STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. BUILDING _____ B. WING _____	**09/12/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE HEALTHCARE	**620 LAUREL STREET LEE, MA 01238**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to provide care in a dignified manner and in an environment that promotes maintenance or enhancement of his or her quality of life, for 1 resident (#12), out of a total sample of 19 residents. Findings include: Resident #12 was admitted in 3/2008, with [DIAGNOSES REDACTED]. The current care plans for cognitive impairment, incontinence care and self care performance deficit, related to [MEDICAL CONDITION]'s disease, with loss of balance, trunk control and fine motor skills indicated the following interventions: Promote dignity. Provide a homelike environment. 2 person assist for boosting and repositioning. 2 person assist and mechanical lift for transfers. Extra full body bath every evening. Clothing protector to prevent clothes from becoming soiled. The Quarterly assessment, with an Assessment Reference Date of 6/19/18, indicated the resident had long and short term memory deficits, was severely impaired for daily decision making, was dependent for all Activities of Daily Living and was always incontinent of bowel and bladder. Observation, on 9/5/18 at 8:41 [NAME]M., found Resident #12 reclined in a Broda chair. Bilateral thigh straps and the left head rest had cracks and rips in the upholstery. Observation, on 9/5/18 at 2:33 P.M., found Resident #12 in the resident's room sitting in a Broda chair. The room smelled of strong urine and feces odors. There was a brown substance on the front top of the resident's brief, visible to the surveyor and anyone else who entered the room. Observation, on 9/5/18 at 3:15 P.M., (by Surveyor #1 and #2), found Resident #12 in the resident's room, in a Broda chair. There was a strong urine and fecal odor permeating the room. Observation, on 9/5/18 at 3:45 P.M., found Resident #12 in the resident's room in the Broda chair. The resident's arms and legs had uncontrolled movements. Urine and feces odors permeated the room and now into the hallway. Observation, on 9/5/18 at 4:10 P.M., found Resident #12 in the Broda chair. The foul urine and feces odor permeated the room and the hallway near the doorway. This was observed by Surveyors #1 and #2. Observation, on 9/6/18 at 7:03 [NAME]M., found Resident #12 in the resident's room sitting in the Broda chair. The room smelled of strong stale urine. During an interview, on 9/6/18 at 11:44 [NAME]M., Family Representative #2 said that last Saturday (9/1/18), the resident's room reeked of urine. She said that often when she comes to visit the room has strong urine odors. She said she has witnessed the resident with vomit on the floor and on the resident's clothing. She witnessed the staff Hoyer lift the resident back to bed to change the resident. The staff member washed the resident with water and did not use any soap. When questioned by Family Representative #2, the staff member still did not use any soap to clean the resident. Observation, on 9/6/18 at 12:08 P.M., found Resident #12 in the resident's room, in a Broda Chair. The room smelled of strong stale urine. Observation, on 9/6/18 at 4:05 P.M., found Resident #12 in the resident's room, in a Broda chair. The room and the mattress smelled of strong stale urine. Observation, on 9/10/18 at 7:39 [NAME]M., found Resident #12 in the resident's room, in a Broda chair. The right head rest to the Broda chair was hanging to the side of the chair and the resident's head was on the bars to the chair. The mattress and room smelled of strong stale urine. Observation, on 9/10/18 at 1:17 P.M., found Resident #12 sitting in the Broda chair, in the room. There was vomit on the resident's shirt and on the floor, and a puddle of urine on the floor under the resident's Broda chair. This surveyor notified Unit Manager #1. She sent CNA #2 and CNA #3 to the resident's room to provide care. The resident was transferred via the Hoyer lift. The resident's pants were saturated with urine from the waist down to the knees. The resident's shirt and chest binder were soaked with vomit. The Hoyer pad was soaked with urine and the cushion on the Broda chair was saturated with urine and had a small puddle of urine on top of it. During an interview, on 9/10/18 at 1:39 P.M., CNA #2 said that the resident is up in the Broda chair before the 7:00 [NAME]M. to 3:00 P.M., staff come on duty. She said that the resident doesn't go back to bed to be changed until after the tube feeding is finished (12:00 P.M.) or later. She said the resident is up in the Broda chair for at least 6 to 7 hours because of the tube feeding, sometimes longer. During an interview, on 9/10/18 at 2:30 P.M., Family Representative #3 said that the resident's room smells of strong urine and fecal matter when they come to visit. (On 8/3/18 and 8/23/18) during the most recent visits, the resident was found soaked in urine, and the resident's shirt was soaked in vomit. Family Representative #3 said the mattress is embedded with urine and the chair smells of urine. She said this has been reported to staff several times but nothing is ever done about it. Observation, on 9/10/18 at 3:25 P.M., found the urine soaked chair cushion still on the Broda chair. The resident was lying in bed. Observation, on 9/10/18 at 4:01 P.M., found 3 staff members in the room, preparing to transfer the resident to the Broda chair. The urine soaked cushion was still in the Broda chair. This surveyor requested that the urine soaked cushion be removed before placing the resident back in the chair. Observation, on 9/11/18 at 7:01 [NAME]M., found the resident up in the Broda chair. The mattress smelled of strong stale urine that permeated the entire room. Observation of the resident's room, on 9/11/28 at 9:10 [NAME]M., with the Social Worker, found the resident's room with repugnant, offensive odors of strong stale urine. This surveyor requested that the Director of Nursing (DON) inspect the room. The DON and Unit Manager came to the resident's room. The DON said that she would look into getting a new mattress for the bed and also have the chair cleaned. During an interview, on 9/12/18 at 6:45 [NAME]M., Nurse #3 said that the night shift gets the resident up in the morning before (6:00 [NAME]M.,) so the tube feeding can start on time at (6:00 [NAME]M.). During an interview, on 9/12/18 at 12:15 P.M., the DON said that the resident should be checked on rounds.

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

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.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1)
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a clean, comfortable and homelike environment. Findings include: Observation, on 9/5/18 at 8:25 [NAME]M., found Resident #27 reclined in a Broda chair. Bilateral thigh straps were frayed and had cracks in the upholstery. Observation, on 9/5/18 at 8:41 [NAME]M., found Resident #12 reclined in a Broda chair. Bilateral thigh straps and the left head rest had cracks and rips in the upholstery. Observation, on 9/5/18 at 9:03 [NAME]M., found Resident #34 reclined in a Broda chair. Bilateral arms rests and right head rest had cracks and tears in the upholstery. Observation, on 9/6/18 at 9:44 [NAME]M., found room [ROOM NUMBER] filled with a strong foul urine odor. Observation, on 9/10/18 at 11:20 [NAME]M., found Resident #7 reclined in a Broda chair with thigh straps. The thigh straps and upholstery of the chair had cracks, tears, and rips. Observation, on 9/10/18 at 1:17 P.M., found Resident #12 sitting in the Broda chair, in the room. There was vomit on the floor and a puddle of urine on the floor under the resident. The Broda chair had a missing cross strap in the middle of the back of the chair. Observation, on 9/10/18 at 1:18, found room [ROOM NUMBER] with strong offensive urine odors. Observation, on 9/10/18 at 3:13 P.M., found room [ROOM NUMBER] with dirty linen sheets on the bed and a pillow that had cracks and tears on it. Observation, on 9/11/18 at 7:01 [NAME]M., found room [ROOM NUMBER] with strong stale urine odors that permeated the entire room. The mattress smelled of strong stale urine. The cushion on the left upper head support of the Broda chair was hanging on the side of the chair. A mid back support strip was missing from the back of the chair. During an environmental tour, on 9/11/18 at 1:00 P.M., the following was observed: Unit 1: 3 Wheelchairs had ripped and torn arm rests. Unit 2: room [ROOM NUMBER]: The room was in disarray. A fan and radio were stored on the floor. There was a large pile of clothing on the floor. Clothing was tossed on top of the trash receptacle. A large pile of clothing was tossed on a blue container that was on the floor. The wall near the window had scraped paint. A remote control, paper and clothing were on the floor next to the bed. The bureau was broken with a missing door. There was a large gap between the mattress and the foot board. The floor was dirty. The right head rest to the Broda chair was cracked and ripped. room [ROOM NUMBER]: there was scraped paint on the doorway to the room. The bathroom floor was dirty and stained. room [ROOM NUMBER]-A: the mattress was dirty, with a strong foul odor. room [ROOM NUMBER]-B: the mattress was dirty, with a strong foul odor. room [ROOM NUMBER]-A: the Broda chair had cracked and ripped upholstery in the thigh straps. There was dirty tape covering the foot rest attachment. room [ROOM NUMBER]: The dresser drawer was broken and falling off. The walker near the bathroom door was dirty with dust and brown spills. The light fixture near the bathroom door was filled with dead bugs. The bathroom walls and door had large areas of scraped paint. The unit dining room had cracked and chipped paint under the television. During an interview, on 9/12/18 at 12:21 P.M., the Administrator said, things are better than they used to be.
F 0606 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not hire anyone with a finding of abuse, neglect, exploitation, or theft.** Based on review of employee files, abuse policies and interview, the facility failed to complete Nurse Aide Registry checks, prior to hire, for 3 (#1, 2 and 3) out of 5 newly hired employees. Findings include: Review of the Abuse Policy, revised in 12/2017, included the following: 3. The person responsible for hiring prospective employees will verify licensure or recertification status. 4. The Nurse Aide Registry is checked prior to employment for all facility employees. 6. Documentation on all above information will be maintained as part of the employment record. 1. Employee #1 was hired on 6/27/18. Review of the employee file indicated that the Nurse Aide Registry check had not been completed. 2. Employee #2 was hired on 7/18/18. Review of the employee file indicated that the Nurse Aide Registry check was completed on 7/18/18, the date of hire and not prior to hire. 3. Employee #3 was hired on 7/30/18. Review of the employee file indicted that the Nurse Aide Registry check was competed on 7/30/18, the date of hire and not prior to hire. During an interview, on 9/12/18 at 11:15 [NAME]M., the Administrator said that the Nurse Aide Registry check for Employee #1 had never been completed. During an interview, on 9/12/18 at 12:15 [NAME]M., the Administrator said that the Nurse Aide Registry checks for Employees #2 and #3 were completed on the date of hire and not prior to hire.
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide written information to the residents or representatives, prior to transfer to the hospital, that specified the duration of the state bed hold policy during which the resident is permitted to return to the facility, the reserve payment policy in the state plan or the facility's policies regarding bed hold periods, for 3 residents (#9, #10 and #63), in a total sample of 19 residents. Findings include: 1. Resident # 9, with [DIAGNOSES REDACTED]. Review of the Progress Notes, of 6/23/18, indicated the resident was experiencing increased drowsiness and jerky twitchy movements therefore, a physician's orders [REDACTED]. Review of the Progress Notes, of 7/10/18, indicated the resident was experiencing lethargy and confusion with some hallucinations therefore, a physician's orders [REDACTED]. During an interview with Unit Manager (UM) #2, on 9/10/18 at 10:53 [NAME]M., she said that prior to the resident being transferred to the hospital (on 6/23/18 and 7/10/18) that the Nurse on duty was responsible to complete an Acute Care Transfer Document Checklist form which indicates if the Bed Hold Policy information was provided to the resident. However, after UM #2 reviewed the resident's Medical Record, the to be filed tray and the Physician's Book, she said she was unable to locate any evidence (i.e.: Acute Care Transfer Document Checklist form) that written information had been provided to the resident/representative, prior to the hospital transfer, on both occasions, that specified the duration of the state bed hold policy during which the resident is permitted to return to the facility and the reserve payment policy in the state plan, as required. 2. Resident # 63, with [DIAGNOSES REDACTED]. Review of the Progress Notes, of 8/1/18, indicated the resident was slurring his/her words therefore, a physician's orders [REDACTED]. During record review and interview with UM #2, on 9/10/18 at 12:56 P.M., she said that she knew that the resident/representative did not receive the Bed Hold Policy information (that specified the duration of the state bed hold policy during which the resident is permitted to return to the facility and the reserve payment policy in the state plan)

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F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 2) prior to the hospital transfer (on 8/1/18) because the Nurse on duty, at the time of the hospital transfer, did not check off that the Bed Hold Policy information was provided to the resident on the Acute Care Transfer Document Checklist form. 3. Resident #10, with a [DIAGNOSES REDACTED]. Review of the Progress Notes, of 7/23/18, indicated the resident was experiencing a high fever therefore, a physician's orders [REDACTED]. During record review and interview with UM #1, on 9/11/18 at 10:05 [NAME]M., she said that the Nurse on duty, at the time of the hospital transfer, was responsible to complete the Acute Care Transfer Document Checklist form which would indicate if the Bed Hold Policy information was provided to the resident/representative, prior to the transfer. UM #1 further said after reviewing the Medical Record, that she was unable to locate the Checklist form in either the Medical Record or in the to be filed tray, therefore, the facility had no evidence that the Bed Hold Policy information was provided to the resident/representative, at the time of the hospital transfer, as required.
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, observations, and staff interview, the facility staff failed to implement the plan of care relate to applying Geriatric sleeves for one Resident, #19, out of a total sample of 19 residents. For Resident #19, the facility failed to follow the plan of care for geriatric sleeves. Resident #19 was admitted to the facility in 8/2016 with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of 7/3/18, indicated that the resident had short and long term memory loss, required extensive assist with bed mobility, dressing, and eating, and was dependent with transfers, toilet use, bathing, dressing and hygiene. Review of the plan of care for fragile skin, and is prone to bruising/shearing and skin tears included the following intervention: Geriatric sleeves as ordered. Review of the 9/2018 physician's orders [REDACTED].M. and off at bed time, Observation, on 9/12/18 at 6:45 [NAME]M., 8:00 [NAME]M., 9:30 [NAME]M. and 10:20 [NAME]M., found Resident #19 sitting in high back wheelchair. Resident #19 was wearing a short sleeve top. Resident #19 was not wearing protective geriatric sleeves per physician's orders [REDACTED]. During an interview, on 9/12/18 at 10:45 [NAME]M., CNA #6 said that she was not aware that Resident #19 wore geriatric sleeves.
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** Based on observation, record review and interview, the facility failed to provide appropriate treatment and services to maintain ambulation abilities for 1 resident (#58) in a total sample of 19 residents. Findings include: Resident #58 was admitted to the facility in 2/2016 with [DIAGNOSES REDACTED]. Review of the Activities of Daily Living plan of care indicated: Requires assist of one with ambulation. Review of physician's orders [REDACTED]. To include therapeutic exercise/activity, neurological re-training and gait training. Review of PT - Therapist Progress and Discharge Summary of 5/30/18 included the following: At baseline functional level. At supervision/stand by assist for bed mobility, transfers. Resident #58 required a 2 wheeled walker and stand by assist/supervision for safe ambulation for 100 feet with verbal instruction/cues. Review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/29/18, indicated a Brief Interview for Mental Status (BIMS) score of 9 out of 15 (moderate cognitive loss). The resident required limited assist with ambulation in room and corridor, required extensive assist with bed mobility, transfers, and toilet use and was frequently incontinent of bowel and bladder. Review of the Certified Nursing Assistant flow sheet of 5/2018 indicated that Resident #58 ambulated 8 of 31 days. Review of the Certified Nursing Assistant flow sheet of 6/2018 indicated that Resident #58 ambulated 6 of 31 days. Review of the quarterly MDS assessment, with an ARD of 8/21/18, indicated a BIMS score of 9 out of 15 (moderate cognitive loss). The resident required extensive assist with bed mobility, transfers, toilet use, was frequently incontinent of bowel and bladder and did not ambulate in room or corridor. Review of the Certified Nursing Assistant flow sheet of 8/2018 indicated that Resident #58 ambulated 7 of 31 days. Review of the Certified Nursing Assistant flow sheet of 9/2018 indicated that Resident #58 did not ambulate. During an interview, on 9/5/18 at 10:00 [NAME]M., Family Representative #4 said that staff do not walk with Resident #58 anymore. Last year, the facility had a walk to dine program, and staff would assist Resident #58 to walk to the dining room, but that ended. Staff told Family Representative #4 that she could walk with Resident #58. Family Representative #4 said that she didn't feel safe walking with the Resident #58. Observation, on 9/10/18 at 7:50 [NAME]M., found Resident #58 sitting in a wheelchair in the hallway. During an interview, on 9/10/18 at 11:13 [NAME]M., Unit Manager #2 said that she had only been Unit Manager for a couple of months. Unit Manager #2 said that she did not know if Resident #58 could walk. During an interview, on 9/10/18 at 2:00 P.M., Nurse #2 said that she had never seen Resident #58 walk, and Resident #58 did not even have a walker in his/her room. Observation, on 9/11/18 at 8:15 [NAME]M., found Resident #58 sitting in a wheelchair in the main dining room. During an interview, on 9/11/18 at 2:30 P.M., the Rehabilitation Manager said that if a resident was having ambulation difficulties, nursing staff should fill out a therapy screening form. The Rehabilitation Director said that a therapy screening had not been submitted.
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** Based on observation, record review and staff interview, the facility failed to provide the necessary care and services for 3 residents (#7, 12 and 34), out of a total sample of 19 residents, who were unable to carry out activities of daily living (ADL), to maintain good grooming and personal hygiene. Findings include: 1. Resident #7 was admitted in 9/2014, with [DIAGNOSES REDACTED]. The 1/4/18 revised care plan for assistance with ADL task, related to [MEDICAL CONDITION]'s disease, indicated the following interventions: Encourage the resident to allow regular ADL assistance in the morning and evening. Reapproach when the resident refuses. Attempt to involve the resident in care, and encourage to participate. The Quarterly assessment, with an Assessment Reference Date (ARD) of 9/4/18, indicated a Brief Interview for Mental Status (BIMS) score of 9 out of 15 (moderate cognitive impairment). The resident was an extensive assist of 2 for bed mobility, transfer and ambulation. The resident was an extensive assist of 1 for eating, personal hygiene and bathing. The resident was always incontinent of bowel and bladder. Observation, on 9/5/18 at 1:21 P.M., found the resident in the activity room, sitting in a Broda chair. The thigh straps were dirty and had a dried substance on both sides. The resident had a beard stubble and was unshaven. Observation, on 9/10/18 at 11:39 [NAME]M., found the resident in the activity room sitting in the Broda chair, with thigh

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) straps on. The resident had a beard stubble and was unshaven. Observation, on 9/12/18 at 8:45 [NAME]M., found the resident in the small dining room. The resident had a beard stubble and was unshaven. During an interview, on 9/12/18 at 10:55 [NAME]M., CNA #3 said that she took care of the resident today and did not shave the resident. She said she did not know what the shaving schedule was for Resident #7. CNA #3 said that the resident is not resistive to care. 2. Resident #12 was admitted in 3/2008, with [DIAGNOSES REDACTED]. The current care plan for ADL self care performance deficit related to [MEDICAL CONDITION]'s disease, with loss of balance, trunk control and fine motor skills indicated the following interventions: 2 person assist for boosting and repositioning. 2 person assist and mechanical lift for transfers. Extra full body bath every evening. Clothing protector to prevent clothes from becoming soiled. The Quarterly assessment, with an ARD of 6/19/18, indicated the resident had long and short term memory deficits, was severely impaired for daily decision making, was dependent for all ADL care and was always incontinent of bowel and bladder.Observation, on 9/5/18 at 2:33 P.M., found Resident #12 in the resident's room sitting in a Broda chair. The room smelled of strong urine and feces odors. There was a brown substance on the front top of the resident's brief. Observation, on 9/5/18 at 3:15 P.M., (by Surveyor #1 and #2), found Resident #12 in the resident's in room, sitting in a Broda chair. The brown substance on the front top of the resident's brief was spreading, and a strong urine and fecal odor permeated the room. Observation, 9/5/18 at 3:45 P.M., found Resident #12 in the resident's room, sitting in the Broda chair. Urine and feces odors permeated the room and now into the hallway. Observation, on 9/5/18 at 4:10 PM. found Resident #12 sitting in the Broda chair. The brown substance area was larger and a foul urine and feces odor permeated the room and the hallway near the doorway. This was observed by Surveyors #1 and #2. At 4:12 P.M., Surveyor #1 requested that assistance be provided for Resident #12. Observation, on 9/6/18 at 7:03 [NAME]M., found Resident #12 in the resident's room, sitting in the Broda chair. The room smelled of strong stale urine. During an interview, on 9/6/18 at 11:44 [NAME]M., Family Representative #2 said that last Saturday (9/1/18), the resident's room reeked of urine. She said that often when she comes to visit the room has strong urine odors. She said she has witnessed the resident with vomit on the floor and on the resident's clothing. She witnessed the staff Hoyer lift the resident back to bed to change the resident. The staff member washed the resident with water and did not use any soap. When questioned by Family Representative #2, the staff member still did not use any soap to clean the resident. Observation, on 9/6/18 at 12:08 P.M., found Resident #12 in the resident's room, sitting in a Broda Chair. The room smelled of strong stale urine. Observation, on 9/6/18 at 4:05 P.M., found Resident #12 in the resident's room, sitting in a Broda chair. The room and the mattress smelled of strong stale urine. Observation, on 9/10/18 at 7:39 [NAME]M., found Resident #12 in the resident's room, sitting in a Broda chair. The right head rest to the Broda chair was hanging to the side of the chair and the resident's head was on the bars to the chair. The mattress and room smelled of strong stale urine. Observation, on 9/10/18 at 1:17 P.M., found Resident #12 sitting in the Broda chair, in the room. There was vomit on the resident's shirt and floor and a puddle of urine on the floor under the resident's Broda chair. This surveyor notified Unit Manager #1. She sent CNA #2 and CNA #3 to the resident's room to provide care. The resident was transferred via the Hoyer lift. The resident's pants were saturated with urine from the waist down to the knees. The resident's shirt and chest binder were soaked with vomit. The Hoyer pad was soaked with urine and the cushion on the Broda chair was saturated with urine and had a small puddle of urine on top of it. During an interview, on 9/10/18 at 1:39 P.M., CNA #2 said that the resident is up in the Broda chair before the 7:00 [NAME]M., to 3:00 P.M., staff come on duty. She said that the resident doesn't go back to bed to be changed until after the tube feeding is finished (12:00 P.M.) or later. She said the resident is up in the Broda chair for at least 6 to 7 hours because of the tube feeding. During an interview, on 9/10/18 at 2:30 P.M., Family Representative #3 said that the resident's room smells of strong urine and fecal matter when they come to visit. On (8/3/18 and 8/23/18), the most recent visits, the resident was found soaked in urine, and the resident's shirt was soaked in vomit. Family Representative #3 said the mattress is embedded with urine and the chair smells of urine. She said this has been reported to staff several times but nothing is ever done about it. During an interview, on 9/12/18 at 12:15 P.M., the DON said that the resident should be checked on rounds. 3. Resident #34 was admitted in 6/2011, with [DIAGNOSES REDACTED]. The current care plan for ADL care related to self care performance deficit due to [MEDICAL CONDITION]'s disease and cognitive impairment, indicated the following interventions: The resident needs assistance with personal/oral care. Encourage resident participation. Assist of 1 for morning and evening care. The Annual Minimum Data Set (MDS), with an ARD of 7/24/18, indicated a BIMS score of 3 out of 15 (severe cognitive deficits). The resident was an extensive assist for bed mobility, transfer, dressing, eating, personal hygiene and bathing. The resident was always incontinent of bowel and bladder. Observation, on 9/5/18 at 12:23 P.M., found Resident #34 in the unit dining room, sitting in a Broda chair, feeding self the noon meal. Resident #34 had dirty fingernails and long white facial hair on the chin. Observation, on 9/6/18 at 8:20 [NAME]M., found Resident #34 in the unit dining room, sitting in a Broda chair. There was long white facial hair on the resident's chin and the resident had dirty fingernails. Observation, on 9/10/18 at 7:31 [NAME]M., found Resident #34 lying quietly in bed with eyes closed. There was long white facial hair on the resident's chin and the resident had dirty fingernails. Observation, on 9/10/18 at 8:52 [NAME]M., found Resident #34 being assisted out of the resident's room into the unit dining room. There was long white facial hair on the resident's chin and dirty fingernails. During an interview, on 9/10/18 at 3:30 P.M., CNA #3 said that she provided the resident with care in the bathroom that morning. The resident is able to stand and pivot. She said the resident is not resistive to care. She said she did not shave the resident. Observation, on 9/11/18 at 8:46 [NAME]M., found the resident in the unit dining, sitting in a Broda chair. There was long white facial hair on the resident's chin and the resident had dirty fingernails. During an interview, on 9/11/18 at 1:15 P.M., CNA #4 said that he provided the resident with ADL care that morning and did not shave the resident's chin. He said the resident is not resistive to care.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide the necessary treatment and services to promote healing and prevent new pressure ulcers from developing for 2 of 2 applicable residents (#19 and #44), in a total sample of 19 residents. Findings include: 1. Resident #19 was admitted to the facility in 8/2016 with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of 7/3/18, indicated that the resident had short and long term memory loss, required extensive assist with bed mobility, dressing, and eating, and was dependent with transfers, toilet use, bathing, dressing and hygiene. The resident was at risk for pressure ulcers and did not have a pressure ulcer. Review of physician's orders [REDACTED]. Cleanse right buttock abrasion with normal saline. Pat dry and apply foam border dressing. Check placement every shift. Change dressing every 3 days and as needed. Review of the 9/2018 Treatment Administration Record indicated that the foam bordered dressing was applied on 9/1/18, and changed on 9/4/18 and 9/7/18. There was no documentation that the dressing was changed on 9/10/18. There was no

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	225749	A. BUILDING _____ B. WING _____	09/12/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE HEALTHCARE	620 LAUREL STREET LEE, MA 01238

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

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) documentation that the placement of the foam bordered dressing was checked every shift as ordered, and there was no way of knowing when the dressing came off. Observation, on 9/12/18 at 6:45 [NAME]M., found Resident #19 sitting in a high back wheelchair in the hallway with a Hoyer lift pad under him/her. Resident #19 was sleeping. On 9/12/18 at 6:55 [NAME]M., Certified Nursing Assistant (CNA) #5 approached Surveyor #2 and said: I told the nurse yesterday that Resident #19 had a hole on his/her butt. Now today, Resident #19 has 2 holes on his/her butt. I reported it to the nurse today, but she said, What do you want me to do about it? Observation, on 9/12/18 at 11:13 [NAME]M., found Resident #19 lying in bed on his/her left side. Resident #19's buttocks were observed with the Director of Nurses and the Assistant Director of Nurses. The Assistant Director of Nurses measured the right buttock stage II superficial pressure ulcer as 1.5 centimeters (cm) in length by 0.7 cm in width, and the left buttock stage II superficial pressure ulcer as 1.5 cm in length by 0.7 cm in width (new pressure ulcer). There was no dressing on the right buttock per physician's orders [REDACTED]. The Director of Nurses said that staff should put Resident #19 back to bed after breakfast. 2. Resident #44 was admitted to the agency in 11/2017 with [DIAGNOSES REDACTED]. Review of Physician's Progress Notes of 8/17/18 indicated the following: 3 stage II decubitus ulcers with shearing. Review of the physician's orders [REDACTED]. Put back to bed after meals. Needs pressure alternating mattress. Review of Progress Notes of 9/5/18 indicated wound left buttocks 10.0 centimeters (cm) in length by 5.0 cm in width by 0.1 cm in depth black with red edges and foul odor, right buttock 2 areas 5.0 cm by 3.0 cm circle dark brown pink tinge drainage and foul odor and lower buttock 1.0 cm by 2.0 cm circle. Review of the Physician's Progress Notes of 9/5/18 indicated that the resident had a dressing order for the sacral/coccyx decubitus ulcer. A Phrygian's order, dated 9/5/18 indicated DuoDerm ([MEDICATION NAME]) to gluteal fold every 3 days and apply Critic-Aid Paste to open areas buttocks/coccyx not covered by the DuoDerm. Observation, on 9/6/18 at 7:30 [NAME]M., found Resident #44 lying in bed on his/her back. Resident #44 was lying on a house mattress and not a pressure alternating mattress as ordered (8/17/18). Observation, on 9/10/18 at 6:40 [NAME]M. and 7:30 [NAME]M., found Resident #44 lying in bed on his/her back. Resident #44 was lying on a house mattress and not a pressure alternating mattress per physician's orders [REDACTED].>Observation, on 9/10/18 at 9:13 [NAME]M., found Resident #44 lying in bed on his/her back. There was a house mattress on the bed and not a pressure alternating mattress. Observation on 9/10/18 at 10:33 [NAME]M., found Resident #44 lying in bed on his/her right side. Nurse #2 removed 2 Biatin dressings that had a moderate amount of drainage. A DuoDerm dressing was ordered and not 2 Biatin dressings. Unit Manager #2 said that the wounds were pressure ulcers. The left buttock/coccyx stage II pressure ulcer measured 3.0 centimeters (cm) in length by 3.5 cm in width, the right upper buttock/coccyx pressure ulcer measured 2.0 cm in length by 1.0 cm in width with slough and the right lower buttock pressure ulcer measured 1.3 cm in length by 0.7 cm in width. Nurse #2 completed the treatment per physician's orders [REDACTED]. During an interview, on 9/10/18 at 11:40 [NAME]M., Unit Manager #2 said that staff did not classify the wounds as pressure ulcers. Unit Manager #2 said that when the physician identified the wounds as decubitus ulcers (8/17/18) the ulcers were not measured, and she was unable to find any weekly measurements until 9/5/18. Unit Manager #2 said she would order the pressure reduction mattress. During an interview, on 9/10/18 at 1:07 P.M., Nurse #5 said that she reviewed the new orders (of 8/17/18). Nurse #5 said that she didn't know how to order the mattress and passed it on to the next shift. Nurse #5 said, that it must have been missed, because Resident #44 still did not have the pressure alternating mattress in place.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to provide appropriate treatment and services for bowel and bladder incontinence, for 1 resident (#12) out of a total sample of 19 residents. Findings include: Resident #12 was admitted in 3/2008, with [DIAGNOSES REDACTED]. The current care plan for bowel and bladder incontinence related to immobility, decreased sensation, communication deficits and neurological disease indicated the following interventions: * Provide pericare after each incontinent episode. * Provide protective skin barrier and adult briefs as needed. The Quarterly assessment, with an Assessment Reference Date of 6/19/18, indicated the resident had long and short term memory deficits, was severely impaired for daily decision making, was dependent for all ADL care and was always incontinent of bowel and bladder. Observation, on 9/5/18 at 8:22 [NAME]M., found Resident #12 in the resident's room, sitting in a Broda chair. The room had a strong stale urine odor. Observation, on 9/5/18 at 11:33 [NAME]M., found Resident #12 in the resident's room, sitting in a Broda chair. There was a strong stale urine odor by the resident. Observation, on 9/5/18 at 12:00 P.M., found Resident #12 in the resident's room, sitting in a Broda chair. The room smelled of strong urine and feces. Observation, on 9/5/18 at 1:35 P.M., found Resident #12 in the resident's room, sitting in the Broda chair. Urine and feces odors permeated the room. Observation, on 9/5/18 at 2:33 P.M., found Resident #12 in the resident's room, sitting in a Broda chair. The resident and room smelled of strong urine and feces odors. There was a brown substance on the front top of the resident's brief. Observation, on 9/5/18 at 3:15 P.M., by Surveyor #1 and #2, found Resident #12 in the resident's in room, sitting in a Broda chair. The brown substance on the front top of the resident's brief was spreading, and a strong urine and fecal odor permeated the room. Observation, 9/5/18 at 3:45 P.M., found Resident #12 in the resident's room, sitting in the Broda chair. Urine and feces odors permeated the room and now into the hallway. Observation, on 9/5/18 at 4:10 P.M., found Resident #12 in the resident's room, sitting in the Broda chair. The brown substance area was larger and a foul urine and feces odor permeated the room and the hallway near the doorway. This was observed by Surveyors #1 and #2. At 4:12 P.M., Surveyor #1 requested that incontinent care be provided for Resident #12. Observation, on 9/6/18 at 7:03 [NAME]M., Resident #12 was observed sitting in the Broda chair. The room smelled of strong stale urine. During an interview, on 9/6/18 at 11:44 [NAME]M., Family Representative #2 said that last Saturday (9/1/18), the resident's room reeked of urine. She said that often when she comes to visit the room has strong urine odors. She witnessed the staff Hoyer the resident back to bed to change the resident. The staff member washed the resident with water and did not use any soap. When staff was questioned by Family Representative #2, the staff member still did not use any soap to clean the resident. Observation, on 9/6/18 at 12:08 P.M., found Resident #12 in the resident's room, sitting in a Broda Chair. The room smelled of strong stale urine. Observation, on 9/6/18 at 4:05 P.M., found Resident #12 in the resident's room, sitting in a Broda chair. The room and the mattress smelled of strong stale urine. Observation, on 9/10/18 at 7:39 [NAME]M., found Resident #12 in the resident's room, sitting in a Broda chair. The mattress and room smelled of strong stale urine. Observation, on 9/10/18 at 1:17 P.M., found Resident #12 sitting in the Broda chair, in the resident's room. There was a puddle of urine on the floor under the resident's Broda chair. This surveyor notified Unit Manager #1. She sent CNA #2 and CNA #3 to the resident's room to provide care. The resident was transferred via the Hoyer lift. The resident's pants were saturated with urine from the waist down to the knees. The Hoyer pad was soaked with urine and the cushion on the Broda

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) chair was saturated with urine and had a small puddle of urine on top of it. During an interview, on 9/10/18 at 1:39 P.M., CNA #2 said that the resident is up in the Broda chair before the 7:00 [NAME]M. to 3:00 P.M. staff come on duty. She said that the resident doesn't go back to bed to be changed until after the tube feeding is finished (12:00 P.M.) or later. She said the resident is up in the Broda chair for at least 6 to 7 hours because of the tube feeding, sometimes longer. During an interview, on 9/10/18 at 2:30 P.M., Family Representative #3 said that the resident's room smells of strong urine and fecal matter when they come to visit. On (8/3/18 and 8/23/18), the most recent visits, the resident was found soaked in urine. Family Representative #3 said the mattress is embedded with urine and the chair smells of urine. She said this has been reported to staff several times but nothing is ever done about it. During an interview, on 9/12/18 at 12:15 P.M., the DON said that the resident should be checked on rounds.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the Resident Council Minutes and weekly staffing schedules, and interview, the facility failed to provide sufficient nursing staff to provide nursing and related services. Findings include: [NAME] Review of Resident Council Minutes, (of 8/21/18), indicated that the residents complained that the CNAs say that they will come back in a few and not come back On 9/10/18 at 1:35 P.M., during the Resident Group Meeting, 4 of 6 residents (#9, #20, #32, #38) voiced complaints relative to the delay in call bell response time by the staff. The residents said the following: 4 residents informed the surveyor that they believe there is a delay in answering their call bells due to not having enough staff to answer them. 1. Resident #9 said that she/he can wait anywhere between a half an hour to 2 hours before her/his call bell is answered. The resident said that this happens almost every day and it usually occurs on the 11:00 P.M. to 7:00 [NAME]M. shift. 2. Resident #20 said that it can take up to 4 hours before anyone will answer the call bell. The resident said that this occurs usually a couple of times a week, especially on the 3:00 P.M. to 11:00 P.M. shift. 3. Resident #38 said that he/she can usually wait about a half an hour before his/her call bell is answered. The resident said this can occur 2 to 3 times a week and that it usually occurs on the 7:00 [NAME]M. to 3:00 P.M. shift. The resident further said that the weekends are the worst relative to the staff not answering the call bells timely and that he/she will often see staff just walk by the room even though the call light is on. 4. Resident #32 said the staff are very slow answering her/his call bell (but could not give an estimated length of time), on all shifts. The resident said this happens almost every day and that she/he has seen staff ignore the call bell because they will walk by her/his room even when the call bell is sounding. The resident further said the weekends are the worst for answering call bells. B. Review of the weekly staffing schedule indicated that the plan was for 2 Certified Nursing Assistants and 1 licensed staff on the 11:00 P.M. to 7:00 [NAME]M. shift for both units. Review of the actual work schedule on the 11:00 P.M. to 7:00 [NAME]M. shift indicated the following: 8/3/18 - first floor - census 33 - 1 CNA and 1 nurse. 8/4/18 - first floor - census 31 - 1 CNA and 1 nurse. 8/4/18 - second floor - census 38 - 1 CNA and 1 nurse. 8/6/18 - second floor - census 38 - 1 CNA and 1 nurse. 8/8/18 - second floor - census 38 - 1 CNA and 1 nurse. 8/10/18 - first floor - census 33 - 1 CNA and 1 nurse. 8/21/18 - first floor - census 32 - 1 CNA and 1 nurse. 8/21/18 - second floor - census 38 - 1 CNA and 1 nurse. 8/27/18 - first floor - census 33 - 1 CNA and 1 nurse. 9/1/18 - second floor - census 38 - 1 CNA and 1 nurse. 9/3/18 - first floor - census 32 - 1 CNA and 1 nurse. 9/4/18 - first floor - census 33 - 1 CNA and 1 nurse. (9/8/18) - first floor - census 34 - 1 CNA and 1 nurse. (9/9/18) - first floor - census 34 - 1 CNA and 1 nurse. (9/10/18) - first floor - census 36 - 1 CNA and 1 nurse. (9/10/18) - second floor - census 37 - 1 CNA and 1 nurse. (9/11/18) - second floor - census 37 - 1 CNA and 1 nurse. During an interview, on 9/5/18 at 9:59 [NAME]M., Resident #60 informed the surveyor that she/he has to wait a long time (almost daily) for the staff to answer the call bell. Resident #60 tries to hold it as long as he/she can, but starts to leak a little bit. On the previous weekend, he/she did not get any breakfast and rang the call bell. The CNA asked the kitchen for a breakfast tray, but the kitchen said it was too late. The CNA got him/her a coffee. Resident #60 said there was not enough staff. During an interview, on 9/5/18 at 12:34 P.M., Resident #11 informed the surveyor that it can take the staff up to one hour before they will answer the call bell. Resident #11 said that he/she and has to sit in stool or saturated brief. During an observation, on 9/5/18 at 3:20 P.M., Resident #40 was yelling nurse nurse. Surveyors #1 and #2 entered the room and the resident said he/she wanted to go to bed because his/her back was hurting. Surveyor #1 asked the resident to turn on the call light. At 3:22 P.M., the resident turned on the call light. The call light sounded at the nurse's station. There were 4 to 5 staff members at the nurses' station and no one responded to the call light. The resident continued to call out. At 3:42 P.M., Surveyor #2 informed Unit Manager #1 of the resident's call bell and his/her calling out. The Unit Manager #1 said she would have someone go down to the resident's room, (20 minutes later) after surveyor notified staff. During an interview, on 9/10/18 at 10:15 [NAME]M., Family Representative #5, said that on (9/7/18) she arrived around 10:00 [NAME]M., found Resident #58 lying on his/her back in bed, naked from the waist down. Resident #58 was lying in diarrhea up his/her back. Some of the feces was dried on his/her body. Resident #58 said he/she had been lying there for a long time. Family Representative #5 put the call bell on and waited a long time for the call be to be answered. Family Representative #5 said she looked for staff to assist, but could not find any staff. On 9/11/18 at 8:25 [NAME]M., Resident #32's call bell was lit up outside his/her bedroom and at nurses' station. The call bell was sounding loudly. The resident was loudly calling out for help. At 8:35 [NAME]M., when the resident again called out loudly, Surveyor #2 responded, Resident #32 was found sitting on the toilet. Resident #32 said that he/she was sitting there for quite a while. Resident #32 said, I think they forgot about me. Surveyor #2 left to try and find a staff member. Staff responded at 8:39 [NAME]M. (14 minutes). During an interview, on 9/11/18 at 10:05 [NAME]M., Unit Manager #1 said that there were 27 residents on unit 2 with a [DIAGNOSES REDACTED]. On 9/12/18 6:55 [NAME]M., CNA #5 said that she works alone a lot on 11:00 P.M. to 7:00 [NAME]M. shift. CNA #5 said she has to take care of over 30 residents, and it's not safe.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility staff failed to ensure that the medication error rate was not 5 percent or greater. There were 31 opportunities and 2 errors resulting in a 6.25 percent error rate. This affected 2 residents (#5 and #9) in a total sample of 19 residents. Findings include: 1. Resident #5 was admitted to the facility in 12/2010 with a [DIAGNOSES REDACTED]. According to the Nursing (YEAR) DRUG HANDBOOK: If resident receives more than 1 inhalation of [MEDICATION NAME], wait at least 2 minutes between inhalations. Review of physician's orders [REDACTED]. During a medication pass, on 9/11/18 at 10:09 [NAME]M., Resident #5 was observed sitting in a wheelchair in his/her bedroom.

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) Nurse #4 was observed administering medications to Resident #5. Nurse #4 shook the [MEDICATION NAME] inhaler and then handed it to Resident #5 with no instruction. Resident #5 administered 2 simultaneous puffs and did not wait at least 2 minutes in between inhalations. This was an error of wrong time. During an interview, on 9/11/18 at 10:15 [NAME]M., Nurse #4 said that Resident #5 should wait 2 minutes between puffs. 2. Resident #9 was admitted to the facility in 6/2018 with [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED]. During a medication pass, on 9/11/18 at 7:45 [NAME]M., Nurse #2 was observed pouring Resident #9's medications. Nurse #2 poured [MEDICATION NAME], Calcium 630 mg with Vitamin D 500 IU instead of the ordered dose of [MEDICATION NAME], Calcium 250 mg with Vitamin D 200 IU. Surveyor #2 stopped Nurse #2 from administering the [MEDICATION NAME]. Nurse #2 and Surveyor #2 checked the medication cart, medication room and central supply. This was an error of wrong dose. During an interview, on 9/11/18 at 8:00 [NAME]M., Nurse #2 said that the only dose available was [MEDICATION NAME], Calcium 630 mg with Vitamin D 500 IU.
F 0825 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or get specialized rehabilitative services as required for a resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility staff failed to implement the plan of care for rehabilitation services for one Resident, #41< out of a total sample of 19 residents. Resident #41 was admitted to the facility in 3/2011. Review of the Range of Motion (ROM) care plan, of 8/16/18, indicated that a right hand splint should be applied at 8:00 P.M. and removed at 8:00 [NAME]M. Review of the 9/2018 physician's orders [REDACTED]. On 9/10/18 at 6:51 [NAME]M., the surveyor observed the resident sitting in a high back wheelchair, in front of the Nurse's Station and her/his right hand splint was not on, as planned. The resident's hand was lying on her/his right leg with her/his fingers contracted into the palm of her/his hand. On 9/11/18 at 6:42 [NAME]M., the surveyor observed the resident lying in bed and the right hand splint was not on, as planned. During an interview with Certified Nursing Assistant (CNA) #5, on 9/11/18 at 6:50 [NAME]M., she said that when she arrived at 11:00 P.M. for her shift that the resident did not have her right hand splint on. She further said .I think she's supposed to have it (splint) on but I was never educated on how to place it on (her/him) so I don't put the splint on On 9/12/18 at 6:45 [NAME]M., the surveyor observed the resident sitting in a high back wheelchair, in front of the Nurse's Station and her/his right hand splint was not on, as planned. The resident's hand was lying on her/his right leg with her/his fingers contracted into the palm of her/his hand. During an interview with CNA #5, on 9/12/18 at 6:57 [NAME]M., she said that when she arrived at 11:00 P.M. for her shift that the resident again did not have her/his right hand splint on, (as planned). During a discussion and interview with Nurse #3, on 9/12/18 at 7:34 [NAME]M., (regarding CNA #5's interview and review of the Treatment Administration Record/TAR), Nurse #3 said that although the TAR documentation indicated that the resident did have her/his splint put on the previous night that she honestly forgot to put it on . She said the TAR was inaccurate relative to the documentation of the splint application and that the resident's care plan was not being followed. Please refer to F 842.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to maintain medical records for 4 residents (#9, #41, #58 and #63) that were complete and accurately documented, out of a total sample of 19 residents. Findings include: 1. For Resident # 63, the facility failed to ensure that the resident's Code Status was documented accurately. Resident #63 was admitted to the facility in 3/2018. Review of the MOLST (Massachusetts Medical Orders for Life Sustaining Treatment) form (which would be followed by emergency medical services personnel in out of hospital/nursing home settings/signed by the resident on 3/29/18) indicated that his/her wishes were to be a DNR (Do Not Resuscitate) in the event he/she were in cardiac or respiratory arrest. Review of the Social Work Progress Note of 8/21/18 indicated that upon the resident's return from the hospital the resident was a DNR. Review of the physician's orders [REDACTED]. During an interview with Nurse #2, on 9/11/18 at 1:24 P.M., a discussion was held relative to the resident's Code Status and Nurse #2 said that if this resident's heart stopped she would only check the MOLST form and not the Physician orders [REDACTED]. She said that she knows that this resident's wishes were for a DNR due to discussions held with the resident. The surveyor then showed Nurse #2 the (9/6/18) physician's orders [REDACTED]. Nurse #2 said that the Physician orders [REDACTED]. During an interview with the Director of Social Services on 9/11/18 at 1:51 P.M., a discussion was held relative to the Social Work Progress Note (of 8/21/18) which indicated that the resident was a DNR. During the discussion, the Director of Social Services said she would recheck the resident's wishes immediately and upon returning to the surveyor, she said that the resident continued to request to be a DNR. During an interview with Unit Manager (UM) #2 on 9/11/18 at 2:04 PM, the Surveyor showed UM #2 the contradictory documentation relative to the MOLST form and the Physician orders [REDACTED]. 2. For Resident # 9, the facility failed to ensure that the resident's medical record was complete. Resident #9 was admitted to the facility in 6/2018. Review of the Progress Note of 7/10/18 indicated that a physician's orders [REDACTED]. During an interview with UM #2, on 9/10/18 at 10:53 [NAME]M., she said that when the resident was readmitted to the facility, the nurse on duty should have documented in the resident's Progress Notes that the resident was readmitted to the facility. During medical record review with the surveyor, UM #2 said a Progress Note relative to the resident's return to the facility (after the hospitalization on [DATE]) had not been completed, therefore the medical record was incomplete. 3. For Resident #41, the facility failed to ensure that the resident's Treatment Administration Record (TAR) was documented accurately. Resident #41 was admitted to the facility in 3/2011. Review of the Physician orders [REDACTED]. Review of the TAR of 9/11/18 indicated that the resident's right hand splint had been applied at night and was removed in the [NAME]M. During an interview with CNA (Certified Nursing Assistant) #5, on 9/12/18 at 6:57 [NAME]M., she said that when she had arrived at 11:00 P.M. for her shift, the resident did not have his/her right hand splint on (as planned). During a discussion and interview with Nurse #3 on 9/12/18 at 7:34 [NAME]M., (regarding CNA #5's interview and review of the TAR), Nurse #3 said that although the TAR documentation indicated that the resident did have her/his splint put on the previous night that she honestly forgot to put it on. She said the TAR was inaccurate relative to the documentation of the splint application. 4. For Resident #58, the facility failed to ensure that the medical record was complete. Resident #58 was admitted to the facility in 2/2016 with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, with an ARD of 8/21/18, indicated a BIMS score of 9 out of 15 (moderate cognitive loss). The resident required extensive assist with bed mobility, transfers, toilet use, was frequently incontinent of bowel and bladder and did not ambulate in room or corridor. Review of the plan of care for fall risk included the following interventions: *Alarming floor mat. *Bed alarm in bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. BUILDING _____ B. WING _____	09/12/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE HEALTHCARE	620 LAUREL STREET LEE, MA 01238

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** - Some	(continued... from page 7) *Tabs alarm in wheel chair. *Not to be left alone in bathroom. * Supervised area when out of bed. Review of the Progress Notes and Fall Investigation, of 8/28/18 at 12:24 [NAME]M., indicated that Resident #58 was found on the bathroom floor next to the wheelchair. The Tabs alarm was on the wheelchair. Resident #58 said that he/she was trying to wipe himself/herself. There was no further documentation in the medical record regarding the circumstances of the fall. During an interview, on 9/10/18 at 11:13 [NAME]M., Unit Manager #2 said that she wasn't there at the time of the fall. Unit Manager #2 said that the medical record was incomplete, and there was no further investigation regarding the circumstances of the fall or witness statements. Unit Manager #2 did not know if the certified nursing assistant transported Resident #58 to the toilet via the wheelchair, and then left the resident alone on the toilet. Unit Manager #2 did not know if Resident #58 got himself/herself out of bed, and transferred his/herself to the bathroom (the MDS indicated that the resident did not ambulate and was extensive assist with transfers). There was no mention of the bed alarm or alarming floor mat.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policies and interview, the facility failed to: [NAME] Implement policies and procedures that inhibit microbial growth in building water systems, failed to implement a water management program, and failed to conduct a risk assessment for potential areas of growth and spread of Legionella. B. Provide adequate infection control practices related to keeping the indwelling catheter bag and tubing off the floor at all times, to reduce risk of infection, for 2 of 5 applicable residents (#44 and #51) in a total sample of 19 residents. Findings include: [NAME] Review of infection control policies and procedures, indicated a policy for Legionella Water Management Program: the policy was revised in 8/2018 and included the following: 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2. The water management team will consist of at least the following personnel: a. The infection Preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; and e. Other members assigned by the Administrator. 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease . During an interview, on 9/5/18 at 9:20 [NAME]M., the Maintenance Director and the Administrator said that they did not have a water management program in place related to Legionella that was overseen by a water management team. During an interview, on 9/12/18 at 9:00 [NAME]M., the Assistant Director of Nurses/Staff Development Coordinator said that there was a Legionella Water Management Program Policy but it had not been implemented. B1. Resident #44 was admitted to the facility in 11/2017 with a [DIAGNOSES REDACTED]. Review of Progress Notes indicated that the suprapubic catheter was inserted on 2/15/18. Review of the quarterly Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of 8/7/18, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (intact cognitive status). The resident required extensive assist with bed mobility, bathing, hygiene, dressing, was dependent with transfers and utilized an indwelling catheter. Review of 9/2018 physician's orders [REDACTED]. Empty catheter bag every shift. Observation, on 9/05/18 at 7:15 [NAME]M. and 7:30 [NAME]M., found Resident #44 lying in bed on his/her back. The indwelling catheter bag was resting on the floor at the foot of bed. Observation, on 9/6/18 at 11:45 [NAME]M., found Resident #44 sitting in wheelchair in his/her bedroom. The indwelling catheter bag was inside a privacy bag attached to the bottom of the wheelchair, but the catheter tubing was dragging on the floor. During an interview, on 9/10/18 at 11:20 [NAME]M., Unit Manager #2 said that the catheter bag and tubing should be kept off the floor at all times. B2. Resident #51 was admitted to the facility in 7/2018 with [DIAGNOSES REDACTED]. Review of the 7/2018 physician's orders [REDACTED]. Review of the admission MDS assessment, with an ARD date of 7/23/18, indicated a BIMS score of 6 out of 15 (severe cognitive impairment). The resident required extensive assist with bed mobility, transfers, bathing dressing, hygiene and utilized an indwelling catheter. Observation, on 9/05/18 at 7:10 [NAME]M. and 7:30 [NAME]M., found Resident #51 lying in bed. The catheter bag was observed lying directly on the floor. Observation, on 9/10/18 at 6:45 [NAME]M. and 7:15 [NAME]M., found Resident #51 lying in bed. The indwelling catheter bag was observed lying on the floor under the bed. During an interview, on 9/10/18 at 11:15 [NAME]M., Unit Manager #2 said the catheter bag should be kept off the floor at all times.