STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225067	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wedgemere Healthcare	146 Dean Street Taunton, MA 02780

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on observation, interview, and record review, the facility failed to develop and implement an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs for one Resident (#23), out of 18 sampled residents. Specifically, the facility failed to ensure a comprehensive care plan was developed and implemented to address the care and management of Resident #23's Diabetes Mellitus (non-insulin dependent diabetes). Findings include: Review of the facility's policy titled Care Plans: Comprehensive Person-Centered, dated as last revised 1/2024, indicated but was not limited to the following: -A comprehensive care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial, and functional needs. -The care plan interventions are derived from information gathered from the comprehensive assessment. -The comprehensive care plan will identify problem areas and their causes as warranted and developing interventions that are targeted and meaningful to the resident. Resident #23 was admitted to the facility in October 2024 with diagnoses which included Diabetes Mellitus with other specified complications, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and unspecified fall. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #23 had a diagnosis of Diabetes Mellitus, took insulin, and had recent falls. The MDS failed to indicate that the Brief Interview for Mental Status (BIMS) had been completed to determine cognitive status. Further review of the medical record indicated a BIMS assessment was completed on 1/15/25, and Resident #23 scored 4 out of 15, indicating severe cognitive impairment. Review of the Hospital Discharge Summary, dated 10/28/24, indicated: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reason for Exam: status post fall with hypoglycemia (low blood sugar) noted. Given poor intake developed hypoglycemia. Diabetic medication regime was adjusted inpatient and discharged to facility for rehab and further management on a diabetic diet with hypoglycemic protocol. Review of the Physician's Orders indicated but were not limited to the following: -Jardiance Oral Tablet 10 milligrams (mg) by mouth one time a day (10/29/24) (lowers blood sugar) -Metformin HCL 500 mg by mouth two times a day. (10/29/24) (lowers blood sugar) -Lantus SoloStar subcutaneous Solution Pen-Injector 100 units/milliliter (ml) inject 7 units subcutaneously at bedtime. (11/20/24) (long-acting insulin to lower blood sugar) Review of the Comprehensive Care Plan failed to indicate a care plan for Diabetic Management had been developed for Resident #23. During an interview on 1/16/25 at 3:54 P.M., Nurse #1 said Resident #23 should have had a care plan since admission for Diabetes and was unsure why he/she did not have one. Additionally, she said he/she should have diabetic monitoring orders, and he/she did not have those either. During an interview on 1/21/25 at 1:03 P.M., the Director of Nurses (DON) said a Resident with a diagnosis of diabetes should have a care plan in place, monitor blood sugars as ordered, administer medications as ordered, and have a diabetic order set in place, including monitoring for hypo/hyperglycemia and parameters of when to notify the physician.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41106 Based on observation, interview, and record review, the facility failed to follow professional standards of practice for two Residents (#54 and #23), out of a total sample of 18 residents. Specifically, the facility failed: 1. For Resident #54, to ensure the facility implemented the consultant eye doctor's recommendations for eye drops; and 2. For Resident #23, to ensure physician requested/recommended treatments were entered into the electronic medical record and implemented. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #54 was admitted to the facility in May 2023 with diagnoses which included diabetes, dry eye, and presbyopia (gradual, age related loss of eyes to focus on nearby objects). Review of the Minimum Data Set assessment, dated 8/14/24, indicated Resident #54 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the Resident was cognitively intact. Review of the consultant progress note titled Eye Care Group, dated 11/28/24, indicated but was not limited to the following: -New medication order: Refresh Dry Eye Therapy oph. Solution, apply one drop both eyes twice daily for indefinitely. Review of the Physician's Orders from 11/28/24 through 1/21/25, indicated there were no orders for Refresh Dry Eye Therapy. During an interview on 1/14/25 at 3:08 P.M., Resident #54 said he/she was seen by the eye doctor who ordered eye drops, but he/she has never received them. Resident #54 said it has been weeks since he/she saw the eye doctor. During an interview on 1/16/25 at 5:05 P.M., the Director of Nursing (DON) said when a resident has new orders from a consultant physician, the nurse should notify the resident's physician, and the orders should be written and the medication ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 5:10 P.M., Resident #54 was upset and said to the surveyor and the DON, the eye doctor recommended eye drops and he/she still has not received them. The facility does not have a policy for consultant physician appointments. 48084 2. Resident #23 was admitted to the facility in October 2024 with diagnoses which included Diabetes Mellitus with other specified complications, Type 2 Diabetes Mellitus with diabetic neuropathy, and unspecified fall. Review of the MDS assessment, dated 11/1/24, indicated Resident #23 had a diagnosis of Diabetes Mellitus, took insulin, and had recent falls. The MDS failed to indicate that the Brief Interview for Mental Status (BIMS) had been completed to determine cognitive status. Further review of the medical record indicated a BIMS assessment was completed on 1/15/25 and Resident #23 scored 4 out of 15, indicating severe cognitive impairment. Review of the Hospital Discharge Summary, dated 10/28/24, indicated: Reason for Exam: status post fall with hypoglycemia (low blood sugar) noted. Given poor intake developed hypoglycemia. Diabetic medication regime was adjusted inpatient and discharged to facility for rehab and further management on a diabetic diet with hypoglycemic protocol. Review of the Physician's Orders indicated but were not limited to the following: -Health Care Proxy (HCP) invoked (11/26/24) -Diet: Soft bite sized food, one to one supervision with cues for multiple swallows, cue for cough after thin liquids. Follow Aspiration Precautions every shift. (12/26/24) -Jardiance Oral Tablet 10 milligram (mg) by mouth one time a day (10/29/24) (lowers blood sugar) -Metformin HCL 500 mg by mouth two times a day. (10/29/24) (lowers blood sugar) -Lantus SoloStar subcutaneous Solution Pen-Injector 100 units/milliliter (ml) inject 7 units subcutaneously at bedtime. (11/20/24) (long-acting insulin to lower blood sugar) Review of the physician's progress notes indicated the following: -10/31/24: Chief Complaint: Fall with recent history or alcohol intoxication and polypharmacy (use of multiple medications usually more than five to treat medical conditions). Appears in a poor general state. -11/1/24: Chief Complaint: Recent pneumonia with continued cough. Admission orders: Monitor glucose levels and adjust diabetic medications as needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/7/24: Chief Complaint: Routine follow up: Plan: Diabetes Management: reinforce dietary modifications and ensure compliance with antidiabetic medications. Arrange HbA1c (hemoglobin A1C-blood test to show average blood glucose level over the last two to three months) -11/8/24: Chief Complaint: pneumonia: Plan: Start Levaquin 750 mg daily for 10 days, start probiotic daily for 14 days, repeat chest x-ray (CXR) after completion of Levaquin (11/19/24), and repeat complete blood count (CBC) and compete metabolic panel (CMP) (blood tests) after completion of Levaquin (11/19/24). Nursing made aware of new orders. New orders will be input into Point Click Care (PCC-the electronic medical record). -11/14/24: Chief Complaint: routine follow up: white blood cell count (WBC) remains elevated, currently on Levaquin for suspected infection. Plan: Repeat WBC on the next lab day to assess trend. 1/2/25: Chief Complaint: routine follow up: Recent hospitalization : Diabetes Mellitus Plan: continue current regimen, monitor glucose levels closely, HbA1c follow up in 3 months. -1/7/25: Chief Complaint: Progress Note 30/60 day: Diabetes Management: Continue Lantus and Metformin. Monitor blood glucose levels regularly. Further review of the medical record failed to indicate blood glucose monitoring was implemented, failed to indicate the lab work was scheduled (HbA1c, CBC, CMP), and failed to indicate the repeat CXR was scheduled. During an interview on 1/16/25 at 3:54 P.M., Nurse #1said the physician's progress notes get uploaded directly into PCC and the nurses on the floor do not routinely go in and read them. She said there is no Unit Manager and is unsure if anyone reads the notes on a regular basis. She said regarding the orders the physician wants written, they are relayed to nursing either verbally or sometimes they write them on a physician order sheet and leave them for us. She said she did not know why these orders from their progress notes were never clarified and carried out. Review of the progress notes failed to indicate communication between the provider and nursing had taken place to clarify the frequency of requested glucose monitoring. During an interview on 1/17/25 at 9:07 A.M., Physician #1 said the plan/orders written in his notes is reviewed with the nurse and his expectation is for the order to be entered into PCC. He said he usually communicates his plan verbally. Additionally, he said Resident #23 was hospitalized with hypoglycemia and had medication adjustments made. He said his expectation is that the hypoglycemic protocol was in place and CBGs were ordered to monitor his/her blood sugars to adjust medication as needed. He said he was not aware the CBGs were not ordered nor the follow up labs and CXR and did not know why they were not done as they should have been.

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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. 41106 Based on observation, interview, and record review, the facility failed to provide an ankle foot orthosis (AFO) brace and to ensure left arm sling was worn for one Resident (#66), out of a total of 18 residents, so that he/she could carry out their activities of daily living, specifically regarding mobility and left shoulder support. Findings include: Resident #66 was admitted to the facility in October 2024 with diagnoses which included hemiplegia (weakness or paralysis of one side of body) following a cerebrovascular disease (stroke) affecting left side, dislocated left shoulder, and a history of falls. Review of the Minimum Data Set (MDS) assessment, dated 11/6/24, indicated Resident #66 scored 10 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident had moderate cognitive impairment. In addition, Section GG 0115 indicated Resident #66 had functional limitations in range of motion with lower extremity impairment on one side. Resident #66 also required substantial to maximal assistance to put on/off footwear. Review of Resident #66's Care Plan (initiated 11/13/24) indicated but was not limited to the following: -Activities: The Resident requires assistance from staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and physical limitations. Ensure that adaptive equipment that the resident needs is provided and is present and functional. -Fall risk: The Resident is at risk for falls related to confusion, deconditioning, gait (walking)/balance problems. Rehab to evaluate and treat as ordered. Stroke: The Resident has hemiplegia related to stroke. Left-sided weakness. The Resident will maintain optimal status and quality of life within limitations imposed by the hemiplegia through review date. Review of Resident #66's Physician's Orders indicated but were not limited to the following: -Left AFO brace in place at all times while out of bed, initiated 12/10/24. -Check skin integrity daily, initiated 12/10/24. -Sling in place to left arm, remove and check skin integrity daily at bedtime, initiated 11/22/24 and discontinued 1/21/25. Review of Resident #66's Treatment Administration Record (TAR) for January 2025 indicated but was not limited to the following: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Left AFO brace in place at all times while out of bed. Check skin integrity daily. Review of the TAR indicated the AFO brace was applied daily from 1/1/25 through 1/20/25 (total of 20 days). -Sling in place to left arm, remove and check skin integrity daily at bedtime. Review of the TAR indicated the sling was applied 1/1/25 through 1/5/25, 1/7/25 through 1/11/25, and 1/13/25 through 1/20/25 (Total of 17 days). During an interview on 1/14/25 at 10:32 A.M., Resident #66 said they stopped his/her therapy, and he/she does not know why. The surveyor then observed Resident #66 walking in his/her room, with no shoes on, no AFO brace on the left lower leg, and no sling on left arm. On 1/14/25 at 1:32 P.M., the surveyor observed Resident #66 sitting in a chair in his/her room, wearing socks with no AFO brace and no left arm sling. On 1/15/25 at 4:32 P.M., the surveyor observed Resident #66 in his room walking with a cane, wearing slipper socks on both feet. The Resident was not wearing an AFO brace or a left arm sling. During an interview on 1/17/25 at 2:15 P.M., Rehab Staff #2 said Resident #66 received physical therapy services from 11/1/24 through 1/20/25. During that time, Resident #66 tried a couple different AFO braces, but the ones they had, the Resident said, hurt his/her leg. Rehab Staff #2 said she did request to her Rehab director the need for a custom AFO and was not sure where it went. Rehab Staff #3 said Resident #66 has a sling to wear and a palm guard to wear for the left hand. He said Resident #66 doesn't always wear them. During an interview on 1/21/25 at 10:05 A.M, the Rehab Director (RD) said Resident #66 came in with an old AFO which he/she will not wear. The RD said he remembers a discussion about obtaining a custom AFO for Resident #66, but said they do not have anyone that comes to the facility to provide a custom splint. The RD said he was not aware the AFOs tried in the facility were causing pain, he just thought Resident #66 would not wear the AFO. During an interview on 1/21/25 at 10:12 A.M., Rehab Staff #2 said they were trialing AFOs they had in the facility, but they were not comfortable. She said she spoke to the RD about getting a custom AFO for Resident #66. Rehab Staff #2 showed the surveyor the shoe and the AFO which was last trialed with Resident #66 which she had in the rehab room. Rehab Staff #2 said she removed it from the Resident's room because it caused pain and didn't want the Resident using it. The RD and Rehab Staff #2 both agreed they had discussions about obtaining a custom AFO, but they never followed up arranging for Resident #66 to get a custom AFO. During an interview on 1/21/25 at 10:55 A.M., the Director of Nurses (DON) said she was not aware of any request for a custom AFO and the last she heard, Resident #66 had an AFO in his/her room. The DON said the nurses should not be signing off the AFO is being put on daily when it's not available. During an interview using an interpreter (Certified Nursing Assistant #4) on 1/21/25 at 10:32 A.M., Resident #66 said he/she does have a sling in the bag on the bedside table, but nobody puts it on him/her. Resident #66 said the brace (AFO) is not in the room, therapy took it back the last day of therapy. Resident #66 said the brace (AFO) was too hard and hurt his/her leg, pointing at the back of the lower leg. Resident #66 said if he/she had a better brace, he/she would be able to walk better.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 49425 Based on observation, record review and interviews, the facility failed to ensure staff provided appropriate care and services for one Resident (#46) with a Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication), out of 18 sampled residents. Specifically, the facility failed to administer the prescribed enteral (form of nutrition that is delivered into the digestive system as a liquid) feeding, document administration tubing set changes every 24 hours and ensure the labels included the accurate Resident name, date, start time and rate of infusion. Findings include: Review of the facility's policy titled Enteral Nutrition, dated as revised 9/2018, included but was not limited to the following: -An enteral formulary is established to meet the nutrient needs of the residents and guide physician's orders Review of Lippincott Nursing Procedures - 9th Edition (2023), indicated but was not limited to the following: -Verify the practitioner's order, including the patient's identifiers, prescribed enteral formula, -Compare the label on the enteral formula container to the order in the patient's medical record. -Make sure that the enteral formula container is labeled with the patient's identifiers; formula name (and strength if diluted); date and time of formula preparation; date and time that the formula was hung; administration route, rate, and duration (if cycled or intermittent); initials of who prepared, hung, and checked the enteral formula against the order; expiration date and time. -Label the enteral administration set with the date and time that it was first hung. -If you're using a closed system, change the administration set according to the manufacturer's instructions Resident #46 was admitted to the facility in September 2024 with diagnoses including dysphagia (difficulty swallowing liquid or food), and intercranial hemorrhage (bleeding in the brain). Review of the Minimum Data Set (MDS) assessment, dated 11/13/24, indicated Resident #46 had a feeding tube and the portion of the total calories the resident received through a feeding tube was 51% or more. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 9:35 A.M., the surveyor observed Resident #46 lying in bed with the head of the bed elevated. The feeding pump was set at 45 milliliters (ml) per hour (hr) and flush 150 ml per 6 hr. The formula label said Osmolite 1.5. The label was dated 1/14 with the Resident's last name. No other information was documented on the label. The water flush bag was dated 1/12/25 at 7:00 A.M. No further information was documented on the label. On 1/15/25 at 8:49 A.M., the surveyor observed Resident #46 lying in bed with the head of the bed elevated. The feeding pump was set at 45ml/hr and flush 150ml/6hrs. The formula label said Osmolite 1.5. The label was filled out with a different resident's name and room number, rate 55ml/hr, dated 1/15/25. The water flush was dated 1/15/25 with Resident #46 name and room number, and initials of staff member who hung the bag. Further review of the handwritten label indicated the substance inside was Jevity 1.5 at 45ml/hr. On 1/15/25 at 11:33 A.M., the surveyor observed Resident #46 sitting up in a reclining chair in their room. The feeding pump was set at 45 ml/hr and flush 150 ml/6hr. The formula said Jevity 1.5, dated 1/15/25, with no other information written on the label. The water flush bag remained unchanged. During an interview on 1/15/25 at 11:51 A.M., Nurse #4 said she just changed the formula because she noticed it was the wrong one. She said Resident #46 is supposed to receive Jevity 1.5 not Osmolite 1.5. Nurse #4 said she only changed the formula and did not change the water flush bag or tubing. Review of the care plans indicated Resident #46 was dependent on the G-tube with the following interventions: -Provide and serve enteral formula as ordered -Give 45 cc of Jevity 1.5 via tube with free water flush (fwf) of 150 cc every 6 hours Review of the Physician's Orders indicated Resident #46 had the following orders related to the feeding tube: -Diet NPO (nothing by mouth) (9/20/24) -Give free water (H20) 150 milliliters (ml) every six hours (8/16/24) -Every shift Jevity 1.5 at 45ml/hr (hour) continuous, total 1080ml (11/20/24) -Change feeding bag and tubing every 24 hours (8/16/24) -Change piston syringe every night shift (8/16/24) Review of the Physician's Orders failed to indicate an order for Osmolite 1.5. Review of the nursing progress notes failed to indicate the feeding bag and tubing were changed every 24 hours as ordered. Review of the Treatment Administration Record (TAR) failed to indicate the feeding bag and tubing were changed as ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 7:14 A.M., Nurse #2 said she changed the feeding formula, water flush bag, tubing and supplies for Resident #46 on 1/14/25 and 1/15/25. She said she reviews the physician's order, fills out the labels on the formula and water flush bag, and then administers it to the Resident. Nurse #2 said she does not know why she wrote two different dates on the formula and the water bag on 1/14/25. She said she changed them together. She said on 1/15/25 she wrote Jevity 1.5 on the water bag because that is the formula Resident #46 receives and can see how this could be confusing. Nurse #2 said she has another resident using Osmolite 1.5 and must have confused the formulas both days and hung the wrong one by mistake. Reviewing the TAR with Nurse #2, she said the order to change the tubing is not scheduled on the TAR as it should be, however she does change the tubing every 24 hours. During an interview on 1/16/25 at 2:39 P.M., the Director of Nursing (DON) reviewed Resident #46 physician's orders with the surveyor and confirmed the Resident should have been given Jevity 1.5 and not Osmolite 1.5. She said the physician's order was not followed. She said the label on the formula and the water flush bag should be filled out completely to ensure it is clear what resident the formula is for and the time and date the feeding and the flushes were administered. She said the order for changing the administration tubing set every 24 hours should be on the TAR to allow each nurse to sign off as completed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49425 Based on observation, interview, and record review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles for two Residents (#31 and #67), out of 18 sampled residents. Specifically, the facility failed: 1. For Resident #31, to ensure a bottle of Tylenol was not left unsecured in the Resident's room; and 2. For Resident #67, to ensure two bottles of Latanoprost eye drops (decreases pressure in the eye) and one bottle of Timolol eye drops (decreases pressure in the eye) were not left unsecured in the Resident's room. Findings include: Review of the facility's policy titled Self-Administration of Medications dated as revised September 2024, indicated but was not limited to the following: -Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. -Medications must be stored in a safe and secure place, which is not accessible by other residents. -Staff shall identify and give to the nurse any medications found at the bedside, that are not authorized for self-administration. 1. Resident #31 was admitted to the facility in October 2024 with diagnoses including end stage renal disease dependent on renal dialysis. Review of the Minimum Data Set (MDS) assessment, dated 10/14/24, indicated Resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. On 1/14/25 at 2:50 P.M., the surveyor observed the following in Resident #31's room: -A bottle of Tylenol in an open pink bin on top of the overbed table, unsecured. On 1/16/25 at 7:24 A.M., the surveyor observed the following in Resident #31's room: -A bottle of Tylenol in an open pink bin on top of the overbed table, unsecured. Review of Resident #31's active Physician's Orders indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225067	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wedgemere Healthcare	146 Dean Street Taunton, MA 02780

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Acetaminophen tablet (Tylenol) 650 milligrams (mg) give 975 mg by mouth every 8 hours as needed for pain not to exceed 3,000 mg in 24 hours Review of the medical record failed to indicate a Self-Administration of Medications Assessment was completed for self-administration of any medications. During an observation with interview on 1/16/25 at 10:22 A.M., Nurse #1 said if a resident would like to self-administer medications an evaluation must be completed first to ensure it is safe to do so. She said if medications are kept in a resident room, they must be stored in a locked box. The surveyor and Nurse #1 entered Resident #31's room and observed a bottle of Tylenol in a pink bin placed on the overbed table. Nurse #1 said she had never seen the Tylenol bottle before, and did not know it was there. She said the Resident does not self-administer medications and it should not be in the room. During an interview on 1/16/25 at 10:22 A.M., Resident #31 said he/she had their friend bring in the bottle of Tylenol a few weeks ago in case he/she needed it. Resident #31 said he/she has not taken any and was not aware he/she could not have medications in the room. 2. Resident #67 was admitted to the facility in October 2024 with diagnoses including glaucoma (increased eye pressure). Review of the MDS assessment, dated 11/6/24, indicated Resident #67 scored 9 out of 15 on the BIMS, indicating he/she had moderate cognitive impairment. On 1/14/25 at 10:38 A.M., the surveyor observed the following in Resident #67's room: -One bottle of Timolol eye drops -Two bottles of Latanoprost eye drops All three bottles of eye drops were in a clear plastic bag placed on top of Resident #67's bureau, unsecured. On 1/15/25 at 11:27 A.M., the surveyor observed the following in Resident #67's room: -One bottle of Timolol eye drops -Two bottles of Latanoprost eye drops All three bottles of eye drops were in a clear plastic bag placed on top of Resident #67's bureau, unsecured. Review of Resident #67's active Physician's Orders indicated the following: -Latanoprost Solution 0.005% instill one drop in both eyes at bedtime for glaucoma -Timolol Maleate Gel Forming Solution 0.5% Instill one drop in both eyes one time a day for eye pressure (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record failed to indicate a Self-Administration of Medications Assessment was completed for self-administration of any medications. During an interview on 1/16/25 at 10:24 A.M., Nurse #1 said she was unaware Resident #67 had eye drops in his/her room. She said she administers eye drops to the Resident daily. She said the eye drops must have come with the Resident from the hospital. During an interview on 1/16/25 at 2:33 P.M., the Director of Nursing (DON) said Residents #31 and #67 should not have medications kept in their rooms which are not locked and secure. She said her expectation is if a resident would like to self-administer medications an assessment is completed, a physician's order is obtained, and the medications are kept in a locked box.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46862 Based on interviews and record review, the facility failed to ensure staff maintained accurate documentation for four Residents (#37, #50, #32, and #23), out of a total of 18 sampled residents. Specifically, the facility failed to: 1. For Resident #37, ensure November 2024 through January 2025 Medication Administration Records (MAR) were accurate and reflected the administration of multiple medications according to physician's orders; 2. For Resident #50, ensure December 2024 and January 2025 MAR were accurate and reflected the administration of multiple medications according to physician's orders; 3. For Resident #32, ensure November 2024 through January 2025 Treatment Administration Records (TAR) accurately reflected the administration of multiple treatments according to physician's order; and 4. For Resident #23, ensure November 2024 through January 2025 MAR accurately reflected the administration of multiple medications according to physician's orders. Findings include: Review of the facility's policy titled Charting and Documentation, dated 8/2019, indicated but was not limited to the following: -Documentation in the medical record may be electronic, manual or a combination. -The following information is to be documented in the resident medical record as warranted: -Objective observations; -Medications administered; -Treatments or services performed -Documentation in the medical record will be objective, complete, and accurate. 1. Resident #37 was admitted to the facility in May 2024 with diagnoses including hypertension, diabetes mellitus, depression, and chronic kidney disease. Review of Physician's Orders included but was not limited to: -Ascorbic Acid Tablets (used for wound healing) 500 milligrams (mg), twice a day (6/13/24) -Atorvastatin Calcium (lowers cholesterol) 40 mg, once daily in the evening (5/10/24) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Calcium Carbonate (antacid) 500 mg, 2 tablets two times a day (8/14/24) -Clopidogrel Bisulfate (antiplatelet blood-thinning drug) 75 mg, once daily (5/10/24) -Cyanocobalamin (Vitamin B12) 500 micrograms (mcg), 2 tablets once daily (5/10/24) -Famotidine (acid reducer) 20 mg, at bedtime (5/10/24) -Finasteride (blocks the action of an enzyme called 5-alpha reductase) 5 mg, once daily (5/10/24) -Folic acid (B-viamin to treat folate deficiency anemia) 1 mg, once daily (5/10/24) -Januvia (antidiabetic agent) 25 mg, once daily (5/23/24) -Magnesium Oxide (mineral that aids in blood sugar levels) 400 mg, twice a day (5/10/24) -Melatonin (for sleep) 5 mg, at bedtime (5/10/24) -Protonix (treats high levels of stomach acid) 40 mg, once daily (5/23/24) -Zoloft (antidepressant) 50 mg, once daily (5/10/24) Review of November 2024 through January 2025 MAR indicated the following medications were not signed off as administered as evidenced by several blank, unsigned boxes corresponding to the dates and times medications were to be administered on 53 occasions as follows: -Ascorbic Acid: 11/19/24, 11/26/24, 12/12/24, 12/22/24, 1/7/25 -Atorvastatin Calcium: 12/11/24, 12/12/24, 12/20/24, 12/28/24, 1/7/25 -Calcium Carbonate: 11/19/24, 11/26/24, 12/12/24, 12/22/24, 12/28/24, 1/7/25 -Clopidogrel Bisulfate: 11/19/24, 11/26/24, 12/22/24 -Cyanocobalamin: 11/19/24, 11/26/24, 12/22/24 -Famotidine: 12/11/24, 12/12/24, 12/20/24, 12/28/24, 1/7/25 -Finasteride: 11/19/24, 11/26/24, 12/22/24 -Folic acid: 11/19/24, 11/26/24, 12/22/24 -Januvia: 11/19/24, 11/26/24, 12/22/24 -Magnesium Oxide: 11/19/24, 11/26/24, 12/12/24, 12/22/24, 12/28/24, 1/7/25 -Melatonin: 12/11/24, 12/12/24, 12/20/24, 12/28/24, 1/7/25 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Protonix: 11/19/24, 11/26/24, 12/22/24 -Zoloft: 11/19/24, 11/26/24, 12/22/24 2. Resident #50 was admitted to the facility in July 2023 with diagnoses including dementia, diabetes mellitus, and depression. Review of Physician's Orders included but was not limited to: -Amlodipine Besaylate (lowers blood pressure) 5 mg, once daily (1/13/25) -Amlodipine Besaylate 5 mg, twice daily (2/28/24, Discontinued 1/13/25) -Atorvastatin Calcium 40 mg, once daily in the evening (12/27/24) -Carvedilol (for blood pressure) 12.5 mg, one half tablet 2 times per day (2/26/24) -Cholecalciferol (vitamin D deficiency) 25 mcg, 2 tablets once daily (1/13/25) -Cholecalciferol 25 mcg, 2 tablets once daily (7/25/23, Discontinued 1/9/25) -Furosemide (diuretic) 40 mg, once in the morning (10/2/24) -Gabapentin (for pain) 100 mg, 3 times a day (10/2/24) -Hydralazine HCL (to treat high blood pressure) 10 mg, 2 tablets 3 times a day (12/27/24) -Memantine HCL (used to treat memory loss) 5 mg, 2 times a day (7/23/24) -Protonix 40 mg, once daily (12/27/24) -Sennosides-Docusate Sodium (laxative) 8.6-50 mg, once daily (7/24/23) -Sertraline HCL (Used for depression) 50 mg, once daily (7/24/23) -Spironolactone (diuretic) 25 mg, once daily (11/5/23) -Trazodone HCL (antidepressant) 50 mg, once daily (7/24/23) -Xarelto (blood thinner) 10 mg, once daily (1/14/25) -Xarelto 2.5 mg, once daily (8/23/23, Discontinued 12/27/24) -Aspirin Chewable (blood thinner) 81 mg, once daily (7/25/23, Discontinued 1/14/25) -Celecoxib (anti-inflammatory) 200 mg, once daily (10/8/24, Discontinued 12/27/24) -Multivitamin with Iron 1 tablet daily (7/25/23, Discontinued 12/27/24) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ascorbic Acid Tablets 500 mg, 2 times a day (2/26/24, Discontinued 12/27/24) -Bumetanide (diuretic) 1 mg, 2 times a day (7/12/24, Discontinued 12/27/24) -Lactobacillus (probiotic) 1 capsule, 2 times a day (7/25/23, Discontinued 12/27/24) -Polyethylene Glycol 3360 powder (for constipation) 17 grams (gm), 2 times a day (12/27/24) -Heparin Sodium Solution (anticoagulant) 5000 Unit per Millimeter, inject 5000 units every 8 hours (12/27/24, Discontinued 1/14/25) Review of December 2024 and January 2025 MAR indicated the following medications were not signed off as administered as evidenced by several blank, unsigned boxes corresponding to the dates and times medications were to be administered on 148 occasions as follows: -Amlodipine Besaylate twice daily: (day dose) 12/9/24, 12/22/24, 12/25/24, 12/26/24 (evening dose) 12/8/24,12/11/24,12/12/24,12/17/24,12/18/24,12/24/24,12/25/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24 -Amlodipine Besaylate once daily: 1/1/25, 1/7/25 -Atorvastatin Calcium: 1/1/25, 1/7/25 -Carvedilol: (day dose) 12/9/24, 12/22/24, 12/25/24, 12/26/24 (evening dose) 12/8/24,12/11/24, 12/12/24,12/17/24,12/18/24,12/24/24,12/25/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/7/25 -Cholecalciferol: 12/9/24, 12/22/24, 12/25/24, 12/26/24 -Furosemide: 12/3/24, 12/5/24, 12/12/24, 12/18/24, 12/23/24, 12/24/23, 12/25/24, 12/26/24, 1/11/25 -Gabapentin: (morning dose) 12/9/24, 12/22/24, 12/25/24, 12/26/24 (afternoon dose) 12/9/24, 12/22/24, 12/25/24, 12/26/24 (evening dose) 12/8/24, 12/11/24, 12/12/24, 12/17/24, 12/18/24, 12/24/24, 12/25/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/7/25 -Hydralazine: (evening dose) 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/7/25 -Memantine (day dose) 12/9/24, 12/22/24, 12/25/24, 12/26/24 (evening dose) 12/8/24, 12/11/24, 12/12/24, 12/17/24, 12/18/23, 12/2/24, 12/25/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/7/25 -Protonix: 1/11/25 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sennosides-Docusate Sodium: 12/8/24, 12/11/24, 12/12/24, 12/17/24, 12/18,24 12/24/24, 12/25/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/7/25 -Sertraline: 12/9/24, 12/22/24, 12/25/24, 12/26/24 -Spironolactone: 12/9/24, 12/22/24, 12/25/24, 12/26/24 -Trazadone: 12/8/24, 12/11/24, 12/12/24, 12/17/24, 12/18/24, 12/24/24, 12/25/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/7/25 -Xarelto 2.5 mg: 12/9/24, 12/22/24, 12/25/24, 12/26/24 -Aspirin Chewable: 12/9/24, 12/22/24, 12/25/24, 12/26/24 -Celecoxib: 12/9/24, 12/22/24, 12/25/24, 12/26/24, 12/27/24 -Multivitamin with Iron 12/9/24, 12/22/24, 12/25/24, 12/26/24 -Ascorbic Acid: (day dose) 12/9/24, 12/25/24, 12/26/24 (evening dose) 12/8/24, 12/11/24, 12/12/24, 12/17/24, 12/18/24, 12/24/24, 12/25/24 -Bumetanide: (day dose) 12/9/24, 12/25/24, 12/26/24 (evening dose) 12/8/24, 12/11/24, 12/12/24, 12/17/24, 12/18/24, 12/24/24, 12/25/24 -Lactobacillus: (day dose) 12/9/24, 12/22/24, 12/25/24, 12/26/24 (evening dose) 12/8/24, 12/11/24, 12/12/24, 12/17/24, 12/18/24, 12/24/24, 12/25/24 -Polyethylene Glycol: (evening dose) 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/7/25 -Heparin: (morning dose) 1/11/25 (evening dose) 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/7/25 During an interview on 1/16/25 at 1:45 P.M., Nurse #3 said she was unaware there was an issue with documentation on the MARs. Nurse #3 said she could only see what she was assigned to give that shift. Nurse #3 said when a Resident was out of the facility she could document that on the MAR. Nurse #3 said the internet goes out periodically, but she was not told the procedure to document on a paper MAR. Nurse #3 said nurses needed to document on the MAR at the end of their shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/17/25 at 7:25 A.M., the Director of Nurses (DON) said she was aware there was an issue with the documentation of medication administration on the MARs and did not know why the nurses were not consistently documenting on them. The DON said she could not verify if it was an issue with the internet connection or if a resident had been out of the facility. The DON said there is an emergency protocol for when the internet was unavailable. The DON said she had not been notified of any computer issues. The DON said when a resident is out of the facility it should be noted on the MAR. The DON said the expectation is that the nurses should be documenting on the MAR before they leave their shift for the day. 28450 3. Resident #32 was admitted to the facility in May 2021 with diagnoses including Traumatic Spinal Cord Dysfunction, Neuromuscular Dysfunction of bladder, obstructive and reflux uropathy (Obstructive uropathy is a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). Review of the Minimum Data Set (MDS) assessment, dated 11/18/24, indicated Resident #32 has a suprapubic catheter in place. Review of the January 2025 Physician's Orders included but was not limited to: 1) clean around suprapubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen) daily; and 2) suprapubic catheter care, every shift for monitoring. Review of Resident #32's November 2024 through January 2025 TAR failed to indicate: - the suprapubic catheter was cleaned, drain sponge had been changed and documented as done on 11/8/24, 11/11/24, 11/15/24, 11/22/24, 11/30/24, and 12/6/24, as ordered (4/12/23); and - the suprapubic catheter care every shift for monitoring on 12/6/24, 12/2/24, and 1/10/25 had been provided and documented as ordered (9/18/24) During an interview on 1/14/25 at 11:00 A.M., Nurse #9 said anytime a treatment is provided it should be documented on the TAR to reflect the date and time it was done. During an interview on 1/17/25 at 10:25 A.M., Nurse #7 said the nurses are to document anytime a treatment is provided. During an interview on 1/17/25 at 7:25 A.M., the DON said she was aware there was an issue with the documentation of treatment administration on the TARs and did not know why the nurses were not consistently documenting them. The DON said the expectation is that the nurses should be documenting on the TAR before they leave their shift for the day. 48084 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #23 was admitted to the facility in October 2024 with diagnoses which included Diabetes Mellitus with other specified complications, Type 2 Diabetes Mellitus with diabetic neuropathy. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated he/she had a diagnosis of Diabetes Mellitus and took insulin. Review of the physician orders indicated but were not limited to the following: -Acidophilus (probiotic/GI health) give one capsule, one time a day for 14 days (11/8/24) -Atorvastatin 80 mg, once daily at bedtime (10/29/24) -Cholecalciferol 1000-unit tablet (vitamin), 2 tablets one time a day (10/29/24) -Duloxetine HCL Capsule 30mg (for depression), give 90mg one time a day (10/29/24) -Famotidine 40mg, one time a day (11/21/24) -Famotidine 20mg one time a day (10/29/24-11/20/24) -Jardiance 10mg (lowers blood sugar), one time a day (10/29/24) -Lantus SoloStar Insulin (lowers blood sugar), inject 7 units at bedtime (11/21/24) -Levofloxacin 750mg (antibiotic), one time a day for pneumonia for 10 days (11/8/24) -Magnesium Oxide 400mg, one time a day (10/29/24) -Multivitamin tablet, one time a day (10/29/24) -Nicotine 14mg Patch, apply once daily (11/9/24) -Tamsulosin 0.8mg (for prostate), one time a day (10/29/24) -Trazodone 50mg, at bedtime (10/29/24) -Tresiba Insulin (lowers blood sugar), inject 7 units one time a day (10/29/24-11/20/24) -Calcium Carbonate 500mg, two times a day (10/29/24) -Eliquis 5mg (blood thinner), two times daily (10/29/24) -Guaifenesin ER tablet 600mg (for mucus/congestion), twice daily (10/29/24) -Metformin 500mg (lowers blood sugar), two times a day (10/29/24) -Tramadol 50mg (pain), two times a day (10/29/24-11/14/24) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Benzonatate 100mg (for cough), three times a day (10/29/24) -Gabapentin 600mg, three times a day (10/29/24) -Tramadol 50mg (for pain), three times a day (11/14/24) -Ipratropium/Albuterol 0.5mg/2.5mg (respiratory), - 3ml inhale four times a day (11/5/24) -Phenytoin 100mg (seizures), every six hours (10/29/24) Review of the November 2024 through January 2025 MARs indicated the following medications were not signed off as administered, as evidenced by blank, unsigned boxes corresponding to the dates and times medications were to be administered on 236 occasions as follows: -Acidophilus: November 4 of 14 opportunities. -Atorvastatin: November 4 of 30 opportunities; December 4 of 19 opportunities; January 2 of 14 opportunities. -Cholecalciferol: November 2 of 30 opportunities. -Duloxetine HCL: November 2 of 30 opportunities. -Famotidine: November 4 of 30 opportunities; December 4 of 37 opportunities; January 2 of 14 opportunities. -Jardiance: November 2 of 30 opportunities. -Lantus Insulin: November 2 of 10 opportunities; December 2 of 19 opportunities; January 2 of 14 opportunities. -Levofloxacin: November 2 of 10 opportunities. -Magnesium Oxide: November 2 of 30 opportunities. -Multivitamin: November 2 of 30 opportunities. -Nicotine 14mg Patch: November 2 of 20 opportunities. -Tamsulosin: November 2 of 30 opportunities. -Trazodone: November 4 of 30 opportunities; December 4 of 19 opportunities; January 2 of 14 opportunities. -Tresiba Insulin: November 2 of 20 opportunities. -Calcium Carbonate: November 6 of 60 opportunities; December 4 of 37 opportunities; January 1 of 29 opportunities. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Eliquis: November 6 of 60 opportunities; December 3 of 33 opportunities; January 1 of 29 opportunities. -Guaifenesin: November 6 of 60 opportunities; December 4 of 37 opportunities; January 1 of 29 opportunities. -Metformin: November 7 of 60 opportunities; December 4 of 37 opportunities; January 1 of 29 opportunities. -Tramadol: November 4 of 26 opportunities. -Benzonatate: November 11 of 90 opportunities; December 4 of 55 opportunities; January 2 of 43 opportunities. -Gabapentin November 11 of 90 opportunities; December 4 of 56 opportunities; January 2 of 44 opportunities. -Tramadol: November 5 of 48 opportunities; December 4 of 55 opportunities; January 3 of 44 opportunities. -Ipratropium/Albuterol Nebulizer: November 21 of 102 opportunities; December 18 of 68 opportunities; January 4 of 58 opportunities. -Phenytoin: November 20 of 120 opportunities; December 19 of 76 opportunities; January 2 of 58 opportunities. During an interview on 1/16/25 at 3:54 P.M., Nurse #1 said the MAR should not have any blanks, every mediation should be signed off as administered, held, refused etc. During an interview on 1/21/25 at 1:23 P.M., the DON said when a nurse administers medications, they should document that it was administered on the MAR. She said the MAR should not have any holes (blank/unsigned boxes).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48084 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections for three Residents (#50, #61, and #46), out of a total sample of 18 residents. Specifically, the facility failed: 1a. For Resident #50, to ensure staff performed hand hygiene when indicated, adhered to Contact Precautions, and sanitized shared medical equipment (blood pressure cuff) after use; and b. For Resident #61, to ensure staff performed hand hygiene when indicated, adhered to Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities), and sanitized shared medical equipment (blood pressure cuff) after use; and 2. For Resident #46, to ensure Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication) equipment was maintained in a clean and sanitary manner to decrease the risk of potential contamination and infection. Findings include: 1. Review of the facility's policy titled Infection Control Guidelines for Nursing Procedures, dated as last revised 7/2024 indicated but was not limited to the following: -Standard Precautions are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the residents, in any setting where health care is delivered. Standard Precautions include hand hygiene, use of personal protective equipment (PPE), sterile instruments and devices, and clean and disinfected environmental surfaces. -Transmission Based Precautions (TBP) will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. TBP will be initiated when there is reason to believe that a resident has a communicable infectious disease. TBP may include Contact Precautions, Droplet Precautions, Airborne Precautions, or Enhanced Barrier Precautions (EBP). Types of TBP: Contact Precautions: In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident care items in the resident's environment. Examples of such infections include infection with MDROs. -PPE: In addition to wearing gloves as outlined under Standard Precautions, don (put on) disposable gown when entering the room. After removing gloves, gown, and washing hands do not touch potentially contaminated environmental surfaces. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident Care Equipment: When possible, dedicate the use of non-critical resident care equipment items such as a stethoscope, sphygmomanometer (blood pressure cuff), thermometer to a single resident to avoid sharing between residents. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. ENHANCED BARRIER PRECAUTIONS (EBP): Infection Control intervention designed to reduce transmission of MDROs. EBP is indicated for nursing home residents with any of the following: Infection or colonization with an MDRO when Contact Precautions do not otherwise apply, Chronic wounds, Indwelling medical devices, including but not limited to IV, feeding tubes, trach, drains, and urinary catheters. -PPE: use of gown and gloves during high-contact resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing. Examples of high contact resident activities are dressing, bathing, showering, transferring, changing linen, personal hygiene, toileting/brief change, device care, Central line. -Resident Care Equipment: If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub: -Before and after direct contact with residents -Prior to donning and post doffing (removing) gloves -Before preparing or handling medications -After contact with the resident's skin -After contact with objects (medical equipment) in the immediate vicinity of the resident a. Resident #50 was admitted to the facility in December 2024 with diagnoses which included acute osteomyelitis of the ankle and foot (infection to the bone), surgical amputation, and chronic ulcer of the left lower leg. Review of the Physician's Orders indicated but were not limited to the following: -Maintain CONTACT precautions due to MRSA use of gown and gloves every shift. (12/27/24) Review of the Comprehensive Care Plan indicated but was not limited to the following: -Resident has actual impairment to the skin related to constant picking. Multiple scabbed areas to bilateral lower extremities. (Revision 11/29/24) -Alteration in skin integrity related to patient non-compliance with treatment and retraumatizing healing wound via picking at skin. Post surgical wound right foot status post amputation of great and second toe with wound vac in place. (Revision 1/9/25) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident has MRSA in the right foot wound. Contact Isolation; Instruct family/visitors to wear gown/gloves during physical contact with resident. Wash hands before leaving room. On 1/15/25 at 8:25 A.M., the surveyor observed a Contact Precautions sign posted at the door to Resident #50's room. Review of the Contact Precautions sign indicated the following: STOP: Contact Precautions: Everyone Must: -Clean their hands, including before entering and when leaving the room. -Providers and Staff must also: Put on gloves and gown before room entry. -Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. On 1/15/25, the surveyor observed Nurse #4 administer medications to Resident #50 as follows: -8:26 A.M., Nurse #4 poured the medications for Resident #50 at the medication cart outside the resident's room. -8:37 A.M., Nurse #4 entered the room with the medication cup and a cup of water with no PPE on (no gloves or gown). She proceeded to check Resident #50's blood pressure with a wrist cuff, move items around on the bedside/overbed table, and adjust his/her bed linens covering lower extremities with exposed and visible wounds/scabs. The cuff did not read the blood pressure, so the cuff was repositioned and taken again. The medications were administered. Nurse #4 exited the room without performing hand hygiene (HH) and returned to the medication cart, placing the blood pressure cuff on top of the cart. -8:42 A.M., without performing HH, Nurse #4 proceeded to access the electronic Medication Administration Record (eMAR) on the computer, opened the medication cart, opened the narcotic box, removed Oxycodone (narcotic for pain), signed the narcotic book and at 8:46 A.M. re-entered Resident #50's room without performing HH or donning PPE. She administered the medication and exited the room without performing HH. On 1/15/25, the surveyor made additional observations during the medication pass of staff entering Resident #50's room as follows: -8:36 A.M., Certified Nursing Assistant (CNA) #1 entered the room without performing HH and without PPE on. She collected the breakfast tray, exited the room and placed the tray in the meal cart. Without performing HH, she entered the next room to collect the breakfast tray. -9:01 A.M., Housekeeper #2 entered the room with gloves on but no gown and proceeded to sweep the room, adjust personal items on the Resident's bedside/overbed table, including trash, and exit the room without performing HH. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Resident #61 was admitted to the facility in July 2024 with diagnoses which included peripheral vascular disease, absence of left leg below the knee, and gangrene. Review of the Physician's Orders indicated but were not limited to the following: -EBP every shift. (10/9/24) Review of the Comprehensive Care Plan indicated but was not limited to the following: -Skin: Actual alteration in skin integrity related to admitted with surgical wound left below the knee amputation. (Revision 12/3/24) -EBP (10/24/24) On 1/15/25 at 8:46 A.M., the surveyor observed an EBP sign posted at the door to Resident #61's room. Review of the EBP Precautions sign indicated the following: STOP: EBP: Everyone Must: -Clean their hands, including before entering and when leaving the room. -Providers and Staff must also: Put on gloves and gown for the following High-Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing brief or assisting with toileting, Device Care or use, Wound Care On 1/15/25, the surveyor observed Nurse #4 administer medications to Resident #50 and then continue on to administer medications and provide care to Resident #61 as follows: -8:47 A.M., Nurse #4 logged back into the eMAR and reviewed the medication list for Resident #61. She walked away from the medication cart (still without performing HH) and entered the nurses' station, retrieved two cartons of Glucerna (liquid nutritional supplement) from the cabinet and returned to the medication cart. Without performing HH, she proceeded to pour the medications for Resident #61. Nurse #4 was unable to locate one over the counter (OTC) medication needed, so she proceeded to lock the medication cart and walk to the medication storage room (still without performing HH). She entered the medication storage room, located the OTC medication and returned to the medication cart. Nurse #4, without performing HH, finished pouring the medications for Resident #61. Nurse #4 entered the room without PPE, placed the medication cup on the beside/overbed table, exited the room and returned to the medication cart in the hallway to retrieve the blood pressure cuff from the top of the cart. Nurse #4 re-entered the room without PPE or performing HH and without cleaning the blood pressure cuff proceeded to check Resident #61's blood pressure, administered medications, and exited the room. She placed the blood pressure cuff back on the top of the medication cart without cleaning it. -9:00 A.M., without performing HH, Nurse #4 then opened a small canvas bag to retrieve a thermometer and an oximeter. She placed those items on the top of the medication cart. She accessed the eMAR and started to prepare medications for the next resident and was stopped by the surveyor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/25 at 9:00 A.M., Nurse #4 said she did not know why Resident #50 had a Contact Precautions sign hanging up and did not think he/she was on true precautions. She said she thought Residents #50 and #61 were both on EBP for wounds. Additionally, she said they do not have to wear PPE for medication administration. She said during the medication pass she tries to do HH before entering a room at least every few residents. She said usually it's every 2-3 unless there is a treatment, then HH is done. She said she does not perform HH between every resident. Nurse #4 said the blood pressure cuff is usually wiped down with an alcohol-wipe every three residents or so. During an interview on 1/15/25 at 9:26 A.M., CNA #1 said Resident #50 was on Contact Precautions, but they did not need PPE to enter the room or to deliver/collect trays. She said they only needed to wear PPE (gloves, gown, and mask) when providing care. During an interview with Housekeeper #2 and the Director of Housekeeping #1 on 1/15/25 at 9:17 A.M., Housekeeper #2 said she did not speak English well and indicated she would get the supervisor to assist. The Director of Housekeeping #1 said Housekeeper #2 should have had full PPE on to enter Resident #50's room due to Contact Precautions. She said Housekeeper #2 doesn't speak good English but would need more education on what PPE is needed in the Precaution rooms. During an interview on 1/15/25 at 12:29 P.M., the Director of Nurses (DON) and Consulting Staff #1 said with Contact Precautions staff should perform HH prior to entering the residents' room and have PPE on for resident contact/care. Consulting Staff #1 said Housekeeping should be okay just sweeping but touching the environment they should have PPE on. Additionally, she said the sign does indicate to don PPE prior to entering the room, so they all should have it on based on that. They said with EBP staff should be performing HH prior to entering the room and PPE should be used when providing resident care/contact with the area (i. e. wound). The DON said equipment should be cleaned between residents if shared and HH should be performed between every resident and when entering/exiting any room with a precaution sign. During an interview on 1/15/25 at 2:43 P.M., Nurse #4 said Resident #50 is on Contact Precautions and therefore she should have had full PPE on to enter the room, administer meds, check his/her blood pressure, and adjust the bed linens. Additionally, she said the blood pressure cuff should have been sanitized before being used for the next resident and it was not. 49425 2. Review of the facility's policy titled Infection Control Guidelines for Nursing Procedures, dated as revised 7/2024, indicated but was not limited to the following: -Standard precautions are the minimum infection prevention practices that apply to all resident care areas Resident #46 was admitted to the facility in September 2024 with diagnoses including dysphagia (difficulty swallowing liquid or food), and intercranial hemorrhage (bleeding in the brain). Review of the Minimum Data Set (MDS) assessment, dated 11/13/24, indicated Resident #46 had a feeding tube and the portion of the total calories the resident received through a feeding tube was 51% or more. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/14/25 at 2:57 P.M., the surveyor observed a piston syringe (needleless syringe to administer fluids through a feeding tube) lying on the Resident's bedside table, uncovered and undated. The syringe did not have a protective barrier underneath it potentially exposing it to environmental contaminants. Review of the Physician's Orders indicated Resident #46 had the following orders related to the feeding tube supplies: -Change piston syringe every night shift During an observation with an interview on 1/16/25 at 7:43 A.M. Nurse #2 and the surveyor observed a piston syringe lying uncovered and undated on top of Resident #46's nightstand, potentially exposed to environmental contaminants. Nurse #2 said the syringes are supposed to be stored in individual bags that are labeled with the Resident's name and date. She said they are coming in one large bag now and she has nothing to store it in, so she places it on the table. During an interview on 1/16/25 at 2:39 P.M., the Director of Nursing (DON) said all G-tube supplies should be stored in a sanitary manner with a protective barrier, to reduce the risk of contamination. She said it also should have the Resident's name and date labeled on it, and it is to be changed every 24 hours.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41106 Based on observation and interview, the facility failed to maintain a safe and clean environment in the designated smoking area by not properly disposing of cigarette butts in designated safe ashtrays. Findings include: Review of the Centers for Medicare & Medicaid Services (CMS) circular letter, dated November 10, 2011, titled Smoking Safety in Long Term Care Facilities indicated but was not limited to the following: -The facility is obligated to ensure the safety of designated smoking areas which includes protection of residents from weather conditions and non-smoking residents from secondhand smoke. -The Life Safety Code (NFPA 101, 2000 ed., 19.7.4) requires each smoking area be provided with ashtrays made of noncombustible material and safe design. On 1/16/25 at 10:40 A.M., the surveyor observed the outside smoking area as follows: -Along the entire border of the smoking area there were hundreds of cigarette butts observed in the bushes lining the smoking area. -White glass bowls, stained with a black substance and ashes were in the bushes. -Plastic outdoor self-extinguishing ashtray with bucket at its base. The neck of the ashtray was disconnected from the bucket leaving the cigarette butts exposed. -On two of the outdoor tables there were one white glass bowl and three clear glass bowls with numerous cigarettes butts. There were no covers to the bowls. -Cigarette butts disposed of in the trash can lined with a plastic bag containing empty cigarette boxes. -Cigarette butts in the planter by the door to the facility. During an interview on 1/16/25 at 10:45 A.M., Resident #51 said the ashtrays blew over with the wind and the top of the ashtray blew off, blowing cigarette butts everywhere. During an interview on 1/16/25 at 10:50 A.M., the Maintenance Director (MD) said he cleans up the smoking area every Monday and Friday. He said when he comes out on Mondays it is worse. The MD said the residents know they are supposed to dispose of cigarettes in the ashtrays, but they don't. He said when he tells the residents they must dispose of cigarettes in the ashtray, they tell him they have rights, and they don't listen. The area needs to be kept cleaner. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/25 at 11:35 A.M., the MD said the outdoor ashtray was missing a screw and that's why the top came off, and he removed all the open ashtrays from the tables. During an interview on 1/16/25 at 11:55 P.M., the Administrator said he was not aware of the numerous cigarettes on the ground or the screw missing from the ashtray. He said there is a staff member out there supervising all smoking sessions.