online at https://emedicine.medscape.com/article/304381-overview on 10/22/22 included the following: - Obesity-Hypoventilation Syndrome ([NAME]) is defined as a combination of obesity with chronic hypercapnia (too much carbon dioxide in the blood). - Patients with [NAME] demonstrate an excessive work of breathing and an increase in carbon dioxide production. - Treatment is aimed at assisting ventilation. Therapies that may be beneficial are non-invasive ventilatory techniques such as BiPAP. - Use Oxygen therapy with caution because it may worsen hypercapnia in some situations. Resident #45 was admitted to the facility in June 2020 with diagnoses including: Chronic Obstructive Pulmonary Disease (COPD) with respiratory failure, Hypoventilation Syndrome (breathing at an abnormally slow and shallow rate, that causes too much carbon dioxide to build up in the blood) and morbid obesity. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 8/13/22, indicated the Resident had mild cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 12 out of a possible 15. Review of the Resident's current plan of care, dated 5/19/21 included the following: -Apnea (temporary cessation of breathing, especially during sleep). (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-Resident at risk of Apnea, ineffective breathing pattern and cardiac arrhythmia (irregular heartbeat) related to Obstructive Sleep Apnea (OSA- a type of apnea that occurs when your throat muscles intermittently relax and block your airway during sleep). Interventions, dated 4/28/22: -Apply BiPAP at ordered settings via nasal mask or face mask. -Remove BiPAP in the morning. -Ensure the device/mask is properly fitted. -Respiratory Therapist may be consulted as needed. Review of the October 2022 Physician's Orders included the following: -Apply BiPAP at bedtime (HS) and remove in the morning upon rising. -Apply one liter (L) of Oxygen through BiPAP, Inspiratory Positive Airway Pressure (IPAP- the amount of pressure with inhalation), set at 16 centimeters (cm) of water (H2O) and Expiratory Positive Airway Pressure (EPAP- the amount of pressure with exhalation), set at 10 cm H2O, initiated 8/31/22. - Please ensure patient is wearing BiPAP whenever he/she is sleeping in bed, initiated 6/4/21. - Albuterol HFA (an inhaled medication used to relax and open air passages to the lungs to make breathing easier), 0.09 milligrams (mg) per one actuation (actuate- depression of the inhaler to spray the medicine out of the canister), two puffs every six hours as needed (PRN) for shortness of breath, initiated 1/27/21. - May apply Oxygen (O2) at 2-4 liters per minute (LPM) as needed (PRN) to maintain oxygen saturation levels (the measure of how much oxygen is traveling through your body in your red blood cells) greater than (>) 90 percent (%), initiated 4/7/21. Review of the medical record included the following Progress Notes: 8/31/22 at 9:45 P.M. - BiPAP mask is broken. O2 at 2 LPM via Nasal Cannula (NC) in place. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	9/1/22 at 8:18 P.M. - Unable to use CPAP (continuous positive airway pressure, a different type of non-invasive therapy), which the writer erroneously identified as the Resident's equipment. 9/3/22 at 12:55 A.M.- Unable to use CPAP -erroneous identification of the Resident's equipment. 9/5/22 at 8:43 P.M. - O2 in place and functioning properly. 9/11/22 at 8:13 P.M. - Oxygen in place at 2 LPM via NC, PRN inhaler (Albuterol) given with positive effect. 9/12/22 at 8:21 P.M. - Resident complains of shortness of breath while in bed, given PRN inhaler and O2 in place. 9/24/22 at 9:27 P.M. - Resident complains of shortness of breath this evening, given PRN inhaler and placed on O2. 10/12/22 at 10:22 P.M. - O2 at 2 LPM via NC, reason: no mask for BiPAP 10/13/22 at 3:41 A.M. - No mask for BiPAP 10/15/22 at 8:21 P.M. - O2 at 2 LPM via NC, reason: BiPAP not useable 10/17/22 at 1:42 A.M. - BiPAP not useable Review of the September 2022 Treatment Administration Record (TAR) indicated the administration of the BiPAP treatment was documented as being held (not applied) on the following dates: 9/2-9/4/22 9/6-9/7/22 9/9/22 9/13/22 9/17-9/23/22 9/25-9/26/22 9/28-9/30/22 Review of the September 2022 TAR Documentation and PRN Results Report indicated the BiPAP treatment was documented as being held for the following reasons: -unable to use -held due to mask broken (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-held/see progress notes -not currently in use -O2 in place -awaiting repair -not working -machine inoperable Review of the October 2022 TAR indicated the administration of the BiPAP treatment was documented as being held on the following dates: 10/2/22 10/5/22 10/7-10/9/22 10/11-10/12/22 Review of the October 2022 TAR Documentation and PRN Results Report indicated the BiPAP treatment was documented as being held for the following reasons: -no mask for BiPAP-on O2 at 2 LPM via NC -machine inoperable -Resident currently not using, awaiting mask - on O2 at 1 LPM via NC -see progress note -no mask. Review of the September 2022 Medication Administration Record (MAR) indicated the Resident required PRN administration of Albuterol for reported shortness of breath on the following dates and times: 9/1/22 at 7:35 P.M. 9/10/22 at 9:01 P.M. 9/11/22 at 7:11 P.M. 9/12/22 at 6:58 P.M. 9/19/22 at 6:51 P.M. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	9/21/22 at 6:59 P.M. 9/22/22 at 6:11 P.M. 9/24/22 at 6:41 P.M. 9/28/22 at 6:53 P.M. Review of the October 2022 MAR indicated the Resident required PRN administration of Albuterol for reported shortness of breath on the following dates and times: 10/3 at 6:57 P.M. 10/4 at 7:52 P.M. 10/6 at 7:25 P.M. 10/9 at 7:05 P.M. 10/10 at 6:54 P.M. 10/11 at 10:53 A.M. 10/13 at 7:09 P.M. Further review of the Medical Record did not include evidence that staff attempted to obtain a replacement BiPAP mask for the Resident after his/hers was reported as broken on 8/31/22. During an observation and interview on 10/12/22 at 11:53 A.M., the surveyor observed the Resident's BiPAP machine to be without a mask. During an interview at the time of the observation, the Resident said the mask was gone, had been gone for a long time and it was supposed to have been replaced. He/she further said that the nurses administered Oxygen to him/her nightly since he/she was unable to use her BiPAP machine. During an interview on 10/14/22 at 4:30 P.M., Unit Manager (UM) #1 said she was aware the Resident's BiPAP mask was broken and thought she reached out to the supplier on 10/11/22 to request a new mask. She further said she had not been in the UM position long and was unaware if any facility staff had requested a new mask for the Resident since it was reported as being broken on 8/31/22. The surveyor then reviewed the documentation in the clinical record with UM #1 that indicated nursing staff were utilizing Oxygen via NC in lieu of the BiPAP device, as well as signing off as applying the device despite it not being available. UM #1 said she thought that utilizing Oxygen was an equivalent intervention since the Resident was unable to utilize his/her BiPAP device, and that the nursing staff should not have signed off that the BiPAP was administered, as it remained broken and was unavailable for use. During an interview on 10/18/22 at 8:53 A.M., the Director of Nursing (DON) said O2 via NC was not an appropriate substitution for BiPAP. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 10/18/22 at 11:19 A.M., the Regional Clinical Manager of O2 Safe Solutions, the facility's contracted respiratory durable medical equipment (DME) company, said that utilizing O2 via NC cannot be considered a substitute for treatment with BiPAP because a NC will not work to keep an airway open in the event of Apnea, for which this Resident has an active diagnosis. He further said that O2 Safe Solutions did not receive any requests for a replacement mask for this Resident after 8/31/22 when it was reported to have been broken, until 10/17/22. During an interview on 10/18/22 at 1:36 P.M., the Staff Development Coordinator (SDC) said while he had BiPAP and CPAP (Continuous Positive Airway Pressure, a type of non-invasive therapy) competencies, he has not utilized them nor has he provided any specific BiPAP/CPAP training in the five years he has held the position of SDC.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 42690 Based on observations, record review, and interview, the facility failed to ensure its staff provided appropriate treatment and services related to Dementia care for one Resident (#47), out of a total sample of 27 residents, to assist in promoting the physical, mental and psychosocial well-being of the Resident. Findings include: Resident #47 was admitted to the facility in May 2022 with diagnoses that include Dementia, Urinary Tract Infection (UTI) and Anxiety Disorder. Review of the Severe Cognitive Decline Care Plan, initiated on 5/19/22, indicated the following interventions: -Keep routines as consistent as possible -Determine residents' interests and encourage participation in activities preferred -Redirect and validate as needed -Provide activities requiring a short attention span -Encourage appropriate activity program Review of the Mood Care Plan, initiated on 8/16/22, indicated the following interventions: -Allow resident to choose activity of interest daily -Encourage group, social/recreational activities for diversion On 10/17/22 the surveyor made the following observations from 3:50 P.M. through 4:45 P.M. while sitting at the nurses station, located approximately 20-30 feet away from the Resident's room: -From 3:50 through 4:25 P.M., Resident #47 could be heard calling out repeatedly, help me, take me to the bathroom. During this observation, the surveyor observed a Certified Nursing Assistant (CNA) sitting outside of the Resident's room documenting on a computer. Additionally, a Nurse was working at the medication cart, one door down from the Resident's room. Neither the CNA or the Nurse acknowledged the yelling, redirected or validated the Resident's request for assistance. -At 4:33 P.M., the surveyor observed the CNA bring the Resident out to the dayroom and place him/her in front of a table. Resident #47 said don't put me out here. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 4:34 P.M., the surveyor observed the Resident sitting at a table with other residents, located in the back of the room, with his/her back to the television (which was on). The Resident was observed to not be engaged with the television, other residents at the table or any other activity. During the observation time from 3:50 P.M. through 4:45 P.M., the surveyor did not observe that the facility staff provided any of the interventions as required per the Resident's care plan. During an interview on 10/18/22 at 4:58 P.M., Social Worker #1 said that when the CNA placed the Resident at the table in the dayroom, a diversional activity should have been offered per his/her care plan but was not done as required. She further said that the Resident will typically have a positive response when the interventions are utilized. She also said that the interventions may be short lived due to his/her Dementia, but they are effective. Refer to F684

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37400 Based on interview, and record review, the facility and its staff failed to ensure a pharmacy recommendation for one Resident (#111), out of a total sample of 27 residents, was reviewed and addressed by the Physician as required. Findings include: Resident #111 was admitted to the facility in February 2021. Review of the clinical record indicated the consultant Pharmacist completed a Medication Regimen Review (MRR) on 2/3/22 for Resident #111 and made a recommendation. Further review of the clinical record indicated no documented evidence of the Pharmacist recommendation. On the following days and times: -On 10/14/22 at approximately 2:00 P.M., -On 10/18/22 at 8:50 A.M., and 11:50 A.M., the surveyor requested evidence of the consultant Pharmacist recommendation dated 2/3/22 from the facility administration. During an interview on 10/18/22 at 1:26 P.M., the Director of Nurses (DON) provided the surveyor with a copy of the 2/3/22 consultant pharmacy recommendation that she had sent from the pharmacy. The DON said that there was no indication that the 2/3/22 pharmacy recommendation was reviewed and addressed by the Physician as required. She further said that when the consultant Pharmacist had recommendations, these recommendations were given to the facility staff who then communicate with the Physician to review and address. She said that once the Physician reviewed and addressed the recommendation, it would be filed in the resident's clinical record, but there was no indication that this process occurred for the 2/3/22 pharmacy recommendation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44129 Based on interviews, and record review, the facility failed to ensure its staff prevented significant medication errors for one Resident (#114) out of a total sample of 27 residents. Specifically, the scheduled prescribed medications were administered outside of acceptable time parameters. Findings include: Review of the facility policy titled, Medication Administration, General Guidelines, dated 6/1/10 indicated the following: - Medications are administered as prescribed in accordance with good nursing principles and practices . - Medications are administered within 60 minutes of scheduled time, except before or after meal orders which are administered based on mealtimes. Review of the Nursing 2022 Drug Handbook 42nd Edition, copyright 2022 included the following: - Lantus (generic: Insulin Glargine), administer subcutaneous (injected under the skin) daily at the same time every day. - The eight rights of medication administration as follows: the right drug, the right patient, the right dose, the right time (ensure that the drug is administered at the correct time and frequency), the right route, the right reason, the right response and the right documentation. Resident #114 was admitted to the facility in March 2022 with diagnoses including: Type 2 Diabetes (a condition that results from the body's insufficient production of insulin causing high blood sugar, and Atrial Fibrillation (A-Fib, an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart). Review of the Minimum Data Set (MDS) assessment, dated 9/24/22, indicated the Resident was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of a possible 15. Review of the October 2022 Physician's Orders included the following: - Metformin HCL (a medication used to regulate high blood sugar), 1000 milligram (mg) tablet, administer one tablet orally twice per day, scheduled to be administered 8:00 A.M. and 8:00 P.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lantus (a long acting hormone called insulin used to regulate blood sugar), 100 Units (U) per one milliliter (ml) solution, administer 24 U subcutaneous daily, scheduled to be administered 8:00 A.M. - Eliquis (a medication used to inhibit the clotting of blood used to reduce stroke risk for patients with A-Fib) 5 mg tablet, administer one tablet orally twice per day, scheduled to be administered 8:00 A.M. and 8:00 P.M. Review of the October 2022 Medication Administration Record (MAR) indicated the following medications were administered outside of acceptable time parameters on the following dates and times: Metformin, scheduled for 8:00 A.M. and 8:00 P.M., was administered: 10/2 - 6:34 A.M. 10/4 - 10:48 A.M. 10/6 - 6:13 P.M. 10/8 - 10:24 A.M. 10/9 - 9:22 A.M. 10/10 - 10:29 A.M. 10/16 - 10:27 P.M. Lantus, scheduled for 8:00 A.M., was administered: 10/2 - 6:34 A.M. 10/4 - 10:49 A.M. 10/8 - 10:24 A.M. 10/9 - 9:23 A.M. 10/10 - 10:37 A.M. Eliquis, scheduled for 8:00 A.M. and 8:00 P.M., was administered: 10/2 - 6:34 A.M. 10/4 - 10:48 A.M. 10/6 - 6:13 P.M. 10/8 - 10:24 A.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/10 - 10:29 A.M. 10/16 - 10:27 P.M. During an interview on 10/12/22 11:46 A.M., Resident #114 said that he/she understood staffing was difficult everywhere and tried to be patient, however there were times that he/she received his/her medications up to two hours later than when he/she was supposed to. Resident #114 further said that he/she had diabetes and cardiac issues, including a history of open heart surgery. During an interview on 10/18/22 at 3:32 P.M., Nurse #3 said the administration time recorded on the MAR reflected the time the medications were administered. During an interview on 10/18/22 at 3:37 P.M., the Director of Nursing (DON) said medications should be administered within an hour either before or after the ordered administration time. During an interview on 10/18/22 at 3:53 P.M., Nurse #1 said that the time reflected in the computer is expected to be the time of medication administration. She further said that these examples would be considered to be medication errors.

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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 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. 42741 Based on interview, and record review, the facility failed to ensure its staff accurately documented the type of pneumococcal vaccination received for one Resident's (#70), out of five sampled residents, potentially putting him/her at risk for infection from not receiving additional recommended pneumococcal vaccinations. Findings Include: Review of the facility policy titled Resident Pneumococcal Immunization, Revised April 22, 2022, indicated the following: -Residents will be offered immunization to protect them from pneumococcal disease unless the vaccine is medically contraindicated, or the resident had already been immunized. -The pneumococcal vaccine/s will be documented within the Immunization Record inside the Electronic Health Record (EHR). Resident #70 was admitted to the facility in October 2020. Review of the EHR Immunization Record section indicated the Resident had received a pneumococcal vaccination prior to entering the facility on 5/19/2020. Further review indicated no additional information on which pneumococcal vaccination the Resident had received. During an interview on 10/18/22 at 4:15 P.M., the Director of Nursing (DON) said she was unable to tell which pneumococcal vaccination the Resident had received as it was not documented in his/her medical record. She further said she could not be sure if the Resident was eligible for any additional doses since she was unable to tell which pneumococcal vaccination the Resident had already received.