| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225268 | A. Building<br>B. Wing | 07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Newton | 2101 Washington Street<br>Newton, MA 02462 |

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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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671<br><br>Based on record review and interviews, the facility failed to formulate an advance directive for one Resident (#10) out of a total sample of 27 residents. Specifically, the facility failed to initiate the court process to renew an expired [NAME] guardianship (a treatment plan that states that antipsychotic medications are so intrusive, and their side effects are potentially so severe, that a court must approve them).<br><br>Findings include:<br><br>Review of the facility policy titled Advanced Directives, dated as revised on [DATE], indicated the following:<br><br>-Advance care planning- a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions.<br><br>- Advance Directives-a written instruction, such as a living will or durable power of attorney for healthcare, recognized by state law (whether statutory or as recognized by the courts of the stat), relating to the provisions of health care when the individual is incapacitated.<br><br>-Legal Representative (i.e., substitute decision-maker, proxy, agent) - a person designated and authorized by an advance directive or state law tot make treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.<br><br>Determining Existence of Advanced Directive<br><br>1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and /or his or her legal representative, about the existence of any written advance directives.<br><br>If the Resident Has an Advanced Directive<br><br>1. If the resident or the resident's representative as executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintain in the same section of the residents medical record and are readily retrievable any facility staff.<br><br>(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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. The residents wishes are communicated to the residents direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meetings.<br><br>4. The care plan for each resident is consistent with his or her documented treatment preferences and/or advance directive.<br><br>7. The interdisciplinary team will review annually with the resident his or her advance directive to ensure that such directive are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record.<br><br>8. Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may required new documents if changes are extensive. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan.<br><br>Resident #10 was admitted to the facility in [DATE] with diagnoses including suicidal ideations, major depressive disorder, post-traumatic stress disorder, schizoaffective disorder, and panic disorder.<br><br>Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated intact cognition. Further review of the MDS indicated Resident #10 is taking three high-Risk medications, Antipsychotic, Antianxiety and Antidepressant and has a legal guardian in place.<br><br>Review of Resident #10's [DATE] physician's orders indicated the following:<br><br>-Clozapine Oral Tablet 50 MG (Clozapine) Give 3 tablet by mouth at bedtime for Schizophrenia. Dated, [DATE].<br><br>Review of the medical record indicated that the Resident has a legal guardian and a [NAME] monitor.<br><br>Further review of Resident #10's medical record indicated a letter for order of appointment of successor temporary guardian with authority to monitor treatment with antipsychotic medication from the court dated [DATE].<br><br>Further review of Resident #10's medical record failed to indicate a [NAME] treatment plan with permission from the court to treat Resident #10 with antipsychotic medications since his/her admission. No copy of the [NAME] treatment plan was provided to the surveyor throughout survey.<br><br>During an interview on [DATE] at 9:51 A.M., the Director of Nurses (DON) said [NAME] and psychotropic consents must be tracked and signed yearly before they expire. The DON said this process should take place prior to the expiration dates.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 9:53 A.M., the Regional Nurse said the Social Worker is responsible for tracking all [NAME] treatment plans and start the renewal process in advance before they expire. The Director of Nurses said starting the renewal process in advance ensures that the treatment plan is renewed in a timely manner so that the Resident can continue to receive their antipsychotic medication as ordered. She said the Social Worker started the renewal process today.<br><br>During an interview on [DATE] at 10:00 A.M., the Social Worker said Resident #10's [NAME] treatment plan had expired on [DATE] and said she was waiting to hear back from the court. The Social Worker showed the surveyor emails regarding expired orders dated February 23, 2024, indicating the following:<br><br>-Treatment orders have expired a while ago. Will need to file new expansions for [NAME] authority.<br><br>-The following documents needed: Medical Certificate (with medication list enclosed), Clinician's Affidavit as to competency and treatment, and Signature page for petition to expand.<br><br>The Social Worker said [NAME] forms and psychotropic medications need to be reviewed on admission, yearly and when new medications are added. The Social Worker said she will email or mail out forms to the responsible party 30 days prior to expiration. The Social Worker said she did not have a copy of the [NAME] form because it had expired in 2018.<br><br>During an interview on [DATE] at 2:56 P.M., Resident #10's Legal Guardian said she has been trying to update the [NAME] information but has been unsuccessful in obtaining needed information from the facility and it has caused a delay in submission of paperwork to the court. The Legal Guardian said she has been trying for months and sent numerous email correspondence to the facility regarding clarification on physician orders and documents that were non legible. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846<br><br>Based on observations, record review and interview the facility failed to implement a person centered care plan for two Residents (#82, #31) out of a total sample of 27 residents. Specifically,<br><br>1. For Resident #82 who was assessed as an elopement risk, the facility failed to ensure a wander guard was in place,<br><br>2. For Resident #31, that facility failed to ensure his/her heels were offloaded and that his/her glasses were donned daily.<br><br>Findings include:<br><br>1. Resident #82 was admitted to the facility in August 2021 with diagnoses that included dementia, major depressive disorder, and Alzheimer's disease.<br><br>Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Further review of the MDS indicated Resident #33 does wander 1 to 3 days.<br><br>Review of Resident #82's nursing progress note, dated 7/18/24, indicated wander guard placed on L/ankle (left ankle) every shift related to Alzheimer's disease, attempting to leave unit unassisted removed by resident.<br><br>On 7/23/24 at 9:00 A.M. and 1:02 P.M., the surveyor observed Resident #82 without a wander guard on his/her ankle.<br><br>On 7/24/24 at 8:58 A.M. and 12:37 P.M., the surveyor observed Resident #82 without a wander guard on his/her ankle.<br><br>Review of Resident #82's quarterly elopement assessment, dated 5/15/24, indicated:<br><br>- Does the patient ambulate independently, with or without the use of an assistive device (including a wheelchair)? Answer - Yes.<br><br>- Does the patient have a history of attempting to leave the facility without needed supervision? Yes - twice.<br><br>- Has the patient verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door? Yes.<br><br>- Does the patient exhibit any wandering behavior? Yes.<br><br>- At risk for elopement (implement plan of care for unsafe wandering/exit seeking behavior) - Continue with current care plan and interventions.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #82's wandering care plan, dated 3/9/24, indicated:<br><br>- Wander guard on left ankle.<br><br>- Check for replacement function of security bracelet as indicated.<br><br>Review of Resident #82's active CNA Kardex, dated 7/23/24, indicated:<br><br>- Behavior Tracking: Wandering.<br><br>- WANDERGUARD/ALARMING BRACELET (FYI).<br><br>- When exhibiting exit seeking behavior, redirect to an appropriate area and provide supervision.<br><br>During an interview on 7/25/24 at 9:06 A.M., Certified Nurse Aide (CNA) #1 said Resident #82 does try to leave the unit at times because he/she wants to go home. CNA #1 said the Resident should have a wander guard on. CNA #1 and the surveyor observed Resident #82 in bed without a wander guard in place.<br><br>During an interview on 7/25/24 at 9:18 A.M., Unit Manager #1 said Resident #82 should have a wander guard on as ordered as he/she is an elopement risk. Unit Manager #1 said if the Resident removes the wander guard the nursing staff should attempt to re apply the wander guard and document in a nursing progress note. Unit Manager #1 said she was unaware Resident #82 did not have his/her wander guard on.<br><br>During an interview on 7/25/24 at 10:25 A.M., the Director of Nurses (DON) said Resident #82 should have a wander guard on as ordered as he/she is an elopement risk. The DON said if the Resident refused the wander guard placement nursing should be documenting the re attempt to place the wander guard.<br><br>45343<br><br>2a. Resident #31 was admitted to the facility in August 2015 with diagnoses that included pulmonary embolism, presence of cerebral spinal fluid drainage device, and hydrocephalus.<br><br>Review of Resident #31's most recent Minimum Data Set (MDS) assessment, dated 6/14/24, indicated that Resident #31 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating he/she had a severe cognitive impairment. The MDS assessment also indicated that Resident #31 requires dependent assistance for bed mobility and is at risk for developing pressure ulcers.<br><br>On 7/23/24 at 12:38 P.M., 7/24/24 at 8:36 A.M., 9:17 A.M., and 1:28 P.M., and 7/25/24 at 9:05 A.M., the surveyor observed Resident #31 lying in bed with his/her heels directly on the mattress.<br><br>Review of Resident #31's physician's order, dated 7/11/19, indicated: Off load pressure heels when in bed, every shift for wound healing.<br><br>During an interview on 7/25/24 at 9:23 A.M., Nurse #4 said that Resident #31 should have his/her heels elevated while in bed per the physician's order.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 7/25/24 at 10:50 A.M., the Director of Nursing (DON) said that she would expect that staff offload Resident #31's heels as ordered.<br><br>2b. Resident #31 was admitted to the facility in August 2015 with diagnoses that included pulmonary embolism, presence of cerebral spinal fluid drainage device, and hydrocephalus.<br><br>Review of Resident #31's most recent Minimum Data Set (MDS) assessment, dated 6/14/24, indicated that Resident #31 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating he/she had a severe cognitive impairment. Further review of the MDS assessment indicated Resident #31 has adequate vision with corrective lenses.<br><br>During an interview on 7/23/24 at 12:39 P.M., Resident #31 said he/she has a hard time seeing without his/her eyeglasses. Resident #31 said he/she has eyeglasses but has not worn them recently.<br><br>On 7/23/24 at 8:07 A.M., and 12:39 P.M., 7/24/24 at 8:37 A.M., 9:17 A.M., and 1:28 P.M., and 7/25/24 at 9:05 A.M., the surveyor observed Resident #31 lying in bed without wearing his/her eyeglasses.<br><br>Review of Resident #31's physician order, dated 6/4/21, indicated: Glasses to be put on in the morning and removed at bedtime, two times a day.<br><br>Review of Resident #31's vision care plan, revised 6/7/18, indicated:<br><br>-Eye exam consult as needed.<br><br>-Glasses (FYI)<br><br>-Report any signs and symptoms of infection such as drainage, redness, complaints of itching, pain, etc.<br><br>During an interview on 7/25/24 at 9:23 A.M., Nurse #4 said that Resident #31 has his/her glasses on his/her bedside table, and we put them on him/her in the morning. Nurse #4 said the physicians' orders should be followed as ordered.<br><br>During an interview on 7/25/24 at 10:52 A.M., the Director of Nursing (DON) said that she would expect staff to follow the doctors' orders for Resident #31's eyeglass wearing schedule.<br><br>Review of Resident #31's medical record failed to indicate he/she refused to wear his/her eyeglasses. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671<br><br>Based on observations, record review, policy review and interviews, the facility failed to provide supervision with meals for one Resident, (#390) out of a total sample of 27 residents.<br><br>Findings include:<br><br>Review of the facility policy titled Activities of Daily Living (ADL) Supporting, dated as revised March 2018, indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: D. dining (meals and snacks).<br><br>Resident #390 was admitted to the facility in July 2024 with diagnoses including acute respiratory failure with hypoxia, pneumonia, metabolic encephalopathy, and hyperlipidemia.<br><br>Review of the Minimum Data Set (MDS) assessment, dated 7/27/2024, indicated Resident #390 did not have a Brief Interview for Mental Status (BIMS) assessment completed.<br><br>On 7/23/24 at 8:06 A.M., the surveyor observed Resident #390 in bed, with their privacy curtain pulled halfway across the bed with his/her breakfast attempting to eat the meal. The Resident was not visible from the hallway, no staff were present in the room throughout the breakfast meal.<br><br>On 7/23/24 at 12:31 P.M., the surveyor observed Resident #390 in bed, with their privacy curtain pulled halfway across the bed with his/her lunch attempting to eat the meal. The Resident was not visible from the hallway, no staff were present in the room throughout the lunch meal.<br><br>On 7/24/24 at 8:10 A.M., the surveyor observed a staff member deliver a breakfast tray to Resident #390 and exit the Residents room. Resident #390 was observed in bed, with their privacy curtain pulled halfway across the bed with his/her breakfast attempting to eat the meal. The Resident was not visible from the hallway, no staff were present in the room throughout the breakfast meal.<br><br>Review of Resident #390's Diet care plan, dated 7/22/24, indicated Will tolerate diet, texture and fluid consistency without signs and symptoms of aspiration.<br><br>Review of Resident #390's hospital nutritional assessment dated [DATE], indicated inadequate oral intake, regular adult diet, aspiration precautions.<br><br>Review of Resident #390's Admission nursing evaluation dated 7/21/24 indicated the following:<br><br>-Aspiration Precautions<br><br>-Regular Diet<br><br>-Thin Liquids<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Requires one person assistance with eating<br><br>Review of Resident #390's speech therapy evaluation dated 7/22/24, indicated the following:<br><br>-Seen by speech therapy diet downgraded to Regular, Pureed (PU4), transitional food allowed, thin Liquids.<br><br>During an interview on 7/24/24 at 11:27 A.M., Certified Nursing Assistant (CNA) #2 said Resident #390 is a feeder and requires supervision and one to one assistance with eating<br><br>During an interview on 7/24/24 at 11:44 A.M., Unit Manager #2 said Resident #390 needs supervision due to aspiration precautions and said she expects staff to supervise him/her during meals.<br><br>During an interview on 7/24/24 at 11:49 AM Speech Therapist #1 said she completed an evaluation for nutrition and safety and said Resident #390 requires one to one feeding assistance due to aspiration precautions. The speech therapist said she expects the care plan to be updated and that Resident #390 was downgraded to a puree diet and should have been supervised during meals.<br><br>During an interview on 7/24/24 at 1:54 P.M. with the Director of Nursing (DON) and Regional Nurse #2, the DON said Resident #390 should not be eating unsupervised and requires one to one supervision. The Regional Nurse #2 said she expects the care plan to be updated and supervision is required for Residents on aspiration precautions. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>48671<br><br>Based on observation and interview, and record review, the facility staff failed to provide the necessary services to ensure 1 Resident (#390) out of a total sample of 27 Residents, was able to effectively communicate his/her needs.<br><br>Findings include:<br><br>Review of the facility policy titled Communication With Persons With Limited English Proficiency, dated as revised 10/21/16, indicated the following:<br><br>-It is the policy of this center to take responsible steps to ensure that persons with limited English proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits.<br><br>-Ensure meaningful communication with LEP patient/residents and their authorized representatives involving their medical conditions and treatment.<br><br>-Provide for communication of information contained in vital documents including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forums, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served. The patient residents, and their families will be informed of the availability of such assistance free of charge<br><br>-Provide language assistance through the use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services.<br><br>Purpose of this policy is to:<br><br>-Provide meaningful communication and access for patients/residents who have LEP<br><br>-Ensure compliance with federal regulatory requirements<br><br>Process:<br><br>1. Identifying LEP Persons and Their Language<br><br>-This center will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or I speak cards, available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients and residents or family members the language used to communicate with the LEP person will be included as part of the record.<br><br>2. Obtaining A Qualified Interpreter<br><br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The Social Worker or designee is/are responsible for:<br><br>(a) maintaining an accurate and current list showing the name, language, phone number, and hours of availability of bilingual staff;<br><br>(b) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language.<br><br>3. Providing Written Translations<br><br>(a) When translation of vital documents is needed, each unit in the Center will submit documents for translation into frequently encountered languages to the Social Worker or designee. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.<br><br>Resident #390 was admitted to the facility in July 2024 with diagnoses including acute respiratory failure with hypoxia, pneumonia, metabolic encephalopathy, and hyperlipidemia.<br><br>Review of the Minimum Data Set (MDS) assessment, dated 7/27/2024, indicated Resident #390 did not have a Brief Interview for Mental Status (BIMS) assessment completed.<br><br>Review of Resident #390's communication care plan dated, 7/21/24, indicated the following:<br><br>-Resident has difficulty understanding/communicating related to lack/limited use/understanding of English.<br><br>- Will speak in a manner that can be understood.<br><br>- Will use an alternative method facility interpreter to communicate needs/wants.<br><br>- Utilize interpreter (specify language/how to contact) as needed.<br><br>- Communicate using yes/no questions and responses when able.<br><br>Review of Resident #390's active ADL flow sheet (form indicating type and level of care assistance needed), failed to indicate Resident #390's primary language is Cantonese.<br><br>Review of Resident #390's admission evaluation documentation dated, 7/21/24, indicated the following:<br><br>-Language barrier<br><br>-Unable to comprehend<br><br>Review of Resident #390's hospital discharge paperwork dated 7/21/24, indicated, Resident #390 speaks Cantonese and translator services were used.<br><br>(continued on next page) |

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| Care One at Newton | 2101 Washington Street<br>Newton, MA 02462 |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the laminated care sign hanging in Resident #390's room (in room sign used to communicate ADL information) failed to indicate Resident #390's primary language is Cantonese.<br><br>During an observation on 7/23/24 at 7:58 A.M., Resident #390 was observed sitting up in bed. Certified Nursing Assistant (CNA) #3 entered the room and was observed walking over to the Resident, adjusted the top blanket and then walked out of the room. CNA #3 did not knock on the door, introduce herself, or speak to Resident #390 during the observation.<br><br>During an observation on 7/23/24 at 12:20 P.M., the survey observed CNA #2 deliver a lunch tray to Resident #390. The CNA was observed speaking to Resident #390 in English. Resident #390 did not try to engage or acknowledge CNA #2.<br><br>During an observation on 7/24/24 at 8:12 A.M., Resident #390 was observed sitting up in bed. CNA #2 was observed asking the Resident if he/she wanted more coffee. Resident #390 did not try to engage or acknowledge CNA #2.<br><br>During an observation on 7/24/24 at 11:28 A.M., Resident #390 was observed sitting up in bed while CNA #1 was observed moving items around on the Residents overbed table and then walked out of the room. CNA #1 was not observed speaking to Resident #390 during throughout the observation<br><br>During an interview on 7/24/24 at 12:38 P.M., CNA # 2 said she can't understand the Resident because he/she does not speak English. When the surveyor asked CNA #2 how she communicates with Resident #390 she said the facility has an interpreter but did not use it to speak with the Resident.<br><br>During an interview on 7/24/24 at 2:17 P.M., Nurse #2 said Resident #49 doesn't communicate very well but can understand if you ask questions in his/her language and will nod his/her head.<br><br>During an interview on 7/24/24 at 1:39 P.M., Unit Manager #2 said Resident #390 speaks Cantonese or Chinese and requires an interpreter. Unit Manager #2 said the care plan needs to be updated with the correct language and that staff should call the translator line and use pictures from the communication binder on the unit. Unit Manager #2 said she expects staff to communicate with Resident #390 when providing care.<br><br>During an interview on 7/24/24 at 1:41 P.M., Director of Nurses (DON) said Resident #390 requires translation services and staff should be utilizing translation services to communicate with the Resident. The DON said the communication care plan should be followed by all staff and she expects staff to use the communication binder on the unit to assist with translation.<br><br>During an interview on 7/25/24 at 9:48 A.M., Regional Nurse #1 said she expects staff to communicate with Residents and utilize translations services as indicated. Regional Nurse #1 said the plan of care needs to be updated with the language the Resident speaks and followed when providing care. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876<br><br>Based on observation, interview and record review, the facility failed to administer Total Parenteral Nutrition (a form of administering nutrition through an intravenous (IV) line where nutrients enter through the veins and travel through the blood vessels to the entire body) as ordered by the physician for one Resident (#121) out of a total of 27 sampled residents.<br><br>Findings include:<br><br>Review of the facility's Parenteral Nutrition Standard of Care policy, dated June 2016 indicated:<br><br>Purpose: To provide for the safe and effective administration of parenteral nutrition.<br><br>I Total Parenteral Nutrition (TPN): This form of nutritional therapy provides sufficient nutrients to satisfy total nutritional requirements.<br><br>IV. Due to the dextrose component, abruptly stopping continuous infusions can lead to hypoglycemia.<br><br>XII. The parenteral nutrition form needs to be signed by the physician and faxed to the pharmacy before 2pm if same day delivery is requested.<br><br>XII. The physician, dietitian or pharmacist will complete the PN (parenteral nutrition) form, the nurse will get the physicians' signature and fax it to the IV pharmacy. Verbal or telephone orders from a nurse will not be accepted.<br><br>Resident #121 was admitted to the facility in May 2024 with diagnoses including peritoneal abscess, adult failure to thrive and cognitive communication deficit.<br><br>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #121 scored 11 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating he/she is moderately cognitively impaired and requires assistance with bathing and dressing. The MDS also indicated Resident #121 received parenteral/IV feeding.<br><br>Review of Resident #121's care plans indicated:<br><br>Focus: Diet, 5/7/24<br><br>Goal: Will tolerate parenteral feeding<br><br>Interventions: Diet texture; regular. Liquid consistency; thin. Parenteral nutrition per physicians orders.<br><br>Focus: Nutritional status; need for TPN for nutritional support, 5/7/24<br><br>Goal: Will tolerate diet textures/consistency.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interventions: Administer medications as ordered. Administer vitamin/mineral supplements as ordered.<br><br>Review Resident #121's active physician's orders indicated: TPN Custom Solution: Infuse TPN at a Rate of 69 ml (milliliters) x one hr (hour). AND Use 133 ml/hr (milliliters per hour) intravenously in the evening for Nutrition TPN run for 133 ML/HR x14 hrs. AND Use 69 ml/hr intravenously in the morning for Nutrition TPN at 69 ML x one Hr then STOP, initiated 6/14/24.<br><br>Calculating the physicians order indicated Resident #121 should receive a total of 2000 mls of solution.<br><br>On 7/24/24 at 7:29 A.M., the surveyor observed Resident #121 in bed. The surveyor observed his/her TPN running, and the infusion rate was 90 mls per hour. Resident #121 said he/she thought he/she didn't need the TPN anymore.<br><br>On 7/25/24 at 7:07 A.M., the surveyor observed Resident #121 in bed. The surveyor observed the TPN running, and the infusion rate was 90 mls per hour. Observations of the TPN solution bag indicated the total amount of solution contained was 1000 mls. (Resident #121's orders indicated he/she was supposed to receive a total of 2000 mls of solution.) The TPN solution bag also indicated: Flow rate: 50 mL/hour for 1 hour. 90 ml/hour for 10 hours. 50 ml for 1 hour.<br><br>During an interview on 7/25/24 at 7:23 A.M., Nurse #2 said he/she worked the evening shift, (3:00 - 11:00 P. M.), and hung Resident #121's TPN. Nurse #2 said that he follows the instructions on the bag regarding the infusion rate.<br><br>During an interview on 7/25/24 at 7:32 A.M., Nurse #3 said she worked the overnight shift last night, (11:00 P. M. - 7:00 A.M.). Nurse #3 said she did not look at or touch Resident #121's TPN.<br><br>On 7/25/24 at 7:32 A.M., the surveyors heard Resident #121's TPN machine beeping; which indicated the solution had fully infused; approximately one hour and thirty minutes early.<br><br>During an interview on 7/25/24 at 7:35 A.M., Unit Manager #3 said Resident #121's TPN infusion should be running as ordered. Unit Manager #3 said every shift nurse should be checking the TPN infusion to ensure it is running correctly and as ordered. Unit Manager #3 said Resident #121's rate should not be set to 90 ml/hr because the doctor's order indicates otherwise.<br><br>Review of the Dietitian's Notes indicated:<br><br>6/28/2024 12:03 P.M.: Pt (patient) continues on nocturnal TPN. Plan to decrease TPN slowly before discharge. Taper will begin this Sunday. New order sent to pharmacy. Adjust order when TPN arrives. Continue to encourage PO (by mouth) intake. Slight favorable wt (weight) gain. Continue with weekly weights. Will continue to monitor. RD (Registered Dietitian) available PRN (as needed).<br><br>7/5/2024 10:55 A.M.: Pt continues on nocturnal TPN. Continuing to decrease TPN slowly before discharge . Taper has gone from 1600 calories, to 1300 cals, now current TPN 950 cals. Plan to decrease TPN one more time before discontinuing it, when medically appropriate. Continue to encourage PO intake. Slight favorable wt gain. Continue with weekly weights. Will continue to monitor. RD available PRN.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 7/12/2024 7:45 A.M.: Pt continues on nocturnal TPN. Continuing to decrease TPN slowly before discharge . TPN tapered to now 740 total calories. Labs sent to pharmacy weekly. Continue to encourage PO intake. Slight favorable wt gain. Continue with weekly weights. Will continue to monitor. RD available PRN.<br><br>7/24/2024 8:26 A.M.: Pts last bag of TPN will be hung tonight and then d/c per plan of care. MD and family aware. TPN has been slowly tapered. Labs sent to pharmacy weekly. Continue to encourage PO intake. EMR shows favorable +5.5# wt gain in 1 month. Continue with weekly weights. Will continue to monitor. RD available PRN.<br><br>The physician's orders failed to indicate any changes to reflect that Resident #121's TPN had been tapered since 6/13/24.<br><br>During an interview on 7/25/24 at 10:49 A.M., the Dietitian said that she and the pharmacy representative have been in communication regarding the appropriate measures to taper Resident #121 off of TPN. The Dietitian said that her notes related to the decrease in calories also would indicate that Resident #121's TPN solution had also decreased in volume. The Dietitian was not aware that Resident #121's TPN orders had not been changed since 6/14/24. The Dietitian said that when the TPN solution bags arrive at the facility, they should be checked to ensure the solution infusion rates on the bag match the physician orders. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>41105<br><br>Based on record review, policy review and interview the facility failed to assess a history of trauma and failed to develop a care plan with resident specific triggers and interventions for one Resident (#62) with a diagnosis of Post Traumatic Stress Disorder (PTSD), out of a total sample of 27 residents.<br><br>Findings include:<br><br>The facility policy titled Trauma Informed Care and Culturally Competent Care, dated as revised August 2022, indicated the following:<br><br>Resident Screening<br><br>1. Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events.<br><br>2. Utilize screening tools and methods that are facility-approved, competently delivered, culturally relevant and sensitive.<br><br>3. Screening may include information such as:<br><br>a. trauma history, including type, severity and duration;<br><br>b. depression, trauma-related or disassociative symptoms;<br><br>d. concerns with sleep or intrusive experiences;<br><br>e. behavioral, interpersonal or developmental concerns;<br><br>f. historical mental health diagnosis;<br><br>g. substance abuse;<br><br>h. protective factors and resources available; and<br><br>i. physical health concerns.<br><br>4. Utilize initial screening to identify the need for further assessment and care.<br><br>-Resident Assessment<br><br>1. Assessment involved an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments.<br><br>3. Use assessment tools that are facility-approved and specific to the resident population.<br><br>-Resident Care Planning<br><br>1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate.<br><br>Resident #62 was admitted to the facility in January 2023 and had diagnoses that include Post Traumatic Stress Disorder (PTSD) and bipolar disorder.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 6/28/24, indicated the Resident was assessed by staff to have severely impaired cognition. The MDS further indicated Resident #62 has an active diagnosis of PTSD.<br><br>Review of Resident #62's current care plans indicated the following care plan:<br><br>-FOCUS: At risk for behavior symptoms related to Mental illness (PTSD)<br><br>Exhibits behaviors of providing other residents food items that is not appropriate for diets.<br><br>Dated as initiated 4/2/24 by the Director Of Nursing and revised 5/17/24 by the Social Worker.<br><br>-GOAL: Will reduce risk of behavioral symptoms.<br><br>Dated as initiated 4/2/24 by the Director Of Nursing and revised 7/9/24 by the MDS Coordinator.<br><br>-INTERVENTIONS:<br><br>-Ensure nursing staff redirect Resident #62 as appropriate.<br><br>-Observe for mental status/behavioral changes when new medication started or with changes in dosage.<br><br>-Psych referral as needed.<br><br>-Use consistent approaches when giving care.<br><br>The record failed to indicate a PTSD assessment was completed or that an individualized care plan related to Resident #62's PTSD was developed.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the facility Social Worker (#1) on 7/25/24 at 9:49 A.M., she said that the facility does not have an assessment tool to assess residents for a history of trauma. SW #1 explained that the current process in place is that when a resident admits with a diagnosis of PTSD she will meet with the resident one on one and provide support. A care plan would also be developed that includes what the trauma is and indicate resident specific triggers. SW #1 said that if the resident does not speak English she will use the language line to obtain this information or if the resident has impaired cognition she will speak to the family. SW #1 reviewed Resident #62's care plan and said that it does not indicate what the trauma is that led to the PTSD diagnosis nor are there any resident specific triggers or interventions in place, but that there should be. SW #1 said that Resident #62's son is involved and would provide that information but that she cannot recall if she discussed it with him.<br><br>During an interview with the Director of Nursing on 7/25/24 at 11:49 PM she said that she was unsure if the facility had an expectation regarding how PTSD is managed and would defer to the facility's Regional Nurse.<br><br>During an interview with the facility's Regional Nurse on 7/25/24 at 12:56 P.M., she said that the facility does not have a PTSD assessment and that it is embedded into the Social Service admission assessment.<br><br>During a follow-up interview with the Regional Nurse and Regional Case Manger on 7/25/24 at 1:08 P.M., they said that the Social Service Admission Assessment was never done for Resident #62 and that they had reviewed the PTSD care plan for Resident #62 and that it was not complete or appropriate |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846<br><br>Based on observations, interviews and policy review the facility failed to ensure medication carts were locked on one of four nursing units.<br><br>Findings include:<br><br>Review of the facility policy titled Medication Labeling and Storage, not dated, indicated:<br><br>4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.<br><br>On 7/23/24 from 8:45 A.M. to 8:48 A.M., the surveyor observed the right side [NAME] Unit medication cart unlocked and unsupervised.<br><br>On 7/23/24 from 12:23 P.M. to 12:36 A.M., the surveyor observed the right side [NAME] Unit medication cart unlocked and unsupervised.<br><br>During an interview on 7/25/24 at 10:02 A.M., Nurse # said medication carts should be locked at all times if the nurse is not present at the cart.<br><br>During an interview on 7/25/24 at 10:12 A.M., Unit Manager #3 said medication carts should be locked at all times if the nurse is not present at the cart.<br><br>During an interview on 7/25/24 at 10:25 A.M., the Director of Nurses (DON) said the expectation is that if a nurse is not present at their medication cart then it should be locked. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876<br><br>Based on observation, record review and interview, the facility failed to ensure physicians orders were written correctly related to oxygen (02) for one Resident (#14) of a total of 27 sampled Residents.<br><br>Findings include:<br><br>Resident #14 was admitted to the facility in February 2020 with diagnoses including cancer and diabetes.<br><br>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #14 scored 12 out of a possible 15 on the Brief Interview for Mental Status Exam indicating he/she is cognitively intact. The MDS also indicated he/she requires assistance with transfers and bathing and is on oxygen.<br><br>On 7/23/24 at approximately 8:45 A.M., the surveyor observed Resident #14 laying in bed asleep. Resident #14 was wearing 02 and the concentrator was set at four liters .<br><br>Review of Resident #14's physicians orders on 7/23/24 indicated the following orders: 12/11/2023, O2 via aerosolized trach mask three LPM (Liters per minute) of oxygen<br><br>On 7/24/24 at 8:42 A.M. and 7/25/24 at 8:20 A.M., the surveyor observed Resident #14 asleep in bed wearing 02 set at four liters.<br><br>Review of the Respiratory Therapists (RT) notes from June 2024 through July 2024 indicated Resident #14 was on four liters of oxygen and unable to be weaned down.<br><br>During an interview on 7/25/24 at 8:21 A.M. the Respiratory Therapist (RT) said that Resident #14 was hospitalized earlier in the year (May 2024) and upon his/her return to the facility needed to be on four liters of oxygen. The surveyor and the RT then reviewed Resident #14's physicians orders and the RT said that Resident #14's physicians orders should indicate he/she requires four liters of oxygen. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>48671<br><br>Based on observation, interview, record and policy 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 transmission of communicable diseases and infections. Specifically, the facility failed to:<br><br>1) ensure staff utilized the appropriate personal protective equipment prior to entering resident rooms requiring transmission-based precautions for Resident (#22) with Clostridium difficile (a contagious bacteria that causes severe diarrhea and inflammation of the colon);<br><br>2) ensure staff performed hand hygiene after exiting a room identified as being on contact precaution for Clostridium difficile (C. difficile) per facility policy and;<br><br>3. ensure nursing staff performed hand hygiene appropriately during the medication administration task.<br><br>4) failed to ensure staff performed hand hygiene appropriately to prevent the potential spread of infection.<br><br>Findings include:<br><br>Review of the facility policy titled Infection Control, dated as reviewed 10/2018, indicated the following:<br><br>1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payor source.<br><br>2. The object of our infection control policies and practices are to:<br><br>a. Prevent, detect, investigate, and control infections in the facility.<br><br>b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public;<br><br>c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions;<br><br>f. Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment.<br><br>Review of the facility policy titled Clostridium difficile, dated as revised on 10/2018, indicated the following:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Measures are taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. Precautions are taken while caring for residents with C. difficile to prevent transmission to other residents.<br><br>Policy Interpretation and Implementation<br><br>3. The primary reservoirs for C. difficile are infected people and surfaces. Spores can persist on resident -care items and surfaces for several months and are resistant to some common cleaning and disinfection methods.<br><br>4. C. difficile is transmitted via the fecal-oral route. Therefor, any resident -care activity that involves contact with the residents' mouth when hands or instruments are contaminated may provide and opportunity for transmission, for example:<br><br>c. administration of oral medications<br><br>5. Steps toward prevention and early intervention include:<br><br>a. ongoing surveillance of CDI<br><br>b. increasing awareness of symptoms and risk factors among staff, residents and visitors;<br><br>c. considering C. difficile in differential diagnoses, especially in residents with symptoms or risk factors;<br><br>d. frequent hand washing with soap and water by staff and residents;<br><br>e. wearing gloves when handling feces or articles contaminated with feces;<br><br>f. disinfection of items with potential fecal soiling(e.g., bedpans, commode chairs, bed rails, etc.) using a disinfecting agent recommended for C. difficile (e.g., household bleach and water solution or and EPC registered germicidal agent effective against C. difficile spores); and<br><br>g. removal of environmental sources of C. difficile (i.e., replacement of electronic thermometers with disposables).<br><br>10. Residents with diarrhea and suspected CDI are placed on contact precautions while awaiting laboratory results.<br><br>13. Residents with CDI are placed in a private room if available. If a private room is not available, residents will be cohorted with a dedicated commode for each resident.<br><br>14. When caring for residents with CDI, staff is to maintaining vigilant hand hygiene. Hand washing with soap and water is superior to ABHA for mechanical removal of C. difficile spores from hands.<br><br>Review of the facility policy titled Handwashing/Hand Hygiene, dated as edited on 3/18/24, indicated the following:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225268 | A. Building<br>B. Wing | 07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care One at Newton | 2101 Washington Street<br>Newton, MA 02462 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections.<br><br>2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, resident, and visitors.<br><br>Indications for Hand Hygiene:<br><br>1. Hand hygiene is indicated:<br><br>a. immediately before touching a resident;<br><br>c. after contact with blood, body fluids, or contaminated surfaces;<br><br>d. after touching a resident<br><br>e. after touching the residents environment;<br><br>g. immediately after glove removal<br><br>2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations.<br><br>3. Wash hands with soap and water:<br><br>a. when hands are visibly soiled; and<br><br>b. after contact with a resident with infectious diarrhea including but not limited to infections caused by norovirus, salmonella, shigella and C. difficile.<br><br>4. Single-use disposable gloves should be used:<br><br>c. when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions.<br><br>Applying and Removing Gloves<br><br>1. Perform hand hygiene before applying non-sterile gloves.<br><br>2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff.<br><br>3. When removing gloves, pinch the glove at the wrist and peep away from the hand, turning the glove inside out.<br><br>4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove.<br><br>5. Perform hand hygiene<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #22 was admitted to the facility in June 2024 with diagnoses including weakness and adult failure to thrive.<br><br>Review of the medical record for Resident #22 indicated a C. difficile sample was collected by the facility on 7/25/24 and Resident #22 was placed on contact precautions pending results.<br><br>1. On 7/25/24 at 10:40 A.M., the surveyor observed a precaution bin hanging outside Resident #22's room. The precaution bin was filled with personal protective equipment (PPE) masks, gowns, and gloves. There was a contact precaution sign outside of the room along with an enhanced barrier precaution sign placed next to the roommate's name on the wall just outside the room. The door to the room was open and a staff member could be seen standing in the room talking to Resident #22. The staff member was not wearing PPE. The Surveyor and Nurse #7 were outside the room and continued to make the following observation:<br><br>-At 10:41 A.M., the surveyor and Nurse #7 overheard the Resident say I can't go, I am constipated. I tried to dig it out with my finger just now but it's like clay. Resident #22 was observed holding up his/her index finger to show the staff member, who remained without PPE and was therefore exposed to potential pathogens<br><br>Nurse #7 failed to intervene or instruct the staff member to don the required PPE.<br><br>2. On 7/25/24 at 10:42 A.M., the surveyor observed the staff member don gloves and assist Resident #22 to wipe his/her hands with a wet washcloth. The staff member then touched the outside of a plastic bag with her gloved hand, contaminating the bag's exterior, removed her gloves, and without performing hand hygiene she touched the handle to the bedroom door, contaminating its surface, and exited the room carrying the contaminated plastic bag.<br><br>3. During the medication pass on 7/25/24 the surveyor made the following observations:<br><br>-At 10:55 A.M., Nurse #7 gathered the medications to be administered, pushed the vital sign machine into Resident #22's room and took Resident #22's vital signs. Nurse #7 was not wearing PPE. Nurse #7 handed Resident #22 his/her cup of medicine. Upon taking the medication, Resident #22 handed the contaminated cup back to Nurse #7's ungloved hand. Nurse #7 then handed Resident #22 a cup of water which he/she subsequently drank and handed back to Nurse #7's ungloved hand. Nurse #7 then used her bare hand to remove and prime one Advair Inhaler from the box for administration, and handed the inhaler to Resident #22. Resident #22 refused to administer the inhaler and handed the contaminated inhaler back to Nurse #7 who used her bare hands to close the inhaler and place it back into the box. Nurse #7 then exited the room and placed the Advair box on top of the medication cart, contaminating its surface and a few moments later without disinfecting the box placed it inside the medication cart.<br><br>During an interview on 7/25/24 at 11:00 A.M., Nurse #7 said that staff were required to wear a gown and gloves when providing care to Resident #22.<br><br>4. On 7/25/24 the following observations were made from 11:02 A.M. to 11:47 A.M.:<br><br>-At 11:02 A.M., the Director of Case Management entered Resident #22's room without wearing PPE and was observed carrying a computer tablet, cell phone, water bottle and wearing a crossbody bag.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -At 11:35 A.M., the Director of Case Management was observed standing next to Resident #22's overbed table. Her computer tablet, cell phone, and water jug were placed on top of Resident #22's overbed table. The surveyor observed the Director of Case Management touch Resident #22's tissue box and adjust the Resident's call light. At 11:37 A.M. the surveyor observed the Director of Case Management pick up the computer tablet, cell phone and green water jug and without sanitizing the items or performing hand hygiene exit Resident #22's room.<br><br>-At 11:47 A.M., Nurse #7 entered Resident #22's room without donning PPE. Nurse #7 shut off the overbed light, then without performing hand hygiene she exited the room and touched items on top of the medication cart.<br><br>During an interview on 7/25/24 at 12:15 P.M., the Director of Nurses (DON) said Resident #22 is on contact precautions pending C. difficile results and said no personal belongings should be brought into resident rooms. The DON said she expects all staff to follow PPE and hand hygiene procedures.<br><br>During an interview on 7/25/24 at 12:25 P.M., the Regional Nurse said Residents on contact precautions should have dedicated equipment and PPE must be worn at all times. The Regional Nurse said she expects staff to follow infection control practices and not bring personal items into Resident rooms.<br><br>During an interview on 7/25/24 at 12:38 P.M., the Infection Control Nurse said contact precautions must be followed and the correct PPE must be worn. The Infection Control Nurse said staff are required to follow the hand hygiene policy and must wash their hands with soap and water especially with C. difficile precautions in place. The Infection Control Nurse said all staff must follow the precaution signs placed on the door before entering resident rooms.<br><br>During an interview on 7/25/24 at 3:15 P.M., the Medical Director said he expects all staff to follow precautions posted for all residents on precautions and said transmission-based precautions and hand hygiene is absolutely paramount to patient safety. The Medical Director said staff must follow appropriate PPE and hand washing guidelines to prevent the spread of infection. |