STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225137	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dexter House Healthcare	120 Main Street Malden, MA 02148

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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 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** 45763 Based on observation, policy review, and interview the facility failed to provide a dignified dining experience for two Residents (#1 and #34) out of a total sample of 19 residents. Specifically, the facility failed to ensure that staff members were not standing over Resident #1 and Resident #34 while providing feeding assistance. Findings include: Review of the facility policy titled Resident Rights, revised January 2024, indicated the following: -Employees shall treat all residents with kindness, respect, and dignity. 1.) Resident #1 was admitted to the facility in August 2013 with diagnosis including traumatic brain injury. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #1 was unable to participate in a Brief Interview for Mental Status (BIMS) as the Resident was rarely/never understood. Further review of the MDS indicated Resident #1 had impaired range of motion of upper extremities on both sides, and that the Resident was dependent on staff for eating assistance. On 10/1/24 at 8:20 A.M., the surveyor observed a staff member providing feeding assistance to Resident #1 in his/her room. The Resident was in bed and the staff member was standing over him/her while providing assistance. The bed was not raised, and the staff member and the Resident were not at eye level. On 10/2/24 at 8:19 A.M., the surveyor observed a staff member providing feeding assistance to Resident #1 in his/her room. The Resident was in bed and the staff member was standing over him/her while providing assistance. The bed was not raised, and the staff member and the Resident were not at eye level. During an interview on 10/2/24 at 12:52 A.M., the Assistant Director of Nursing (ADON) said staff should be at eye level with a resident, and not be standing, while providing feeding assistance. 2.) Resident #34 was admitted to the facility in June 2024 with diagnosis including dementia. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #34 scored an 8 out of 15 on a Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Further review of the MDS indicated Resident #34 was dependent on staff for partial/moderate feeding assistance. On 10/2/24 at 8:30 A.M., the surveyor observed a staff member providing feeding assistance to Resident #34 in his/her room. The Resident was in bed and the staff member was standing over him/her while providing assistance. The bed was not raised, and the staff member and the Resident were not at eye level. During an interview on 10/2/24 at 12:52 A.M., the Assistant Director of Nursing (ADON) said staff should be at eye level with a resident, and not be standing, while providing feeding assistance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to 1.) implement the plan of care related to keeping the call light within reach for one Resident (#50), and 2.) failed to develop a care plan related to a history of suicide attempts for one Resident (#11) out of a total of 19 sampled residents. Findings include: Review of the facility policy, titled Care Plans, Comprehensive Person-centered, indicated, but was not limited to, the following: - A comprehensive, person-centered care plan will be developed for each resident. The care plan will include objectives that meet the resident's physical, psychosocial and functional needs is developed for each resident. - The resident comprehensive care plan will identify problem areas and their causes as warranted and developing interventions that are targeted and meaningful to the resident. - Evaluation of residents is ongoing and care plans are revised as information about the resident and the resident conditions change. 1.) Resident #50 was admitted to the facility in December 2021 with diagnoses including weakness and unsteadiness on feet. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/27/24, indicated Resident #50 was moderately impaired as evidenced by a score of 11 out of a possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated Resident #50 required assistance with ambulation and transfers. Review of Resident #50's fall care plan, dated 12/6/21, indicated the following interventions: call light within reach. Review of the facility's policy titled Answering Call Lights, dated April 2018, indicated: When the resident is in bed, provide the call light within easy reach of the resident. On 10/1/24 at 8:08 A.M., and 2:11 P.M., the surveyor observed Resident #50 laying in bed. His/her call light was draped over his/her overbed light hanging behind Resident and out of reach. On 10/2/24 at 7:50 A.M., and 2:19 P.M., the surveyor observed Resident #50 dozing in bed. His/her call light was draped on top of overbed light hanging behind the Resident and out of reach. During an interview on 10/2/24 at 2:24 P.M., the Assistant Director of Nursing (ADON) and the Administrator said that call lights should be placed within the reach of residents at all time. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45763 2.) Resident #11 was admitted to the facility in July 2024 with diagnoses including cancer, manic depression, and schizophrenia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #11 scored an 11 out of 15 on a Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Review of the behavioral health group note, dated 8/15/24, indicated Resident #11 had a history of suicide attempt and that the Resident had stated he/she had jumped out of a window in a nursing home. Review of Resident #11's care plans failed to indicate that a care plan addressing Resident #11's history of suicide attempts was developed. During an interview on 10/2/24 at 10:47 A.M., Nurse #1 said he was unaware of Resident #11's history of suicide attempts, and that he would expect a care plan to be developed specific to the Resident's history of suicide attempts. Nurse #1 said the interdisciplinary team, including nurses and social workers, review the behavioral health group notes. During an interview on 10/2/24 at 12:22 P.M., the Social Worker (SW) said she would expect nurses and the social workers to review the behavioral health group notes. The SW said she would expect a specific care plan to be developed addressing a resident's history of suicide attempts. During an interview on 10/2/24 at 12:47 P.M., the Assistant Director of Nursing (ADON) said she would expect a resident with a history of suicide attempts to have a care plan developed specifically addressing the history of suicide attempts

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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. 36876 Based on record review and interview, the facility failed to ensure medications were administered as ordered for one Resident (#72) out of a total of 19 sampled residents. Specifically, nursing staff failed to administer insulin per the physicians' sliding scale order. Findings include: Review of the facility's policy titled Administering Medications, dated February 2020, indicated: Medications are administered in a safe, timely manner and as prescribed. Medications are administered in accordance with prescriber orders. Resident #72 was admitted to the facility in April 2024 with diagnoses including diabetes. Review of the Minimum Data Set (MDS) assessment, dated 8/26/24, indicated Resident #72 had severe cognitive impairment as evidenced by a score of 3 out of a possible 15 on the Brief Interview for Mental Status Exam. The MDS also indicated Resident #3 required assistance with bathing, dressing and transfers. Review of Resident #72's physician's orders indicated: Novolin R injection solution 100 unit/ML (insulin) Inject as per sliding scale if: 0-200 if FSBS (fasting blood sugars) between 0-60 administer no insulin and follow hypoglycemic protocol and notify MD/RNP: 200 - 250 = 2 251 - 300 = 4 301 - 350 - 6 351 - 400 = 8 401 - 450 = 10 If greater than 450, call on-call provider. Review of Resident #72's September 2024 Medication Administration Record indicated the following: 9/3/24, 12:00 A.M.: BS (blood sugar) 200; no insulin amount documented. Resident #72 should have received 2 units. 9/8/24, 6:00 A.M.: BS 219; no insulin administered. Resident #72 should have received 2 units. 9/8/24, 6:00 P.M.: BS 219; no insulin administered. Resident #72 should have received 2 units. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/9/24, 6:00 A.M.: No blood sugar level or insulin was documented. 9/13/24, 6:00 A.M.: BS 213; no insulin administered. Resident #72 should have received 2 units. 9/22/24, 8:00 P.M.: BS 213; no insulin administered. Resident #72 should have received 2 units. 9/29/24, 7:30 A.M.: No blood sugar level or insulin was documented. During an interview on 10/2/24 at 2:24 P.M., the Assistant Director of Nursing ADON and the Administrator said that staff should administer medications per the physician's order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed to provide assistance with meals for two Residents (#21 and #59), out of a total of 19 sampled residents. Findings include: Review of the facility's Care Plans policy dated November 2017 indicated: A comprehensive person-centered care plan will be developed for reach resident. The care plan will include objectives that meet the resident's physical and functional needs for each resident. Review of the facility's Activities of Daily Living (ADLs) policy, dated April 2018 indicated: Residents who are unable to carry out activities of daily living independently will receive the services necessary for activities of daily living. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with dining (meals and snacks). 1. Resident #21 was admitted to the facility in September 2022 and has diagnoses that include but are not limited to cerebral infraction, adult failure to thrive, unspecified severe protein-calorie malnutrition, dysphagia, and cognitive communication deficit. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #21 scored an 11 out of 15 on the Brief Interview for Mental Status indicating Resident #21 had moderately intact cognition and required supervision or touching assistance with eating. Review of Resident #21's Activities of Daily Living (ADL) care plan, dated as initiated 9/30/2022, indicated: Resident has ADL self-care deficit as evidenced by needing assistance with all ADLs (activities of daily living) Interventions: Eating: Independent with set up ->continued supervision, 11/13/22. On 10/1/24 at 10:15 A.M., Resident #21 was observed in bed with a breakfast tray in front of him/her. Resident #21's position was reclined at approximately 45 degrees. Resident was observed chewing with his/her eyes closed. When he/she opened his/her eyes, he/she said he/she was not comfortable. There was not staff in the room or nearby. On 10/1/24 at 12:14 P.M., Resident #21 observed in bed. His/her partially consumed breakfast tray remained in front in front of him/her and his/her eyes were closed. On 10/1/24 at 12:28 P.M., a certified nursing assistant (CNA) entered Resident #21's room with a lunch tray. The CNA set up the tray and exited the room with the breakfast tray. Resident #21 was in his/her room with the privacy curtain pulled, Resident #21 was not able to be seen from the hall. Staff were observed passing lunch trays to residents. On 10/1/24 at 12:34 P.M., Resident #21 was observed with his/her lunch tray untouched and had his/her eyes closed. Resident #21 was positioned at approximately 30-40 degrees and was not upright. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 12:38 P.M., Resident #21 had his/her lunch tray which was untouched in front of him/her. Resident #21's eyes were closed. At no time did staff enter the room to supervise or offer any assistance or cueing to eat. On 10/2/24 at 8:53 A.M., Resident #21 was observed with his/her breakfast tray in front of him/her. Resident #21 was not actively eating; the food was untouched and his/her were eyes closed. There were no staff present with Resident #21. At 9:02 A.M., the breakfast tray was no longer present in Resident #21's room. During an interview on 10/2/24 at 12:31 P.M., Nurse #3 said Resident #21 takes his/her time eating. Nurse #3 said we cue him/her from time to time, he/she is not always interested in eating and does need supervision. During an interview on 10/2/24 at 2:04 P.M., CNA #5 said Resident #21 is dependent on care and sometimes refuses and staff need leave and return later. CNA #5 said Resident #21 has not been eating too much and they leave the meal trays. CNA #5 said Resident #21 needs supervision for eating, that staff are not always in the room but check in on him/her to make sure he/she is eating. 36876 2. Resident #59 was admitted to the facility in August 2022 with diagnoses including dementia and malnutrition. Review of the Minimum Data Set (MDS) assessment, dated 7/23/24, indicated Resident #59 had severe cognitive impairment and was dependent on staff for eating. Review of the Activities of Daily Living (ADL) care plan, dated 8/4/22, indicated: Resident has ADL self care deficient [sic]. Interventions: Total assistance with eating, 8/4/22. On 10/1/24 at 8:43 A.M., the surveyor observed Resident #59 seated in his/her room with his/her breakfast plate in front of him/her. Resident #59 was alone and appeared uninterested in the meal. Certified Nurse Assistant (CNA) #4 entered the room and asked Resident #59 if he/she was eating and then left to go to another room saying she would check in later. At approximately 8:50 A.M., the surveyor observed Resident #59 taking small bites of his/her breakfast meal. There was no staff in the room providing assistance. During an interview on 10/1/24 at 12:13 P.M., Family Member #1 said that he was visiting and going to assist Resident #59 with the lunch meal when it arrives. Family Member #1 said he and other family members come in to assist Resident #59 with lunch. Family Member #1 said that staff do not assist Resident #59 with meals. On 10/2/24 at 8:34 A.M., the surveyor observed Resident #59 in bed. His/her breakfast plate was on his/her overbed table and food was splattered across the table. The breakfast tray with his/her drinks and hot cereal was across the room on his/her bureau. Resident #59 was hitting the table repeatedly with his/her hand and not eating. There was no staff in the room providing assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/24 at 8:37 A.M., CNA #3 said that Resident #59 is not on her assignment today but she has cared for him/her in the past. CNA #3 said that the Resident does not need assistance with meals. During an interview on 10/2/24 at 8:38 A.M., CNA #2 said that Resident #59 does not need help with his/her meals. On 10/2/24 at 8:40 A.M., the surveyor observed Resident #59 rubbing his/her blanket on the overbed table across the food that had been splattered on the table. Resident #59's blanket was saturated with food and no staff were in the area. On 10/2/24 at 12:22 P.M., the surveyor observed Resident #59 seated alone in his/her room with his/her lunch plate on the overbed table, uncovered and untouched, in front of him/her. Resident #59's lunch tray with beverages was across the room on top of his/her bureau. CNA #3 observed the surveyor standing outside Resident #59's room and then entered the room and sat to assist Resident #59 with his/her meal. During an interview on 10/2/24 at 2:24 P.M., the Assistant Director of Nursing (ADON) and the Administrator said that resident care plans should be followed. The ADON said that the level of assistance Resident #59 needs for meals changes day to day but that staff should be present with him/her during meals for cuing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review, and interview the facility failed to ensure all drugs and biologicals were stored in a safe and secure manner. Specifically, the facility failed for Resident #73, to ensure topical medications were not left unattended in the Resident's room. Findings include: Review of the facility's policy: Storage of Medications, dated 4/2018 indicated the facility shall store drugs and biologicals in a safe, secure, and orderly manner. Guidelines: 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Drugs for external use, shall be clearly marked as such, and shall be stored separately from other medications. 7. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, automatic dispensing systems. Resident #73 was admitted to the facility in November 2023. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #73 scored an 8 out of fifteen on the Brief Interview for Mental Status (BIMS), indicating he/she had moderately intact cognition. On 10/01/24 at 9:00 A.M., the surveyor observed Resident #73 sitting on the side of his/her bed with the curtain drawn between him/her's roommate. The surveyor observed a bottle labeled Ammonium Lactate 12% lotion with Resident #73's name on it, on the bed side table of Resident #73's roommate. The roommate said that is not mine, referring to the lotion bottle. Review of the medical record for Resident #73 indicated the Resident had not been assessed for self-administering medications. Further review of Resident #73's medical record indicated the following physician's pharmacy order: -Amlactin Daily External Lotion 12% (lactic acid) (Ammonium Lactate) Apply to bilat (bilateral) feet topically every evening shift for dryness, dated 1/31/24. The surveyor made the following observations: -On 10/01/24 at 9:32 A.M., the Ammonium Lactate 12% lotion bottle ordered for Resident #73 was on the bedside table of Resident #73's roommate. -On 10/01/24 at 12:22 A.M., the Ammonium Lactate 12% lotion bottle ordered for Resident #73 was on the bedside table of Resident #73's roommate. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/01/24 at 3:22 PM the Ammonium Lactate 12% lotion bottle ordered for Resident #73 was on the bedside table of Resident #73's roommate. -On 10/02/24 at 8:38 A.M. the Ammonium Lactate 12% lotion bottle ordered for Resident #73 was on the bedside table of Resident #73's roommate. During an interview and observation on 10/2/24 at 8:40 A.M., Nurse #3 said Resident #73 does not self-administer medications and the nursing staff are responsible for administering the Ammonium Lactate 12% lotion for Resident #73. Nurse #3 went to Resident #73's room with the surveyor, removed the Ammonium Lactate 12% lotion from Resident #73's roommates bedside table and said it should not be left in a resident's room and should be locked in the treatment cart. During an interview on 10/2/24 at 12:19 P.M., the Assistant Director of Nursing said all medications including topical medications should be locked in the medication or treatment carts and not left in a resident's room.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on interview and record review the facility failed to obtain routine and 24-hour emergency dental care for one Resident (#11) out of a total sample of 19 residents. Specifically, the facility failed to provide dental services after Resident #11 had voiced that his/her dentures were ill-fitting, and failed to implement the dentist's recommendations for follow-up appointments. Findings include: Review of the facility policy, titled Dental Services, revised November 2017, indicated, but was not limited to, the following: - Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. - All dental services provided are recorded in the resident's medical record. Resident #11 was admitted to the facility in July 2024 with diagnosis including cancer. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #11 scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she had moderate cognitive impairment. Further review of the MDS indicated the Resident had obvious or likely cavity or broken natural teeth. During an interview on 10/1/24 at 8:01 A.M., Resident #11 said his/her dentures don't fit and that he/she would like to have the dentures fitted as he/she would prefer to use them; the Resident said that this has been the case for a few weeks and that he/she had told staff about his/her ill-fitting dentures. Review of Resident #11's care plans indicated the following care plan initiated on 8/7/24: - Care deficit pertaining to the teeth oral cavity characterized by; altered oral mucous membrane; problems with dentures/ teeth/ gums related to: Broken/carious teeth noted on exam. Further review of the care plan indicated the following intervention initiated on 8/7/24: - Refer to dentist as needed. Review of the dental group note, dated 9/5/24, indicated Resident #11 was seen by a dentist for denture step 5. Further review of the note indicated the Resident received dentures with a recommendation for an annual exam. The following appointments were recommended: - Denture Follow-Up on 9/6/24 (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Annual Exam on 9/21/24 Review of Resident #11's medical record failed to indicate the Resident attended the recommended denture follow up or annual exam or that the Resident was seen by a dentist after 9/5/24. Further review of the medical record failed to indicate the Resident was scheduled to see the dentist, or that the Resident had refused to attend any dental appointments. During an interview on 10/2/24 at 10:39 A.M., Certified Nursing Aide (CNA) #6 said that Resident #11 had dentures but he/she does not wear them because the Resident said they don't fit and were too small; CNA #6 said the Resident first mentioned this three weeks ago. During a follow-up interview on 10/2/24 at 1:19 P.M., CNA #6 said that she did not tell the nurse about Resident #11's complaint of his/her dentures being too small and not fitting well because the nurse already knew. During an interview on 10/2/24 at 10:43 A.M., Nurse #1 said the dentist comes every month and that if there was a dental issue the facility would call the dentist and they could come sooner. Nurse #1 said that nurses review the dental group notes/dentist paperwork for recommendations after each visit. Nurse #1 said that Resident #11 recently received dentures but did not wear them and said he was not aware of the Resident's complaints that the dentures were ill-fitting. Nurse #1 said nurses were involved in upcoming dental appointments and would leave notes for upcoming appointments. Nurse #1 said he was unaware of any upcoming dental appointments and that he would have expected the CNA to notify him of the Resident's complaints that the dentures did not fit well and were too small. During an interview on 10/2/24 at 12:48 P.M., the Assistant Director of Nursing (ADON) said refusal for dental appointments would be documented and that she would expect the dentist recommendations for follow-up appointments to be implemented. The ADON said she would expect the CNA to have notified the nurse or tell supervisors about the Resident's complaints about the dentures not fitting well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225137	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dexter House Healthcare	120 Main Street Malden, MA 02148

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50338 Based on observations and staff interviews, the facility failed to follow infection control standards of practice for the cleaning of shared resident equipment. Findings include: Review of the facility policy titled Obtaining a Fingerstick Glucose Level, dated 11/2020, indicated the purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. The following equipment and supplies will be necessary when performing this procedure: -Disinfected blood glucose meter (glucometer). Steps in the Procedure: -Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Review of the facility policy titled Infection Control Guidelines for Nursing Procedures, dated as revised 7/2024, indicated guidelines for general infection control while caring for residents. Resident-Care Equipment: -When possible, dedicate the use of non-critical resident-care equipment items such as sphygmomanometer (used to take blood pressure) to avoid sharing between residents. -If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. During Medication Observation on the Dolphin Lane unit on 10/2/24 at 7:41 A.M., the surveyor observed breaches in infection control practices when the nurse did not clean the shared resident equipment of the glucometer that was observed to be carried in and out of Residents rooms without cleaning the device. The glucometer is a handheld device that is used in diabetes management to measure the concentration of glucose in the blood. The surveyor observed Nurse #2 entered four different resident's room to take blood sugar measurement using the glucometer and after using it did not clean and/or disinfect between each resident. The surveyor observed the glucometer not being cleaned between resident use or before being returned to the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During Medication Observation on the Dolphin Lane unit on 10/2/24 at 7:57 A.M., the surveyor observed breaches in infection control practices when Nurse #2 did not clean the shared resident equipment of the portable vital sign device that was observed to be wheeled in out of resident's rooms without cleaning the device. The portable caddy is a device that measures the vital signs of individual residents including a measurement of pulse, blood pressure, temperature, and oxygen saturation rate. The surveyor observed Nurse #2 entered two different residents' rooms to take and record Vital signs using the portable caddy. The surveyor observed the portable device not being cleaned between each resident use and the caddy device did not have the cleaners/disinfectant wipes housed on the bracket shelf. During interview on 10/2/24 at 8:12 A.M., Nurse #2 said she did not disinfect the glucometer or the vital sign caddy, but she should have. During interview on 10/2/24 at 2:57 P.M., The Assistant Director of Nurses, who was also the designated Staff Development Coordinator and the Infection Control Nurse, said shared resident equipment should be disinfected/cleaned before use for another resident.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 48990 Based on observation and interview, the facility failed identify and minimize areas of possible entrapment in resident beds. Specifically: 1.) For Resident #62, out of a total of 19 sampled residents, the facility failed to minimize a gap between the headboard and mattress end of the Resident's bed. 2.) The facility failed to conduct routine inspections of all bed frames and mattresses to identify possible areas of entrapment for 72 resident beds. Findings include: Review of the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/2006, indicated: The term entrapment describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Resident entrapments may result in deaths and serious injuries. There are 7 zones of bed entrapment: Zone 1 (within the rail), Zone 2 (under the rail), Zone 3 (between rail and mattress), Zone 4 (Under the rail, at the ends of the rail), Zone 5 (between split bed rails), Zone 6 (between the end of the rail and the side edge of the head or foot board) and Zone 7 (Between the head or foot board and the mattress end). Review of guidance from the FDA titled Recommendations for Health Care Providers about Bed Rails, dated 07/09/2018, included: -Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and/or depth, the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. -Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. 1.) Resident #62 was admitted to the facility in June 2023 with diagnoses including dementia and adult failure to thrive. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/10/24, indicated Resident #62 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. This MDS also indicated Resident #62 was able to move from lying to sitting on side of bed with supervision or touching assistance and required partial/moderate assistance to roll left and right in bed. On 10/1/24 at 8:38 A.M., the surveyor observed Resident #62 in bed with a wide gap in Zone 7 (between the head or foot board and the mattress end). (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 11:19 A.M., the Maintenance Director and the surveyor observed Resident #62's bed. The Maintenance Director had a bed system measuring device, which he said should be used to measure Zone 7 (between the head or foot board and the mattress end) of all bedframes in the building to ensure there were no gaps wide enough for a human head to become entrapped in. The Maintenance Director said the white area on this bed system measuring device represents the average size of a human head. During a measurement using the bed system measuring device, the white area of the device (which represents the average size of a human head), passed freely between the mattress and headboard in Zone 7. The Maintenance Director said the mattress was too small because the gap was wide enough for a human head to become entrapped in, and the gap should have been minimized by inserting a mattress extender but was not. The Maintenance Director said the facility had never measured this bed. Review of facility's binder titled Entrapment Log failed to indicate Resident #62's bed had ever been measured for risk of entrapment. During an interview on 10/2/24 at 12:37 P.M., Nurse #1 said there should never be a gap wide enough to fit a human head between the head or foot board and the mattress end. Nurse #1 said any gap that could fit a human head should be minimized by inserting a mattress extender to prevent entrapment. During an interview on 10/2/24 at 12:40 P.M., the Assistant Director of Nursing (ADON) said there should never be a gap wide enough to fit a human head between the head or foot board and the mattress end. The ADON said any gap that could fit a human head should be minimized by inserting a mattress extender or a bolster to prevent entrapment. During a follow up interview on 10/2/24 at 12:58 P.M., the Maintenance Director said every time a new mattress is placed on an existing bed frame, it should be measured to ensure the mattress fits and does not have any gaps. The Maintenance Director said Resident #62 had a new bed frame delivered a few months ago without a mattress and the facility put a different mattress on the bed frame. The Maintenance Director said the facility never measured to ensure the mattress fit and did not have any gaps but should have. During an interview on 10/2/24 at 1:34 P.M., the Administrator said there should never be a gap wide enough to fit a human head in Zone 7 (between the head or foot board and the mattress end). The Administrator said bed gaps should have been monitored and any gaps should have been minimized but was unable to provide information on how the facility ensured bed gaps were identified and minimized for all beds in the facility. During an interview on 10/2/24 at 2:48 P.M., the Director of Clinical Operations said the facility did not have any policies related to bed inspections, bed safety, or entrapment. The Director of Clinical Operations said bed gaps should have been monitored and any gaps should have been minimized but was unable to provide information on how the facility ensured bed gaps were identified and minimized for all beds in the facility. 2.) Review of facility's binder titled Entrapment Log failed to indicate 72 resident beds (out of 91 total resident beds) had been measured since 2019. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/2/24 at 12:58 P.M., The Maintenance Director said the facility only conducts inspections to measure for areas of possible entrapment on beds with side rails. The Maintenance Director said the facility had 72 beds without side rails that had not been inspected or measured to identify areas of possible entrapment, and these beds were only monitored for function. The Maintenance Director said beds without side rails could have gaps in Zone 7 (between the head or foot board and the mattress end) which could increase the risk for entrapment, but that the facility does not have a process in place to inspect, monitor, or identify possible entrapment for any beds without side rails. During an interview on 10/2/24 at 1:34 P.M., the Administrator said there should never be a gap wide enough to fit a human head in Zone 7 (between the head or foot board and the mattress end). The Administrator said all beds should be monitored to identify areas of possible entrapment but was unable to provide information regarding inspections of any beds that do not have side rails to identify areas of possible entrapment. During an interview on 10/2/24 at 2:48 P.M., the Director of Clinical Operations said the facility does not have any policies related to bed inspections, bed safety, or entrapment. The Director of Clinical Operations said all beds should be monitored to identify areas of possible entrapment but was unable to provide information regarding inspections of any beds that do not have side rails to identify areas of possible entrapment.